State and Public School Life
And Health Insurance Board
Minutes
September 14, 2010

The 109th meeting of the State and Public School Life and Health Insurance Board (hereinafter called the Board), met on September 14, 2010 at 1:00 p.m. in the EBD Board Room, 501 Woodlane, Suite 500, Little Rock, AR 72201.

MEMBERS PRESENT	MEMBERS ABSENT
Janis Harrison	Dr. Joseph Thompson
John Kirtley	Robert Watson
William Goff	Lloyd Black
Shelby McCook	Bob Alexander
Renee Mallory	
Vance Strange	
Dr. Andrew Kumpuris	

Jason Lee, Executive Director, Employee Benefits Division.

OTHERS PRESENT:
George Platt, Leigh Ann Chrouch, Michelle Hazelett, Doug Shackelford, Stella Greene, Amy Tustison, Latryce Taylor, Amy Redd, Pamela Lawrence, Laurie Fowler, Sherry Bryant, Sherri Saxby, Tracy Collins, Cathy Harris, EBD; Rhonda Hill, EBD-ACHI; Barbara Melugin, Ron Deberry, ABCBS/Health Advantage; Sarah Sanders, AR Highway & Transportation Dept, Shonda Rocke, Informed Rx; Joseph Chang, Securian; Bryan Meldrum ,Dwane Tankersley; NovaSys; John Greer, Humana; Jill Johnson, UAMS-College of Pharmacy; Saintete' Martinez; Marc Watts, AR State Employee Association; Mark DeClerk, LILLY; Mona Neal, Public Service Commission; Jon Foose, Qualchoice; Diann Shoptaw, USable; Derrick Smith, Mitchell Williams Law Firm

CALL TO ORDER
Meeting was called to order by Janis Harrison, Chairman.

APPROVAL OF MINUTES
The request was made by Harrison to approve the August 10, 2010 minutes. McCook made the motion to approve minutes. Strange seconded. All were in favor. Minutes approved.

FINANCIALS *by Leigh Ann Chrouch, CFO*
Chrouch presented detailed financial statements for the Arkansas State Employees (ASE) and the Public School Employees (PSE) for July 2010 and the penalties assessed by state agencies and school districts.

QUALITY OF CARE SUBCOMMITTEE REPORT *by Scott Pace, Chairman*
Pace reported the committee met on September 1ST. The committee viewed a presentation by EBD's Health Services Officer about Healthcare Reform and Preventive Benefits. The committee was also provided with the Grade A and B Recommendations of the United States Preventative Services Task Force (USPSTF).

Pace informed the Board that the Quality committee presented the following recommendations to Benefits subcommittee for consideration.

1. **Screening for Breast Cancer (MAMMOGRAPHY)**
   The USPSTF recommends screening mammography for women with or without clinical breast examination (CBE), every 1-2 years for women aged 40 and older.

   Currently the Plan Covers - 1 mammogram per year with no age limit.

   Recommendation: Provide an annual screening mammogram for women 40 and older, and for women under the age of 40 with a family history of early breast cancer.

2. **Screening for Colorectal Cancer**
   The USPSTF recommends screening for colorectal cancer (CRC) using fecal occult blood testing (FOBT), sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.

   Currently the Plan covers: Colorectal Screening to begin at age 50: FOBT every year and one of the following: Sigmoidoscopy every 5 years – Colonoscopy every 10 years – Double-Contrast Barium Enema (DCBE) every 5 years.

   Recommendation #1: Adopt the USPSTF recommendation for screening for colorectal cancer - with the exception that the plan also include people over the age 40 with a family history of early colon cancer.

   Recommendation #2: If the examination of the utilization data for Double Contract Barium Enema (DCBE) proves minimum usage by the members of the plan, the committee recommends the removal of DCBE as part of the screening for colorectal cancer benefit.

BENEFITS SUBCOMMITTEE REPORT *by Jason Lee*
Lee reported the Benefits Subcommittee met on Friday, September 10th and discussed the following:

a. PSE open enrollment
The committee received an update on the PSE Open Enrollment period. PSE Open enrollment began on August 1st through the 31st. Lee said they had a net growth in enrollment of 1,316 primary subscribers, and a 77% increase enrollment in the HD PPO plan.

b. Early Retiree Reinsurance Program
Lee reported their application for the Early Retiree Reinsurance Program (ERRP) has been accepted and they will begin the process of submitting claims once directions are established by the federal government. The Patient Protection and Affordable Care Act created a temporary reinsurance program for sponsors of employment-based health plans that provide retiree health benefits to retirees who are over age 55 and not yet eligible for the Medicare program.

Lee said one issue has come up and they are looking for more information. It deals with the citizenship of the member and that (it appears) as if they have to verify that the member (retiree and dependent) is a citizen or legal resident of the United States.

c. Internal Appeals & External Review
In an attempt to standardize the operations of health plans throughout the country, all plans are now required to incorporate the services of Independent Review Organizations (IRO) as a resource for the member who experiences any adverse benefit determination. This is a requirement that they have been exempt from due to their ERISA exemption and governmental plan configuration but fully-insured plans have been subject to this for many years. The regulations may potentially adjust how the plan handles their internal appeals process.

d. Smoking Cessation Medication
Under our current arrangement, the tobacco cessation program is not in compliance with the new federal rules; specifically the issue around the member's 50% co-pay for Chantix and Bupropion (generic for Wellbutrin).

Under the new rules, they are required to cover tobacco counseling and therapy at no cost to the member. Nicotine replacement patches are paid at 100% by the plan but not the prescription drugs.

Recommendation: Cover all costs associated with Chantix & Bupropion for those members enrolled in the smoking cessation program subject to a 6-month prior-authorization and move the two medications to the formulary and assign a co-pay for those members electing not to participate in the smoking cessation

program. A claims report will be provided to the Benefits Committee in 6-months to measure utilization.

McCook made the motion to adopt the recommendation for smoking cessation medications. Strange seconded. Motion carried.

e. Plan limitations

Federal law requires they remove any dollar amount annual / lifetime limit on "essential" services (yet to be defined). Lee said they have identified three current benefits that fall into this category. They are the $2,000 limit for ground ambulance, $10,000 limit for durable medical equipment, and $1,000,000 for out-of-network lifetime limit.

Recommendation: Remove the durable medical equipment annual limit and the out of network lifetime limit; and convert the $2,000 annual limit for ground ambulance to a $2,000 "per-trip" limit. A claims report will be provided to the Benefits Committee in 6-months to measure utilization.

McCook made the motion to adopt the recommendation for durable medical equipment, out of network lifetime limit and ground ambulance. Strange seconded. Motion carried.

f. Preventative Care Services

A series of recommendations were referred to the Benefits Committee by the Quality Committee dealing with the new federal requirements for preventative care services. The recommendation was made to adhere to the new A & B rated recommendations with regard to frequency and individual age with two additional considerations:

- Annual screening mammography for women under age 40 with a family history of early breast cancer *and* that screening mammograms for women under who have no family history be considered for exclusion under the plan as a non-covered service.

- Screenings for Colorectal Cancer for men or women age 40 to 50 with a history of early colon cancer, and remove DCBE as a preventative care service.

Recommendation: Adopt the recommendations from Quality Committee but delay any benefit change till plan year 2012 providing time to review other potential preventative care changes and to analyze the rating impact.

g. "Individual" Medical Needs

Previously the Board received a request from a member for an exception to the reference pricing because of an individual side-effect of the lower priced medication option. The Board's referred the issue to the Benefits committee for further analysis.

Lee explained HIPAA restrictions prevent any personal information from being discussed in an open forum and so the discussion centered on administrative policies and how they are enforced and what (if any) grounds there are for financial appeals.

Lee reported the issue was reviewed to the Benefits Strategic Planning Workgroup (BSPW) as well. Both groups agreed that the current practice of using the DUEC to identify potential medical issues was sufficient. Lee said the DUEC has not identified any rationale for adjustments to the Statin drug class. The BSPW will propose some formulary management rules to the Benefits Subcommittee in the future.

Meeting Adjourned.

AGENDA

State and Public School
Life and Health Insurance Board
EBD Board Room
501 Building, 5th Floor
1 p.m.
September 14, 2010

1. **Call to Order** ..... *Janis Harrison, Chairman*
2. **Approval of Minutes** ..... *Janis Harrison, Chairman*
3. **Financials – July 2010** ..... *Leigh Ann Chrouch, CFO*
4. **Quality Subcommittee Report** ..... *Scott Pace, Chairman*
5. **Benefits Subcommittee Report** ..... *Jason Lee, Director*
    a. **PSE Open Enrollment Update**
    b. **Early Retiree Reinsurance Program**
    c. **Internal Appeals & External Review**
    d. **Smoking Cessation Medication**
    e. **Plan Limitations**
        i. *Plan Limitations on Essential Benefits*
            1. *Ambulance ($2,000)*
            2. *Durable Medical Equipment ($10,000)*
            3. *Out-of-Network Lifetime ($1,000,000)*
        ii. *Plan Limitations on Non-Essential Benefits*
            1. *Travel for Transplant ($10,000)*
            2. *TMJ ($1,000)*
            3. *Hearing Aid ($1,400 per ear)*
    f. **Preventative Care Services**
    g. **"Individual" Medical Needs**
6. **Director's Report** ..... *Jason Lee, Director*

Next Meeting

October 12th

Public School Employees (PSE) Financials - October 1, 2009 through July 31, 2010				
	ARHealth	**Health Adv**	**NovaSys**	**Total**
Actives		37,359	3,652	41,011
Actives HD			2,509	2,509
Retirees	7,485			7,485
COBRA		768	86	854
Total	7,485	38,127	6,247	51,859

Operations as of 07/31/10				
Funding		**Current Month**		**Year to Date (10 months)**
District Contribution	$	5,702,954	$	57,538,082
Employee Contribution, Rebates	$	12,133,789	$	123,926,137
Dept of Ed $35,000,000 & $15,000,000	$	6,931,818	$	43,636,364
Total Funding	$	24,768,561	$	225,100,583
Expenses				
Medical Expenses:				
Claims Expense	$	11,503,171	$	155,122,407
Claims IBNR	$	-	$	3,250,000
Medical Admin Fees	$	1,246,988	$	12,878,783
Refunds	$	(27,785)	$	(25,111)
Behavioral Health	$	307,613	$	3,107,355
Pharmacy Expenses:	$	-		
RX Claims	$	2,133,688	$	40,816,273
RX IBNR	$	-	$	90,000
RX Admin	$	30,940	$	616,964
Plan Administration	$	456,466	$	3,086,013
Total Expenses	$	15,651,081	$	218,942,685
Net Income/(Loss)	$	9,117,480	$	6,157,898
Reserve Activity:				
Allocation for Active Premiums for Plan Yr 10/01/09-09/30/10	$	166,667	$	1,666,670
Retiree Premiums for Plan Year 01/01/10-12/31/10	$	383,402	$	2,683,813
Net Income/(Loss) After Reserves	$	9,667,549	$	10,508,382

Balance Sheet as of 07/31/10		
Assets		
Bank Account	$	14,599,408
State Treasury	$	62,636,935
Receivable from Provider	$	486,395
Accounts Receivable	$	211,808
Due from ASE	$	-
Total Assets	$	77,934,546
Liabilities		
Accounts Payable	$	4,727
Due to ASE	$	-
Deferred Revenues	$	1,547,197
Health IBNR	$	25,500,000
RX IBNR	$	2,340,000
Total Liabilities	$	29,391,924
Net Assets	$	48,542,622
Less Reserves Allocated:		
Active Premiums for Plan Year 10/01/09-09/30/10 ($2,000,000)	$	(333,330)
Retiree Premiums for Plan Year 01/01/10-12/31/10 ($4,000,000 + $600,823 = $4,600,823)	$	(1,917,010)
Active Premiums for Plan Year 10/01/10-12/31/11 ($11,840,000)	$	(11,840,000)
Retiree Premiums for Plan Year 01/01/11-12/31/11 ($760,000)	$	(760,000)
Active Premiums for Plan Years 1/01/12-12/31/13 ($7,344,000 + $3,296,000 = $10,640,000)	$	(10,640,000)
Retiree Premiums for Plan Years 01/01/12-12/31/13 ($456,000 + $304,000 = $760,000)	$	(760,000)
Catastrophic Reserve	$	(9,100,000)
Pharmacy Reward Program (2009-$1,500,000)	$	(1,500,000)
Net Assets Available	$	11,692,282

Arkansas State Employees (ASE) Financials - January 1, 2010 through July 31, 2010				
	ARHealth	**Health Adv**	**NovaSys**	**Total**
Actives		25,412	1,234	26,646
Actives HD			946	946
Retirees	8,664			8,664
COBRA		127	7	134
Total	8,664	25,539	2,187	36,390

Operations as of 07/31/10

		Current Month		**Year to Date (7 months)**
Funding				
State Contribution	$	13,646,674	$	95,178,292
Employee Contribution, Rebates, Life	$	7,128,153	$	57,111,703
Medicare Subsidy	$	-	$	2,372,705
Total Funding	$	20,774,827	$	154,662,699
Expenses				
Medical Expenses				
Claims Expense	$	8,866,662	$	90,724,455
Claims IBNR	$	-	$	2,570,000
Medical Admin Fees	$	866,778	$	6,177,435
Refunds	$	(7,770)	$	11,481
Behavioral Health	$	285,416	$	1,992,354
Life Insurance	$	79,710	$	556,927
Pharmacy Expenses				
RX Claims	$	2,504,643	$	32,788,124
RX IBNR	$	-	$	180,000
RX Admin	$	34,571	$	462,051
Plan Administration	$	319,569	$	1,588,815
Total Expenses	$	12,949,579	$	137,051,643
Net Income/(Loss)	$	7,825,248	$	17,611,056

Balance Sheet as of 07/31/10

Assets		
Bank Account	$	10,838,005
State Treasury	$	86,146,854
Receivable from Cafeteria Plan	$	8,767,656
Receivable from PSE	$	-
Receivable from Provider	$	518,728
Receivable from Medicare	$	-
Accounts Receivable	$	1,015,851
Total Assets	$	107,287,094
Liabilities		
Accounts Payable	$	1,847
Deferred Revenues	$	4,189,660
Due to Cafeteria	$	2,525
Due to PSE	$	-
Health IBNR	$	21,570,000
RX IBNR	$	2,680,000
Total Liabilities	$	28,444,032
Net Assets	$	78,843,063
Less Reserves Allocated:		
Catastrophic Reserve	$	(8,100,000)
Pharmacy Reward Program (2009-$1,500,000)	$	(1,500,000)
Net Assets Available	$	69,243,063

ASE Cafeteria Plan Financials 2010- January 1, 2010 through July 31, 2010

Cafeteria Plan Operations as of 07/31/10

Funding	**Current Month**	**Year to Date (7 months)**
FICA Savings	$ 354,324	$ 2,509,366
Interest, Penalties, Tax Set Off	$ 5,696	$ 54,815
Total Funding	$ 360,020	$ 2,564,182
Expenses		
Plan Administration	$ 14,174	$ 99,242
Forfeited Benefits (Annual Expense)	$ -	$ 6,297,637
FICA Savings Transfer (Annual Expense)	$ -	
Total Expenses	$ 14,174	$ 6,396,880
Net Income/(Loss)	$ 345,845	$ (3,832,698)

Balance Sheet as of 07/31/10

Assets	
State Cafeteria (Flexible Benefits)	$ 738,340
Admin Acct (FICA Savings)	$ 578,905
State Treasury	$ 8,020,385
Due from Health Plan	$ 2,525
Due from State Employee Fund	$ -
Accounts Receivable	$ 13,992
Total Assets	$ 9,354,147
Liabilities	
Accounts Payable	$ 107,625
Due to Health Plan (FICA Savings Annual)	$ 7
Due to Health Plan (Forfeited Benefits Annual)	$ 8,767,649
Total Liabilities	$ 8,875,281
Net Assets	$ 478,866

State and Public life and Health Insurance Board

Quality of Care Sub-Committee Report

Meeting Date: September 1, 2010

The committee viewed a presentation by EBD's Health Services Officer, Michelle Hazelett t about Healthcare Reform and Preventive Benefits. The committee was also provided with the Grade A and B Recommendations of the United States *Preventative Services* Task Force (USPSTF).

The Quality of Care Committee had the following recommendations for the **Benefits subcommittee:**

1. **SCREENING FOR BREAST CANCER (MAMMOGRAPHY)**
   The USPSTF recommends screening mammography for women with or without clinical breast examination (CBE), every 1-2 years for women aged 40 and older.

   Currently the Plan Covers - 1 mammogram per year with no age limit.

   Recommendation: Provide an annual screening mammogram for women 40 and older, and for women under the age of 40 with a family history of early breast cancer.

2. **SCREENING FOR COLORECTAL CANCER**
   The USPSTF recommends screening for colorectal cancer (CRC) using fecal occult blood testing (FOBT), sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.

   Currently the Plan covers: Colorectal Screening to begin at age 50: FOBT every year and one of the following: Sigmoidoscopy every 5 years – Colonoscopy every 10 years – Double-Contrast Barium Enema (DCBE) every 5 years

   Recommendation #1: Adopt the USPSTF recommendation for screening for colorectal cancer - with the exception that the plan also include people over the age 40 with a family history of early colon cancer.

   Recommendation #2: If the examination of the utilization data for Double Contract Barium Enema (DCBE) proves minimum usage by the members of the

plan, the committee recommends the removal of DCBE as part of the screening for colorectal cancer benefit.

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State and Public School Life and Health Insurance Board

Benefits Sub-Committee Report

Meeting Date: September 10, 2010

The committee received an update on PSE Open Enrollment period for the 2010-2011 plan year, and the Early Retiree Reinsurance program.

The committee also received a report from the Benefits Strategic Planning Workgroup (BSPW)

Lee informed the committee about Internal Appeals & External Review - No action taken by the Benefits Committee but a detailed report will be presented in October regarding internal appeals and process.

The Benefits Sub- committee have the following recommendations for the Board consideration:

1. **Smoking Cessation Medication**
   Under our current arrangement, our tobacco cessation program is not in compliance with the new federal rules; specifically the issue around the member's 50% co-pay for Chantix and Bupropion (generic for Wellbutrin).

   Under the new rules, we are required to cover tobacco counseling and therapy at no cost to the member. Nicotine replacement patches are paid at 100% by the plan but not the prescription drugs.

   Recommendation: Cover all costs associated with Chantix & Bupropion for those members enrolled in the smoking cessation program subject to a 6-month prior-authorization and move the two medications to the formulary and assign a co-pay for those members electing not to participate in the smoking cessation program.
   - A claims report will be provided to the Benefits Committee in 6-months to measure utilization

2. **Plan Limitations**
   Federal law requires that we remove any dollar amount annual / lifetime limit on "essential" services (yet to be defined). In looking at the federal employee health plan and other sources, we have identified 3 current benefits that need to have their respective limits removed. They are the $2,000 limit for ground ambulance, $10,000 limit for durable medical equipment, and $1,000,000 for out-of-network lifetime limit. Non-essential benefits can still have their annual limits and we feel that Travel for

Transplant services, TMJ, and Hearing Aids will be classified as non-essential benefits once defined by federal rules.

Recommendation: Remove the durable medical equipment annual limit and the out of network lifetime limit; and convert the $2,000 annual limit for ground ambulance to a $2,000 “per-trip” limit.

- A claims report will be provided to the Benefits Committee in 6-months to measure utilization

3. Preventative Care Services

A series of recommendations were referred to the Benefits Committee by the Quality Committee dealing with the new federal requirements for preventative care services. The recommendation was made to adhere to the new A & B rated recommendations with regard to frequency and individual age with two additional considerations:

- Mammograms – exceed the federal recommendations to offer the following as a Preventative Care Service:
  - Annual screening mammogram for women under age 40 with a family history of early breast cancer *and* that screening mammograms for women under who have no family history be considered for exclusion under the plan as a non-covered service.
  - Federal rules require screenings to begin at age 40.
  - Current coverage has no age limit and implementing an age limit / family history requirement on screenings would be a benefit reduction.

- Colorectal Cancer Screenings – exceed the federal recommendations and offer the following as a preventative care service:
  - Screening services for men or women age 40 to 50 with a history of early colon cancer and remove Double Contract Barium Enema as a preventative care service.
  - Federal rules require screenings to begin at age 50 and do not include DCBE as a recommended service.
  - Current coverage begins at 50 and has no option for under 50 but for diagnostic evaluations subject to co-pays / co-insurance / deductibles.

Recommendation: adopt the recommendations from Quality but delay any benefit change till plan year 2012 providing time to review other potential preventative care changes and to analyze the rating impact.

Previous Board Request for committee review- Individual Medical Needs – This issue stems from a member requesting an exception to the reference pricing structure of the Statin class of drugs due to an individual side-effects of the lower priced medication option, a side effect that is known to exist with many medications within the class. HIPAA restrictions prevent any personal information from being discussed in an open forum so it will be critical for the discussion to center around administrative policies and how they are enforced and what (if any) grounds there are for financial appeals.

- Although no formal recommendation was made, it was the conversation that the current practice of using the DUEC to identify potential medical issues was sufficient. Currently there are adjustments to the reference pricing allowed for children taking certain PPI medications where a co-pay is applicable instead of the reference pricing. As of now, the DUEC has not identified any rationale for adjustments to the Statin drug class.