Tucson Unified School District No. 1
Employee Benefits Trust Meeting
Grey Room, Morrow Education Center
1010 East Tenth Street
Tucson, Arizona 85719

November 18, 2013
5:30 p.m.

MINUTES

Committee Members Present:
Dr. Neil West        Yousef Awwad      Dr. Stegeman (phone)
Mark Mansfield     Robert Harbour

Others Present:
Janet Underwood – Recordkeeper
Robert Burnell, Robert Ferraro, Dan Zentgraf – Buck Consultants
Kristi Olivas – Buck (phone)
Debbie Hainke, Ben Wright – AmeriBen
Dustin Jones, Wayne Pomeroy – CVS Caremark

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<thead>
<tr>
<th>MEETING CALLED TO ORDER</th>
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<td>Meeting called to order at 5:33 p.m.</td>
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<th>QUORUM</th>
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<td>A quorum is present.</td>
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<tr>
<th>CALL TO THE AUDIENCE</th>
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<td>No one requested to speak.</td>
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<th>INFORMATION / ACTION ITEMS</th>
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<tr>
<th>Minutes – October / Review and Approval</th>
<th>Mark Mansfield made a motion to approve the minutes which was seconded by Yousef Awwad; the motion passed 4-0.</th>
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<tr>
<th>Financials</th>
<th>Cliff is working with auditors therefore the September and October financials will be presented at the December meeting. If possible, November will be included.</th>
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<th>Subrogation / Appeals</th>
<th>AmeriBen reported that there are no subrogations or appeals to present.</th>
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<th>Pharmacy Plan Review</th>
<th>The Board prefaced this discussion with requests and/or comments:</th>
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<tr>
<td>Ensuring adjudication of claims is moving as it should be</td>
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<td>Rebates are coming in as planned.</td>
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<tr>
<td>Sees a significant amount of oncology treatment</td>
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<td>Identification of medications that are moving from Brand to Generic</td>
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Caremark:

- Overview of Current Plan Design
- Summary of Rx Data
- 2014 Recommendations
  - Specialty meds are <1% of the total spend and 31% of overall Rx spend. Generic dispensing rate is very good
  - Appendix page shows medications not approved
  - Dose Optimization
  - Quantity Limits – require PA (prior authorization).
  - Total savings about $40k

Exec Summary Snapshot
This shows us that the net cost had an 8% increase ($2.8 to $3.2M); 12.5% is net trend increase. Bob Ferraro showed our last plan year for total cost was $5.194M (US Script). Caremark was $6.8 or $6.9M – large increase over last 12 months; utilization versus price. Bob also shows about 90,282 prescriptions were processed at Caremark versus about 89,000 prescriptions that were process the prior year at US Script, and noted that enrollment was somewhat flat. He can provide a year over year difference; last plan year was $1.2m on Specialty and Caremark’s first year is $1.7m; so the increase in Specialty is there; more folks are taking these types of medications.

Specialty Pharmacy Trend
Three (3) categories
  - Price Inflation 6% increase
  - Utilization up 17%
  - Drug Mix up 6%

Total prescriptions 528; last year there were 565; while there is a reduction in the number of prescriptions the cost of the prescriptions are higher.

As shown before, Caremark does ask for qualifying questions (clinical criteria) and most people meet those criteria; there is a large category of a specific chronic disease. While there is the option to put a 4 tier specialty copay structure in place, the Board is not in favor of adding costs to this group.

With regard to whether there are reasonable lower cost drugs and what was used before, we see that there are newer generation drugs that enable folks to better manage their disease(s). The Board feels that step therapy and the clinical questions being asked are appropriate. Bob Ferraro pointed out that even a 4-tier would not change the 1% Specialty Utilization as a percent of members.

Top Medications
Doctors are incentivized to prescribe drugs like Crestor that have heavy marketing. The Plan can use generic step therapy to gain savings. Oxycontin: there are no limitations on this in Plan and its showing in the top 25 meds. There could be quantity limits put around this pain medicine. Caremark noted that there is a safety monitoring program in place that watches for certain conditions, or too many prescriptions from one doctor. Overall, program performance looks good.
### Adherence

The Adherence Measures page is about 6 months of data, and so far it does show that TUSD lags in adherence; more effort needed in this area. AmeriBen and CVS will drill into who are the doctors seeing the folks making up the categories of Asthma, Diabetes, Heart failure, etc.

### Other

A future meeting will show the MedAi data from AmeriBen, which shows the Rx data coming in with the medical; incentives can help with this.

The Plan must revisit the goals for test strips, asthma, step therapy, etc.; Dustin will communicate his takeaways from the meeting.

There is a preventive drug list for the HDP but there would still be copay. There is a push/pull with this if you were to offer diabetic test strips at no cost; Dr West said if those classes of drugs were to be in the preferred band it would be beneficial to the Plan in the long run, as we need those folks to take their meds and remove the economic barriers. We can see the impact of cost; Caremark can run this for this if we went that way. To Dr. West’s earlier point of rebates, Bob Ferraro said the reconciliation is due not and we’ll see that guarantee report in January.

Dr. West would like the Plan to determine if there are better delivery and source methods for oncology medications due to costs. Bob Ferraro has some clients trying to do this in Phoenix however physicians have pushed back. Dr. West acknowledges we’d have to study this and be careful in our approach; we have a small number of patients on a relative basis. Pricing is managed by BCBS if they are in-network; Ben Wright feels plan design could dictate sourcing through the pharmacy plan, however we do not want to jeopardize network rates either.

### 5-Year Projected Cost and Premium

Kristi Olivas, the Buck Actuary reported on the plan:

**Current Financial Status**

9% moved to HDP and 91% to PPO.

When developing projections, they take existing claims (for benefits no longer offered and adjust for new plan). Therefore, the EPO calculation of the actual difference to PPO or HDP and those factors are .7988 and .9141 for PPO. This is used as the base for PPO and HDP.

An additional factor to PPO of .9852 used to reflect the revised drug copays for PPO Brand and Non-Preferred Brand. Included in slide 3 is summary of PEPM projections and premium; between 2013 and 2014 there is a1.7% increase. The PYE 15 is higher due to that all copays must apply to the OOP. The next 3 years’ increases are due to trend.

Loss Ratio (LR) is claims against premiums. Currently this year’s plan cost sharing is 90/10 and next year we need to get to 85/15; its also recognized that the District is already at 85/15 and Mark Mansfield noted we need to reduce our Reserves also in the future.

Potentially:
- FYE 13 LR is 90.8%; year will end at less than 100% LR
- FYE 2014; LR is 88.5
- FY15 is LR of 99.2% and get a Rate Pass
FY16 would be increase of 6.4%

- Slide 5 is detail for YE 2013. Experience paid claims and adjusted for Stop Loss over $400k; divide by lag enrollment = $401.07. Split out by plan, then applied plan design changes i.e. Women’s Health and excise tax, and then applied trend. The result is Projected incurred claims PEPM of $4404.98. After adding in administrative expenses and ACA, the cost is 90 cents per dollar (LR).
- FYE 14; now we have 2 plans. These numbers are fairly conservative due to the plan change factors as we do not really know what behaviors the employees in the PPO plan vs. HDHP plan have.
- Buck applied PPACA, and then trend; is then $396.45; you can see how the split is different for PPO and HDP; this is what they feel will happen to the claims and the behavior changes in HDP will result in lower cost. Slides 7 and 8 are similar - on average 5% difference in PPO and HDP.
- Starting in PYE 2015 copays have to count toward the OOP Max so the 2015 costs will jump.
- Mark Mansfield noted if we did not increase our rates this year we’d still have a LR of less than 1 this year. Dr. West noted that the Plan could drop the rates and even increase the Stop Loss Individual Deductible to drive down the reserves.
- Slide 9 is rolling 12 month claims to date for med/drug.
- Slide 10 is the graph for rolling months.
- Slide 11 is the Cadillac tax; projected the premiums and those projected numbers in 2nd bullet are from slide 3. Plan Year of 2015 recommended a rate pass, and 2016 showed a recommendation of 6.4% increase; 7.3% increase of 2017 (?) .
  a. Definition of Cadillac Tax: compare the annual premium to a set limit. Slide 11 shows the limits (3rd bullet). Must compare the premium cost to these limits and the excess is taxed at 40%. This shows overall that TUSD will not be liable for a Cadillac tax until 2023, and it hits the PPO Family Plan. The limit for EE/SP and EE/CH are lower than EE/Family rate.
- This is useful to let us know what the Plan looks like through 2015, 2016.
- Page 12 – IBNR. If plan were to shut down, the cost to payout all the claims left (have occurred) (p 13 shows details of calc) is $2.9m which is lower than the most recent data (our total reserve).
- The RFP process over the next 2 years may also show some relief as it pertains to the Cadillac Tax impact.

**RFP Timeline**
RFPs will be developed for dental, vision and EAP. Additionally, the Trust discussed adding certain benefits to the Board’s oversight; Janet will work on proposed changes to the Trust Agreement for the December meeting.

**Clearway Presentation for December 1**
Dr. West has been in contact with a group, Clearway. To provide an educational WebEx on this, there are things to consider due to procurement rules. Janet will review with Purchasing and Dr. West.

**ACO Metrics with TMC**
TMC/ACO model: Dr. West notes that the Plan spends over $1m or more at TMC; can they tell us their experience with our patients? The TMC
consortium is looking at many specialty groups; what is their experience/what is their actual cost? Dr. West is concerned that we have members who have had treatment out of state. The Plan would prefer to provide that care in Arizona instead. This is more of an education process recognizing we can review how to approach this in an RFP process. We need the Tax ID number of all their providers and then AmeriBen can pull the de-identified details.

Debbie reminded us that a narrower network may affect the OON (out of network) part and the Stop Loss rates. Ben Wright added that for high cost transplants, a 2nd opinion at Mayo could be implemented. There is an area being developed by AmeriBen / AmeriBen clients that a 2nd opinion is needed for all transplants; Symetra is also willing to provide a premium relief of some sort.

Succession Planning
The current board has been on for 3 years and the new development of successors should be considered and put on the agenda for next year. The Board could increase the group to 7 and bring those folks along.

Next Meetings:
- December Agenda
  o Wellness Requests - discuss multiple requests and how to coordinate our efforts.
  o AmeriBen – present MedAi data on Dec meeting

- February Agenda
  o Caremark reconciliation
  o Planning session (Clearway, Symetra, 2nd opinion, 2014 plan design, strategic issues). Dr. West asked Bob Burnell to begin thinking about those.

Mark Mansfield made motion to adjourn the meeting; Dr. Stegeman seconded the motion; the meeting adjourned at 7:37pm.

Approved this 16th day of December, 2013.

TUSD EMPLOYEE BENEFITS TRUST BOARD

By

Dr. Neil R. West, EBT Board Chair