# STATE OF MISSISSIPPI

# STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE MANAGEMENT BOARD

## Request for Proposal

## Medical Claims and Performance Audit Services

## July 11, 2024

Contact information for this request for proposal:
Medical Claims and Performance Audit Services RFP
c/o MDFA Office of Insurance
501 North West Street
Suite 1201-C Woolfolk Building
Jackson, Mississippi 39201
InsuranceRFP@dfa.ms.gov

TABLE OF CONTENTS

SECTION 1. INTRODUCTION ..... 4
1.1 Background, Authority, and Purpose ..... 4
SECTION 2. SCOPE OF SERVICES ..... 6
2.1 Account Management ..... 6
2.2 Medical Claims and Performance Audit Services ..... 6
2.3 Cooperation with Other Board Vendors ..... 8
SECTION 3. MINIMUM VENDOR REQUIREMENTS ..... 9
SECTION 4. STATEMENT OF COMPLIANCE AND EXCEPTION(S) FORM ..... 12
SECTION 5. STATUTORY REQUIREMENT DISCLOSURE STATEMENT ..... 14
SECTION 6. GENERAL QUESTIONNAIRE ..... 16
SECTION 7. TECHNICAL QUESTIONNAIRE ..... 18
7.1 Account Management ..... 18
7.2 Client Service and Communications ..... 18
7.3 Medical Claims and Performance Audit Services ..... 19
7.4 Medical Claims and Performance Audit Experience ..... 19
SECTION 8. FEE SCHEDULE ..... 21
SECTION 9. RFP PROCESS OVERVIEW FOR VENDORS ..... 24
9.1 Instructions to Vendors ..... 24
9.2 Important Dates and Deadlines ..... 28
9.3 Contact, Questions/Requests for Clarification, and Acknowledgment of Responses/RFP Amendments ..... 28
9.4 Corrections and Clarifications ..... 29
9.5 Modification, Withdrawal, or Rejection of a Proposal ..... 29
9.6 Right to Consider Historical Information ..... 30
9.7 Right to Reject, Cancel and/or Issue Another RFP ..... 30
9.8 Cost of Proposal Preparation ..... 31
9.9 Registration with Mississippi Secretary of State ..... 31
9.10 Vendor Investigations and Certifications ..... 31
9.11 State Approval ..... 31
9.12 Proposal Evaluation and Basis for Award ..... 32
9.13 Post-Award Vendor Debriefing ..... 35
9.14 Protest ..... 35
9.15 Required Contract Terms and Conditions ..... 35
9.16 Agency Website ..... 35

9.17 Attachments ........................................................................................................36

Appendix A 37
*Draft Medical Claims and Performance Audit Services Contract* ..............................................37

Appendix B 38
*Fiscal Year 2023 Actuarial Report*........................................................................................38

## SECTION 1. INTRODUCTION

### 1.1 Background, Authority, and Purpose

The State of Mississippi State and School Employees' Health Insurance Management Board (Board) seeks a qualified, experienced auditor to provide medical claims and performance services to the Board relating to its management of the State and School Employees' Life and Health Insurance Plan (Plan). The Plan's health insurance component is a self-insured, non-ERISA (Employee Retirement Income Security Act of 1974) health insurance plan, currently providing health insurance coverage to approximately 190,000 participants. Eligible participants in the Plan include active, retired, and Consolidated Omnibus Budget Reconciliation Act (COBRA) employees (and their enrolled dependents) of the State's agencies, universities, community colleges, school districts, and public library systems. Plan participants are located primarily within Mississippi, although a small number of participants reside in other states. The 2024 Plan Document provides specific details of the Plan and is located on the Plan's website at https://knowyourbenefits.dfa.ms.gov/publications/. The Board desires to contract with an auditor that specializes in providing medical claims and performance audit services to large, self-insured health plans, and has prior experience directly related to the services requested in this RFP. The required services are described in **Request for Proposals (RFP) Section 2, Scope of Services**.

The Board's current medical claims and performance services contract with Brown & Brown f/k/a Claims Technologies Inc. is scheduled to expire on December 31, 2024, necessitating the need for this RFP. The effective date for this contract will be January 1, 2025. Implementation and/or transition services provided by the selected vendor prior to January 1, 2025, are not compensable; As such, any costs incurred by the vendor prior to January 1, 2025 may not be invoiced to the Board.

The Mississippi Department of Finance and Administration's (MDFA) Office of Insurance (OI) under the direction of the State Insurance Administrator is responsible for the management and administration of the Plan and provides administrative support to the Board. OI is coordinating this RFP. The Board seeks to enter into a multi-term, fixed price, indefinite quantity contract for the aforementioned services. A draft contract has been included as **Appendix A** of this RFP for your review and comment. This RFP, any amendment thereto, such as Questions and Answer document(s), if any were issued, as well as the awarded vendor's proposal(s), and any requested best and final offer shall constitute the Contract. The Contract will be for four (4) years with an option to renew for one (1) additional year at the Board's discretion. This procurement and any resulting contract shall be governed by the applicable provisions of the *Mississippi Public Procurement Review Board (PPRB) Office of Personal Service Contract Review (OPSCR) Rules and Regulations*, a copy of which is available at 501 N. West Street, Suite 701E, Jackson, Mississippi 39201 for inspection or at https://www.dfa.ms.gov/personal-service-contract-review.

A copy of this RFP, including any subsequent amendments, along with a copy of all questions from vendors and responses to those questions, will be posted on MDFA's website under the heading "Solicitations" at https://www.dfa.ms.gov/bids-and-rfps-notices. Before the award of any contract, the Vendor will be required to document to the Board that it has the necessary capabilities to provide the services specified in this RFP. The Vendor may also be required to provide additional client references, as well as related project experience detail, for OI to determine if the Vendor is qualified. The OI may make reasonable investigations, as it deems necessary and proper,

to determine the ability of the Vendor to perform the work, and vendor shall be required to furnish all information that may be requested for this purpose. The OI reserves the right to reject any proposal if the Vendor fails to provide the requested information and/or fails to demonstrate the Vendor is properly qualified to carry out the obligations of the Contract and to complete the work described within this RFP.

## SECTION 2. SCOPE OF SERVICES

This section contains information on services and procedures the selected vendor must provide, or adhere to, in servicing the Board's account, either directly or through identified subcontractors. **The descriptions are not all-inclusive** but are provided to alert you to services or procedures that may require additional planning or programming on your part. The following is a list of services the Board expects the successful vendor to provide.

Please respond by restating each service listed below, including the number, and confirm your intention to provide the service as described by stating "*Confirmed*". If your company can provide the service, but not exactly as described, respond by stating "*Confirmed, but with exceptions*", and state the specific exceptions. If your company intends to provide a listed service through a subcontractor, respond, "*Confirmed, service will be provided through subcontractor*", and name the subcontractor. If your company is currently unable to provide a listed service, respond by stating "*Unable to provide this service*". Any additional details regarding these services should be provided in your responses to the questionnaire, or as additional information included as an appendix to your proposal.

The selected vendor is expected to provide the following services:

### 2.1 Account Management

**2.1.1** Must comply with staffing minimum requirements provided in **RFP Section 3.2 through 3.5**.

**2.1.2** All other services directly related to this contract must be provided from an office located within the United States.

### 2.2 Medical Claims and Performance Audit Services

**2.2.1** At the request of the Board, at least annually perform a comprehensive and objective medical claims and performance audit of the Plan's medical claims third party administrator to determine if the medical claims were adjudicated according to appropriate Plan benefits, the contractual standards, industry standards, and State and federal regulations. The medical claims and performance audit must be based on a statistically valid stratified random sample that achieves a minimum 95% confidence level +/-3%, and must include at a minimum the results for the following key performance indicators: financial accuracy, payment accuracy, processing accuracy, and claims processing turnaround time. The audit must include a review of the medical claims processed by the medical claims third party administrator, including re-adjudicating medical claims to evaluate the administrator's processes and systems relating to such areas as: eligibility, coding, pricing (including proper application of allowable charge and discount arrangements), deductible accumulators, identification of duplicate bills, application of Plan benefits, COB, subrogation, medical necessity, ineligible/eligible charges, compliance with the Plan Document, timeliness of processing, interaction with other vendors, and file documentation.

**2.2.2** In addition to the statistically valid random sample audit, will conduct an electronic screening of 100% of the medical claims processed, with targeted sample analysis to target

and test known administrative issues and identify process improvements and cost recovery opportunities. The Auditor will screen medical claims with material errors in a wide variety of high-risk categories and apply unique and proprietary error codes when potential errors are found. The categories may include, but are not limited to:

a. Medical Claims Payment and Pricing
b. Duplicate payments to providers and/or employees
c. Provider discounts and fees
d. Coordination of benefits
e. Plan limitations and exclusions
f. Multiple surgical procedures
g. Large claim review and case management
h. Denial of mandated benefits
i. Workers' Compensation
j. Subrogation/right of recovery from third parties
k. Fraud, Waste and Abuse Review

**2.2.3** Operational Review – A detailed operational audit of the medical claims Third Party Administrator (hereinafter "TPA") shall include, but is not limited to, the following:

a. Claims payment system and procedures
b. Exception processing
c. Mail (paper claim) receipt and tracking
d. Forms and communication process
e. Training programs and employee evaluation process
f. Quality procedural manuals provided to claims processing, customer service, etc.
g. Evaluation of the security of records and data
h. Security and override procedures relating to approval of claims and access to records
i. Internal audit process
j. Compliance with HIPAA/HITECH Act to verify the Plan's vendors are HIPAA compliant during the annual claims and performance audits
k. Evaluation of customer service, including communication of the Plan's benefits, policies, and procedures; and audit of performance guarantees related to call answering response time and abandonment rate
l. Cost containment procedures

**2.2.4** For any medical claims and performance audit performed, will provide a comprehensive, detailed written report to include the methodology used by the auditor, the medical claims and performance audit findings, recommendation to the Board regarding such findings, and provide an oral presentation of the report, if deemed necessary by the Board.

**2.2.5** Maintain full and accurate records (data) with respect to all matters covered under the resulting contract. The Contractor will permanently maintain and store data in electronic format in a safe, secure, and monitored locations(s) or security site(s). All data remains the property of the Board and shall be accessible by the Board at all times. Data will not be released or destroyed for any reason unless expressly requested by the Board or required under State or Federal law.

**2.2.6** At the request of the Board, provide the Board copies of all spreadsheets, assumptions, and calculations for any project authorized and funded by the Board in a format acceptable to the Board.

**2.2.7** Based on the medically claims and performance audits conducted, must be pro-active in presenting recommendations and ideas to the Board regarding the management of the Plan and/or the evaluation of the Plan's vendor.

**2.2.8** During the resulting contract, agree to work with the Board in the development, implementation, and evaluation of quality improvement projects and innovative plan designs or projects as may be requested and authorized by the Board. The Auditor is encouraged to bring ideas on improving the quality of health care and innovative plan design to the Board for consideration.

**2.2.9** If requested by the Board, must agree to testify before the State Legislature or Performance Evaluation and Expenditure Review Committee, and testify or provide assistance in connection with any legal or audit proceedings in which the Board or the State of Mississippi is a party in relation to the services provided under the resulting contract.

**2.2.10** It is mutually understood and agreed by both parties that this is not an exclusive contract. The Board and/or MDFA is free to contract with other professionals to perform similar and like services as those contained in the resulting contract.

## 2.3 Cooperation with Other Board Vendors

The Vendor will cooperate as required with the Board's other contracted vendors and will work with other vendors to facilitate the provision of the on-going coordination and delivery of services, and in any transfer of responsibility.

## SECTION 3. MINIMUM VENDOR REQUIREMENTS

The following minimum vendor requirements are mandatory. Failure to meet any of these requirements will result in disqualification of the proposal submitted by your company. Please respond by restating each minimum requirement, including the number listed below with documentation that proves specifically how your company meets that minimum criterion. **Note that for the purposes of fulfilling the minimum vendor requirements, except as otherwise indicated, "Auditor" refers to the primary contracting vendor only, not including any proposed subcontractors.** Please include in your responses the total number of years and types of experience of your company. If, in the opinion of the procurement team, you fail to prove that your company meets any of these minimum requirements, the proposal will be disqualified from further evaluation. If this happens, you will be notified of the decision and will have an opportunity to provide additional information to prove your company does meet the minimum requirements. It is incumbent upon the disqualified vendor to respond timely and completely to any such notice as unreasonable delays and/or non-responsive submissions may result in the disqualification being upheld without further review.

**3.1** **References:** References provided by the company must be familiar with the Vendor's abilities in the areas involved with this solicitation. MDFA staff will use these references to determine the Vendor's ability to perform the services. It is the responsibility of the Vendor to ensure that the reference contact information is correct and current. MDFA staff will not track down references. Vendors should verify before submitting their proposal that the contact information provided is correct for each reference. Client references that cannot be contacted for verification will not be considered. The determination of the length of time an entity has provided these services will be based upon the initial date the Vendor established a contractual relationship to provide such services.

For each client provided pursuant to **Subsections 3.1.1 through 3.1.5,** please specify:

a. Client contact information, including the name, title, address, email address, and phone number of a person whom we may contact to confirm as needed,
b. The specific type of work your company provided to the client, include the type of claims and performance audit performed by your company,
c. The number of covered lives in the client's group,
d. Contract effective dates for the time period(s) (beginning and end dates) your company provided services to the client.

If two or more of the following reference requirements are met by the same client, list additional clients so there are at least three (3) clients listed for each section. If you are unable to provide three (3) clients for each reference, provide as many as you have and indicate in the response additional references meeting this requirement are not available.

**3.1.1** The proposing vendor must possess at least five (5) years' experience **as of August 1, 2024**, as an organization providing the equivalent or similar in type, scope, requirements, and scale to those required in this RFP. The proposing vendor must provide sufficient detail to demonstrate it has the minimum required experience in working with programs similar in type, size, and complexity to the Board by providing client reference(s).

**3.1.2** List at least four (4) clients who can serve as references, consisting of two (2) clients from the public sector and two (2) clients from the private sector, for whom your company has provided services equivalent or similar in type, requirements, and scale to those required in this RFP.

**3.1.3** List your company's longest standing client.

**3.1.4** List your company's client with the largest employee population.

**3.1.5** List the names of all clients that have discontinued use of your services or terminated their relationship with your organization in the past two (2) years. Include the client contact information, including name, title, address, email address, and phone number, the services provided, duration of relationship, and your understanding for their discontinued use or reason for their termination of your services.

**3.2** The proposing vendor must provide a dedicated (but not necessarily exclusive) account manager, who will act as the Board primary contact for activities relative to all aspects of the Contract between the Board and the Auditor. The individual who will serve in this role must have a minimum of five (5) years' experience conducting and supervising independent medical claims and performance audit services to self-insured health plans consisting of at least 100,000 covered lives. This position shall be, at a minimum, senior auditor level and will supervise all aspects of the resulting contract with the Board. The proposing organization must provide sufficient detail to demonstrate the proposed individual meets this requirement via resumes as an appendix to your proposal in Section 10. Please confirm.

**3.3** The proposing vendor must have a system and staff capable of screening all claims processed by the medical third-party administrator during the resulting contract period.

**3.4** The proposing vendor must agree that all services performed must be provided within the United States. Please confirm.

**3.5** The proposing vendor must be an independent entity. An insurance company, medical claims administrator, pharmacy benefit manager, or similar organization subject to the jurisdiction of the Mississippi Insurance Department and/or the Mississippi State Board of Pharmacy shall not be considered qualified. Additionally, if the majority ownership of the proposing vendor is an insurance company or similar organization referenced in this item, the proposing vendor will not be considered qualified. The proposing vendor must provide sufficient detail to demonstrate its standing as an independent entity. Please confirm.

**3.6** The proposing vendor must comply with Mississippi Code Annotated § 79-4-15.01 regarding authorization to transact business in Mississippi. Please confirm.

**3.7** The proposing vendor must agree to provide and maintain, throughout the term of the Contract, at its own expense, **Professional Liability** insurance that covers any damages caused by an error, omission or any negligent acts related to the services to be provided under this Contract. Such policy of insurance shall provide a minimum coverage in the amount of One Million Dollars ($1,000,000.00) per occurrence and Three Million Dollars ($3,000,000.00) annual aggregate issued by an insurance company authorized to do business under the laws of the State of

Mississippi, meaning the insurance carrier must be licensed or hold a Certificate of Authority from the Mississippi Insurance Department. The Board must be named as Certificate Holder on the policy. The Auditor shall annually provide the Board a current Certificate of Insurance. Please confirm.

**3.8** The proposing vendor must agree to provide and maintain, throughout the term of the Contract, at its own expense, **Employee Dishonesty or Fidelity Bond** insurance with third party liability coverage and with minimum limits of One Million Dollars ($1,000,000.00) per occurrence and Three Million Dollars ($3,000,000.00) annual aggregate issued by an insurance company authorized to do business under the laws of the State of Mississippi, meaning the insurance carrier must be licensed or hold a Certificate of Authority from the Mississippi Insurance Department. The Board must be named as Certificate Holder on the policy. The Auditor shall annually provide the Board a current Certificate of Insurance. Please confirm.

**3.9** The proposing vendor must agree to provide and maintain, throughout the term of the Contract, at its own expense, **Cyber Liability** insurance. Such policy of insurance shall provide a minimum coverage in the amount of Two Million Dollars ($2,000,000.00). Coverage must include security and privacy liability, business interruption, business interruption waiting period, data recovery, regulatory proceedings, and cyber extortion. Please confirm.

**3.10** The proposing vendor must agree to perform all services required in this RFP in accordance with customary and reasonable industry standards as well as in strict conformance to all laws, statutes, and ordinances and the applicable rules, regulations, methods and procedures of all government boards, bureaus, offices, and other agents whether currently in place, updated and replaced, or newly created. The proposing vendor shall be responsible for the complete performance of all work; for the methods, means, and equipment used; and for furnishing all materials, tools, apparatus, and property of every description used in connection therewith. No statement within this RFP shall negate compliance with any applicable governing regulation. The absence of detailed specifications or the omission of detailed description shall be recognized as meaning that only the best commercial practices are to prevail, and that only first quality materials and workmanship are to be used. Please confirm.

## SECTION 4. STATEMENT OF COMPLIANCE AND EXCEPTION(S) FORM

If a vendor objects to any terms, conditions, or requirements listed in the *MDFA OI's Request for Proposal for Medical Claims and Performance Audit Services, dated July 11, 2024*, including all RFP attachments and amendments, the Vendor must list and explain the exceptions taken. If no exceptions are taken, then the Vendor shall state on the form "No Exceptions Taken." Failure to indicate any exception will be interpreted as the Vendor's intent to comply fully with the requirements as written. Failure to complete and/or sign may result in vendor being determined nonresponsive. Please carefully review the information located in **RFP Section 4, Statement of Compliance and Exception(s) Form,** and include a copy **signed by an officer, principal, or owner** of your company with your completed proposal. Failure to submit a signed Statement of Compliance and Exception(s) form may result in your proposal being eliminated from further consideration. If you object to any of the terms and conditions included in the *Draft Medical Claims and Performance Audit Services Contract* (refer to **RFP Appendix A**), or any requirements listed in this RFP, please note and explain your objection(s) on the Statement of Compliance and Exception(s) form. Clauses in **blue** type in the *Draft Contract* are deemed mandatory and are nonnegotiable.

Conditional or qualified proposals, unless specifically allowed, shall be subject to rejection in whole or in part. The proposal must contain a high degree of acceptance of contract terms and conditions listed in the draft contract provided as **Appendix A** of this RFP. Refer to **RFP Section 9.15**.

A proposal response that includes terms and conditions that do not conform to the terms and conditions in the RFP and the draft contract is subject to rejection as non-responsive. The MDFA reserves the right to permit the Vendor to withdraw nonconforming terms and conditions from its proposal response prior to a determination by the MDFA of non-responsiveness based on the submission of nonconforming terms and conditions. As a precondition to proposal acceptance, the MDFA may request the Vendor to withdraw or modify those portions of the proposal deemed non-responsive that do not affect the quality, quantity, price, or delivery of the service.

## Statement of Compliance and Exception(s) Form

Vendor taking exception to any part or section of the solicitation shall indicate such exceptions on the table below. If no exceptions are taken, then the Vendor shall state in this section "No Exceptions Taken." Failure to indicate any exception will be interpreted as the Vendor's intent to comply fully with the requirements as written. Conditional or qualified proposals, unless specifically allowed, shall be subject to rejection in whole or in part.

We agree to adhere to all terms, conditions, and requirements as set forth in the *MDFA OI's Request for Proposal for Medical Claims and Performance Audit Services, dated July 11, 2024*, including all RFP amendments, and the conditions contained in the draft contract included as **RFP Appendix A, Draft Medical Claims and Performance Audit Services Contract**, except as listed below:

| Procurement Section and Page Number | | Original Language | Requested Change/Exception | MDFA Decision |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

An original signature is required below. This statement must be signed by an appropriate vendor officer, principal, or owner and returned as part of your proposal.

**Company Name:** ______________________________

**Printed Name of Representative, Title:** ______________________________

**Date:** ______________________________

**Signature:** ______________________________

**Note:** Failure to sign this form may result in the proposal being rejected as non-responsive. Modifications or additions to any portion of this proposal document may be cause for rejection of the proposal.

## SECTION 5. STATUTORY REQUIREMENT DISCLOSURE STATEMENT

In accordance with § 25-15-9(1)(a) of the Mississippi Code Annotated, each entity that submits a proposal in response to this RFP **must provide a disclosure statement detailing any services or assistance it provided during the previous fiscal year to the Board and/or OI in the development of the Plan including any resulting compensation for these services.** The statement must include a detailed description of the vendor's participation in the development of the Plan, as well as any resulting compensation received from the Board and/or OI during the previous fiscal year. **If you did not provide such assistance to the Board and/or OI, indicate in your statement that this provision does not apply to you.**

Mississippi Code Annotated § 25-15-9(1)(a) states in part:

> *"…The board may employ or contract for such consulting or actuarial services as may be necessary to formulate the plan, and to assist the board in the preparation of specifications and in the process of advertising for the bids for the plan. Those contracts shall be solicited and entered into in accordance with Section 25-15-5. The board shall keep a record of all persons, agents and corporations who contract with or assist the board in preparing and developing the plan. The board in a timely manner shall provide copies of this record to the members of the advisory council created in this section and those legislators, or their designees, who may attend meetings of the advisory council. The board shall provide copies of this record in the solicitation of bids for the administration or servicing of the self-insured program. Each person, agent or corporation that, during the previous fiscal year, has assisted in the development of the plan or employed or compensated any person who assisted in the development of the plan, and that bids on the administration or servicing of the plan, shall submit to the board a statement accompanying the bid explaining in detail its participation with the development of the plan. This statement shall include the amount of compensation paid by the bidder to any such employee during the previous fiscal year. The board shall make all such information available to the members of the advisory council and those legislators, or their designees, who may attend meetings of the advisory council before any action is taken by the board on the bids submitted. The failure of any bidder to fully and accurately comply with this paragraph shall result in the rejection of any bid submitted by that bidder or the cancellation of any contract executed when the failure is discovered after the acceptance of that bid.…"*

**Failure to provide this disclosure statement may result in your proposal being eliminated from further consideration**.

The following is a list of persons, agents, and corporations who have contracted with or assisted the Board in preparing and developing the State of Mississippi State and School Employees' Health Insurance Plan within the past fiscal year:

**Vendors:**

| | |
|---|---|
| ActiveHealth® Management, Inc. | Health & Wellness Management Services |
| Blue Cross & Blue Shield of Mississippi | Third Party Medical Claims Administrator |
| Caremark PCS Health (CVS Pharmacy, Inc) | Pharmacy Benefit Manager |
| Cavanaugh Macdonald Consulting, LLC | Other Post-Employment Benefits Actuary |
| Brown & Brown f/k/a Claims Technologies Inc. | Medical Claims & Perf. Audit Services |
| Gallagher Benefit Services, Inc. | Health & Life Insurance Consulting Services |
| Health Data & Management Solutions, Inc. | Decision Support Services |

| | |
|---|---|
| Acentra Health f/k/a Keystone Peer Review Organization, Inc. (Kepro) | Utilization Management Review Services |
| Minnesota Life Insurance Company | Life Insurance Services |
| PillarRx Consulting, LLC | Pharmacy Claim & Perf. Audit Services |
| Wm. Lynn Townsend, FSA, MAAA | Consulting Actuary |

**State and School Employees Health Insurance Management Board Members**:

Liz Welch (Chairman) – Executive Director, Department of Finance and Administration
Christopher J. Burkhalter (Vice-Chairman) – Consulting Actuary, Burkhalter Consulting Actuaries
Commissioner Mike Chaney – Commissioner, Mississippi Insurance Department
Dr. Alfred Rankins, Jr. – Commissioner, Institutions of Higher Learning
Mark Formby – Chairman, Workers' Compensation Commission
Kelly Hardwick – Executive Director, State Personnel Board
Kell Smith – Executive Director, State Board of Community Colleges
Ray Higgins, Jr. – Executive Director, Public Employees' Retirement System
Larry Fortenberry – President, Executive Planning Group
The Honorable J. Walter Michel – Chairman, Senate Insurance Committee
The Honorable Henry Zuber – Chairman, House Insurance Committee
The Honorable W. Briggs Hopson – Chairman, Senate Appropriations Committee
The Honorable John Read – Chairman, House Appropriations Committee

**MDFA OI Staff:**

Bert Emrick – State Insurance Administrator
Carlotta Edwards – Director, Benefits & Participant Services
Alicia Coleman – Director, Procurement and Contracts
Cindy Bradshaw – Contractual Consultant

## SECTION 6. GENERAL QUESTIONNAIRE

Failure to answer the following general questionnaire completely will result in Vendor being determined nonresponsive. In preparing your written response to the narrative questionnaire below, you are required to repeat each question, including the number, or requirement followed by your response. Please provide complete answers and explain all issues in a concise, direct manner. If you cannot provide a direct response for some reason (e.g., your company does not collect or furnish certain information), please indicate the reason rather than providing general information that fails to answer the question. "Will discuss" and "will consider" are not appropriate answers.

**6.1** Provide the name, title, mailing address, email address, and telephone number of the contact person for this proposal.

**6.2** Provide the physical location and mailing address of your company's home office, principal place of business, and place of incorporation.

**6.3** State the full legal name of your company, and provide the web address, address, and telephone number of your principal place of business.

**6.4** List the office that will service the Board. If it is located at a different address than the home office, provide the complete address, phone number, and facsimile number for this office.

**6.5** Describe your organizational structure. Indicate whether your company operates as a corporation, partnership, individual, etc. If it is incorporated, include the state in which it is incorporated, and list the names and occupations of those individuals serving on your company's Board of Directors.

**6.6** How long has the company been providing the equivalent or similar services in requirements and scale to those medical claims and performance audit services described within this RFP? Please indicate the month and year in which your company was established, as well as the date it began providing said services.

**6.7** What was the average number of employees of your company during calendar year 2022? Please list the net change in the number of employees in your company from December 2021 to December 2022, with an explanation if change is significant.

**6.8** List the name(s) of any medical claims third party administrator or any insurance company which your company has performed any work for, services to, or received compensation from.

**6.9** List the name and principal occupation or business of any person or entity owning ten percent (10%) or more of your company.

**6.10** List the name(s) of any organizations of which your company owns or controls five percent (5%) or more.

**6.11** State if the proposed account manager, any officers or principals and/or their immediate families are or have been within the preceding twelve (12) months, employees of the State of Mississippi.

**6.12** Is your company currently for sale or involved in any transaction to expand or to become acquired

by another business entity?  If the answer is yes, please discuss the impact both in organizational and directional terms.

**6.13** Describe any ownership, name changes, or other organizational structure changes (such as, but not limited to mergers, acquisitions, addition or elimination of product or business lines, etc.) that your company has been through in the past three (3) years or that is planned in the next three (3) years?

**6.14** Provide a brief description of any outside vendors or subcontractors that will be involved in providing key services detailed within your proposal. Please include the term of your current contract with each vendor or subcontractor. Describe the nature of the relationship with the subcontractor, including any ownership interest.

**6.15** Has your company ever been involved in a lawsuit involving any area covered by this RFP? If the answer is yes, please provide details including dates and outcomes.

**6.16** Has your company been cited or threatened with citation within the last three (3) years by federal or state regulators for violations of any federal, state, or local law or federal, state, or local regulation? If the answer is yes, please describe the circumstances in detail.

**6.17** Has your company had any HIPAA breaches or incidents determined to be reportable to the U.S. Department of Health and Human Services (DHHS) within the last five (5) years? If the answer is yes, please describe the circumstances and the corrective action in detail.

**6.18** During the past five (5) years, has your company, related entities, principals, or officers ever been a party in any material criminal litigation, whether directly related to this RFP or not? If the answer is yes, please provide details including dates and outcomes.

**6.19** Does your company perform any work for, services to, or receive compensation from any third-party administration company or any insurance company? If the answer is yes, please explain.

**6.20** The selected auditor must cooperate with the Board and with all other contractors of the Board with respect to ongoing coordination and delivery of services and in any transition of responsibilities. Confirm your company will comply with this requirement.

**6.21** Confirm the proposal is valid for one (1) year after the date of submission.

## SECTION 7. TECHNICAL QUESTIONNAIRE

Failure to answer the following questionnaire completely will result in Vendor being determined nonresponsive. In preparing your written response to the narrative questionnaire below, you are required to repeat each question, including the number, or requirement followed by your response. Please provide complete answers and explain all issues in a concise, direct manner. If you cannot provide a direct response for some reason (e.g., your company does not collect or furnish certain information), please indicate the reason rather than providing general information that fails to answer the question. "Will discuss" and "will consider" are not appropriate answers.

### 7.1 Account Management

**7.1.1** Describe the team dedicated to providing the requested scope of services for the Board. Specifically,

a. Identify the dedicated account manager who will serve as the primary contact for the Board and OI.
b. Provide a job description including experience requirements of the account manager and any supervisory and/or support personnel who will be assigned to this contract and include resumes as an appendix to your proposal in Section 10.
c. Provide the name(s) and resumes of all key personnel who will oversee and provide the services rendered to the Board, a brief statement as to why each person is qualified relative to this work and identify area(s) of expertise for each key person, detailed information on any special training or designation, and each person's respective total number of years of experience related to the services being requested in this RFP. Specifically identify the account manager who will serve as the primary contact for the Board and the auditor(s). Include all resumes as an appendix to your proposal in Section 10. The Board understands that auditor(s) will be assigned to projects based on the type of project to be undertaken and the expertise and experience of the individual auditor. For example, based on an auditor's expertise and experience, the proposed vendor may assign the auditor to assist in the selection and implementation of a medical third-party administrator claims, but may assign a different auditor to assist in the selection of a life insurance company. Briefly identify the area(s) of expertise for each auditor and provide specific examples of previous work.

**7.1.2** The Board and OI must have prompt and direct access to the auditor(s) throughout the contract period. Describe in detail how your company will provide this access.

### 7.2 Client Service and Communications

**7.2.1** Do you publish newsletters and other informative publications that are routinely provided to your clients? If the answer is yes, please provide recent samples.

**7.2.2** Has your company conducted surveys of major private and public employers to determine trends in medical benefit plans and their administration? If the answer is yes, what were the specific topics of surveys your company conducted during the past two (2) years? Are the results routinely provided to clients? If the answer is yes, please provide recent survey copies.

**7.2.3** Detail your company's ability to monitor and level of service support for upcoming technical, regulatory, and legislative updates/changes at both the state and federal level that are routinely

provided to your clients? Please provide recent sample copies. Describe how this would be communicated to the Board.

## 7.3 Medical Claims and Performance Audit Services

**7.3.1** Describe your organization's process for conducting a comprehensive and objective audit of medical claims processed by a medical claims third party administrator. Please provide three (3) "sanitized" examples of medical claims third party administrator audit findings and recommendation report prepared by your company within the last two (2) years. These examples should not include any auditor or client identifiers.

**7.3.2** Describe your company's technique for determining a sample size for a plan of our size including confidence level, confidence interval, etc. Please provide an explanation and justification for the sample size selected. Will the OI be allowed to adjust this sample size? What is the minimum sample size your company uses?

**7.3.3** Describe your company's work experience with clients and resources available to assist clients related to compliance with the Health Insurance Portability and Accountability Act (HIPAA) to include the Administrative Simplification and Security Rule provisions, specifically as it relates to the Standards for Privacy of Individually Identifiable Health Information.

**7.3.4** The Board may request the contracted medical claims and performance auditor to provide information on current medical practices and procedures to include coding and filing practices. Describe your company's ability to assist the Board with such inquiries. Please provide "sanitized" examples of any such reports or communications you have prepared to demonstrate your experience and proficiency in this area.

**7.3.5** Describe your company's system controls, security protocols, and any other resources used to ensure the confidentiality and integrity of the Plan's data and information to include a general description of your company's information and data systems.

**7.3.6** What information or services will your company need from MDFA OI to ensure a smooth audit?

**7.3.7** Describe your company's process for analyzing claims to ensure appropriate Plan benefits have been approved by the TPA.

## 7.4 Medical Claims and Performance Audit Experience

**7.4.1** Has your company performed medical claims audits for other state employer health plans? If the answer is yes, please provide a brief description of the specific audits' duties, the number of covered lives for the plan, and indicate whether the plans were self-insured.

**7.4.2** Has your company ever performed an audit of Blue Cross Blue Shield? If the answer is yes, please provide a brief description.

**7.4.3** What auditing standards does your organization adhere to?

**7.4.4** Does your company routinely undergo SOC audits? If the answer is yes, when was the last such audit completed, and were there any material findings? Provide a copy of your most recent audit. Indicate how often these audits are performed.

## SECTION 8. FEE SCHEDULE

The Fee Schedule must be submitted as described herein. Modification or addition to any portion of the Fee Schedule may be cause for rejection of the proposal. The pricing quoted shall be inclusive of, but not limited to the following: general office expense; all required labor; all required equipment/material; all required insurance, bond, or other surety; all required overhead/profit; all required applicable taxes; all required vehicles; all required fuel and mileage; all required travel; all required labor and supervision; all required training; all required business and professional certifications, licenses, permits, or fees; and, any and all other direct or indirect costs, incurred or to be incurred. All pricing shall include all associated costs with no additional or hidden fees. The pricing quoted shall constitute the entire compensation due to the Vendor for services rendered. Pricing must be firm, flat dollar amounts, as percentage of other variable amounts will not be accepted. The fees/rates for each of the five (5) years must be included.

The proposing vendor's position units, unit rates (hourly charges), along with maximum annual project rates to provide medical claims and performance audit services are listed below.

| Hourly Fee by Position | Year 1 | Year 2 | Year 3 | Year 4 | Year 5* |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

* *Optional Renewal Year*

### MAXIMUM PROJECT COSTS

Maximum project fees are not to be construed as the annual fees to be paid for each project. The amount paid each year for the specified annual project will be the lesser of the total fees based on the fee schedule above, or the stated maximum project cost listed below. Maximum project fees include any and all necessary expenses, including but not limited to travel for the annual trip to Jackson, Mississippi or other location designated by the Board and/or MDFA to present the report(s) as well as any and all necessary expenses, unless otherwise approved by the Board.

| PROJECT | Year 1 | Year 2 | Year 3 | Year 4 | Year 5* |
|---|---|---|---|---|---|

| Claims and Performance Audit | | | | | |
|---|---|---|---|---|---|

* *Optional Renewal Year*

The fees listed above are firm for the duration of the contract and are not subject to escalation for any reason unless the contract is duly amended. No additional compensation shall be provided by the Board for any expense, cost, or fee not specifically authorized by the resulting contract. The Board will not pay any upfront fees prior to the contract effective date nor any prepayments or initial deposits in advance of services being rendered. All fees or charges related to any service to be provided must be identified.

The fees listed above shall constitute the entire compensation due to the selected vendor for services and all of the selected vendor's obligations hereunder regardless of the difficulty, materials, or equipment required. Fees for services provided by the selected vendor shall be billable to the Board in arrears on a monthly basis. Only those services agreed to by contract shall be considered for reimbursement/compensation by the Board. Payment for any and all services provided by the selected vendor to the Board shall be made only after said services have been duly performed and properly invoiced.

The Contractor shall submit all invoices in a form acceptable to the Board with all of the necessary supporting documentation prior to the payment of allowable costs. Such invoices will, at a minimum, include the appropriate/sufficient descriptions of the services being billed or other bases for charges included in **RFP Section 8, Fee Schedule**, such as, but not limited to, the quantity or number of hours billed, the compensation rate, the time period in which the services were provided, total compensation requested for each individual service being billed, and the total administrative fee requested for the period being invoiced. Details will be determined during contract negotiations.

The payment of an invoice by the Board shall not prejudice the Board's right to object or question any invoice or matter in relation thereto. Such payment by the Board shall neither be construed as acceptance of any part of the work or service provided nor as an approval of any costs invoiced therein. The Contractor's invoice or payment shall be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the Board, on the basis of audits, not to constitute allowable costs. Any payment shall be reduced for overpayment or increased for underpayment on subsequent invoices. For any amounts which are or shall become due and payable to the Board and/or the Plan by the Contractor, the Board reserves the right to (1) deduct from amounts which are or shall become due and payable to the Contractor under contract between the parties; or (2) request and receive payment directly from the Contractor within fifteen (15) days of such request, at the Board's sole discretion.

The Board reserves the right to deduct from amounts which are or shall become due and payable to the Contractor under the Contract between the parties. Notwithstanding anything to the contrary herein, any reduction of payments to shall be made only with the prior agreement of both parties. In addition, in the event of termination of the Contract for any reason, the Contractor shall be paid for services rendered and allowable expenses incurred up to the effective date of termination.

Compensation to the Contractor for travel outside of the annual trip to Jackson, Mississippi or other location designated by the Board and/or MDFA that is included in the maximum project fees to present the report(s) shall be subject to the following criteria:

a. To be compensable by the Board, travel expenses must be reasonable and necessary for the fulfillment of the project and contractual obligations;

b. Air travel reimbursement will be limited to “Coach” or “Tourist” class rates, and must be supported by a copy of an original invoice;

c. Meals and lodging expenses will be reimbursed in the amount of actual costs, subject to the maximum per diem as defined in the Federal Register. A copy of all hotel and meal receipts must be provided.

d. Taxi fares, reasonable rental car expenses, and airport parking expenses will be reimbursed in the amount of actual costs, and must be supported by a copy of an original receipt/invoice;

e. Personal automobile mileage and related costs are not compensable expenses;

f. Time spent in “travel status” is not compensable. Unit rates in the Fee Schedule for Medical Claims and Performance Audit Services, are to be charged for actual hours worked only and shall not include travel time.

## SECTION 9. RFP PROCESS OVERVIEW FOR VENDORS

### 9.1 Instructions to Vendors

- Proposals must be submitted by **2:00 PM CST on August 14, 2024**.

- Proposals may be submitted in a paper format via the two address options below or electronically via the State of Mississippi's Accountability System for Governmental Information and Collaboration (MAGIC). Registering as a supplier with the State of Mississippi allows businesses to register for upcoming RFx opportunity notifications by the products or services they supply, search the system for upcoming RFxs, respond to RFxs electronically, and receive purchase orders by email. In order to register, please go to the following website: https://www.dfa.ms.gov/vendor-information. Electronic proposals submitted through MAGIC shall follow the same format as specified within this section.

- **Paper Format** - To prevent opening by unauthorized individuals, all proposal submissions must be sealed in an envelope or package and marked, "**SEALED PROPOSAL – DO NOT OPEN**". The sealed envelope or package shall be marked with the Proposal opening time and date, and the number of the RFP. Proposals are subject to rejection unless submitted with the information included on the outside the sealed proposal envelope or package.

  Sealed proposals should be mailed or hand-delivered to and labeled as follows:

  **Address if mailing proposals:**

  RFP RFx Number 3120002810 for Medical Claims and Performance Audit Services
  Opening Date: 3:00 PM CST, August 14, 2024
  Mississippi Department of Finance & Administration, Office of Insurance
  Attention: Alicia Coleman, MDFA OI Procurement and Contracts Director
  P.O. Box 24208
  Jackson, Mississippi 39225-4208
  **SEALED PROPOSAL – DO NOT OPEN**

  **Address if hand delivering proposals:**

  RFP RFx Number 3120002810 for Medical Claims and Performance Audit Services
  Opening Date: 3:00 PM CST, August 14, 2024
  Mississippi Department of Finance & Administration, Office of Insurance
  Attention: Alicia Coleman, MDFA OI Procurement and Contracts Director
  501 North West Street, Suite 1201-C Woolfolk Building
  Jackson, Mississippi 39201
  **SEALED PROPOSAL – DO NOT OPEN**

  The time and date of receipt will be indicated on the sealed proposal envelope or package by Agency staff. The only acceptable evidence to establish the time of receipt at the office identified for proposal opening is the time and date stamp of that office on the proposal wrapper or other documentary evidence of receipt used by that office.

If submitted in a paper format, the original written proposal shall be signed with two identical copies of the original each submitted in a three-ring binder. The three (3) file versions of their proposal described below (Complete, Blind and Redacted) must be clearly labeled/identified. One electronic copy must be included with the three (3) separate/distinct files in a searchable Microsoft Office® format, preferably in Word® or Portable Document Format (PDF®) on flash drive or compact disk.

- Proposals submitted by facsimile (fax) machine will not be accepted/considered.

- All vendors are urged to take the possibility of delay into account when submitting a proposal. Timely submission of the proposal package is the responsibility of the Vendor. Proposals received after the specified time will not be considered. It is suggested that if a proposal is mailed to MDFA, it should be posted in certified mail with a return receipt requested. MDFA will not be responsible for mail delays or lost mail. All risk of late arrival due to unanticipated delay – whether delivered by hand, U.S. Postal Service, courier or other delivery service or method – is entirely on the Vendor.

- Proposals received after the specified time will be rejected and maintained unopened in the procurement file. A proposal received at the place designated in the solicitation for receipt of proposals after the exact time specified for receipt will not be considered unless it has been determined by the Agency that the late receipt was due solely to mishandling by the Agency after receipt at the specified address.

- **Submission Format** – Each vendor must submit their proposal in the style and format outlined herein.

  The proposal shall consist of three (3) separate units: Cost, Technical, and Management. Pursuant to Mississippi Code Annotated §§ 27-104-7 and 31-7-401 through 31-7-423, the State of Mississippi requires a blind evaluation of certain factors not requiring knowledge of the name of the Vendor. All vendor-identifying information shall be removed and/or redacted. Identifying information includes, but is not limited to, any prior, current, and future names or addresses of the Vendor, any names of incumbent staff, any prior, current and future logos, watermarks, and company colors, any information which identifies the Vendor as an incumbent, and any other information, which would affect the blind evaluation of technical factors. The Technical Unit shall have no identifying information, while the Cost and Management Units will be allowed to have identifying information. Any proposals that do not adhere to these requirements within the "Blind" copy described below will be deemed non-responsive and may be rejected on that basis.

  The three units of the proposal shall be comprised of the following eleven (11) sections. It is the Vendor's responsibility to organize and separate the information into units and sections accordingly. **Cost Unit is Section 8; Technical Unit consists of Section 7; and Management Unit consists of Sections 1-6 and 9-11.**

  **The proposal should be labeled and submitted as applicable per file version:**

  **Section 1 –** Introduction/Signed Proposal Cover Letter

  **Section 2 –** Scope of Services Confirmation

  **Section 3 –** Minimum Vendor Requirements Confirmation

**Section 4** –Signed Statement of Compliance and Exception(s) form

**Section 5** – General Questionnaire

**Section 6** – Signed Statutory Requirement Disclosure Statement

**Section 7** – Technical Questionnaire

**Section 8** – Fee Schedule

**Section 9** – Signed Acknowledgement of RFP Amendments (if any)

**Section 10** – Résumés for Key Staff: Provide a complete résumé of key vendor staff who will be assigned to render services to the Board, including detailed information on any special training or designations and each person's respective total number of years of experience related to the services being requested in this RFP.

**Section 11** – Any Additional Information Not Specifically Requested: If you have additional information you would like to provide, include it as Section 11 of your proposal. It is the Vendor's sole responsibility to submit information relative to the evaluation of its proposal and the MDFA is under no obligation to solicit such information if it is not included in the proposal.

- Each page of the proposal should be numbered. Multiple page attachments and samples should be numbered internally within each document, and not necessarily numbered in the overall page number sequence of the entire proposal. The intent of this requirement is for the Vendor to submit all information in a manner that is clearly referenced and easily located.

- Vendors shall submit the following three (3) versions of their proposal as separate/distinct files:

1. **Complete Proposal File** - Provide one (1) electronic copy of the complete proposal including all attachments in a searchable Microsoft Office® format, preferably in Word® or Portable Document Format (PDF®);

2. **Blind Proposal File** - Provide one (1) electronic "blind" technical proposal (Section 7 or Technical Unit) in a searchable Microsoft Office® format, preferably in Word® or PDF®. The Vendor is responsible for ensuring that the "blind" copy shall have no identifying information, specifically within the technical proposal. This requirement is necessary to help ensure the anonymity of the vendors from the evaluation committee that will review proposals. **Blind proposals containing vendor-identifying information may be disqualified**; and

3. **Redacted Proposal File** - Provide one (1) "redacted" electronic copy of the complete proposal including all attachments and referenced documents in a searchable Microsoft Office® format, preferably in Word® or PDF®, if the proposal contains confidential information, as described below. If any portion of the proposal is considered confidential or proprietary, the Vendor shall also include an additional electronic "redacted" copy in PDF® of the complete proposal, including all appendices and exhibits, with all trade secrets or confidential commercial or financial information redacted. If the proposal does not contain any confidential information to be redacted, please state such in your Introduction/Signed Proposal Cover Letter. Failure to submit an

electronic “redacted” copy of your proposal or include a statement that no information will be redacted may cause your proposal to be considered incomplete and it may be rejected from consideration.

Any vendor claiming that its response contains information exempt from the Mississippi Public Records Act (Mississippi Code Annotated §§ 25-61-1 *et seq.* and 79-23-1), shall segregate and mark the information as confidential and provide the specific statutory authority for the exemption. If the proposal contains confidential information, one (1) redacted electronic copy of the complete proposal including all attachments shall be submitted in a searchable Microsoft Office® format, preferably in Word® or PDF®.

**<u>If a redacted copy is not submitted, OI shall consider the entire Proposal to be public record.</u>** The redacted copy should identify which section or information has been redacted and the Vendor shall provide the specific statutory authority for the exemption. Per Mississippi Code Annotated § 25-61-9(7), the type of service to be provided, the price to be paid, and the term of the Contract cannot be deemed confidential.

The redacted copy shall be considered public record and immediately released, without notification to the Vendor, pursuant to any request under the Mississippi Public Records Act, Mississippi Code Annotated §§ 25-61-1 *et seq.* and 79-23-1. Redacted copies shall also be used/released for any reason deemed necessary by OI, including but not limited to, submission to the PPRB, posting to the Transparency Mississippi website, etc.

In accordance with *PPRB OPSCR Rules and Regulations Section 1-301*, “Any party seeking a protective order on a procurement contract awarded by state agencies shall give notice to and provide the reasons for the protective order to the party requesting the information in accordance with the Mississippi Rules of Civil Procedure. The notice and reasons for the protective order must also be posted on the Mississippi Procurement Portal for a minimum of seven (7) days before filing the petition seeking the protective order in a chancery court. Any party seeking a protective order in violation of this subsection may be barred by a state agency from submitting bids, proposals or qualifications for state procurements for a period not to exceed five (5) years.” Any records requested through a public records request shall be released no later than twenty-one (21) days from the date the third parties are given notice by the public body unless the third parties have followed the notification requirements and also filed in chancery court a petition seeking a protective order on or before the expiration of the twenty-one (21) daytime period.

- All documentation submitted in response to this RFP and any additional information submitted in response to subsequent requests for information pertaining to this RFP shall become the property of OI and will not be returned to the Vendor.

- All information requested is considered important. Failure to provide all requested information and in the required format may result in disqualification of the Proposal. OI has no obligation to locate or acknowledge any information in the proposal that is not presented under the appropriate outline and in the proper location according to the instructions herein.

- If determined that the Vendor has altered any language in the original RFP, the Board may, at its sole discretion, disqualify the Vendor from further consideration. The RFP issued by the Board is the official version and will supersede any conflicting language subsequently submitted in proposals.

## 9.2 Important Dates and Deadlines

| | |
|---|---|
| **July 11, 2024** | Request for Proposal released |
| **July 25, 2024, 5:00 PM CST** | Questions and Requests for Clarification due to OI |
| **July 30, 2024, 5:00 PM CST** | Anticipated responses to vendor questions to be posted |
| **August 14, 2024, 2:00 PM CST** | Proposals submission deadline |
| **August 14, 2024, 3:00 PM CST** | Proposal Opening |
| **September 13, 2024** | Anticipated Finalists selected |
| **September 19-20, 2024** | Anticipated Presentations by finalists* |
| **October 2024 Board Meeting** | Anticipated Notice of Intent to Award distributed |
| **2 Days following Board Meeting** | Anticipated Notice of Contract Award published |
| **3 Business Days of Notice of Intent to Award** | Anticipated Post-Award Debriefing Request Due Date |
| **3 Business Days of Debriefing Request** | Anticipated Post-Award Debriefing Held by Date |
| **7 Calendar Days of Notice of Intent to Award** | Anticipated Protest Deadline Date |
| **January 1, 2025** | Contract(s) Effective Date/Services Begin |

* Adjustments to the schedule may be made as deemed necessary by OI. The Board anticipates vendors selected as finalists will make presentations (possibly virtual) in Jackson, Mississippi. **Due to the constraints of the RFP timeline and the relative importance of presentations in the evaluation process, interested vendors are encouraged to be prepared to accommodate this schedule.**

## 9.3 Contact, Questions/Requests for Clarification, and Acknowledgment of Responses/RFP Amendments

Vendors must carefully review this solicitation, the Contract, risk management provisions, and all attachments for defects, questionable, or objectionable material. Following review, vendors may have questions to clarify or interpret the RFP to submit the best proposal possible. To accommodate the questions and requests for clarifications, vendors shall submit any such question via email by the deadline reflected in **RFP Section 9.2**. All questions and requests for clarifications must be directed by email to:

**Alicia Coleman, MDFA OI Procurement and Contracts Director**
**Email: InsuranceRFP@dfa.ms.gov**

Vendors should enter "**RFP RFx Number 3120002810 - Questions**" as the subject for the email. Question submittals should include a reference to the applicable RFP section and be submitted in the format shown below:

| | RFP Section, Page Number | Vendor Question/Request for Clarification |
|---|---|---|
| 1. | | |

Official responses will be provided only for questions submitted as described above and only to clarify information already included in the RFP. The identity of the organization submitting the question(s) will not be revealed. All questions and answers will be published on the Mississippi Contract/Procurement Opportunity Search Portal website and the MDFA's website as an amendment to the RFP by the date and time reflected in **RFP Section 9.2**.

The MDFA will not be bound by any verbal or written information that is not contained within this RFP unless formally noticed and issued by the contact person as an RFP amendment. Vendors are cautioned that any statements made by MDFA personnel that materially change any portion of the proposal document shall not be relied upon unless subsequently ratified by a formal written amendment to the proposal document.

All vendor communications regarding this RFP must be directed to the Proposal Coordinator, Alicia Coleman. Unauthorized contact regarding the RFP with other employees of the MDFA may result in the Vendor being disqualified, and the Vendor may also be suspended, disbarred, or removed from consideration for award of contracts with the State of Mississippi for a period of two (2) years. At no time shall any vendor or its personnel contact, or attempt to contact, any MDFA staff regarding this RFP except the contact person as set forth and, in the manner, prescribed herein.

No pre-proposal conference will be held for this RFP.

OI reserves the right to amend this RFP at any time. Should an amendment to the RFP be issued, it will be posted on the Mississippi Contract/Procurement Opportunity Search Portal website and the MDFA's website under the heading "Solicitations" in a manner that all vendors will be able to view. Vendors must acknowledge receipt of any amendment to the solicitation by signing and returning the amendment with the proposal package, by identifying the amendment number and date in the space provided for this purpose on the RFP amendment, or by letter. The acknowledgment should be received by the MDFA by the time, date, and at the place specified for receipt of proposals. It is the Vendor's sole responsibility to monitor the websites for any updates or amendments to the RFP. Questions and Answer document(s), if any are issued/posted on the Mississippi Contract/Procurement Opportunity Search Portal website and the MDFA's website, must be treated the same as an RFP Amendment, meaning they will require acknowledgement.

The RFP is comprised of the base RFP document, any attachments, any amendments issued prior to the submission deadline, and any other documents released before contract award.

### 9.4 Corrections and Clarifications

OI reserves the right to request clarifications or corrections to proposals. Any proposal received which does not meet any of the requirements of this RFP, including clarification or correction requests, may be considered non-responsive and eliminated from further consideration.

### 9.5 Modification, Withdrawal, or Rejection of a Proposal

Modifications or additions to any portion of the procurement document may be cause for rejection of the Proposal. OI reserves the right to decide, on a case-by-case basis, whether to reject a proposal with modifications or additions as non-responsive. As a precondition to proposal acceptance, OI may request the Vendor to withdraw or modify those portions of the proposal deemed non-responsive that do not affect

quality, quantity, price, or delivery of the service. The RFP issued by OI is the official version and will supersede any conflicting RFP language subsequently submitted in proposals.

A vendor may withdraw a submitted proposal by submitting a written notification for its withdrawal to OI, signed by the Vendor, and emailed, or mailed to the addresses provided **within RFP Section 9.1** prior to the time and date set for proposal opening. OI shall not accept any amendments, revisions, or alterations to proposals after the due date unless requested by OI. Late proposals shall not be considered for award and the Vendor shall be notified as soon as practicable.

If the price bid/offered is substantially lower than those of other vendors, a mistake may have been made. A vendor may withdraw its proposal from consideration if certain conditions are met:

1. The proposal is submitted in good faith;
2. The price bid/offered is substantially lower than those of other vendors because of a mistake;
3. The mistake is a clerical error, not an error of judgment; and,
4. Objective evidence drawn from original work papers, documents, and other materials used in the preparation of the proposal demonstrates clearly that the mistake was an unintentional error in arithmetic or an unintentional omission of a quantity of labor or material.

To withdraw a proposal that includes a clerical error after proposal opening, the Vendor must give notice in writing to OI of claim of right to withdraw a proposal. Within two (2) business days after the proposal opening, the Vendor requesting withdrawal must provide to OI all original work papers, documents, and other materials used in the preparation of the bid/offer.

A vendor may also withdraw a bid/offer, prior to the time set for the opening of proposals, by simply making a request in writing to OI. No explanation is required.

No vendor who is permitted to withdraw a proposal shall, for compensation, supply any material or labor to or perform any subcontract or other work for the person to whom the Contract is awarded, or otherwise benefit from the Contract.

No partial withdrawals of a proposal are permitted after the time and date set for the proposal opening; only complete withdrawals are permitted.

A proposal that includes terms and conditions that do not conform to the terms and conditions in the RFP document is subject to rejection as non-responsive. Further, submission of a proposal that is not complete and/or signed is subject to rejection as non-responsive. OI reserves the right to permit the Vendor to withdraw nonconforming terms and conditions from its proposal prior to a determination by OI staff of non-responsiveness based on the submission of nonconforming terms and conditions.

### 9.6 Right to Consider Historical Information

OI reserves the right to consider historical information regarding the Vendor, whether gained from the Vendor's proposal, conferences with the Vendor, references, or any other source during the evaluation process. This may include, but is not limited to, information from any state or federal regulatory entity.

### 9.7 Right to Reject, Cancel and/or Issue Another RFP

OI specifically reserves the right to reject any or all proposals received in response to the RFP, cancel the RFP in its entirety, or issue another RFP.

### 9.8 Cost of Proposal Preparation

All costs incurred by the Vendor in preparing and delivering its proposal, making presentations, and any subsequent time and travel to meet with the Board regarding its proposal shall be borne exclusively by the Vendor.

### 9.9 Registration with Mississippi Secretary of State

By submitting a proposal, the Vendor certifies that it is registered to do business in the State of Mississippi as prescribed by Mississippi law and the Mississippi Secretary of State or, if not already registered, that it will do so within seven (7) business days of being notified by the MDFA that it has been selected for contract award. Sole proprietors are not required to register with the Mississippi Secretary of State.

### 9.10 Vendor Investigations and Certifications

Before submitting a proposal, each vendor shall make all investigations and examinations necessary to ascertain all site conditions and requirements affecting the full performance of the Contract and to verify any representations made by the MDFA upon which the Vendor will rely. If the Vendor receives an award because of its proposal submission, failure to have made such investigations and examinations will in no way relieve the Vendor from its obligation to comply in every detail with all provisions and requirements of the Contract documents, nor will a plea of ignorance of such conditions and requirements be accepted as a basis for any claim whatsoever for additional compensation.

By submitting a proposal, the Vendor certifies the following:

1. That he/she has thoroughly read and understands the RFP and all attachments thereto;
2. That the company meets all requirements and acknowledges all certifications contained in the RFP and attachments thereto;
3. That it is not currently debarred from submitting proposals for contracts issued by any political subdivision or agency of the State of Mississippi and that it is not an agent of a person or entity that is currently debarred from submitting proposals for contracts issued by any political subdivision or agency of the State of Mississippi;
4. That the prices submitted in response to the solicitation have been arrived at independently and without, for the purpose of restricting competition, any consultation, communication, or agreement with any other vendor or competitor relating to those prices, the intention to submit a proposal, or the methods or factors used to calculate the prices bid/offered; and,
5. That such vendor has not retained any person or agency on a percentage, commission, or other contingent arrangement to secure this Contract.

The Vendor agrees that submission of a signed proposal, fee schedule, and best and final offer (BAFO) (if requested), is certification that the Vendor will accept an award made to it because of the submission. Under no circumstances, shall the maximum time for proposal acceptance by the State extend beyond one (1) year from the date of opening.

### 9.11 State Approval

It is understood that the resulting contract may require approval by the PPRB. If required and if this contract is not approved, it is void and no payment shall be made hereunder. Every effort shall be made by OI to facilitate rapid approval and a start date consistent with the proposed schedule.

### 9.12 Proposal Evaluation and Basis for Award

All proposals received in response to this RFP by the stated deadline will receive a comprehensive, fair, and impartial evaluation. A formal scoring methodology comprised of three phases – compliance, analysis, and finalist, will be utilized with each proposal required to pass the previous phase to qualify for further evaluation in the next phase. MDFA will use an evaluation committee to review and evaluate the proposals using a 100-point scale as well as consensus scoring. Consensus scoring involves a solidarity or general agreement of opinion among evaluators, based on information and data contained in the RFP proposals. The evaluation of any proposal may be suspended and/or terminated at the OI's discretion at any point during the evaluation process at which time OI determines that said proposal and/or vendor fails to meet any of the mandatory requirements as stated in this RFP, the proposal is determined to contain fatal deficiencies to the extent that the likelihood of selection for contract negotiations is minimal, or OI receives reliable information that would make contracting with the Vendor impractical or otherwise not in the best interests of the Board and/or the State of Mississippi.

**Compliance Phase** - In this initial phase of the evaluation process, all proposals received are reviewed by the MDFA OI Procurement and Contracts Director and/or designee to determine if mandatory RFP requirements have been satisfied, meaning whether a proposal/vendor is responsive, responsible, and/or acceptable. Compliance requirements are not assigned a point percentage or score but are simply recorded as Pass or Fail.

- Every statement containing "must," "shall," "will," etc., is a mandatory requirement. Failure to respond leads to mandatory proposal disqualification. Such mandatory requirements are to be clear and (preferably) standing alone.

- Every statement containing "may," "can," "should," etc., is a desirable requirement. Vendors may ignore these if they wish. The only penalty for doing so is a possible loss of scoring points if the requirement has scoring points tied to it.

A Pass score is assigned to each factor for which the response to the question(s) defined is "Yes." If any factor receives a Fail score or for some reason cannot be evaluated, an explanation of the problem or concern and the corresponding question must be evaluated and made part of the record, to include any allowable waivers.

Proposals with errors that do not alter the substance of the proposal can be accepted, and the MDFA OI Procurement and Contracts Director may allow the Vendor to correct the problem prior to review if the irregularities are insignificant mistakes that can be waived or corrected without prejudice to other vendors. MDFA has the right to waive minor defects or variations of a proposal from the exact requirements of the specifications that do not affect the price, quality, quantity, delivery, or performance time of the services being procured. If insufficient information is submitted by a vendor with the proposal for the MDFA to properly evaluate the proposal, the MDFA has the right to require such additional information as it may deem necessary after the time set for receipt of proposals, provided that the information requested does not change the price, quality, quantity, delivery, or performance time of the services being procured. Discussions may be conducted with vendors who submit proposals determined to be reasonably

susceptible of being selected for the award, but proposals may also be accepted without such discussions. If any component received a Fail score (a "No" response) on any item or contains an item which for some reason cannot be evaluated, it shall be deemed as non-responsive and/or non-responsible. Failure to comply with these RFP requirements may result in the proposal being eliminated from further consideration. All proposals which are determined to be responsive, responsible, and/or acceptable will continue to next phase.

**Analysis Phase** - In this phase of the evaluation process, the evaluation committee will utilize consensus scoring to determine numerical scores for each proposal. The evaluation factors are listed in order of their relative importance and weight:

1. **Cost (Weight/Value of 35%/Points)** – Cost is reviewed by the MDFA OI Procurement and Contracts Director and/or designee as it is objectively scored based on the competitiveness of the proposed fees, rates, price, or cost offered. The lowest cost proposed will receive a maximum of 35 points allocated to cost. The point allocations for cost on the other offers will be evaluated according to the following formula: Price of the lowest responsive and responsible offer divided by the price of the responsive and responsible offer being rated times the maximum 35 points allocated for cost equals the awarded points.

2. **Technical (Weight/Value of 35%/Points)** – Technical factors are scored by the evaluation committee without knowledge of the identity of the Vendor (blind) and generally aid in determining the Vendor's technical ability to perform the service or provide the commodity. The evaluation committee will provide consensus scores of the quality and completeness of the Vendor's solutions and action plans for providing the services identified, demonstrating understanding, responsiveness, effectiveness, efficiency, and value to the Board in proposed approach.

3. **Management (Weight/Value of 25%/Points)** – Management factors are scored with knowledge of the identity of the Vendor and generally aid in determining the Vendor's past performance of the service or provision of the commodity. The evaluation committee will provide consensus scores of the personnel, equipment, and facilities to provide timely access to medical claims and performance audit services for a plan of comparable size; the ability to technically implement and maintain the structure and resources for providing all services listed in this RFP, demonstrating where applicable the ability to perform the service reflected by technical training, education and general experience of staff and a documented record of past performance of providing services required in this RFP.

**Finalist Phase -** Upon completion of the Analysis Phase, the evaluation committee reviews and compares the numerical scores from among the vendors to determine finalists. The top scoring vendor, as well as all other vendors with scores within ten (10) points of the top scoring vendor, will be named as finalists and will be further evaluated. In the finalist phase of the evaluation process, the evaluation committee will seek to determine from among the finalists whose proposal is the most advantageous to the Board. This phase consists of the following components:

1. **Record of Past Performance of Similar Work (Experience and Qualifications)** – From among the finalists, client references will be contacted to verify a demonstration of an acceptable level of past performance for programs of a similar size and complexity to this program. **Weight/Value – This component of the evaluation is considered pass/fail.**

2. **Finalist Presentations and Site Visits (Weight/Value of 5%/Points)** – At the OI's discretion, all finalists may be required to make a presentation to the evaluation committee. If scheduled, individual finalist presentations shall be held either in Jackson, Mississippi, or virtually, to allow the evaluation committee the opportunity to conduct technical interviews of the finalists, and to confirm/clarify information provided in the submitted proposals or otherwise gathered during the evaluation process. Any substantial oral clarification shall be reduced to writing by the Vendor. The Board may also determine the need to conduct site visits as a component of the evaluation process. The Board will provide at least five (5) days advance notice to the impacted vendors. At the Board's discretion, site visits may be conducted for each finalist to allow the evaluation committee the opportunity to observe, confirm, and evaluate the Vendor's operations, systems, and respective resources as described in the response to the RFP. The Board may require access to the Vendor's claims data to confirm the accuracy of information provided in its proposal, and to evaluate the quality of service provided. Due to the constraints of the RFP timeline and the relative importance of presentations and site visits in the evaluation process, interested vendors are encouraged to be prepared to accommodate this schedule.

3. **Best and Final Offer (BAFO)** – At the OI's discretion, all finalists may be given the opportunity to provide a BAFO relative to their cost proposal. OI will notify finalists if a BAFO may be submitted and will establish a date and time for submission. Although a finalist is under no obligation to submit such an offer, any such BAFO should include any applicable revised financial exhibits and must be signed by an appropriate representative of your company. If a finalist chooses to not make a BAFO, the financial proposal included in your company's response to the RFP will be considered as the BAFO. NOTE: Unsolicited BAFO, including but not limited to such offers submitted by non-finalists, will not be accepted. **Weight/Value – The numerical scores for the Cost factor from the Analysis Phase will be adjusted for any BAFO received from a finalist.**

Upon completion of the evaluation of proposals, the evaluation committee will determine the top scoring proposal and provide a recommendation to the Board. The Board will decide as to the proposal deemed most advantageous to the Board and will authorize the issuance of (an) intent to award the contract(s) to the selected vendor(s) and authorize contract negotiations with selected vendor(s). After such authorization by the Board, all participating vendors will be notified in writing of the contract award(s) and will be afforded the opportunity to participate in a post-award debriefing.

The MDFA intends to award one contract to provide the services described within this RFP to a responsible and responsive vendor whose proposal is determined in writing to be the most advantageous to the State taking into consideration the price and the evaluation factors set forth in this RFP. No other factors or criteria shall be used in the evaluation. Award for this procurement will be posted on the Mississippi Contract/Procurement Opportunity Search Portal website and the agency website at https://www.dfa.ms.gov/bids-and-rfps-notices. Vendors will be notified via email of the awards.

OI reserves the right to further clarify and/or negotiate with selected vendor(s) evaluated best following completion of the evaluation of proposals but prior to contract execution if deemed necessary. OI reserves the right to further clarify and/or negotiate with selected vendor(s) on any matter submitted to facilitate arriving at contract(s). OI also reserves the right to move to the next best vendor if negotiations do not lead to executed contract(s) with the best vendor(s).

### 9.13 Post-Award Vendor Debriefing

A vendor, successful or unsuccessful, may request a post-award vendor debriefing, in writing, by email (InsuranceRFP@dfa.ms.gov). Vendors should enter "**RFP RFx Number 3120002810 – Debriefings**" as the subject for the email. The written request must be received by Alicia Coleman, MDFA OI Procurement and Contracts Director, within three (3) business days of notification of contract award(s). A post-award vendor debriefing is a meeting and not a hearing; therefore, legal representation is not required. A debriefing typically occurs within three (3) business days of receipt of the request. If a vendor prefers to have legal representation present, the Vendor must notify Alicia Coleman, MDFA OI Procurement and Contracts Director, in writing and identify its attorney by name, address, and telephone number. The MDFA will schedule and/or suspend and reschedule the meeting at a time when a Representative of the Office of the Mississippi Attorney General can be present.

For additional information regarding Post-Award Vendor Debriefing, as well as the information that may be provided and excluded, please see Section 7-113 through 7-113.07, Post-Award Vendor Debriefing, of the *PPRB OPSCR Rules and Regulations* as updated and replaced by PPRB.

### 9.14 Protest

Any actual or prospective vendor who is aggrieved in connection with this solicitation or the outcome of this RFP may file a protest with Alicia Coleman, MDFA OI Procurement and Contracts Director. The protest shall be submitted within seven (7) calendar days of notification of contract award(s) or on or **before 5:00 PM CST, October 30, 2024**, in writing after such aggrieved person or entity knows or should have known of the facts giving rise thereto. The written protest letter shall contain an explanation of the specific basis for the protest. All protests must be in writing, dated, signed by the Vendor or an individual authorized to sign contracts on behalf of the protesting vendor, and contain a statement of the reason(s) for protest, citing the law(s), rule(s) and regulation(s) or procedure(s) on which the protest is based. The protesting vendor must provide facts and evidence to support the protest. A protest is considered filed when received by Alicia Coleman, MDFA OI Procurement and Contracts Director, via either U.S. mail, postage prepaid, or by personal delivery. Protests filed **after 5:00 PM CST, October 30, 2024**, will not be considered.

### 9.15 Required Contract Terms and Conditions

A draft contract has been included as Appendix A to this RFP for your review and comment. Any contract entered into with the MDFA pursuant to this RFP shall have the clauses in blue font as these are required pursuant to the PPRB OPSCR Rules and Regulations as updated and replaced by PPRB. These required clauses are mandatory and are non-negotiable. MDFA discourages exceptions from the draft contract content, regardless of content being required or not. Such exceptions may cause a proposal to be rejected as non-responsive. Proposals which condition the proposal based upon the State accepting other terms and conditions not found in the RFP, or which take exception to the State's terms and conditions, may be found non-responsive, and no further consideration of the proposal will be given.

### 9.16 Agency Website

This RFP, any amendment thereto, such as Questions and Answer document(s) and Summary of Pre-Proposal Conference, Tour, or Site Visit, if any were issued, the Notice of Intent To Award, and the Evaluation Report will be posted on the agency website at https://www.dfa.ms.gov/bids-and-rfps-notices

and on the Mississippi Contract/Procurement Opportunity Search Portal website at https://www.ms.gov/dfa/contract_bid_search.

### 9.17 Attachments

The attachments to this RFP are made a part of this RFP as if copied herein in words and figures.

# Appendix A

***Draft Medical Claims and Performance Audit Services Contract***

**MEDICAL CLAIMS AND PERORMANCE ADUIT SERVICES CONTRACT**

This Medical Claims and Performance Audit Services Contract (Contract) is made by and between the State of Mississippi State and School Employees' Health Insurance Board (Board), acting administratively through the Mississippi Department of Finance and Administration (MDFA) and [Insert Company Name] (Contractor), effective January 1, 2024, under the following terms and conditions under which the Contractor agrees to provide services to the Board relating the State and School Employees' Life and Health Insurance Plan (Plan).

## 1. Scope of Services

The Contractor will provide all services and otherwise do all things necessary for or incidental to the performance of work, as set forth below:

### A. Account Management

i. Assign a dedicated (but not necessarily exclusive) Account Manager, who will act as the Board primary contact for activities relative to all aspects of the Contract between the Board and the Auditor, who must have a minimum of five (5) years' experience conducting and supervising independent medical claims and performance audit services to self-insured health plans consisting of at least 100,000 covered lives, who shall be classified, at a minimum, as a senior auditor level, and who will supervise all aspects of the resulting contract with the Board;.

ii. Provide all services directly related to this Contract from an office located within the United States.

iii. Perform all services provided in the Contract between the Contractor and MDFA in accordance with customary and reasonable industry standards as well as in strict conformance to all laws, statutes, and ordinances and the applicable rules, regulations, methods and procedures of all government boards, bureaus, offices, and other agents. The Contractor shall be responsible for the complete performance of all work; for the methods, means, and equipment used; and for furnishing all materials, tools, apparatus, and property of every description used in connection therewith. No statement within this Contract shall negate compliance with any applicable governing regulation. The absence of detail specifications or the omission of detail description shall be recognized as meaning that only the best commercial practices are to prevail, and that only first quality materials and workmanship are to be used.

### B. Medical Claims and Performance Audit Services

i. At the request of the Board, at least annually perform a comprehensive and objective medical claims and performance audit of the Plan's medical claims third party administrator to determine if the medical claims were adjudicated according to appropriate Plan benefits, the contractual standards, industry standards, and State

DRAFT

and federal regulations. The medical claims and performance audit must be based on a statistically valid stratified random sample that achieves a minimum 95% confidence level +/-3% and must include at a minimum the results for the following key performance indicators: financial accuracy, payment accuracy, processing accuracy, and claims processing turnaround time. The audit must include a review of the medical claims processed by the medical claims third party administrator, including readjudicating medical claims to evaluate the administrator's processes and systems relating to such areas as: eligibility, coding, pricing (including proper application of allowable charge and discount arrangements), deductible accumulators, identification of duplicate bills, application of Plan benefits, COB, subrogation, medical necessity, ineligible/eligible charges, compliance with the Plan Document, timeliness of processing, interaction with other vendors, and file documentation.

ii. In addition to the statistically valid random sample audit, will conduct an electronic screening of 100% of the medical claims processed, with targeted sample analysis to target and test known administrative issues and identify process improvements and cost recovery opportunities. The Auditor will screen medical claims with material errors in a wide variety of high-risk categories and apply unique and proprietary error codes when potential errors are found. The categories may include, but are not limited to:

a. Medical Claims Payment and Pricing
b. Duplicate payments to providers and/or employees
c. Provider discounts and fees
d. Coordination of benefits
e. Plan limitations and exclusions
f. Multiple surgical procedures
g. Large claim review and case management
h. Denial of mandated benefits
i. Workers' Compensation
j. Subrogation/right of recovery from third parties
k. Fraud, Waste and Abuse Review

iii. Operational Review – A detailed operational audit of the medical claims Third Party Administrator (hereinafter "TPA") shall include, but is not limited to, the following:

a. Claims payment system and procedures
b. Exception processing
c. Mail (paper claim) receipt and tracking
d. Forms and communication process
e. Training programs and employee evaluation process
f. Quality procedural manuals provided to claims processing, customer service, etc.
g. Evaluation of the security of records and data
h. Security and override procedures relating to approval of claims and access to records

DRAFT

i. Internal audit process
j. Compliance with HIPAA/HITECH Act to verify the Plan's vendors are HIPAA compliant during the annual claims and performance audits
k. Evaluation of customer service, including communication of the Plan's benefits, policies, and procedures; and audit of performance guarantees related to call answering response time and abandonment rate
l. Cost containment procedures

iv. For any medical claims and performance audit performed, will provide a comprehensive, detailed written report to include the methodology used by the auditor, the medical claims and performance audit findings, recommendation to the Board regarding such findings, and provide an oral presentation of the report, if deemed necessary by the Board.

v. Maintain full and accurate records (data) with respect to all matters covered under the resulting contract. The Contractor will permanently maintain and store data in electronic format in a safe, secure, and monitored locations(s) or security site(s). All data remains the property of the Board and shall be accessible by the Board at all times. Data will not be released or destroyed for any reason unless expressly requested by the Board or required under State or Federal law.

vi. At the request of the Board, provide the Board copies of all spreadsheets, assumptions, and calculations for any project authorized and funded by the Board in a format acceptable to the Board.

vii. Based on the medically claims and performance audits conducted, must be pro-active in presenting recommendations and ideas to the Board regarding the management of the Plan and/or the evaluation of the Plan's vendor.

viii. During the resulting contract, agree to work with the Board in the development, implementation, and evaluation of quality improvement projects and innovative plan designs or projects as may be requested and authorized by the Board. The Auditor is encouraged to bring ideas on improving the quality of health care and innovative plan design to the Board for consideration.

ix. If requested by the Board, must agree to testify before the State Legislature or Performance Evaluation and Expenditure Review Committee, and testify or provide assistance in connection with any legal or audit proceedings in which the Board or the State of Mississippi is a party in relation to the services provided under the resulting contract.

x. It is mutually understood and agreed by both parties that this is not an exclusive contract. The Board and/or MDFA is free to contract with other professionals to perform similar and like services as those contained in the resulting contract.

**C. Cooperation with Other Board Vendors**

DRAFT

The Contractor will cooperate as required with the Board's other contracted vendors and will work with other vendors to facilitate the provision of the on-going coordination and delivery of services, and in any transfer of responsibility.

## 2. Contract Term

**A.** The term of the Contract will be for four (4) years, effective January 1, 2025 through December 31, 2028. MDFA reserves the right to renew the Contract for up to one (1) additional year at the sole discretion of MDFA. By July 1, 2028, MDFA will notify the Contractor, in writing, of MDFA's intent to renew the Contract for the additional year.

**B.** All records and information provided by MDFA or through its vendors to the Contractor are the sole property of the MDFA and will be returned to the MDFA within thirty (30) days of the termination date of this Contract.

**C.** Upon termination of this Contract, the Contractor shall fully cooperate with MDFA and the selected new auditor as requested, in accordance with professional standards.

## 3. Consideration

The Board agrees to compensate the Contractor for services approved by the Board and performed by the Contractor under the terms of this Contract in an amount not to exceed [Insert Amount], as follows:

**A.** The unit rates and maximum project costs, listed in ***Exhibit A, Fee Schedule for Medical Claims and Performance Audit Services***, of this Contract shall constitute the entire compensation due to the Contractor for services and all of the Contractor's obligations hereunder regardless of the difficulty, materials, or equipment required. These fees include, but are not limited to, all applicable taxes, fees, general office expenses, overhead, profit, and all other direct and indirect costs, incurred or to be incurred, by the Contractor. All pricing shall include all associated costs with no additional or hidden costs. All fees or charges related to any service to be provided must be identified. No additional compensation will be provided by the MDFA for any expense, cost, or fee not specifically authorized by this Contract, or by written authorization from the MDFA. OI shall not provide any prepayments or initial deposits in advance of services being rendered. The MDFA will not pay any upfront fees prior to the contract effective date. Fees for services provided by the Contractor shall be billable to OI in arrears on a monthly basis. Only those services agreed to by Contract shall be considered for reimbursement/compensation by OI. Payment for any and all services provided by the Contractor to OI shall be made only after said services have been duly performed and properly invoiced. The fees and rates listed in ***Exhibit A, Fee Schedule for Medical Claims and Performance Audit Services***, of this Contract are firm for the duration of this Contract and are not subject to escalation for any reason, unless otherwise provided for within this Contract, or unless this Contract is duly amended.

DRAFT

**B.** The Contractor shall submit all invoices in a form acceptable to OI (provided that such acceptance will not be unreasonably withheld) with all of the necessary supporting documentation, prior to the payment to the Contractor of allowable costs. Fees will be invoiced in sufficient detail and format as determined by the MDFA. Such invoices will, at a minimum, include the appropriate descriptions of the services being billed, the quantity or number of units billed, the compensation rate, the time period in which services were provided, the total administrative fees requested for the period being invoiced, or other bases for charges included in ***Exhibit A, Fee Schedule for Medical Claims and Performance Audit Services***.

**C.** The payment of an invoice by the MDFA shall not prejudice the MDFA's right to object or question any invoice or matter in relation thereto. Such payment by the MDFA shall neither be construed as acceptance of any part of the work or service provided nor as an approval of any costs invoiced therein. The Contractor's invoice or payment shall be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the MDFA, on the basis of audits, not to constitute allowable costs. Any payment shall be reduced for overpayment or increased for underpayment on subsequent invoices. For any amounts which are or shall become due and payable to OI and/or OI by the Contractor, OI reserves the right to (1) deduct from amounts which are or shall become due and payable to OI under contract between the parties; or (2) request and receive payment directly from the Contractor within fifteen (15) days of such request, at OI's sole discretion.

**D.** OI reserves the right to deduct from amounts which are or shall become due and payable to the Contractor under the contract between the parties any amounts which are or shall become due and payable to OI by the Contractor. Notwithstanding anything to the contrary herein, any reduction of payments to shall be made only with the prior agreement of both parties. In addition, in the event of termination of the contract for any reason, the Contractor shall be paid for services rendered and allowable expenses incurred up to the effective date of termination.

**E.** Upon the effective date of termination of this Contract, the Contractor will remain liable for any obligations arising hereunder prior to the effective date of such termination.

**F.** Compensation to the Contractor for travel outside of the annual trip to Jackson, Mississippi or other location designated by the Board and/or MDFA that is included in the maximum project fees to present the report(s) shall be subject to the following criteria:

1. To be compensable by the Board, travel expenses must be reasonable and necessary for the fulfillment of the project and contractual obligations;
2. Air travel reimbursement will be limited to "economy" class rates, and must be supported by a copy of an original invoice;
3. Meals and lodging expenses will be reimbursed in the amount of actual costs, subject to the maximum per diem as defined in the Federal Register. A copy of all hotel and meal receipts must be provided.

DRAFT

4. Taxi fares, reasonable rental car expenses, and airport parking expenses will be reimbursed in the amount of actual costs, and must be supported by a copy of an original receipt/invoice;
5. Personal automobile mileage and related costs are not compensable expenses;
6. Time spent in "travel status" is not compensable. Unit rates in the Fee Schedule for Medical Claims and Performance Audit Services, are to be charged for actual hours worked only and shall not include travel time.

## 4. Anti-Assignment/Subcontracting

Contractor acknowledges that it was selected by the MDFA to perform the services required hereunder based, in part, upon Contractor's special skills and expertise. The Contractor shall not assign, subcontract, or otherwise transfer this Contract, in whole or in part, without the prior written consent of the MDFA, which the MDFA may, in its sole discretion, approve or deny without reason. Any attempted assignment or transfer without such consent shall be null and void. No such approval by the MDFA of any subcontract shall be deemed in any way to provide for the incurrence of any obligation of the MDFA in addition to the total fixed price agreed upon in this Contract. Subcontracts shall be subject to the terms and conditions of this Contract and to any conditions of approval that the MDFA may deem necessary. Subject to the foregoing, this Contract shall be binding upon the respective successors and assigns of the parties.

## 5. Applicable Law

The Contract shall be governed by and construed in accordance with the laws of the State of Mississippi (State), excluding its conflicts of laws provisions, and any litigation with respect thereto shall be brought in the courts of the State. The Contractor shall comply with applicable federal, state, and local laws and regulations.

## 6. Approval

It is understood that if this Contract requires approval by the Public Procurement Review Board (PPRB) and/or the MDFA Office of Personal Service Contract Review (OPSCR), and this Contract is not approved by the PPRB and/or OPSCR, it is void and no payment shall be made hereunder.

## 7. Authority to Contract

Contractor warrants: (a) that it is a validly organized business with valid authority to enter into this Contract; (b) that it is qualified to do business and in good standing in the State of Mississippi; (c) that entry into and performance under this Contract is not restricted or prohibited by any loan, security, financing, contractual, or other contract of any kind; and, (d) notwithstanding any other provision of this Contract to the contrary, that there are no existing legal proceedings or prospective legal proceedings, either voluntary or otherwise, which may adversely affect its ability to perform its obligations under this Contract.

DRAFT

## 8. Availability of Funds

It is expressly understood and agreed that the obligation of the MDFA to proceed under this Contract is conditioned upon the appropriation of funds by the Mississippi State Legislature and the receipt of state and/or federal funds. If the funds anticipated for the continuing time fulfillment of the Contract are, at any time, not forthcoming or insufficient, either through the failure of the federal government to provide funds or of the State of Mississippi to appropriate funds or the discontinuance or material alteration of the program under which funds were provided or if funds are not otherwise available to the MDFA, the MDFA shall have the right upon ten (10) working days written notice to the Contractor, to terminate this Contract without damage, penalty, cost or expenses to the MDFA of any kind whatsoever. The effective date of termination shall be as specified in the notice of termination.

## 9. Change in Scope of Work

The MDFA may order changes in the work consisting of additions, deletions, or other revisions within the general scope of the Contract. No claims may be made by the Contractor that the scope of the project or of the Contractor's services have been changed, requiring changes to the amount of compensation to the Contractor or other adjustments to the Contract, unless such changes or adjustments have been made by written amendment to the Contract signed by the MDFA and the Contractor. If the Contractor believes that any particular work is not within the scope of the project, is a material change, or shall otherwise require more compensation to the Contractor, the Contractor shall immediately notify the MDFA in writing of this belief. If the MDFA believes that the particular work is within the scope of the Contract as written, the Contractor shall be ordered to and shall continue the work as changed and at the cost stated for the work within the Contract.

## 10. Compliance with Laws

The Contractor understands that the MDFA is an equal opportunity employer and therefore maintains a policy which prohibits unlawful discrimination based on race, color, creed, sex, age, national origin, physical handicap, disability, genetic information, or any other consideration made unlawful by federal, state, or local laws. All such discrimination is unlawful and the Contractor agrees during the term of the Contract that the Contractor shall strictly adhere to this policy in its employment practices and provision of services. The Contractor shall comply with, and all activities under this Contract shall be subject to, all applicable federal, State of Mississippi, and local laws and regulations, as now existing and as may be amended or modified.

## 11. Confidentiality

Notwithstanding any provision to the contrary contained herein, it is recognized that MDFA is a public agency of the State of Mississippi and is subject to the Mississippi Public Records Act. Mississippi Code Annotated § 25-61-1 et seq. If a public records request is made for any information provided to MDFA pursuant to the Contract and designated by the Contractor in writing as trade secrets or other proprietary confidential information, MDFA shall follow the

DRAFT

provisions of Mississippi Code Annotated §§ 25-61-9 and 79-23-1 before disclosing such information. The MDFA shall not be liable to the Contractor for disclosure of information required by court order or required by law.

The Contractor acknowledges that in the course of the performance of this Contract, it may have access to confidential business information of MDFA and/or its vendors. The Contractor agrees to maintain all confidential business information of MDFA and/or its vendors in strictest confidence using at least the same degree of care it takes in protecting its own confidential business information, but always at least a reasonable degree of care. Except as expressly provided herein or as may be required by law or legal process, the Contractor agrees it will not use confidential business information of MDFA and/or its vendors for its own benefits or disclose it to third parties without written consent.

**12. Contractor Personnel**

The MDFA shall, throughout the life of the Contract, have the right of reasonable rejection and approval of staff or subcontractors assigned to the work by the Contractor. If the MDFA reasonably rejects staff or subcontractors, the Contractor shall provide replacement staff or subcontractors satisfactory to the MDFA in a timely manner and at no additional cost to the MDFA. The day-to-day supervision and control of the Contractor's employees and subcontractors is the sole responsibility of the Contractor.

**13. Debarment and Suspension**

The Contractor certifies to the best of its knowledge and belief, that it: (i) Is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transaction by any federal department or agency or any political subdivision or agency of the State of Mississippi; (ii) Has not, within a three-year period preceding this proposal, been convicted of or had a civil judgment rendered against it for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction; (iii) Has not, within a three-year period preceding this proposal, been convicted of or had a civil judgment rendered against it for a violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; (iv) Is not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state, or local) with commission of any of these offenses enumerated in paragraphs two (ii) and three (iii) of this certification; and, (v) Has not, within a three-year period preceding this proposal, had one or more public transactions (federal, state, or local) terminated for cause or default.

**14. Disclosure of Confidential Information**

In the event that either party to this Contract receives notice that a third-party requests divulgence of confidential or otherwise protected information and/or has served upon it a subpoena or other validly issued administrative or judicial process ordering divulgence of confidential or otherwise protected information that party shall promptly inform the other party

DRAFT

and thereafter respond in conformity with such subpoena to the extent mandated by law. This section shall survive the termination or completion of this Contract. The parties agree that this section is subject to and superseded by Mississippi Code Annotated § 25-61-1 *et seq*.

**15. E-Payment**

The Contractor agrees to accept all payments in United States currency via the State of Mississippi's electronic payment and remittance vehicle. The MDFA agrees to make payment in accordance with Mississippi law on "Timely Payments for Purchases by Public Bodies", which generally provides for payment of undisputed amounts by the agency within forty-five (45) days of receipt of the invoice. Mississippi Code Annotated § 31-7-301, *et seq.*

**16. E-Verification**

If applicable, the Contractor represents and warrants that it shall ensure its compliance with the Mississippi Employment Protection Act of 2008, and shall register and participate in the status verification system for all newly hired employees. Mississippi Code Annotated § 71-11-1 et seq. The term "employee" as used herein means any person that is hired to perform work within the State of Mississippi. As used herein, "status verification system" means the Illegal Immigration Reform and Immigration Responsibility Act of 1996 that is operated by the United States Department of Homeland Security, also known as the E-Verify Program, or any other successor electronic verification system replacing the E-Verify Program. The Contractor agrees to maintain records of such compliance. Upon request of the State and after approval of the Social Security Administration or Department of Homeland Security when required, the Contractor agrees to provide a copy of each such verification. The Contractor further represents and warrants that any person assigned to perform services hereafter meets the employment eligibility requirements of all immigration laws. The breach of this agreement may subject the Contractor to the following:

A. termination of this Contract for services and ineligibility for any State or public contract in Mississippi for up to three (3) years with notice of such cancellation/termination being made public; or
B. the loss of any license, permit, certification, or other document granted to the Contractor by an agency, department, or governmental entity for the right to do business in Mississippi for up to one (1) year; or
C. both.

In the event of such cancellation/termination, the Contractor would also be liable for any additional costs incurred by the State due to Contract cancellation or loss of license or permit to do business in the State.

**17. Failure to Deliver**

Failure by the MDFA at any time to enforce the provisions of the Contract shall not be construed as a waiver of any such provisions. Such failure to enforce shall not affect the validity of the contract or any part thereof or the right of the MDFA to enforce any provision at any time in accordance with its terms.

DRAFT

**18. Failure to Enforce**

Failure by the MDFA at any time to enforce the provisions of the Contract shall not be construed as a waiver of any such provisions. Such failure to enforce shall not affect the validity of the Contract or any part thereof or the right of the MDFA to enforce any provision at any time in accordance with its terms.

**19. Force Majeure**

Each party shall be excused from performance for any period and to the extent that it is prevented from performing any obligation or service, in whole or in part, as a result of causes beyond the reasonable control and without the fault or negligence of such party and/or its subcontractors. Such acts shall include without limitation acts of God, strikes, lockouts, riots, acts of war, epidemics, governmental regulations superimposed after the fact, fire, earthquakes, floods, or other natural disasters ("force majeure events"). When such a cause arises, the Contractor shall notify the MDFA immediately in writing of the cause of its inability to perform, how it affects its performance, and the anticipated duration of the inability to perform. Delays in delivery or in meeting completion dates due to force majeure events shall automatically extend such dates for a period equal to the duration of the delay caused by such events, unless MDFA determines it to be in its best interest to terminate the Contract.

**20. Indemnification**

To the fullest extent allowed by law, the Contractor shall indemnify, defend, save and hold harmless, protect, and exonerate the MDFA, its Commissioners, Board Members, officers, employees, agents, and representatives and the State of Mississippi from and against all claims, demands, liabilities, suits, actions, damages, losses, and costs of every kind and nature whatsoever, including, without limitation, court costs, investigative fees and expenses, and attorneys' fees, arising out of or caused by Contractor and/or its partners, principals, agents, employees, and/or subcontractors in the performance of or failure to perform this Contract. In the State's sole discretion, upon approval of the Office of the Mississippi Attorney General, the Contractor may be allowed to control the defense of any such claim, suit, etc. In the event the Contractor defends said claim, suit, etc., the Contractor shall use legal counsel acceptable to the Office of the Mississippi Attorney General. The Contractor shall be solely responsible for all costs and/or expenses associated with such defense, and the State shall be entitled to participate in said defense. The Contractor shall not settle any claim, suit, etc., without the concurrence of the Office of the Mississippi Attorney General, which shall not be unreasonably withheld.

**21. Independent Contractor Status**

The Contractor shall at all times, be regarded as, and shall be legally considered an Independent Contractor and shall at no time act as an agent for the State. Nothing contained herein shall be deemed or construed by the State, the Contractor, or any third party as creating the relationship of principal and agent, master and servant, partners, joint ventures, employer and employee, or any similar such relationship between the State and the Contractor. Neither the method of

DRAFT

computation of fees or other charges, nor any other provision contained herein, nor any acts of the State or the Contractor hereunder creates, or shall be deemed to create a relationship other than the independent relationship of the State and Contractor. The Contractor's personnel shall not be deemed in any way, directly or indirectly, expressly or by implication, to be employees of the State. Neither the Contractor nor its employees shall, under any circumstances, be considered servants, agents, or employees of the MDFA, and the MDFA shall be at no time be legally responsible for any negligence or other wrongdoing by the Contractor, its servants, agents, or employees. The MDFA shall not withhold from the Contract payments to the Contractor any federal or state unemployment taxes, federal or state income taxes, Social Security tax, or any other amounts for benefits to the Contractor. Further, the MDFA shall not provide to the Contractor any insurance coverage or other benefits, including Worker's Compensation, normally provided by the State for its employees.

## 22. Information Designated by Contractor as Confidential

Any disclosure of those materials, documents, data, and other information which Contractor has designated in writing as proprietary and confidential shall be subject to the provisions of Mississippi Code Annotated §§ 25-61-9 and 79-23-1. As provided in the Contract, the personal or professional services to be provided, the price to be paid, and the term of the Contract shall not be deemed to be a trade secret, or confidential commercial or financial information.

Any liability resulting from the wrongful disclosure of confidential information on the part of the Contractor or its subcontractor shall rest with Contractor. Disclosure of any confidential information by the Contractor or its subcontractor without the express written approval of the MDFA shall result in the immediate termination of this Contract.

## 23. Insurance

The Contractor shall maintain, throughout the term of this Contract, at its own expense, workers' compensation coverage as required by the State of Mississippi; professional liability coverage in an amount no less than One Million Dollars ($1,000,000.00) per occurrence and Three Million Dollars ($3,000,000.00) annual aggregate; employee dishonesty or fidelity bond insurance with third party liability coverage and with minimum limits of One Million Dollars ($1,000,000.00) per occurrence and Three Million Dollars ($3,000,000.00) annual aggregate; and cyber liability insurance. Such policy of insurance shall provide a minimum coverage in the amount of Two Million Dollars ($2,000,000.00) that includes security and privacy liability, business interruption, business interruption waiting period, data recovery, regulatory proceedings, and cyber extortion. The State of Mississippi will be listed as a certificate holder on the professional liability and the certificates shall be issued by insurance companies authorized to do business under the laws of the State of Mississippi, meaning insurance carriers must be licensed or hold a Certificate of Authority from the Mississippi Insurance Department. Contractor shall not commence work under this Contract until it obtains all insurances required under this provision and furnishes certificate(s) or other form(s) showing proof of current coverage to the MDFA. After work commences, the Contractor shall maintain in force all required insurance until the Contract is terminated or expires. Contractor shall submit renewal certificates as appropriate during the term of the Contract. Contractor shall ensure that should

DRAFT

any of the above-described policies be cancelled before the expiration date thereof, or if there is a material change, potential exhaustion of aggregate limits or intent not to renew insurance coverage(s), that written notice will be delivered to the MDFA. There shall be no cancellation, material change, potential exhaustion of aggregate limits or non-renewal of insurance coverage(s) to MDFA. Any failure to comply with the reporting provisions of this clause shall constitute a material breach of Contract and shall be grounds for immediate termination of this Contract by MDFA.

**24. Integrated Agreement/Merger**

This Contract, including all contract documents, represents the entire and integrated agreement between the parties hereto and supersedes all prior negotiations, representations or agreements, irrespective of whether written or oral. This Contract may be altered, amended, or modified only by a written document executed by the State and Contractor. Contractor acknowledges that it has thoroughly read all contract documents and has had the opportunity to receive competent advice and counsel necessary for it to form a full and complete understanding of all rights and obligations herein. Accordingly, this Contract shall not be construed or interpreted in favor of or against the State or Contractor on the basis of draftsmanship or preparation hereof.

**25. Modification or Renegotiation**

This Contract may be modified, altered or changed only by written agreement signed by the parties hereto. The parties agree to renegotiate the Contract if federal, State and/or the MDFA revisions of any applicable laws or regulations make changes in this Contract necessary.

**26. Oral Statements**

No oral statement of any person shall modify or otherwise affect the terms, conditions, or specifications stated in this Contract. All modifications to the Contract shall be made in writing by the MDFA and agreed to by the Contractor.

**27. Paymode**

Payments by state agencies using the State's accounting system shall be made and remittance information provided electronically as directed by the State. These payments shall be deposited into the bank account of the Contractor's choice. The State may, at its sole discretion, require the Contractor to submit invoices and supporting documentation electronically at any time during the term of this Contract. The Contractor understands and agrees that the State is exempt from the payment of taxes. All payments shall be in United States currency.

**28. Procurement Regulations**

The Contract shall be governed by the applicable provisions of the *Mississippi Public Procurement Review Board Office of Personal Service Contract Review Rules and Regulations*, a copy of which is available at 501 North West Street, Suite 1301C, Jackson,

DRAFT

Mississippi 39201 for inspection, or downloadable at http://www.dfa.ms.gov/dfa-offices/personal-service-contract-review/opscr.

**29. Record Retention and Access to Records**

**A.** The working papers prepared in conjunction with the services under this Contract are the property of the Contractor and constitute confidential information. The Contractor shall maintain and make available to MDFA and OSA any financial records, supporting documents, statistical records and all other records pertinent to the services performed under this Contract in accordance with the Contractor's policies and procedures or professional regulatory requirements. Such records shall be kept by the Contractor for a period of seven (7) years after final payment under this Contract, unless MDFA authorizes in writing, their earlier disposition. However, if any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the seven (7) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it.

**B.** The Contractor agrees, upon request by MDFA, to make its workpapers available to subsequent fiscal year audit firms, in accordance with professional standards.

**C.** Except as may otherwise be required by law or permitted under this Contract, the Contractor may not release any confidential and/or protected information or reports relative to the Board's and/or MDFA's contracts without prior written authorization by MDFA.

**D.** The Contractor agrees that the MDFA or any of its duly authorized representatives at any time during the term of this Contract shall have unimpeded, prompt access to and the right to audit and examine any pertinent books, documents, papers, and/or records of the Contractor related to the Contractor's charges and performance under this Contract. The MDFA agrees to provide the Contractor with reasonable advance notice for any standard audits or reviews, with the expectation that such reviews shall be made during normal business hours of the Contractor. The parties shall cooperate to schedule and conduct such audit or inspection to prevent disruption to Contractor's performance of the services hereunder and for Contractor's other customers.

**E.** To the extent any applicable personal health information (PHI) is reviewed, the Contractor agrees to the provisions, terms and conditions of the attached Business Associate Statement. The Contractor recognizes that it may have access to certain confidential and proprietary information pertaining to the business of MDFA, including but not limited to, policy benefits, names and addresses of Plan Participants, employer units and contracts with other parties. The Contractor agrees that it will not, at any time, directly or indirectly, disclose such confidential or proprietary information to any other person or organization for any purpose, except as may be required by law, authorized by the individual to which such information pertains, or as reasonably relates to the services being provided by the Contractor and contemplated by the terms of the Contract, without the express, written approval of MDFA. Any and all medical, financial, and personal information reviewed and collected in connection with this Contract regarding individual Plan Participants shall

DRAFT

be held in strict confidence in compliance with all applicable state and federal legal requirements, specifically the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and shall not be released, disclosed, published, or used for any purpose not defined in this Contract by the Contractor without the written consent of MDFA, except to MDFA or its Claims Administrator. Except as otherwise provided under this Contract, the Contractor agrees that confidential information including, but not limited to, medical and other pertinent information relative to Plan Participants in the Plan, shall not be disclosed to any person or organization for any purpose, other than in connection with Contractor's performance of the services under this Contract, without the expressed, written authority from MDFA or as otherwise required by law..

**30. Recovery of Money**

Whenever, under the Contract, any sum of money shall be recoverable from or payable by the Contractor to the MDFA, the same amount may be deducted from any sum due to the Contractor under the Contract or under any other Contract between the Contractor and the MDFA. The rights of the MDFA are in addition and without prejudice to any other right the MDFA may have to claim the amount of any loss or damage suffered by the MDFA on account of the acts or omissions of the Contractor.

**31. Representation Regarding Contingent Fees**

The Contractor represents that it has not retained a person to solicit or secure a State Contract upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee except as disclosed in the Contractor's bid.

**32. Representation Regarding Gratuities**

The Contractor represents that it has not violated, is not violating, and promises that it will not violate the prohibition against gratuities set forth in Section 6-204 (Gratuities) of the *Mississippi Public Procurement Review Board Office of Personal Service Contract Review Rules and Regulations*.

**33. Right to Audit**

Contractor shall maintain such financial records and other records as may be prescribed by MDFA or by applicable federal and state laws, rules, and regulations. Contractor shall retain these records for a period of three years after final payment, or until they are audited by MDFA, whichever event occurs first. These records shall be made available for inspection during regular business hours and with reasonable advance notice during the term of the Contract and the subsequent three-year period for examination, transcription, and audit by the Mississippi Office of the State Auditor, its designees, or other authorized bodies.

**34. Right to Inspect**

DRAFT

MDFA, the Mississippi Office of the State Auditor, or any other auditing agency prior-approved by MDFA, or their authorized representative shall, at all reasonable times, have the right to enter onto the Contractor's premises, or such other places where duties under this Contract are being performed, to inspect, monitor, or otherwise evaluate the work being performed. The Contractor shall provide access to all facilities and assistance for MDFA and OSA's representatives. All inspections and evaluations shall be performed in such a manner as to not delay work. Refusal by the Contractor to allow access to all documents, papers, letters or other materials, shall constitute a breach of Contract. All audits performed by persons other than MDFA staff shall be coordinated through MDFA and its staff.

**35. Severability**

If any part of this Contract is declared to be invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision of the Contract that can be given effect without the invalid or unenforceable provision, and to this end the provisions hereof are severable. In such event, the parties shall amend the Contract as necessary to reflect the original intent of the parties and to bring any invalid or unenforceable provisions in compliance with applicable law.

**36. Standards of Care/Remedies**

The Contractor shall exercise reasonable care and due diligence consistent with standards in the industry in the performance of its obligations under this Contract.

**37. Stop Work Order**

**A.** *Order to Stop Work.* The MDFA, may, by written order to the Contractor at any time, and without notice to any surety, require the Contractor to stop all or any part of the work called for by this Contract. This order shall be for a specified period not exceeding 90 days after the order is delivered to the Contractor, unless the parties agree to any further period. Any such order shall be identified specifically as a stop work order issued pursuant to this clause. Upon receipt of such an order, the Contractor shall forthwith comply with its terms and take all reasonable steps to minimize the occurrence of costs allocable to work covered by the order during the period of work stoppage. Before the stop work order expires, or within any further period to which the parties shall have agreed, the MDFA shall either:

1. cancel the stop work order; or,
2. terminate the work covered by such order as provided in the "Termination for Default" clause or the "Termination for Convenience" clause of this Contract.

**B.** *Cancellation or Expiration of the Order.* If a stop work order issued under this clause is canceled at any time during the period specified in the order, or if the period of the order or any extension thereof expires, the Contractor shall have the right to resume work. An appropriate adjustment shall be made in the delivery schedule or Contractor price, or both, and the Contract shall be modified in writing accordingly, if:

**1.** the stop work order results in an increase in the time required for, or in the Contractor's costs properly allocable to, the performance of any part of this Contract; and,

2. the Contractor asserts a claim for such an adjustment within 30 days after the end of the period of work stoppage; provided that, if the MDFA decides that the facts justify such action, any such claim asserted may be received and acted upon at any time prior to final payment under this Contract.

**C.** *Termination of Stopped Work*. If a stop work order is not canceled and the work covered by such order is terminated for default or convenience, the reasonable costs resulting from the stop work order shall be allowed by adjustment or otherwise.

## 38. Termination for Convenience

**A.** *Termination.* The MDFA may, when the interests of the State so require, terminate this Contract in whole or in part, for the convenience of the State. The MDFA shall give written notification of the termination to the Contractor specifying the part of the Contract terminated and when the termination becomes effective.

**B.** *Contractor's Obligations.* The Contractor shall incur no further obligations in connection with the terminated work, and on the date set in the notice of termination, the Contractor shall stop work to the extent specified. The Contractor shall also terminate outstanding orders and subcontracts as they relate to the terminated work. The Contractor shall settle the liabilities and claims arising out of the termination of subcontractors and orders connected with the terminated work. The MDFA may direct the Contractor to assign the Contractor's right, title, and interest under terminated orders or subcontracts to the State. The Contractor shall still complete the work not terminated by the notice of termination and may incur obligations as are necessary to do so.

## 39. Termination for Default

**A.** *Default.* If the Contractor refuses or fails to perform any of the provisions of this Contract with such diligence as shall ensure its completion within the time specified within this Contract, or any extension thereof or, otherwise fails to timely satisfy the Contract provisions, or commits any other substantial breach of this Contract, the MDFA may notify the Contractor in writing of the delay or nonperformance and if not cured within ten (10) days or any longer time specified in writing by the MDFA, the MDFA may terminate the Contractor 's right to proceed with the Contract or such part of the Contract as to which there has been delay or failure to properly perform. In the event of termination in whole or in part, the MDFA may procure similar supplies or services in a manner and upon terms deemed appropriate by the MDFA. The Contractor shall continue performance of the Contract to the extent it is not terminated and shall be liable for excess costs incurred in procuring similar goods or services.

**B.** *Contractor's Duties.* Notwithstanding termination of the Contract and subject to any directions from the MDFA, the Contractor shall take timely, reasonable, and necessary action to protect and preserve property in the possession of the Contractor in which the State has an interest.

DRAFT

**C.** *Compensation.* Payment for completed services delivered and accepted by the State shall be at the Contract price. The State may withhold from amounts due the Contractor such sums as the MDFA deems to be necessary to protect the State against loss because of outstanding lien holders or claims of former lien holders and to reimburse the State for the excess costs incurred in procuring similar goods and services.

**D.** *Excuse for Nonperformance or Delayed Performance.* Except with respect to defaults of subcontractors, the Contractor shall not be in default by reason of any failure in performance of this Contract in accordance with its terms (including any failure by the Contractor to make progress in the prosecution of the work hereunder which endangers performance) if the Contractor has notified the MDFA within 15 days after the cause of the delay and the failure arises out of causes such as: acts of God; acts of the public enemy; acts of the State and any other governmental entity in its sovereign or contractual capacity; fires; floods; epidemics; quarantine restrictions; strikes or other labor disputes; freight embargoes; or unusually severe weather. If the failure to perform is caused by the failure of a subcontractor to perform or make progress, and if such failure arises out of causes similar to those set forth above, the Contractor shall not be deemed to be in default, unless the services to be furnished by the subcontractor were reasonably obtainable from other sources in sufficient time to permit the Contractor to meet the Contract requirements. Upon request of the Contractor, the MDFA shall ascertain the facts and extent of such failure, and, if the MDFA determines that any failure to perform was occasioned by any one or more of the excusable causes, and that, but for the excusable cause, the Contractor 's progress and performance would have met the terms of the Contract, the delivery schedule shall be revised accordingly, subject to the rights of the State under the clause of this Contract entitled “Termination for Convenience”. (As used in this Paragraph of this clause, the term “subcontractor” means subcontractor at any tier).

**E.** *Erroneous Termination for Default.* If, after notice of termination of the Contractor 's right to proceed under the provisions of this clause, it is determined for any reason that the Contract was not in default under the provisions of this clause, or that the delay was excusable under the provisions of Paragraph D (Excuse for Nonperformance or Delayed Performance) of this clause, the rights and obligations of the parties shall, if the Contract contains a clause providing for termination for convenience of the State, be the same as if the notice of termination had been issued pursuant to a termination for convenience.

**F.** *Additional Rights and Remedies.* The rights and remedies provided under this clause are in addition to any other rights and remedies provided by law or under this Contract.

## 40. Termination Upon Bankruptcy

This Contract may be terminated in whole or in part by the MDFA upon written notice to the Contractor, if the Contractor should become the subject of bankruptcy or receivership proceedings, whether voluntary or involuntary, or upon the execution by Contractor of an assignment for the benefit of its creditors. In the event of such termination, Contractor shall be entitled to recover just and equitable compensation for satisfactory work performed under this Contract, but in no case shall said compensation exceed the total Contract price.

DRAFT

## 41. Third Party Action Notification

The Contractor shall give the MDFA prompt notice in writing of any action or suit filed, and prompt notice of any claim made against the Contractor by any entity that may result in litigation related in any way to this Contract.

## 42. Trade Secrets, Commercial and Financial Information

It is expressly understood that Mississippi law requires that the provisions of this Contract which contain the commodities purchased or the personal or professional services provided, the price to be paid, and the term of the Contract shall not be deemed to be a trade secret or confidential commercial or financial information and shall be available for examination, copying, or reproduction.

## 43. Transparency

This Contract, including any accompanying exhibits, attachments, and appendices, is subject to the "Mississippi Public Records Act of 1983," and its exceptions. See Mississippi Code Annotated §§ 25-61-1 *et seq.* and 79-23-1. In addition, this Contract is subject to the provisions of the Mississippi Accountability and Transparency Act of 2008. Mississippi Code Annotated § 27-104-151 *et seq.* Unless exempted from disclosure due to a court-issued protective order, a copy of this executed Contract is required to be posted to the MDFA's independent agency contract website for public access at http://www.transparency.mississippi.gov. Information identified by Contractor as trade secrets, or other proprietary information, including confidential vendor information or any other information which is required confidential by state or federal law or outside the applicable freedom of information statutes, shall be redacted.

## 44. Waiver

No delay or omission by either party to this agreement in exercising any right, power, or remedy hereunder or otherwise afforded by contract, at law, or in equity shall constitute an acquiescence therein, impair any other right, power or remedy hereunder or otherwise afforded by any means, or operate as a waiver of such right, power, or remedy. No waiver by either party to this agreement shall be valid unless set forth in writing by the party making said waiver. No waiver of or modification to any term or condition of this agreement will void, waive, or change any other term or condition. No waiver by one party to this agreement of a default by the other party will imply, be construed as or require waiver of future or other defaults.

**45.** Business Associate Statement

In the paragraphs that follow under this section, the term "BA Statement" shall refer to this section of the Contract, the term "Business Associate" shall refer to the Contractor, and the term "Covered Entity" shall refer to the Plan. The purpose of this BA Statement is to satisfy certain standards and requirements of the Health Insurance Portability and Accountability Act

of 1996, Public Law 104-191 (HIPAA) and regulations promulgated thereunder by the U.S. Department of Health and Human Services (HHS) (the HIPAA Regulations) and other applicable laws, including the American Recovery and Reinvestment Act (ARRA) of 2009, as applicable. The Covered Entity wishes to disclose certain information (Information) to Business Associate pursuant to the terms of the Contract, some of which may constitute Protected Health Information (PHI). The Covered Entity desires and directs Business Associate to share PHI with other Business Associates of the Covered Entity. In consideration of mutual promises below and exchange of information pursuant to this BA Statement, the parties agree as follows:

**A. Definitions**

Terms used, but not otherwise defined, in this BA Statement shall have the same meaning as those terms in the Standards for Privacy of Individually Identifiable Information (the Privacy Rule) and the Security Standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In the event of an inconsistency between the provisions of this BA Statement and mandatory provisions of the Privacy Rule and or the Security Standards, as amended, the Privacy Rule and/or the Security Standards shall control. Where provisions of this BA Statement are different than those mandated in the Privacy Rule and/or the Security Standards, but are nonetheless permitted by the Privacy Rule and/or the Security Standards, the provisions of this BA Statement shall control.

1. Breach. Breach shall be as defined in HITECH and the HIPAA regulations at 45 CFR §164.402.
2. Business Associate. Business Associate shall have the meaning given to such term under the HIPAA Regulations, including, but not limited to, 45 CFR § 160.103.
3. Covered Entity. Covered Entity shall have the same meaning given to such term under the HIPAA Regulations, including, but not limited to, 45 CFR § 160.103.
4. Designated Record Set. Designated Record Set shall have the same meaning given to such term under 45 CFR § 164.501 and shall mean a group of records maintained by or for the Covered Entity that is the payment, enrollment, claims adjudication and case or health management record systems maintained by or for the Covered Entity, or used, in whole or in part, by or for the Covered Entity, to make decisions about Individuals.
5. Electronic Media. Electronic Media has the same meaning as the term "electronic media" in 45 CFR § 160.103, which is:
    a. Electronic storage material on which data is or may be recorded electronically, including for example, devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or
    b. Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), or intranet, leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media if the information being exchanged did not exist in electronic form immediately before the transmission.

DRAFT

6. Electronic Protected Health Care Information or (EPHI). EPHI has the same meaning as the term ‘electronic protected health care information’ in 45 CFR § 160.103, and is defined as that PHI that is transmitted by or maintained in electronic media.
7. Individual. Individual shall have the same meaning as the term “individual" in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
8. Privacy Rule. Privacy Rule shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, subparts A and E.
9. Protected Health Information or (PHI). PHI shall have the same meaning as the term “protected health information" in 45 CFR § 164.103, limited to the information created, maintained, transmitted or received by Business Associate from or on behalf of Covered Entity.
10. Required By Law. Required By Law shall have the same meaning as the defined term “required by law” in 45 CFR § 164.103.
11. Security Incident has the meaning in 45 CFR § 164.304, which is: the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
12. Security Standards shall mean the Security Standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) codified at 45 CFR Parts 160 and 164, subpart C (Security Rule).
13. Unsecured PHI as defined in HIPAA and the HIPAA regulations at 45 CFR § 164.402, means protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of technology or methodology specified by the Secretary in guidance issued under 13402(h)(2) of Public Law 111-5 on HHS website.

## B. Obligations and Activities of Business Associate

1. Compliance with Applicable Laws. Business Associate shall fully comply with the standards and requirements of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA), the American Recovery and Reinvestment Act of 2009, Public Law 111-5 (ARRA) and regulations promulgated thereunder by the U.S. Department of Health and Human Services (the HIPAA Regulations) and other applicable laws as of the date(s) the requirements under these laws become effective for Business Associates. This compliance shall include all requirements noted in Section 13404(a), (b) and (c) of the HITECH Act.
2. Business Associate directly subject to certain HIPAA provisions. Under HITECH, Business Associate acknowledges that it is directly subject to certain HIPAA provisions including, but not limited to, Sections 13401, 13404, 13405 of HITECH.
3. Use and Disclosure of Protected Health Information. Business Associate may use and/or disclose the Covered Entity’s PHI received by Business Associate pursuant to this BA Statement, the Contract, or as required by law, or as permitted under 45 CFR §164.512, subject to the provisions set forth in this BA Statement. Business Associate may use PHI in its possession for its proper management and administration or to fulfill any of its legal responsibilities. The Covered Entity specifically requests that Business Associate disclose PHI to other Business Associates of the Covered Entity for Health

DRAFT

Care Operations of the Covered Entity. The Covered Entity shall provide a list of the affected Business Associates and shall request specific disclosures in written format. If any affected Business Associate is no longer under a BA Statement with the Covered Entity, the Covered Entity shall promptly inform Business Associate of such change.

4. Safeguards Against Misuse of Information. Business Associate shall use appropriate safeguards to prevent the use or disclosure of the Covered Entity's PHI in any manner other than as required by this BA Statement or as required by law. Business Associate shall maintain a comprehensive written information privacy and security program that includes administrative, technical, and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities.
5. Reporting of Disclosures. Business Associate shall report to the Covered Entity any use or disclosure of the Covered Entity's PHI in violation of this BA Statement or as required by law of which the Business Associate is aware, including Breaches of Unsecured PHI as required by 45 CFR §164.410, and agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of the Covered Entity's PHI by Business Associate in violation of this BA Statement.
6. Business Associate's Agents. Business Associate shall ensure that any agents, including subcontractors, to whom it provides PHI received from (or created or received by Business Associate on behalf of) the Covered Entity agree to be bound to by restrictions and conditions on the use or disclosure of PHI that are no less protective that those that apply to Business Associate with respect to such PHI. Business Associate represents that in the event of a disclosure of PHI to any third party, the information disclosed shall be in a limited data set if practicable and in all other cases the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request.
7. Nondisclosure. Business Associate shall not use or further disclose the Covered Entity's PHI otherwise than as permitted or required by this BA Statement, the Contract, or as required by law.
8. Availability of Information to the Covered Entity and Provision of Access and Accountings. Business Associate shall make available to the Covered Entity such Protected Health Information maintained by the Business Associate in a Designated Record Set as the Covered Entity may require to fulfill the Covered Entity's obligations to provide access to, or provide a copy of, such Designated Record Set as necessary to satisfy the Covered Entity's obligations under 45 CFR § 164.524. Business Associate shall also maintain and make available the information required to provide an accounting of disclosures of Protected Health Information to Covered Entity as necessary to satisfy Covered Entity's obligations under 45 CFR § 164.528.
9. Amendment of PHI. Business Associate shall make the Covered Entity's PHI available to the Covered Entity as the Covered Entity may require to fulfill the Covered Entity's obligations to amend PHI pursuant to HIPAA and the HIPAA Regulations, including, but not limited to, 45 CFR § 164.526 and Business Associate shall, as directed by the Covered Entity, incorporate any amendments to the Covered Entity's PHI into copies of such PHI maintained by Business Associate. Business Associate agrees to make any amendment(s) to Protected Health Information that the Covered Entity directs or agrees

DRAFT

to pursuant to 45 CFR § 164.526 at the request of the Covered Entity or an Individual, and in the time and manner designated by the Covered Entity. [45 CFR § 164.504(e)(2)(F)]

10. Internal Practices. Business Associate agrees to make its internal practices, policies, procedures, books, and records relating to the use and disclosure of PHI received from the Covered Entity (or received by Business Associate on behalf of the Covered Entity) available to the Secretary of the U.S. Department of Health and Human Services for inspection and copying for purposes of determining the Covered Entity's compliance with HIPAA and the HIPAA Regulations.
11. Notification of Breach. During the term of this BA Statement, Business Associate shall notify the Covered Entity following discovery and without unreasonable delay (but in no case later than 60 days) any Breach of Unsecured PHI. Business Associate shall take (i) prompt corrective action to cure any such deficiencies and (ii) any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations.
12. Safeguard of EPHI. The Business Associate shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Covered Entity.
13. Subcontractors. The Business Associate shall ensure that any agent, including a subcontractor, to whom it provides PHI agrees to implement reasonable and appropriate safeguards to protect it.
14. Notification. The Business Associate shall report to the Covered Entity through the Mississippi Department of Finance and Administration, Office of Insurance any Breach of Unsecured PHI of which it becomes aware, without unreasonable delay, in the following time and manner:
    a. any actual, successful Security Incident shall be reported to the Covered Entity in writing, without unreasonable delay; and
    b. any attempted, unsuccessful Security Incident, of which Business Associate becomes aware, shall be reported to the Covered Entity in writing, on a reasonable basis, at the written request of the Covered Entity. If the Security Rule is amended to remove the requirement to report unsuccessful attempts at unauthorized access, this subsection (ii) shall no longer apply as of the effective date of the amendment of the Security Rule.
15. Business Associate shall maintain and provide to the Covered Entity without unreasonable delay and in no case later than 60 days of discovery of a Breach of Unsecured PHI, (as these terms are defined in the HIPAA Regulations), the appropriate information to allow the Covered Entity to adhere to Breach notification.
16. The information provided to the Covered Entity shall include, at a minimum and to the extent possible, the identification of each individual whose Unsecured PHI has been, or is reasonably believed by the Business Associate to have been accessed, acquired, used, or disclosed during the Breach, and the Business Associate shall provide the Covered Entity with any other available information that the Covered Entity is required to include in its notification to the Individual following discovery of a Breach and without unreasonable delay or promptly thereafter as information becomes available, including:

DRAFT

a. A brief description of what happened, including the date of the breach, if known, and the date of the discovery of the breach.
b. A description of the types of unsecured protected health information that were involved in the breach (such as full name, Social Security number, date of birth, home address, account number, or disability code).
c. The steps individuals should take to protect themselves from potential harm resulting from the breach.
d. A brief description of what the Business Associate involved is doing to investigate the breach, to mitigate losses, and to protect against any further breaches.

17. Minimum Necessary. Business Associate shall limit its uses and disclosures of, and requests for, PHI (a) when practical, to the information making up a Limited Data Set; and (b) in all other cases subject to the requirements of 45 CFR § 164.502(b), to the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request.
18. Marketing. Business Associate shall not sell PHI or use or disclose PHI for purposes of marketing, as defined and proscribed in the Regulations.
19. Data Aggregation. Business Associate may use PHI in its possession to provide data aggregation services relating to the health care operations of the Covered Entity, as provided for in 45 CFR §164.501.
20. De-identification of PHI. Business Associate may de-identify any and all PHI, provided that the de-identification conforms to the requirements of 45 CFR § 164.514(b), and further provided that Business Associate maintains the documentation required by 45 CFR § 164.514(b), which may be in the form of a written assurance from Business Associate. Pursuant to 45 CFR § 164.502(d), de-identified information does not constitute PHI and is not subject to the terms of the BA Statement.
21. Business Associate may not use or disclose PHI in a manner that would violate the Privacy Rule if done by Covered Entity, except for uses or disclosures necessary for (1) Business Associate's proper management and administration and legal responsibilities or (2) for data aggregation services.

**C. Obligations of the Covered Entity**

1. Covered Entity's Representatives. The Covered Entity shall designate, in writing to Business Associate, individuals to be regarded as the Covered Entity's representatives, so that in reliance upon such designation Business Associate is authorized to make disclosures of PHI to such individuals or to their designee(s).
2. Restrictions on Use or Disclosure of PHI. If the Covered Entity agrees to restrictions on use or disclosure, as provided for in 45 CFR § 164.522 and the HITECH Act, of PHI received or created by Business Associate regarding an Individual, the Covered Entity agrees to pay Business Associate the actual costs incurred by Business Associate in accommodating such voluntary restrictions.
3. Limitation on Requests. The Covered Entity shall not request or require that Business Associate make any use or alteration of PHI that would violate HIPAA or HIPAA Regulations if done by the Covered Entity.

**D. Audits, Inspection, and Enforcement**

DRAFT

Upon reasonable notice, upon a reasonable determination by the Covered Entity that Business Associate has breached this BA Statement; the Covered Entity may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this BA Statement. Business Associate shall promptly remedy any violation of any term of this BA Statement and shall certify the same to the Covered Entity in writing. The fact that the Covered Entity inspects, or fails to inspect, or has the right to inspect, Business Associate's facilities, systems and procedures does not relieve Business Associate of its responsibility to comply with this BA Statement, nor does the Covered Entity's (i) failure to detect or (ii) detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices constitute acceptance of such practice or a waiver of the Covered Entity's enforcement rights under this BA Statement. Business Associate shall fully cooperate with the U.S. Department of Health and Human Services, as the primary enforcer of the HIPAA, who shall conduct periodic compliance audits to ensure that both Business Associate and the Covered Entity are compliant.

## E. Termination

1. Material Breach. A breach by Business Associate of any provision of this BA Statement, as determined by the Covered Entity, shall constitute a material breach of the BA Statement and shall provide grounds for immediate termination of the BA Statement and the Contract by the Board pursuant to Section E.2. of this BA Statement. [45 CFR § 164.504(e)(3)]
2. Reasonable Steps to Cure Breach. If either Party knows of a pattern of activity or practice of the other that constitutes a material breach or violation of that Party's obligations under the provisions of this BA Statement or another arrangement and does not terminate this BA Statement pursuant to Section E.1., then that Party shall take reasonable steps to cure such breach or end such violation, as applicable. If the Party's efforts to cure such breach or end such violation are unsuccessful, that Party shall either (i) terminate this BA Statement if feasible; or (ii) if termination of this BA Statement is not feasible, the non-breaching Party shall report the other Party's breach or violation to the Secretary of the Department of Health and Human Services. [45 CFR § 164.504(e)(1)(ii)]
3. Judicial or Administrative Proceedings. Either party may terminate this BA Statement, effective immediately, if (i) the other party is named as a defendant in a criminal proceeding for a violation of HIPAA or (ii) a finding or stipulation that the other party has violated any standard or requirement of HIPAA or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.
4. Effect of Termination. Upon termination of this BA Statement and the Contract for any reason, Business Associate shall return or destroy PHI received from the Covered Entity (or created or received by Business Associate on behalf of the Covered Entity) that Business Associate still maintains in any form, and shall retain no copies of such PHI except for one copy that Business Associate shall use solely for archival purposes and to defend its work product, provided that documents and data remain confidential and subject to this BA Statement, or if return or destruction is not feasible, it shall continue to extend the protections of this BA Statement to such information, and limit



DRAFT

further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. [45 CFR § 164.504(e)(2)(I)]

**F. Disclaimer**

The Covered Entity makes no warranty or representation that compliance by Business Associate with this BA Statement, HIPAA or the HIPAA Regulations shall be adequate or satisfactory for Business Associate's own purposes or that any information in Business Associate's possession or control, or transmitted or received by Business Associate, is or shall be secure from unauthorized use or disclosure. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

**G. Amendment**

Amendment to Comply with Law. The parties acknowledge that state and federal laws relating to electronic data security and privacy are rapidly evolving and that amendment of this BA Statement and the Contract may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HIPAA Regulations and other applicable laws relating to the security or confidentiality of PHI. The parties understand and agree that the Covered Entity shall receive satisfactory written assurance from Business Associate that Business Associate shall adequately safeguard all PHI that it receives or creates pursuant to this BA Statement. Upon the Covered Entity's request, Business Associate agrees to promptly enter into negotiations with the Covered Entity concerning the terms of an amendment to this BA Statement and the Contract embodying written assurances consistent with the standards and requirements of HIPAA, the HIPAA Regulations or other applicable laws. The Covered Entity may terminate this BA Statement upon 90 days written notice in the event (i) Business Associate does not promptly enter into negotiations to amend this BA Statement and the Contract when requested by the Covered Entity pursuant to this Section; or (ii) Business Associate does not enter into an amendment to this BA Statement and the Contract providing assurances regarding the safeguarding of PHI that the Covered Entity, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA and the HIPAA Regulations.

**H. Assistance in Litigation or Administrative Proceedings**

Business Associate shall make itself, and any subcontractors, employees or agents assisting Business Associate in the performance of its obligations under this BA Statement, available to the Covered Entity to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against the Covered Entity, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA Regulations or other laws relating to security and privacy, except where Business Associate or its subcontractor, employee or agent is a named adverse party.

**I. No Third-Party Beneficiaries**



DRAFT

Nothing expressed or implied in this BA Statement is intended to confer, nor shall anything herein confer, upon any person other than the Covered Entity, Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

**J. Effect on Contract**

Except as specifically required to implement the purposes of this BA Statement, or to the extent inconsistent with this BA Statement, all other terms of the Contract shall remain in force and effect.

**K. Electronic Health Records (EHR)**

If electronic health records are used or maintained with respect to PHI, individuals shall have the right to obtain a copy of such information in "electronic format".

**L. No Remuneration for PHI**

Business Associate shall not directly or indirectly receive remuneration in exchange for any PHI, unless it first obtains a valid authorization from the individual whose PHI is being disclosed.

**M. Interpretation**

This BA Statement shall be interpreted as broadly as necessary to implement and comply with HIPAA, HIPAA Regulations and applicable state laws. The parties agree that any ambiguity in this BA Statement shall be resolved in favor of a meaning that complies and is consistent with HIPAA and the HIPAA Regulations

## 46. Notices

All notices required or permitted to be given under this Contract shall be in writing and personally delivered or sent by certified United States mail, postage prepaid, return receipt requested, to the party to whom the notice should be given at the address set forth below. Notice shall be deemed given when actually received or when refused. The parties agree to promptly notify each other in writing of any change of address.

**If to MDFA:** Attention: Executive Director
Mississippi Department of Finance and Administration
501 N. West St., Suite 1301 Woolfolk Building
Post Office Box 267
Jackson, Mississippi 39205-0267

**With copy of any notice to:** Mississippi State Insurance Administrator
Office of Insurance
Mississippi Department of Finance and Administration

DRAFT

501 N. West St., Suite 1201-C Woolfolk Building
Post Office Box 24208
Jackson, Mississippi 39225-4208

**If to the Contractor:** [Name, Title]
[Contractor Name]
[Address]
[City, State, Zip]

**47. Incorporation of Documents**

This Contract consists of and precedence is hereby established by the order of the following documents incorporated herein:

A. This Contract signed by the parties including ***Exhibit A - Fee Schedule for Medical Claims and Performance Audit Services;***

B. The ***Mississippi Department of Finance and Administration's Request for Proposals for Medical Claims and Performance Audit Services, dated July 11, 2024***, and attached hereto as ***Exhibit B*** and incorporated fully herein by reference; and

C. The ***Contractor's Response to the Mississippi Department of Finance and Administration's Request for Proposals for Medical Claims and Performance Audit Services, dated August 14, 2024,*** attached hereto as ***Exhibit C*** and incorporated fully herein by reference.

The Remainder of this Page is Left Blank Intentionally

DRAFT

**IN WITNESS WHEREOF, the parties hereto have caused this Contract to be executed on the date shown below:**

| **[Contractor Name]** | Mississippi Department of Finance and Administration |
|---|---|
| By: ______________________________ | By: ______________________________ |
| Name: ______________________________ | Name: Liz Welch______________________ |
| Title: ______________________________ | Title: Executive Director_______________ |
| Date: ______________________________ | Date: ______________________________ |

DRAFT

**Exhibit A.** ***Fee Schedule for Medical Claims and Performance Audit Services***

For the Medical Claims and Performance Audit Services rendered under this Contract, the following all-inclusive hourly rates are listed below, including any expenses such as printing, binding, or photocopy:

| Hourly Fee by Position | Year 1 | Year 2 | Year 3 | Year 4 | Year 5* |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

* *Optional Renewal Year*

**MAXIMUM PROJECT COSTS**

Maximum project fees are not to be construed as the annual fees to be paid for each project. The amount paid for the specified annual project will be the lesser of the total fees based on the fee schedule above, or the stated maximum project cost listed below. Maximum project fees include any and all necessary expenses, including but not limited to travel for the annual trip to Jackson, Mississippi or other location designated by the Board and/or MDFA to present the report(s) as well as any and all necessary expenses, unless otherwise approved by the Board.

| PROJECT | Year 1 | Year 2 | Year 3 | Year 4 | Year 5* |
|---|---|---|---|---|---|
| Annual TPA Claims and Performance Audit | | | | | |

* *Optional Renewal Year*

**All fees/rates listed are guaranteed through the term of the Contract.**

DRAFT

**Exhibit B.** ***Mississippi Department of Finance and Administration's Request for Proposals for Medical Claims and Performance Audit Services, dated July 11, 2024***

DRAFT

**Exhibit C.** ***Contractor's Response to the Mississippi Department of Finance and Administration's Request for Proposals for Medical Claims and Performance Audit Services, dated August 14, 2024***

DRAFT

## Appendix B

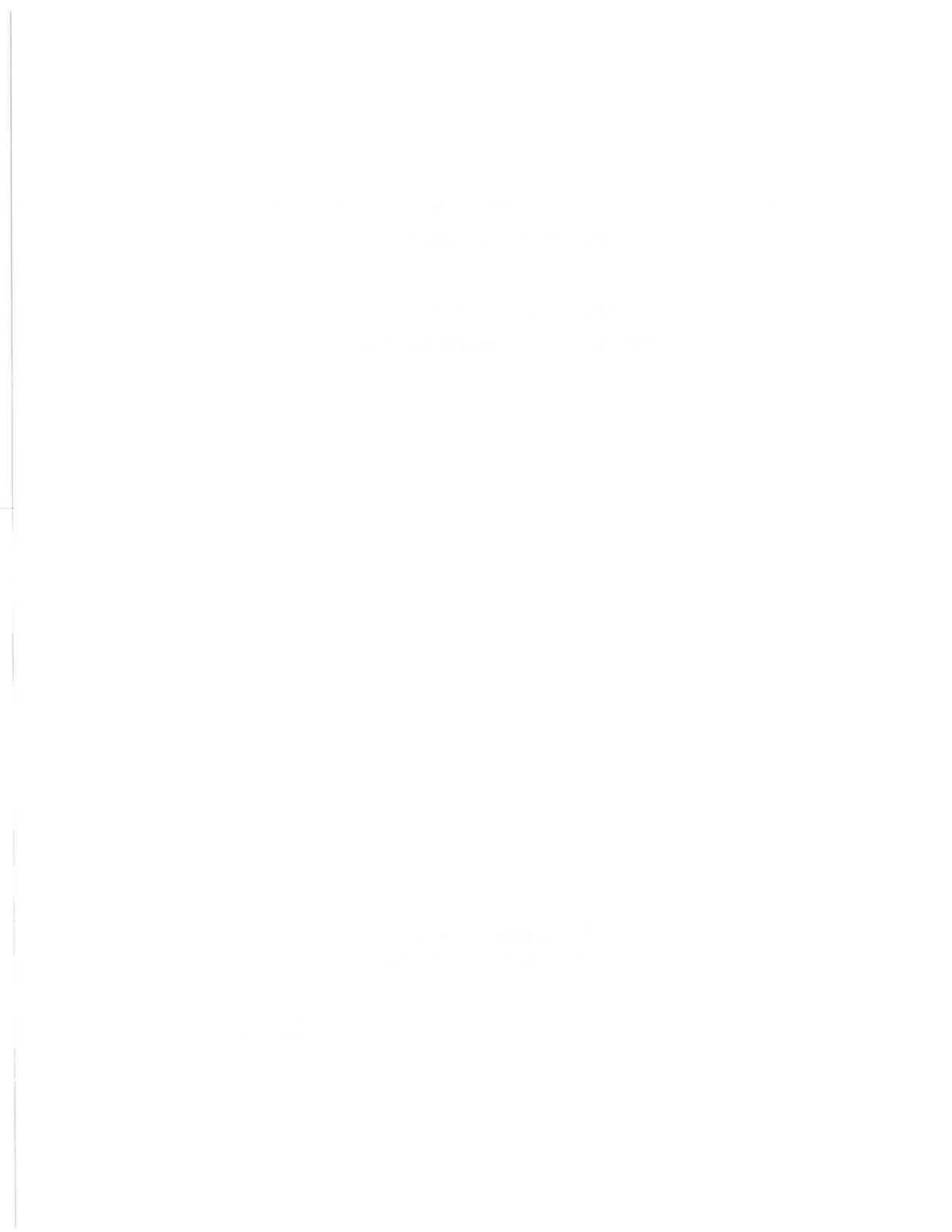
***Fiscal Year 2023 Actuarial Report***

# STATE OF MISSISSIPPI'S

# STATE & SCHOOL EMPLOYEES' LIFE & HEALTH INSURANCE PLAN

## ACTUARIAL REPORT
## CALENDAR YEAR 2023

PREPARED BY:
Wm. Lynn Townsend, FSA, MAAA
Consulting Actuary



**Wm. Lynn Townsend, FSA**
CONSULTING ACTUARY

103 Hatheway Lane
Madison, MS 39110

WLTFSA@AOL.COM
601-362-1650

March 6, 2024

Mississippi State and School Employees Health Insurance Management Board
P. O. Box 24208
Jackson, Mississippi 39225

Members of the Board:

This Actuarial Report is based on a review of the experience through December 31, 2024, of the State and School Employees' Life and Health Insurance Plan ("Plan").

In performing my review and preparing my report, I relied on certain information and data provided by DFA, Blue Cross/Blue Shield of Mississippi ("BCBS"), CVS Caremark, Health Data & Management Solutions ("HDMS"), and Minnesota Life Insurance Company.

To the best of my knowledge and belief:

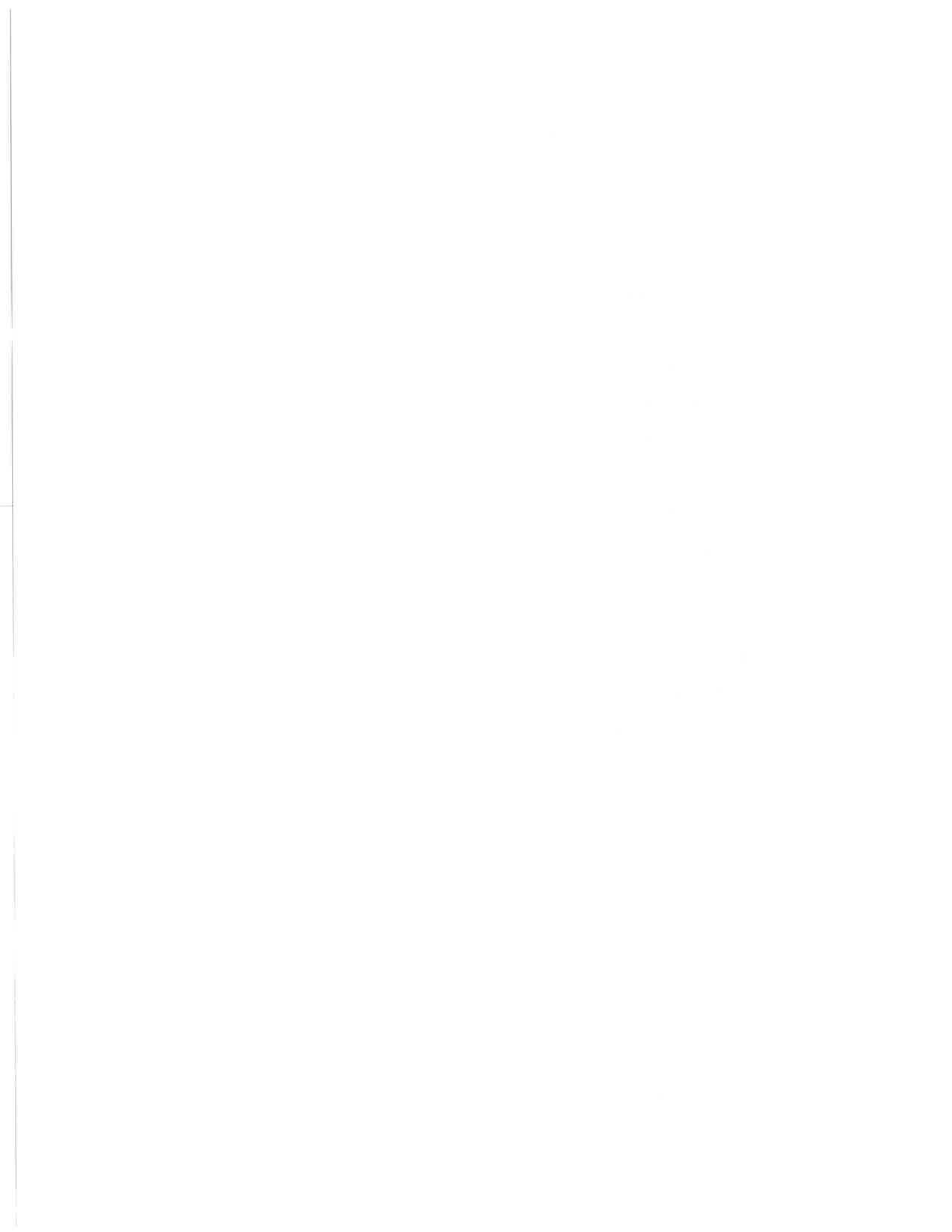
1.) All material aspects of my review have been communicated to DFA in this report.
2.) The calculations of the current claim liabilities of the Plan are in accordance with currently applicable Actuarial Standards of Practice.
3.) The projections of future cash flows and balance sheet items are based on future assumptions which, in the aggregate, appear to me to be fair and reasonable.

Sincerely,

Wm. Lynn Townsend, FSA, MAAA

# TABLE OF CONTENTS

| | Page |
|---|---|
| **Executive Summary** | **1** |
| **CY23 Financial Summary** | **5** |
| **Current Funding Status** | **6** |
| **Life Insurance** | **10** |
| **Health Plan Enrollment** | **13** |
| **Health Insurance Experience** | **18** |
| **Plan Benefit Changes** | **32** |
| **Historical Health Insurance Rate Increases** | **34** |
| **Funding Policy** | **35** |
| **Plan Projections** | **36** |
| **Postemployment Benefits** | **45** |
| **Appendix** | |
| **Assumptions** | **46** |
| **Significant Historical Benefit Changes** | **48** |
| **Federal Health Care Reform** | **50** |
| **Retiree Life Insurance Rates** | **53** |



## EXECUTIVE SUMMARY

For the last several years prior to CY23, the State and School Employees' Life and Health Insurance Plan used previously accumulated surplus to fund a portion of increasing annual benefit costs.

Following 7 straight years with no increase in the premium rates for non-Medicare rate classes, premium rates for active employees, dependents, and Legacy non-Medicare retirees were increased by 3% each year for CY19, CY20, and CY21 and by 6% each year in CY22 and CY23.

The Plan experienced surplus reductions of $21 million in CY16, $25 million in CY17, $40 million in CY18, $45 million in CY19, $32 million in CY20, and $53 million in CY21.

With the receipt of $60 million in December 2022 from the federal government under the American Rescue Plan Act ("ARPA"), Plan surplus increased in CY22 by $46 million instead of declining by $14 million.

During CY23 the premium rates in use by the Plan were essentially in actuarial balance; claims and expenses in CY23 exceeded premium and other revenue by $2 million, which represents a loss as a percent of premium of about 1/4$^{th}$ of 1%. With the receipt of another $31 million ARPA payment transferred into the Plan's accounts in January 2024, Plan surplus increased in CY23 by $29 million instead of declining by $2 million.

At its 8/23/23 meeting, the Board voted to increase rates by 5% on 1/1/24 for all premium classes.

### Recent Significant Benefit Changes

For CY21 the Plan increased the in network medical deductible for Select coverage by $300 from $1,000 to $1,300, and the coinsurance maximums for both Select and Base coverage were increased by $500 from $2,500 to $3,000.

For CY22 the Plan increased the in network medical deductible for Select coverage by $200 from $1,300 to $1,500, and on 7/1/22 the Plan implemented a formulary for prescriptions drugs based on the CVS Caremark "Value" Formulary.

For CY23 the Plan increased the in network medical deductible for Select coverage by $300 from $1,500 to $1,800.

### Premiums versus Claims

Based on current claim liability estimates, incurred claims (net of subrogation receipts, claim refunds, and drug rebates) increased by about 4.0% in CY23, from $796.6 million in CY22 to $828.8 million in CY23. Health insurance premiums are estimated to have exceeded health insurance claims (prior to administrative expenses but after drug rebates) by about $24.2 million during CY23. The loss ratio in CY23 was about 97.2%. Including interest and Plan expenses, a loss ratio of about 97% would have been required for the premiums to have been completely breakeven in CY23.

| Premium versus Claims Incurred (in Millions) | | | | | |
|---|---|---|---|---|---|
| | CY19 | CY20 | CY21 | CY22 | CY23 |
| Health Premiums | $747.4 | $767.8 | $777.5 | $810.8 | $853.1 |
| Health Claims Incurred | $765.7 | $768.3 | $802.1 | $796.6 | $828.8 |
| Loss Ratio (Claims/Premium) | 102.4% | 100.1% | 103.2% | 98.3% | 97.2% |

## EXECUTIVE SUMMARY (Continued)

### Review of Monthly Health Insurance Claims Costs Trends for Non-Medicare Members

| | Medical Benefits | Net Drug Benefits | Total Benefits | Year over Year Increase Rates: Medical Benefits | Net Drug Benefits | Total Benefits |
|---|---|---|---|---|---|---|
| CY16 | $253 | $75 | $329 | 5.7% | -5.7% | 2.8% |
| CY17 | $253 | $78 | $330 | -0.3% | 3.1% | 0.5% |
| CY18 | $255 | $81 | $336 | 0.9% | 4.1% | 1.7% |
| CY19 | $263 | $84 | $347 | 3.1% | 4.0% | 3.3% |
| CY20 | $259 | $89 | $348 | -1.3% | 5.7% | 0.4% |
| CY21 | $275 | $90 | $365 | 6.0% | 1.2% | 4.8% |
| CY22 | $264 | $101 | $366 | -3.9% | 12.5% | 0.2% |
| CY23 | $267 | $115 | $382 | 0.9% | 13.8% | 4.5% |

### Projections

The projections appearing in this Report are consistent in most material respects with the preliminary projections presented at the meeting of the Board on 2/28/24. The projections in this Report assume current benefits and assume rate increases of 5% on 1/1/24 and 5% on 1/1/25.

Summary projections appear below and detailed projections appear in the body of this Report.

Under the assumptions and rate increases used in these projections, the Plan is expected to experience close to break-even results each year throughout the projection period, and Plan surplus is expected to meet the Plan's revised stated funding objective throughout the projection period.

**SUMMARY PROJECTIONS (in Millions)**
**Assumes Current Benefits and the Rate Increase Assumptions Indicated Below**
**Does Not Yet Include the Affect of Any Pending Legislation**

| | Health Premium | Health Claims | Health Expense | Life Ins Interest & ACA Fees | Total Gain (Loss) | Gain (Loss) as a % of Premium | ARPA Payment | Year End Projected Surplus | Surplus Objective | Rate Increase |
|---|---|---|---|---|---|---|---|---|---|---|
| **Actual** | | | | | | | | | | |
| CY16 | $720 | ($704) | ($35) | ($2) | ($21) | -2.8% | | $254 | | 0% |
| CY17 | $723 | ($717) | ($37) | $6 | ($25) | -3.4% | | $229 | | 0% |
| CY18 | $722 | ($733) | ($35) | $7 | ($40) | -5.5% | | $189 | | 0% |
| CY19 | $747 | ($766) | ($33) | $7 | ($45) | -6.0% | | $145 | | 3% |
| CY20 | $768 | ($768) | ($33) | $2 | ($32) | -4.2% | | $113 | | 3% |
| CY21 | $777 | ($802) | ($30) | $1 | ($53) | -6.8% | | $60 | | 3% |
| CY22 | $811 | ($797) | ($29) | $1 | ($14) | -1.7% | $60 | $106 | | 6% |
| CY23 | $853 | ($829) | ($29) | $3 | ($2) | -0.2% | $31 | $135 | | 6% |
| **Projected** | | | | | | | | | | |
| CY24 | $894 | ($871) | ($30) | $4 | ($4) | -0.4% | | $131 | $77 | 5% |
| CY25 | $938 | ($917) | ($31) | $4 | ($5) | -0.6% | | $126 | $81 | 5% |

**TREND ASSUMPTIONS**

| | Plan Primary: Medical | Drugs-Net | Total | Medicare Primary |
|---|---|---|---|---|
| CY24 | 3.0% | 10.0% | 5.1% | 5.0% |
| CY25 | 3.0% | 10.0% | 5.2% | 5.0% |

**RATE INCREASE ASSUMPTIONS**

| | Plan Primary | Medicare Primary |
|---|---|---|
| 01/01/24 | 5% | 5% |
| 01/01/25 | 5% | 5% |

## EXECUTIVE SUMMARY (Continued)

### Discussion of Assumptions and their Effect on the Projections

These projections are based on cost trends and other assumptions that are difficult to predict and are subject to change due to unanticipated benefit changes or other fundamental changes that affect future costs. There may also be elevated risk that health care costs could increase at higher rates than in prior years simply as a result of higher general inflation; no specific provision has been included for this contingency.

It is also noted that the Plan has periodically taken action to reduce costs. For example, in CY11 deductible and other benefit and Plan changes were implemented to significantly reduce Plan costs. In CY14, significant cost reductions were achieved thru the introduction of the Blue Card network for out-of-state claims and enhancements in the AHS network for in-state claims.

Future operating results could be worse – or better – than projected. If experience worsens, rate increases higher than those shown in future years, or other Plan changes, could be required. If these projections prove to be conservative, future rate increases could perhaps be reduced or delayed, or Plan surplus in excess of that projected could still exist at the end of any of the projection periods shown.

### Postemployment Benefits

The CY23 Actuarial Report being provided herein does not separately identify and quantify the liabilities and costs that must be reported and recognized by the State, as an employer, under accounting rules established by the Governmental Accounting Standards Board for post-employment benefits. Therefore, Plan surplus – as defined in this Report – does not take into account the liabilities of the State, as an employer, associated with retiree health and life insurance.

Although there are significant surplus funds that exist in the Plan, there are much higher liabilities for the State – as an employer – for future retiree benefits that have not been funded. For example, based on current claims liability estimates, the Plan's surplus was about $135 million as of 12/31/23. Based on the most recent valuation prepared by Cavanaugh Macdonald, the State's total liability for retiree life and health insurance benefits provided through the Plan was about $554 million as of 6/30/23.

In evaluating the extent to which existing or projected surplus of the Plan is necessary or even sufficient, this Report should be reviewed in conjunction with the most recent version of the GASB Statement No. 74 Report that has been submitted to the Health Insurance Management Board by Cavanaugh Macdonald.

## CY23 FINANCIAL SUMMARY

The monthly financial statements prepared by DFA were adjusted to reflect the updated estimates of Plan liabilities and certain items of a similar nature were combined, as follows. Note that the amount shown for Plan surplus as of 12/31/22 is based upon a retroactive review of the life and health insurance claims liabilities based on actual incurred claims and incurred drug rebates.

| Financial Summary for CY23 (in millions) | | |
|---|---|---|
| Health Premiums | $ 853.1 | |
| Health Claims Incurred | (828.8) | |
| Administrative & Cost Containment Expenses | (29.5) | |
| PCORI Fees Incurred | (1.2) | |
| Subtotal Health Insurance | | $ (6.4) |
| Life Insurance Premium Contributions to the Plan | $ 20.6 | |
| Life Insurance Premiums to Minnesota Life | (20.6) | |
| Subtotal Life Insurance | | (0.0) |
| Interest and Other Revenue | | 4.3 |
| Total Gain (Loss) Before ARPA Payment | | (2.1) |
| ARPA Payment | | 31.2 |
| Total Gain (Loss) After ARPA Payment | | $ 29.1 |
| Plan Surplus, 12/31/22 (1), (2) | | $ 106.0 |
| Plan Surplus, 12/31/23 (2) | | $ 135.1 |

(1) Based on a retroactive evaluation of claims liabilities using actual paid claims.

(2) Plan Surplus, as shown above, does not take into account the liabilities of the State, as an employer, for other postemployment benefits ("OPEB"). According to the most recent valuation prepared by Cavanaugh Macdonald, the State's Total OPEB Liability associated with retiree benefits provided through the State and School Employees' Life and Health Insurance Plan was about $554 million as of 6/30/23.

### Historical Financial Summary

The following historical financial summary is based upon a retroactive review of the life and health insurance claims liabilities based on actual incurred claims and incurred drug rebates.

| Historical Financial Summary (in Millions) | CY19 | CY20 | CY21 | CY22 | CY23* |
|---|---|---|---|---|---|
| Health Insurance Gain (Loss) | ($52.1) | ($34.4) | ($54.7) | ($15.8) | ($6.4) |
| Life Insurance Gain | 3.2 | 0.5 | 0.9 | 0.9 | (0.0) |
| Interest and Other Income | 4.4 | 1.8 | 0.9 | 1.1 | 4.3 |
| Total Gain (Loss) before ARPA | ($44.5) | ($32.0) | ($53.0) | ($13.8) | ($2.1) |
| ARPA Payment | 0.0 | 0.0 | 0.0 | 60.0 | 31.2 |
| Total Gain (Loss) After ARPA | ($44.5) | ($32.0) | ($53.0) | $46.2 | $29.1 |
| Plan Surplus, Beginning of Year | $189.2 | $144.8 | $112.8 | $59.8 | $106.0 |
| Plan Surplus, End of Year | $144.8 | $112.8 | $59.8 | $106.0 | $135.1 |

# CURRENT FUNDING STATUS

## Plan Balance Sheet

As of 12/31/23 the Plan had an estimated funding surplus of $135.1 million.

| BALANCE SHEET | |
|---|---|
| **AS OF DATE:** | **12/31/2023** |
| **ASSETS** | |
| Cash and Invested Assets | $ 198,601,030 |
| Accrued Interest | 350,519 |
| ARPA Payment Receivable (Received in January 2024) | 31,219,250 |
| Total Assets | $ 230,170,800 |
| **LIABILITIES** | |
| Estimated Medical Claims IBNR (Incurred But Not Reported) | $ 78,807,768 |
| less Estimated Accrued Rebates on Medical Claim Drugs | (1,600,000) |
| Estimated Accrued Hospital Provider Incentive Payments | 1,600,000 |
| Medical Claims Due on Out-of-State Blue Card Claims | 8,418,683 |
| Provision for Claims Settlement Expenses | 8,000,000 |
| Estimated Drug Claims IBNR (Net of Adjustments) | (850,000) |
| Drug Claims Paid by CVS Caremark But Not Yet Paid by the Plan | 25,734,068 |
| less Estimated Drug Pricing Penalty for CY23 | (3,540,424) |
| less Estimated Rebates Receivable on Drug Card Claims | (38,766,401) |
| Accrued PCORI Fees for CY23 | 573,608 |
| Premium Payable to Minnesota Life for Billed Life Claims & Expense Charges | 1,649,148 |
| Estimated Future Premium for Life Claims Pending, Incurred prior to CY20 | 168,666 |
| Premium Contributions Received in Advance (less Arrears) | 12,470,591 |
| Due & Accrued Prior Period Expenses | |
| BCBS (Plan Administration) | 1,601,538 |
| Active Health | 266,590 |
| CVS Caremark | 310,895 |
| HDMS Decision Support System | 20,153 |
| KEPRO (Utilization Management) | 192,000 |
| Miscellaneous Expenses | 34,455 |
| Total Claim Liabilities and Due & Accrued Expenses | $ 95,091,340 |
| **PLAN SURPLUS [1]** | $ 135,079,459 |

*(1) Plan Surplus, as shown above, does not take into account the liabilities of the State, as an employer, for other postemployment benefits ("OPEB"). According to the most recent valuation prepared by Cavanaugh Macdonald, the State's Total OPEB Liability associated with retiree benefits provided through the State and School Employees' Life and Health Insurance Plan was about $554 million as of 6/30/23.*

## CURRENT FUNDING STATUS (Continued)

### Claims Liability for Incurred but Not Reported Medical Claims

The evaluation of the claims liability for claims paid by Blue Cross/Blue Shield of Mississippi ("BCBS" or "BCBS of MS") was completed following an extensive review of claims lag reports that BCBS provided for claims paid through January 2024. In general, claims liability estimates for the current period were determined by applying historical claims lag statistics to incomplete claims. These lag statistics were developed using system reports that summarize claims paid each month by the month in which the claim was incurred. Based on that analysis, I have evaluated the regular health insurance claims liability as of 12/31/23 to be about $78.8 million. About $40.7 million of this was paid in January 2024, leaving an estimated $38.1 million left to be paid after January 2024. The $78.8 million liability represents about 1.51 months of estimated average medical claims (excluding drug claims) incurred in the last 6 months.

### Rebates on Certain Drug Clams Paid by BCBS under the Medical Benefit

Through its own pharmacy benefit manager, BCBS receives rebates on certain drugs filed as medical claims by hospitals, physicians, and other outpatient providers. The rebates received by BCBS related to the claims on Plan members are paid by BCBS to the Plan. In January 2024, the Plan received a second payment of approximately $200,000 in rebates related to medical drug claims incurred in the 2nd quarter of CY23; including that amount, the Plan will have received about $645,000 in rebates incurred in the 2nd quarter of 2023 and has already received a total of about $850,000 for the 1st quarter of 2023. No rebates for 2023 Q3 and Q4 have been received yet by the Plan; including an estimate of $700,000 for each of those two quarters and the $200,000 payment for 2023 Q2 received in January, the Plan held as a receivable a total of $1,600,000 as of 12/31/23 for medical drug rebates due and accrued.

### Hospital Provider Quality Incentive Payment

The Plan participates in a program administered by the BCBS AHS network whereby participating hospital providers are eligible to receive additional payments if they meet certain quality measure benchmarks set by AHS. The Plan previously paid $2.0 million in hospital incentive payments related to claims incurred in CY21, and in May 2023 the Plan paid $1.6 million in incentive payments related to CY22 claims. Based on the results for the prior 2 years, an estimated liability of $1.6 million was held by the Plan as of 12/31/23 for hospital incentive payments related to claims incurred in CY23.

### Liability for Claims Paid by BCBS in December 2023 but Not Reimbursed until January

In general, medical claims paid by BCBS of MS to in-state providers are immediately reflected by the Plan as paid claims because those claims are paid by BCBS of MS from the Plan's bank account. However, medical claims paid by BCBS of MS to out-of-state providers are administered in conjunction with other states' Blue Cross plans in order to obtain network pricing under the Blue Card program, and BCBS of MS bills the Plan after the fact for those claims' payments. In January 2024, the Plan was billed $8.4 million by BCBS of MS for medical claims paid to out-of-state providers thru December 31, 2023. This amount has been handled as a separate claims liability.

### Provision for Claims Settlement Expenses

A provision of $8.0 million was held as a liability as of 12/31/23 for future administrative and claims settlement expenses related to claims incurred prior to 12/31/23.

## CURRENT FUNDING STATUS (Continued)

### Claims Liability for Incurred but Not Reported Drug Claims

In general – for most valuation periods – the vast majority of incurred drug claims have been paid by the pharmacy benefit manager within the month in which the drug claim was incurred, and future negative adjustments have been more likely than additional future claims payments. As of 12/31/23, the drug claims liability, net of negative adjustments in July, was estimated to be negative $850,000.

### Liability for Claims Paid by CVS Caremark in December 2023 but Not Reimbursed until January

Claims paid by CVS Caremark during December 2023 that were not reimbursed by the Plan until January totaled $25.7 million. This amount has been handled as a separate claims liability.

### Drug Pricing Performance Guarantee Payment Due and Accrued

The contract between the Plan and CVS Caremark includes an annual performance guarantee related to drug pricing. Based on a preliminary analysis for CY23 provided by CVS Caremark in January 2024, the Plan expects to receive a payment of about $3.5 million from CVS Caremark sometime later this year after calculations are complete.

### Rebates on Drug Claims Paid by CVS Caremark

The Plan receives rebate payments as a result of contracts in place between its pharmacy benefit manager, CVS Caremark, and various drug manufacturers. Under the Plan's contract with CVS Caremark, the Plan receives 100% of all rebates that are received by CVS Caremark that are related to the Plan's claims. The Plan's contract with CVS Caremark also includes certain minimum rebate guarantees. After the end of each quarter, CVS Caremark bills the various manufacturers for applicable rebates, and by the end of the next quarter, the Plan receives a preliminary rebate payment. Final rebate payments for a given quarter could take quite some time, perhaps as long as a year or longer after the completion of a given quarter, to obtain the total amount of rebates applicable.

As of 12/31/23, the Plan held an estimated receivable of $38.8 million for future rebates related to prescription drug claims incurred in CY23 that had not been received by the Plan by 12/31/23. This amount was based on an estimate of final rebate receipts of 97% of the rebates billed to the various drug manufacturers. For CY23, this assumption slightly exceeded the applicable rebate guarantees.

### Patient Centered Outcomes Research Institute

The Affordable Care Act (ACA) created the Patient-Centered Outcomes Research Institute (PCORI), which according to the PCORI website, "is authorized by Congress to conduct research to provide information about the best available evidence to help patients and their health care providers make more informed decisions. PCORI's research is intended to give patients a better understanding of the prevention, treatment, and care options available, and the science that supports those options." Provisions of ACA specified that PCORI is to be funded, in part, by fees payable by all insured and self-insured plans, including governmental plans. Those fees are to be based on total Plan enrollment and were payable – under the ACA – only for Plan years 2012-2018 (payable the following July). However, the fees required for PCORI were extended for an additional 10 years for 2019 thru 2028 by the "Further Consolidated Appropriations Act, 2020" that was passed by Congress in December 2019.

As of 12/31/2023, the Plan held a liability of $573,608 for accrued PCORI fees related to CY2023.

## CURRENT FUNDING STATUS (Continued)

**Liability for Life Insurance Premiums to Minnesota Life**

The life insurance policy with Minnesota Life limits the annual amount (determined on a calendar year basis) of life insurance premiums payable by the Plan to the amount of claims actually incurred and paid, plus contractual administration charges, up to a stated maximum annual premium. Incurred benefits are estimated to have exceeded the maximum annual premium by about $1.9 million in CY20, $4.9 million in CY21, and $1.9 million in CY22. Under the Minnesota Life policy, these deficits are subject to being recouped in future years from future excess premiums but are not carried back and recouped from prior excess premiums.

Cumulative incurred claims experience prior to CY20 was very favorable, and any such remaining claims that are to be paid in the future will not be affected by the maximum premium feature; those claims will in fact be billed to the Plan by Minnesota Life as those claims are paid. Minnesota Life provided an estimate for those claims equal to $168,666, and the Plan established a liability on its accounts for the same amount.

The premium to Minnesota Life for June of $1,705,811 (i.e., the administration charge of $79,099 and the claims charge of $1,626,722) was billed to the Plan in July 2023 and therefore was a liability as of 12/31/23.

# LIFE INSURANCE

### Minnesota Life Insurance Company

Life insurance provided by the Plan has been insured with Minnesota Life Insurance Company since January 1, 2009. Under the Minnesota Life policy, the amount of premiums payable by the Plan to Minnesota Life for each calendar year are limited to the amount of claims actually incurred and paid, plus contractual administration charges, up to a stated maximum annual premium, with annual calendar year deficits carried forward to the next year, but not back to the prior year.

Prior to its recent renewal, the prior Minnesota Life policy was set to expire on 12/31/2022. At its June 22, 2022, meeting, the Board voted to renew the Minnesota Life policy as of January 1, 2023, with a 10% increase in the maximum premium and a 10% reduction in the administrative fee.

### Life Insurance Benefits for Active Employees

The amount of life insurance and accidental death benefit insurance currently available to active employees is equal to 2 times the employee's annual wage rounded to the next highest $1,000, subject to a minimum of $30,000 and a maximum of $100,000. The current benefit level has been in effect since April 10, 1995.

### Life Insurance Benefits for Disabled Employees

Employees who participate in the life insurance plan are covered by a waiver of contribution provision in the event of a covered disability. The life insurance benefit provided to disabled employees is equal to the amount of life insurance in effect at disability. The 50% contribution previously payable by the disabled employee is waived after a 9-month waiting period.

### Life Insurance Benefits for Retired Employees

Employees who retire under the State's Public Employees Retirement System are allowed to continue to participate in the life insurance plan after retirement. Since July 1, 1999, retirees have been allowed to select a benefit at retirement of $5,000; $10,000; or $20,000. Retirees who retired between May 1, 1987, and June 30, 1999, were allowed to select a benefit at retirement of $2,000; $4,000; or $10,000. Prior to May 1, 1987, retirees were limited to a $2,000 benefit.

### Life Insurance Premium Contributions

The premium contribution for active employees is paid 50% each by the employee and the State. Effective 1/1/2014, the premium contribution rate was reduced by 25% from $0.24 to $0.18 per $1,000 benefit. Consistent with the 10% increase in the maximum premium under the Minnesota Life policy effective 1/1/23, the contribution rate for active employees was also increased on 1/1/23 from $0.18 to $0.20 per $1,000 benefit.

Retired employees pay 100% of the cost of life insurance and are charged rates per $1,000 that vary by attained age until age 70. (See the schedule of rates in the Appendix of this Report.)

### Increase in Life Insurance Claims, Presumably Due to COVID-19

Based on current estimates of outstanding claims, life insurance claims incurred were about $19.1 million in CY20, $21.7 million in CY21, $18.7 million in CY22, and $17.5 million in CY23. Compared to the $14 million annual average for CY17 thru CY19, life insurance claims were up about 37% in CY20, 56% in CY21, 34% in CY22, and 25% in CY23. Much of this excess mortality is believed to be due to COVID-19. The adverse effect of the increase in death claims on the Plan's annual funding was mitigated by the maximum premium provision included in the life insurance policy with Minnesota Life.

## LIFE INSURANCE (Continued)

**Life Insurance Experience – PRIOR to the Application of the Maximum Premium Provision in the Minnesota Life Policy**

The life insurance experience under the Plan for the last 5 calendar years is shown in the table below. The following table shows the experience of the Plan, prior to the application of the maximum premium provision.

**Comparison of "Premium" Contributions to Incurred Death Benefits and Admin Charges Prior to the Application of the Maximum Premium Provision**

| | CY19 | CY20 | CY21 | CY22 | CY23 |
|---|---|---|---|---|---|
| **Active Employees** | | | | | |
| Actual "Premium" Contributions | 12,073,290 | 12,300,175 | 12,216,744 | 12,273,223 | 13,736,613 |
| less Claims & Admin Charges | | | | | |
| Death Benefits on Active Employees | 8,346,710 | 12,341,696 | 15,936,757 | 13,256,098 | 12,342,018 |
| Death Benefits on Disabled Employees | 694,710 | 288,514 | 328,712 | 150,351 | 0 |
| Administrative Charges | 656,316 | 632,006 | 620,917 | 640,125 | 642,009 |
| Total Claims & Admin Charges | 9,697,736 | 13,262,217 | 16,886,386 | 14,046,575 | 12,984,027 |
| Net Gain (Loss) | 2,375,554 | (962,042) | (4,669,642) | (1,773,352) | 752,586 |
| Gain (Loss) Percent | 19.7% | -7.8% | -38.2% | -14.4% | 5.5% |
| **Retired Employees** | | | | | |
| "Premium" Contributions | 6,001,769 | 6,256,346 | 6,472,816 | 6,713,211 | 6,895,191 |
| less Claims & Admin Charges | | | | | |
| Death Benefits | 4,808,429 | 6,426,630 | 5,465,222 | 5,299,713 | 5,112,559 |
| Administration Charges | 326,262 | 321,463 | 328,981 | 350,136 | 322,261 |
| Total Claims & Admin Charges | 5,134,691 | 6,748,093 | 5,794,203 | 5,649,849 | 5,434,819 |
| Net Gain (Loss) | 867,078 | (491,748) | 678,613 | 1,063,363 | 1,460,371 |
| Gain (Loss) Percent | 14.4% | -7.9% | 10.5% | 15.8% | 21.2% |
| **Total Active & Retired** | | | | | |
| "Premium" Contributions | 18,075,059 | 18,556,520 | 18,689,561 | 18,986,434 | 20,631,803 |
| less Claims & Admin Charges | | | | | |
| Death Benefits | 13,849,849 | 19,056,841 | 21,730,691 | 18,706,162 | 17,454,577 |
| Administration Charges | 982,578 | 953,469 | 949,899 | 990,261 | 964,269 |
| Total Claims & Admin Charges | 14,832,427 | 20,010,310 | 22,680,589 | 19,696,423 | 18,418,846 |
| Net Gain (Loss) | 3,242,632 | (1,453,789) | (3,991,029) | (709,989) | 2,212,957 |
| Gain (Loss) Percent | 17.9% | -7.8% | -21.4% | -3.7% | 10.7% |

# LIFE INSURANCE (Continued)

**Life Insurance Experience – AFTER Application of the Maximum Premium Provision in the Minnesota Life Policy**

Prior to CY20, the maximum premium provision did not have a significant impact on the Plan's annual funding, and in recent calendar years prior to CY20, the Plan's annual costs were significantly less than the maximum annual premium. However, the dramatic increase in mortality associated with COVID-19 resulted in the premiums paid to Minnesota Life in CY20, CY21, and CY22 to be limited to the maximum premium, and on an incurred basis, resulted in annual deficits absorbed by Minnesota Life on a fully incurred basis estimated to be about $1.9 million in CY20; $4.9 million in CY21; and $1.6 million in CY22.

The following two tables show the financial effect of the maximum premium provision; the 1st table shows the effect on Minnesota Life, and the 2nd table below shows the effect on the Plan.

**Effect on Minnesota Life of the Maximum Premium Provision under the Minnesota Life Contract**

| | CY19 | CY20 | CY21 | CY22 | CY23 |
|---|---|---|---|---|---|
| Minnesota Life Maximum Premium | 17,662,557 | 17,920,324 | 17,819,610 | 18,085,601 | 20,730,781 |
| Incurred Claims & Admin Charges | 14,955,647 | 19,849,231 | 22,683,735 | 19,679,604 | 18,353,970 |
| Minnesota Life Incurred Premiums | 14,955,647 | 17,920,324 | 17,819,610 | 18,085,601 | 20,730,781 |
| Annual Incurred Deficit at Minn Life | | (1,928,907) | (4,864,125) | (1,594,003) | 2,376,811 |
| Cumulative Incurred Deficit at Minn Life | | (1,928,907) | (6,793,032) | (8,387,035) | (6,010,224) |

**Effect on the Plan of the Maximum Premium Provision under the Minnesota Life Contract**

| | CY19 | CY20 | CY21 | CY22 | CY23 |
|---|---|---|---|---|---|
| Life Insurance Contributions | 18,075,059 | 18,556,520 | 18,689,561 | 18,986,434 | 20,631,803 |
| Incurred Premiums to Minn Life | 14,955,647 | 17,920,324 | 17,819,610 | 18,085,601 | 20,647,409 |
| Net Plan Gain (Loss) | 3,119,412 | 636,196 | 869,951 | 900,833 | -15,606 |

# HEALTH PLAN ENROLLMENT

## Total Plan Enrollment

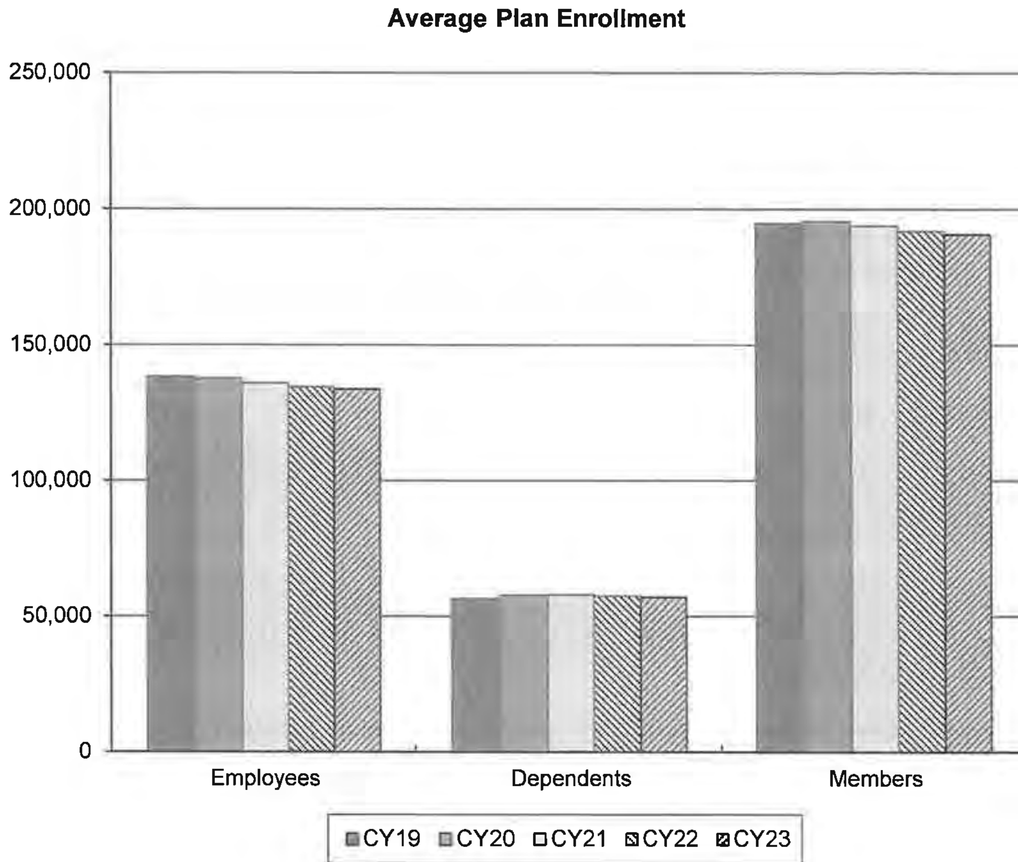
The average number of participating employees, dependents, and total members, by employee subgroup, were derived using the enrollment reports supplied by BCBS.

### Average Calendar Year Enrollment

| Participant | CY21 | | CY22 | | CY23 | |
|---|---|---|---|---|---|---|
| | Count | % | Count | % | Count | % |
| **Employees** | | | | | | |
| Active | 109,382 | 80.5% | 107,864 | 80.2% | 107,423 | 80.3% |
| COBRA | 729 | 0.5% | 641 | 0.5% | 526 | 0.4% |
| Early Retirees | 7,782 | 5.7% | 7,615 | 5.7% | 7,275 | 5.4% |
| Disabled Retiree (Non-Medicare) | 106 | 0.1% | 96 | 0.1% | 84 | 0.1% |
| Disabled Retiree (Medicare) | 765 | 0.6% | 724 | 0.5% | 666 | 0.5% |
| Medicare Retirees | 17,141 | 12.6% | 17,470 | 13.0% | 17,724 | 13.3% |
| Total | 135,906 | 100.0% | 134,410 | 100.0% | 133,697 | 100.0% |
| Total Retirees | 25,795 | 19.0% | 25,906 | 19.3% | 25,748 | 19.3% |
| **Dependents** | | | | | | |
| Active | 52,323 | 90.3% | 51,870 | 90.2% | 51,441 | 90.3% |
| COBRA | 347 | 0.6% | 342 | 0.6% | 275 | 0.5% |
| Early Retirees | 2,004 | 3.5% | 2,019 | 3.5% | 1,959 | 3.4% |
| Disabled Retiree (Non-Medicare) | 21 | 0.0% | 18 | 0.0% | 19 | 0.0% |
| Disabled Retiree (Medicare) | 114 | 0.2% | 107 | 0.2% | 90 | 0.2% |
| Medicare Retirees | 3,134 | 5.4% | 3,145 | 5.5% | 3,151 | 5.5% |
| Total | 57,944 | 100.0% | 57,500 | 100.0% | 56,936 | 100.0% |
| Total Retirees | 5,274 | 9.1% | 5,288 | 9.2% | 5,220 | 9.2% |
| **Members** | | | | | | |
| Active | 161,705 | 83.4% | 159,734 | 83.2% | 158,865 | 83.3% |
| COBRA | 1,076 | 0.6% | 982 | 0.5% | 801 | 0.4% |
| Early Retirees | 9,786 | 5.0% | 9,634 | 5.0% | 9,234 | 4.8% |
| Disabled Retiree (Non-Medicare) | 128 | 0.1% | 114 | 0.1% | 103 | 0.1% |
| Disabled Retiree (Medicare) | 880 | 0.5% | 830 | 0.4% | 756 | 0.4% |
| Medicare Retirees | 20,275 | 10.5% | 20,615 | 10.7% | 20,875 | 11.0% |
| Total | 193,849 | 100.0% | 191,910 | 100.0% | 190,633 | 100.0% |
| Total Retirees | 31,069 | 16.0% | 31,194 | 16.3% | 30,968 | 16.2% |

## HEALTH PLAN ENROLLMENT (Continued)

### Total Plan Enrollment Growth




| Annual Enrollment Growth Rates in CY23 | | | |
|---|---|---|---|
| | Active | Retirees | Total |
| Employees | -0.4% | -0.6% | -0.5% |
| Dependents | | | |
| Spouse | -3.0% | -1.6% | -2.6% |
| Children | -0.4% | -0.2% | -0.5% |
| Total Dependents | -0.8% | -1.3% | -1.0% |
| Employees & Dependents | -0.5% | -0.7% | -0.7% |

## HEALTH PLAN ENROLLMENT (Continued)

### Active Employee Enrollment – Legacy & Horizon Employees – Base & Select Coverage

House Bill 26, as enacted by the Legislature during 2005, included several provisions that affected the Plan beginning in CY06. "Horizon" refers to an employee or retiree who was initially hired on or after January 1, 2006. "Legacy" refers to an employee or retiree who was initially hired prior to January 1, 2006.

The Plan has two coverage options that are available to all employees:

1. "Base" coverage is a High Deductible Health Plan designed to meet the federal requirements for use with Health Savings Accounts.
2. "Select" coverage is a traditional health insurance plan that has a separate deductible applicable to prescription drug benefits.

The State pays 100% of the premium for Base coverage. The State makes the same contribution for all employees for either Base or Select coverage. The monthly contribution paid for by the State was $356 in 2011 thru 2018, $367 in 2019, $378 in 2020, $389 in 2021, $412 in 2022, and $437 in 2023, and is $459 in 2024.

Prior to January 1, 2011, the State also paid 100% of the premium for a Legacy employee who chose Select coverage. Beginning January 1, 2011, Legacy employees have had to pay a monthly premium of $20 for Select coverage.

Horizon employees have always had to pay a portion of the premium for Select coverage. The portion of the monthly Select coverage premium paid by active Horizon employees was $18 for 2006 thru 2010, $38 for 2011 thru 2018, $39 in 2019, $40 in 2020, $41 in 2021, $43 in 2022, and $46 in 2023, and is $48 in 2024.

### Analysis of Active Employee Enrollment – Legacy & Horizon Employees – Base & Select Coverage

Historically, very few Legacy employees have chosen Base coverage (High Deductible Health Plan). However, Base coverage is selected by a significantly higher proportion of Horizon employees. Overall, over 1 out of every 6 active employees now has Base coverage.

**% of Active Employees Choosing Base Coverage (HDHP)**

| Year | Months | Legacy Employees | Horizon Employees | All Employees |
|---|---|---|---|---|
| CY05 | 1-12 | 0.1% | N/A | 0.1% |
| CY06 | 1-12 | 0.3% | 20.0% | 1.1% |
| CY07 | 1-12 | 0.5% | 18.4% | 2.7% |
| CY08 | 1-12 | 0.6% | 15.4% | 3.3% |
| CY09 | 1-12 | 0.6% | 13.2% | 3.5% |
| CY10 | 1-12 | 0.6% | 11.8% | 3.6% |
| CY11 | 1-12 | 1.9% | 14.7% | 5.7% |
| CY12 | 1-12 | 2.5% | 16.9% | 7.3% |
| CY13 | 1-12 | 3.2% | 18.8% | 9.0% |
| CY14 | 1-12 | 3.8% | 20.5% | 10.7% |
| CY15 | 1-12 | 4.4% | 22.0% | 12.3% |
| CY16 | 1-12 | 4.4% | 20.7% | 12.3% |
| CY17 | 1-12 | 4.5% | 19.8% | 12.3% |
| CY18 | 1-12 | 4.7% | 19.5% | 12.7% |
| CY19 | 1-12 | 5.0% | 19.6% | 13.3% |
| CY20 | 1-12 | 5.3% | 19.6% | 13.8% |
| CY21 | 1-12 | 5.7% | 20.4% | 14.9% |
| CY22 | 1-12 | 6.3% | 21.8% | 16.3% |
| CY23 | 1-12 | 6.9% | 23.3% | 17.9% |

## HEALTH PLAN ENROLLMENT (Continued)

### Analysis of Average Active Employee Enrollment

| | | Legacy Employees | | | Horizon Employees | | | Percent of Total | |
|---|---|---|---|---|---|---|---|---|---|
| | | Select | Base | Total | Select | Base | Total | Legacy | Horizon |
| Year | Months | | | | | | | | |
| CY06 | 1-12 | 112,298 | 365 | 112,663 | 3,927 | 981 | 4,908 | 95.8% | 4.2% |
| | | 99.7% | 0.3% | 100.0% | 80.0% | 20.0% | 100.0% | | |
| CY07 | 1-12 | 104,627 | 561 | 105,188 | 11,730 | 2,646 | 14,376 | 88.0% | 12.0% |
| | | 99.5% | 0.5% | 100.0% | 81.6% | 18.4% | 100.0% | | |
| CY08 | 1-12 | 98,928 | 627 | 99,555 | 18,849 | 3,423 | 22,272 | 81.7% | 18.3% |
| | | 99.4% | 0.6% | 100.0% | 84.6% | 15.4% | 100.0% | | |
| CY09 | 1-12 | 94,170 | 600 | 94,770 | 24,740 | 3,762 | 28,501 | 76.9% | 23.1% |
| | | 99.4% | 0.6% | 100.0% | 86.8% | 13.2% | 100.0% | | |
| CY10 | 1-12 | 88,510 | 570 | 89,080 | 28,531 | 3,821 | 32,352 | 73.4% | 26.6% |
| | | 99.4% | 0.6% | 100.0% | 88.2% | 11.8% | 100.0% | | |
| CY11 | 1-12 | 81,000 | 1,544 | 82,544 | 30,182 | 5,208 | 35,390 | 70.0% | 30.0% |
| | | 98.1% | 1.9% | 100.0% | 85.3% | 14.7% | 100.0% | | |
| CY12 | 1-12 | 75,430 | 1,900 | 77,329 | 32,938 | 6,676 | 39,613 | 66.1% | 33.9% |
| | | 97.5% | 2.5% | 100.0% | 83.1% | 16.9% | 100.0% | | |
| CY13 | 1-12 | 70,029 | 2,289 | 72,318 | 35,373 | 8,183 | 43,556 | 62.4% | 37.6% |
| | | 96.8% | 3.2% | 100.0% | 81.2% | 18.8% | 100.0% | | |
| CY14 | 1-12 | 64,940 | 2,530 | 67,471 | 37,887 | 9,799 | 47,686 | 58.6% | 41.4% |
| | | 96.2% | 3.8% | 100.0% | 79.5% | 20.5% | 100.0% | | |
| CY15 | 1-12 | 60,401 | 2,755 | 63,156 | 40,348 | 11,375 | 51,722 | 55.0% | 45.0% |
| | | 95.6% | 4.4% | 100.0% | 78.0% | 22.0% | 100.0% | | |
| CY16 | 1-12 | 56,629 | 2,588 | 59,217 | 44,023 | 11,527 | 55,550 | 51.6% | 48.4% |
| | | 95.6% | 4.4% | 100.0% | 79.3% | 20.7% | 100.0% | | |
| CY17 | 1-12 | 52,784 | 2,474 | 55,259 | 46,559 | 11,501 | 58,060 | 48.8% | 51.2% |
| | | 95.5% | 4.5% | 100.0% | 80.2% | 19.8% | 100.0% | | |
| CY18 | 1-12 | 49,014 | 2,419 | 51,433 | 48,711 | 11,806 | 60,516 | 45.9% | 54.1% |
| | | 95.3% | 4.7% | 100.0% | 80.5% | 19.5% | 100.0% | | |
| CY19 | 1-12 | 45,781 | 2,415 | 48,196 | 51,345 | 12,515 | 63,860 | 43.0% | 57.0% |
| | | 95.0% | 5.0% | 100.0% | 80.4% | 19.6% | 100.0% | | |
| CY20 | 1-12 | 42,628 | 2,366 | 44,994 | 53,287 | 12,996 | 66,283 | 40.4% | 59.6% |
| | | 94.7% | 5.3% | 100.0% | 80.4% | 19.6% | 100.0% | | |
| CY21 | 1-12 | 39,092 | 2,383 | 41,474 | 54,027 | 13,880 | 67,908 | 37.9% | 62.1% |
| | | 94.3% | 5.7% | 100.0% | 79.6% | 20.4% | 100.0% | | |
| CY22 | 1-12 | 35,855 | 2,412 | 38,266 | 54,431 | 15,167 | 69,598 | 35.5% | 64.5% |
| | | 93.7% | 6.3% | 100.0% | 78.2% | 21.8% | 100.0% | | |
| CY23 | 1-12 | 33,034 | 2,435 | 35,469 | 55,166 | 16,788 | 71,954 | 33.0% | 67.0% |
| | | 93.1% | 6.9% | 100.0% | 76.7% | 23.3% | 100.0% | | |

## HEALTH PLAN ENROLLMENT (Continued)

### Expected Growth in Horizon Employees as a % of Total Employees

As older employees retire or otherwise leave employment, and they are replaced by employees who were first hired by the State on or after January 1, 2006, the proportion of employees who are Horizon employees grows. Over the last 12 months, the percentage of employees who were Horizon employees grew from 65.6% on 12/31/22 to 68.0% on 12/31/23, which is an average monthly increase of about 0.20%.

If the percentage of employees who are Horizon employees were to continue to grow by an average of about 0.20% per month, the Horizon proportion would grow to about 70.5% on 12/31/24 and 72.9% on 12/31/25; and the average annual Horizon enrollment proportion would grow from 67.0% in CY23 to 69.3% in CY24 and 71.8% in CY25.

### Historical Enrollment Growth by Premium Class

The following is a summary of the average enrollment, by premium class, for the last year together with the enrollment growth rates within each class for the last 5 years.

**Employee Enrollment Growth by Premium Class**

| | Enrollment Growth Rates | | | | | Average Employee Enrollment * |
|---|---|---|---|---|---|---|
| | CY19 | CY20 | CY21 | CY22 | CY23 | CY23 |
| Employee (Active & COBRA) | 0.0% | -0.7% | -1.7% | -1.4% | -0.6% | 107,987 |
| Spouse Only (Active & COBRA) | -1.2% | -0.9% | -2.2% | -3.5% | -4.1% | 3,632 |
| Full Family (Active & COBRA) | 2.8% | 1.5% | 0.4% | -1.3% | -2.3% | 5,452 |
| Children Only (All Classes) | 6.4% | 4.9% | 1.9% | 0.4% | 0.1% | 8,707 |
| Child Only (All classes) | 1.3% | 1.5% | -1.2% | -1.3% | 0.2% | 10,847 |
| Disabled Retiree - Non Medicare | -3.2% | -20.1% | -16.1% | -9.9% | -12.2% | 84 |
| Retired Employee - Non Medicare | -2.6% | -2.7% | -1.5% | -2.1% | -4.5% | 7,272 |
| Retiree Spouse Only - Non Medicare | -3.6% | -4.7% | -4.7% | -3.1% | -6.5% | 899 |
| Retiree Family - Non Medicare | 0.8% | 5.6% | 4.1% | 4.8% | -3.2% | 228 |
| Retiree Family - 1 on Medicare | 7.2% | -2.1% | 8.2% | -6.5% | 0.1% | 62 |
| Retiree Spouse Only - Medicare | 1.7% | 0.3% | -0.5% | -0.8% | 0.3% | 2,839 |
| Retired Employee - Medicare ** | 3.4% | 2.7% | 1.3% | 1.7% | 1.0% | 18,377 |

* *Refers to employee counts only, i.e., does not include dependents.*
** *Includes disabled retirees eligible for Medicare.*

# HEALTH INSURANCE EXPERIENCE

## Premiums versus Claims

Health insurance premiums are estimated to have exceeded health insurance claims (prior to administrative expenses but after drug rebates) by about $24.2 million during CY23. The following is a summary comparison for the last several years. Note that the amounts shown for incurred claims for prior years are based upon a retroactive review of health insurance claims liabilities based on actual incurred claims.

| Premium versus Claims Incurred (in Millions) | | | | | |
|---|---|---|---|---|---|
| | CY19 | CY20 | CY21 | CY22 | CY23 |
| Health Premiums | $747.4 | $767.8 | $777.5 | $810.8 | $853.1 |
| Health Claims Incurred | $765.7 | $768.3 | $802.1 | $796.6 | $828.8 |
| Loss Ratio (Claims/Premium) | 102.4% | 100.1% | 103.2% | 98.3% | 97.2% |

Based on current claim liability estimates, incurred claims (net of subrogation receipts, claim refunds, and drug rebates) increased by about 4.0% in CY23, from $796.6 million in CY22 to $828.8 million in CY23.

## Premiums versus Claims by Premium Class (Select & Base Coverage Combined)

CY23 paid loss ratios for the Plan as a whole appear in the Table on the following page and are summarized for the major premium classes in the table below:

**CY23 PAID LOSS RATIOS**
**SELECT AND BASE COVERAGE COMBINED: LEGACY AND HORIZON EMPLOYEES**
**Prior to Plan Expenses, but Includes Allocated Drug Rebates**

| | Monthly Average Premium | Monthly Paid Losses | Paid Loss Ratio |
|---|---|---|---|
| Active (& COBRA) Employees | $467 | $414 | 89% |
| Active (& COBRA) Dependents | | | |
| Spouse Only | $533 | $766 | 144% |
| Full Family | $783 | $957 | 122% |
| Child Only* | $179 | $225 | 126% |
| Children Only* | $374 | $397 | 106% |
| Early Retiree (Disabled) | $531 | $2,756 | 519% |
| Early Retiree (Non-Disabled) | $528 | $783 | 148% |
| Spouse Only | $631 | $749 | 119% |
| Full Family | $912 | $1,027 | 113% |
| Medicare Retirees & Spouse Only (Medicare)** | $213 | $212 | 100% |

* The children and child only premium classes are available to all employees.
** Includes disabled retirees eligible for Medicare.

## HEALTH INSURANCE EXPERIENCE (Continued)

**ACTUAL CY23 PAID LOSS RATIOS BY PREMIUM CLASS (INCLUDES DRUG CARD REBATES)**
**SELECT AND BASE COVERAGE COMBINED: LEGACY AND HORIZON EMPLOYEES**

| | Active Employee | COBRA Employee | Early Retiree | Early Retiree Disabled | Medicare Retiree | Total* |
|---|---|---|---|---|---|---|
| **AVERAGE COUNT** | | | | | | |
| Employee | 107,469 | 519 | 7,272 | 84 | 18,377 | 133,720 |
| Spouse (Regular) | 3,595 | 37 | 616 | 2 | 281 | 4,531 |
| Spouse (Medicare) | 0 | 0 | 196 | 3 | 2,640 | 2,839 |
| Family (Regular) | 5,412 | 40 | 196 | 2 | 30 | 5,680 |
| Child Only | 10,371 | 42 | 310 | 6 | 118 | 10,847 |
| Children Only | 8,549 | 31 | 107 | 2 | 18 | 8,707 |
| Family (1 on Medicare) | 0 | 0 | 22 | 0 | 39 | 62 |
| **PREMIUM (in millions)** | | | | | | |
| Employee | 602.0 | 3.0 | 46.0 | 0.5 | 47.0 | 698.5 |
| Spouse (Regular) | 23.0 | 0.2 | 4.6 | 0.0 | 2.1 | 30.0 |
| Spouse (Medicare) | 0.0 | 0.0 | 0.5 | 0.0 | 6.7 | 7.3 |
| Family (Regular) | 50.8 | 0.4 | 2.1 | 0.0 | 0.3 | 53.7 |
| Child Only | 22.2 | 0.1 | 0.7 | 0.0 | 0.3 | 23.3 |
| Children Only | 38.3 | 0.1 | 0.5 | 0.0 | 0.1 | 39.0 |
| Family (1 on Medicare) | 0.0 | 0.0 | 0.1 | 0.0 | 0.2 | 0.3 |
| Total | 736.4 | 3.9 | 54.6 | 0.6 | 56.7 | 852.2 |
| **CLAIMS (in millions)** | | | | | | |
| Employee | 522.4 | 13.9 | 68.4 | 2.8 | 47.0 | 654.5 |
| Spouse (Regular) | 32.9 | 0.5 | 5.4 | 0.0 | 2.7 | 41.5 |
| Spouse (Medicare) | 0.0 | 0.0 | 0.5 | 0.0 | 6.5 | 7.0 |
| Family (Regular) | 61.9 | 0.8 | 2.1 | 0.0 | 0.6 | 65.5 |
| Child Only | 27.5 | 0.1 | 1.3 | 0.0 | 0.2 | 29.3 |
| Children Only | 39.4 | 0.2 | 1.0 | 0.0 | 0.9 | 41.4 |
| Family (1 on Medicare) | 0.0 | 0.0 | 0.1 | 0.0 | 0.2 | 0.3 |
| Total | 684.1 | 15.5 | 78.8 | 2.9 | 58.1 | 839.4 |
| **AVERAGE PREMIUM RATE, CY23** | | | | | | |
| Employee | 466.78 | 484.11 | 527.71 | 531.39 | 213.00 | |
| Spouse (Regular) | 533.14 | 546.65 | 628.05 | 626.00 | 636.49 | |
| Spouse (Medicare) | N/A | N/A | 213.00 | 213.00 | 213.00 | |
| Family (Regular) | 782.96 | 801.06 | 911.08 | 913.00 | 916.09 | |
| Child Only | 178.61 | 182.55 | 189.96 | 191.00 | 191.00 | |
| Children Only | 373.58 | 380.71 | 381.99 | 383.00 | 383.00 | |
| Family (1 on Medicare) | N/A | N/A | 404.00 | N/A | 404.00 | |
| **LOSS RATIO** | | | | | | |
| Employee | 87% | 462% | 148% | 519% | 100% | 94% |
| Spouse (Regular) | 143% | 213% | 116% | 3% | 126% | 138% |
| Spouse (Medicare) | N/A | N/A | 108% | 40% | 96% | 96% |
| Family (Regular) | 122% | 198% | 100% | 183% | 189% | 122% |
| Child Only | 124% | 134% | 189% | 168% | 92% | 126% |
| Children Only | 103% | 141% | 202% | 18% | 1101% | 106% |
| Family (1 on Medicare) | N/A | N/A | 110% | N/A | 91% | 98% |
| Total | 93% | 401% | 144% | 470% | 102% | 98% |

* Totals may not agree due to rounding. Does not include administrative expenses.

## HEALTH INSURANCE EXPERIENCE (Continued)

**Premiums versus Claims by Premium Class (Select versus Base Coverage)**

Paid loss ratios are summarized in the table below for active employees only and appear in detail for all premium classes in the Tables on the next 4 pages for the following subsets:

Legacy Employees – Select Coverage
Legacy Employees – Base Coverage
Horizon Employees – Select Coverage
Horizon Employees – Base Coverage

**CY23 PAID LOSS RATIOS**
**ACTIVE EMPLOYEES ONLY**
**Prior to Plan Expenses, but Includes Allocated Drug Rebates**

| | Average Number of Employees | Monthly Average Premium | Monthly Paid Losses | Paid Loss Ratio | CY23 Average Age |
|---|---|---|---|---|---|
| Legacy Employees | | | | | |
| Select | 33,039 | $457 | $533 | 117% | 52.7 |
| Base (HDHP) | 2,434 | $437 | $326 | 75% | 51.0 |
| Horizon Employees | | | | | |
| Select | 55,201 | $483 | $387 | 80% | 41.3 |
| Base (HDHP) | 16,795 | $437 | $224 | 51% | 38.0 |
| All Employees | | | | | |
| Base & Select | 107,469 | $467 | $405 | 87% | 44.5 |

# HEALTH INSURANCE EXPERIENCE (Continued)

**ACTUAL CY23 PAID LOSS RATIOS BY PREMIUM CLASS (INCLUDES DRUG CARD REBATES)**
**SELECT COVERAGE: LEGACY EMPLOYEES**

| | Active Employee | COBRA Employee | Early Retiree | Early Retiree Disabled | Medicare Retiree | Total* |
|---|---|---|---|---|---|---|
| **AVERAGE COUNT** | | | | | | |
| Employee | 33,039 | 130 | 7,063 | 80 | 18,024 | 58,336 |
| Spouse (Regular) | 1,491 | 6 | 591 | 2 | 269 | 2,360 |
| Spouse (Medicare) | 0 | 0 | 194 | 3 | 2,592 | 2,788 |
| Family (Regular) | 1,789 | 9 | 189 | 2 | 29 | 2,018 |
| Child Only | 3,126 | 11 | 303 | 5 | 114 | 3,560 |
| Children Only | 2,802 | 5 | 100 | 2 | 18 | 2,927 |
| Family (1 on Medicare) | 0 | 0 | 21 | 0 | 39 | 61 |
| **PREMIUM (in millions)** | | | | | | |
| Employee | 181.2 | 0.7 | 44.5 | 0.5 | 46.1 | 273.0 |
| Spouse (Regular) | 9.7 | 0.0 | 4.4 | 0.0 | 2.0 | 16.3 |
| Spouse (Medicare) | 0.0 | 0.0 | 0.5 | 0.0 | 6.6 | 7.1 |
| Family (Regular) | 17.0 | 0.1 | 2.1 | 0.0 | 0.3 | 19.5 |
| Child Only | 7.2 | 0.0 | 0.7 | 0.0 | 0.3 | 8.2 |
| Children Only | 12.9 | 0.0 | 0.5 | 0.0 | 0.1 | 13.5 |
| Family (1 on Medicare) | 0.0 | 0.0 | 0.1 | 0.0 | 0.2 | 0.3 |
| Total | 228.0 | 0.9 | 52.8 | 0.6 | 55.6 | 337.8 |
| **CLAIMS (in millions)** | | | | | | |
| Employee | 211.2 | 4.7 | 66.3 | 2.6 | 46.1 | 331.0 |
| Spouse (Regular) | 15.9 | 0.0 | 5.3 | 0.0 | 2.2 | 23.5 |
| Spouse (Medicare) | 0.0 | 0.0 | 0.5 | 0.0 | 6.4 | 6.9 |
| Family (Regular) | 25.0 | 0.3 | 2.1 | 0.0 | 0.6 | 28.0 |
| Child Only | 7.1 | 0.0 | 1.3 | 0.0 | 0.2 | 8.7 |
| Children Only | 15.4 | 0.0 | 0.9 | 0.0 | 0.9 | 17.2 |
| Family (1 on Medicare) | 0.0 | 0.0 | 0.1 | 0.0 | 0.2 | 0.3 |
| Total | 274.6 | 5.1 | 76.7 | 2.7 | 56.6 | 415.6 |
| **AVERAGE PREMIUM RATE, CY23** | | | | | | |
| Employee | 457.00 | 472.33 | 525.00 | 525.00 | 213.00 | |
| Spouse (Regular) | 544.00 | 555.00 | 626.00 | 626.00 | 626.00 | |
| Spouse (Medicare) | N/A | N/A | 213.00 | 213.00 | 213.00 | |
| Family (Regular) | 794.00 | 810.00 | 913.00 | 913.00 | 913.00 | |
| Child Only | 191.00 | 198.93 | 191.00 | 191.00 | 191.00 | |
| Children Only | 383.00 | 401.38 | 383.00 | 383.00 | 383.00 | |
| Family (1 on Medicare) | N/A | N/A | 404.00 | N/A | 404.00 | |
| **LOSS RATIO** | | | | | | |
| Employee | 117% | 644% | 149% | 513% | 100% | 121% |
| Spouse (Regular) | 164% | 104% | 120% | 3% | 110% | 145% |
| Spouse (Medicare) | N/A | N/A | 108% | 40% | 96% | 97% |
| Family (Regular) | 146% | 330% | 102% | 183% | 189% | 143% |
| Child Only | 99% | 81% | 191% | 170% | 89% | 107% |
| Children Only | 119% | 41% | 206% | 18% | 1101% | 128% |
| Family (1 on Medicare) | N/A | N/A | 113% | N/A | 91% | 99% |
| Total | 120% | 558% | 145% | 463% | 102% | 123% |

* Totals may not agree due to rounding. Does not include plan expenses.

## HEALTH INSURANCE EXPERIENCE (Continued)

**ACTUAL CY23 PAID LOSS RATIOS BY PREMIUM CLASS (INCLUDES DRUG CARD REBATES)**
**BASE COVERAGE: LEGACY EMPLOYEES**

| | Active Employee | COBRA Employee | Early Retiree | Early Retiree Disabled | Medicare Retiree | Total* |
|---|---|---|---|---|---|---|
| **AVERAGE COUNT** | | | | | | |
| Employee | 2,434 | 4 | 134 | 2 | 0 | 2,574 |
| Spouse (Regular) | 118 | 0 | 15 | 0 | 0 | 134 |
| Spouse (Medicare) | 0 | 0 | 0 | 0 | 0 | 0 |
| Family (Regular) | 158 | 0 | 6 | 0 | 0 | 165 |
| Child Only | 316 | 0 | 7 | 0 | 0 | 323 |
| Children Only | 204 | 0 | 6 | 0 | 0 | 210 |
| Family (1 on Medicare) | 0 | 0 | 0 | 0 | 0 | 0 |
| **PREMIUM (in millions)** | | | | | | |
| Employee | 12.8 | 0.0 | 0.8 | 0.0 | 0.0 | 13.6 |
| Spouse (Regular) | 0.7 | 0.0 | 0.1 | 0.0 | 0.0 | 0.8 |
| Spouse (Medicare) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Family (Regular) | 1.4 | 0.0 | 0.1 | 0.0 | 0.0 | 1.5 |
| Child Only | 0.5 | 0.0 | 0.0 | 0.0 | 0.0 | 0.5 |
| Children Only | 0.8 | 0.0 | 0.0 | 0.0 | 0.0 | 0.8 |
| Family (1 on Medicare) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Total | 16.1 | 0.0 | 1.0 | 0.0 | 0.0 | 17.1 |
| **CLAIMS (in millions)** | | | | | | |
| Employee | 9.5 | 0.1 | 1.0 | 0.0 | 0.0 | 10.7 |
| Spouse (Regular) | 1.1 | 0.0 | 0.0 | 0.0 | 0.0 | 1.1 |
| Spouse (Medicare) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Family (Regular) | 0.9 | 0.0 | 0.0 | 0.0 | 0.0 | 0.9 |
| Child Only | 0.3 | 0.0 | 0.0 | 0.0 | 0.0 | 0.3 |
| Children Only | 0.7 | 0.0 | 0.0 | 0.0 | 0.0 | 0.8 |
| Family (1 on Medicare) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Total | 12.5 | 0.2 | 1.1 | 0.0 | 0.0 | 13.8 |
| **AVERAGE PREMIUM RATE, CY23** | | | | | | |
| Employee | 437.00 | 445.00 | 502.00 | 502.00 | N/A | |
| Spouse (Regular) | 478.00 | 488.00 | 550.00 | N/A | N/A | |
| Spouse (Medicare) | N/A | N/A | N/A | N/A | N/A | |
| Family (Regular) | 728.00 | 743.00 | 837.00 | N/A | N/A | |
| Child Only | 124.00 | 127.00 | 143.00 | N/A | N/A | |
| Children Only | 317.00 | 324.00 | 364.00 | N/A | N/A | |
| Family (1 on Medicare) | N/A | N/A | N/A | N/A | N/A | |
| **LOSS RATIO** | | | | | | |
| Employee | 75% | 668% | 129% | 148% | N/A | 79% |
| Spouse (Regular) | 162% | 18% | 14% | N/A | N/A | 143% |
| Spouse (Medicare) | N/A | N/A | N/A | N/A | N/A | N/A |
| Family (Regular) | 63% | 2% | 41% | N/A | N/A | 62% |
| Child Only | 63% | 4472% | 18% | N/A | N/A | 66% |
| Children Only | 94% | 43% | 167% | N/A | N/A | 96% |
| Family (1 on Medicare) | N/A | N/A | N/A | N/A | N/A | N/A |
| Total | 78% | 582% | 112% | 148% | N/A | 81% |

* Totals may not agree due to rounding. Does not include administrative expenses.

## HEALTH INSURANCE EXPERIENCE (Continued)

**ACTUAL CY23 PAID LOSS RATIOS BY PREMIUM CLASS (INCLUDES DRUG CARD REBATES)**
**SELECT COVERAGE: HORIZON EMPLOYEES**

| | Active Employee | COBRA Employee | Early Retiree | Early Retiree Disabled | Medicare Retiree | Total* |
|---|---|---|---|---|---|---|
| **AVERAGE COUNT** | | | | | | |
| Employee | 55,201 | 330 | 73 | 2 | 353 | 55,959 |
| Spouse (Regular) | 1,513 | 26 | 9 | 0 | 12 | 1,559 |
| Spouse (Medicare) | 0 | 0 | 3 | 0 | 48 | 50 |
| Family (Regular) | 2,717 | 26 | 1 | 0 | 1 | 2,745 |
| Child Only | 5,327 | 22 | 0 | 0 | 4 | 5,354 |
| Children Only | 4,527 | 19 | 1 | 0 | 0 | 4,547 |
| Family (1 on Medicare) | 0 | 0 | 1 | 0 | 0 | 1 |
| **PREMIUM (in millions)** | | | | | | |
| Employee | 319.9 | 2.0 | 0.7 | 0.0 | 0.9 | 323.6 |
| Spouse (Regular) | 9.9 | 0.2 | 0.1 | 0.0 | 0.1 | 10.3 |
| Spouse (Medicare) | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 | 0.1 |
| Family (Regular) | 25.9 | 0.3 | 0.0 | 0.0 | 0.0 | 26.2 |
| Child Only | 12.2 | 0.1 | 0.0 | 0.0 | 0.0 | 12.3 |
| Children Only | 20.8 | 0.1 | 0.0 | 0.0 | 0.0 | 20.9 |
| Family (1 on Medicare) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Total | 388.7 | 2.5 | 0.9 | 0.0 | 1.2 | 393.3 |
| **CLAIMS (in millions)** | | | | | | |
| Employee | 256.6 | 8.4 | 1.0 | 0.2 | 0.8 | 267.0 |
| Spouse (Regular) | 13.3 | 0.4 | 0.0 | 0.0 | 0.5 | 14.2 |
| Spouse (Medicare) | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 | 0.1 |
| Family (Regular) | 30.5 | 0.4 | 0.0 | 0.0 | 0.0 | 31.0 |
| Child Only | 16.7 | 0.1 | 0.0 | 0.0 | 0.0 | 16.8 |
| Children Only | 19.8 | 0.1 | 0.0 | 0.0 | 0.0 | 19.9 |
| Family (1 on Medicare) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Total | 336.9 | 9.5 | 1.0 | 0.2 | 1.4 | 349.0 |
| **AVERAGE PREMIUM RATE, CY23** | | | | | | |
| Employee | 483.00 | 495.28 | 830.00 | 830.00 | 213.00 | |
| Spouse (Regular) | 544.00 | 556.68 | 882.00 | N/A | 882.00 | |
| Spouse (Medicare) | N/A | N/A | 213.00 | N/A | 213.00 | |
| Family (Regular) | 794.00 | 810.00 | 1072.00 | N/A | 1072.00 | |
| Child Only | 191.00 | 195.00 | 191.00 | 191.00 | 191.00 | |
| Children Only | 383.00 | 395.87 | 383.00 | N/A | N/A | |
| Family (1 on Medicare) | N/A | N/A | 404.00 | N/A | N/A | |
| **LOSS RATIO** | | | | | | |
| Employee | 80% | 430% | 137% | 903% | 92% | 83% |
| Spouse (Regular) | 134% | 258% | 28% | N/A | 400% | 139% |
| Spouse (Medicare) | N/A | N/A | 123% | N/A | 76% | 79% |
| Family (Regular) | 118% | 175% | 82% | N/A | 178% | 118% |
| Child Only | 137% | 114% | 1036% | 147% | 163% | 137% |
| Children Only | 95% | 89% | 6% | N/A | N/A | 95% |
| Family (1 on Medicare) | N/A | N/A | 37% | N/A | N/A | 37% |
| Total | 87% | 374% | 123% | 867% | 123% | 89% |

* Totals may not agree due to rounding. Does not include plan expenses.

## HEALTH INSURANCE EXPERIENCE (Continued)

**ACTUAL CY23 PAID LOSS RATIOS BY PREMIUM CLASS (INCLUDES DRUG CARD REBATES)**
**BASE COVERAGE: HORIZON EMPLOYEES**

| | Active Employee | COBRA Employee | Early Retiree | Early Retiree Disabled | Medicare Retiree | Total* |
|---|---|---|---|---|---|---|
| **AVERAGE COUNT** | | | | | | |
| Employee | 16,795 | 55 | 2 | 0 | 0 | 16,851 |
| Spouse (Regular) | 474 | 5 | 0 | 0 | 0 | 478 |
| Spouse (Medicare) | 0 | 0 | 0 | 0 | 0 | 0 |
| Family (Regular) | 747 | 5 | 0 | 0 | 0 | 752 |
| Child Only | 1,602 | 8 | 0 | 0 | 0 | 1,610 |
| Children Only | 1,016 | 7 | 0 | 0 | 0 | 1,023 |
| Family (1 on Medicare) | 0 | 0 | 0 | 0 | 0 | 0 |
| **PREMIUM (in millions)** | | | | | | |
| Employee | 88.1 | 0.3 | 0.0 | 0.0 | 0.0 | 88.4 |
| Spouse (Regular) | 2.7 | 0.0 | 0.0 | 0.0 | 0.0 | 2.7 |
| Spouse (Medicare) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Family (Regular) | 6.5 | 0.0 | 0.0 | 0.0 | 0.0 | 6.6 |
| Child Only | 2.4 | 0.0 | 0.0 | 0.0 | 0.0 | 2.4 |
| Children Only | 3.9 | 0.0 | 0.0 | 0.0 | 0.0 | 3.9 |
| Family (1 on Medicare) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Total | 103.6 | 0.4 | 0.0 | 0.0 | 0.0 | 104.0 |
| **CLAIMS (in millions)** | | | | | | |
| Employee | 45.1 | 0.6 | 0.0 | 0.0 | 0.0 | 45.8 |
| Spouse (Regular) | 2.6 | 0.0 | 0.0 | 0.0 | 0.0 | 2.6 |
| Spouse (Medicare) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Family (Regular) | 5.6 | 0.0 | 0.0 | 0.0 | 0.0 | 5.6 |
| Child Only | 3.4 | 0.0 | 0.0 | 0.0 | 0.0 | 3.4 |
| Children Only | 3.4 | 0.1 | 0.0 | 0.0 | 0.0 | 3.5 |
| Family (1 on Medicare) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Total | 60.1 | 0.8 | 0.0 | 0.0 | 0.0 | 60.9 |
| **AVERAGE PREMIUM RATE, CY23** | | | | | | |
| Employee | 437.00 | 447.56 | 802.00 | N/A | N/A | |
| Spouse (Regular) | 478.00 | 488.00 | N/A | N/A | N/A | |
| Spouse (Medicare) | N/A | N/A | N/A | N/A | N/A | |
| Family (Regular) | 728.00 | 743.00 | N/A | N/A | N/A | |
| Child Only | 124.00 | 127.00 | N/A | N/A | N/A | |
| Children Only | 317.00 | 324.00 | N/A | N/A | N/A | |
| Family (1 on Medicare) | N/A | N/A | N/A | N/A | N/A | |
| **LOSS RATIO** | | | | | | |
| Employee | 51% | 205% | 76% | N/A | N/A | 52% |
| Spouse (Regular) | 95% | 104% | N/A | N/A | N/A | 95% |
| Spouse (Medicare) | N/A | N/A | N/A | N/A | N/A | N/A |
| Family (Regular) | 85% | 100% | N/A | N/A | N/A | 85% |
| Child Only | 143% | 151% | N/A | N/A | N/A | 143% |
| Children Only | 89% | 413% | N/A | N/A | N/A | 91% |
| Family (1 on Medicare) | N/A | N/A | N/A | N/A | N/A | N/A |
| Total | 58% | 199% | 76% | N/A | N/A | 59% |

* Totals may not agree due to rounding. Does not include plan expenses.

## HEALTH INSURANCE EXPERIENCE (Continued)

### Wellness/Preventive Benefit Costs

Following is a summary of the adult and child wellness benefits (medical benefits only) incurred in CY11 thru CY22:

**Wellness Benefits Incurred (in Millions)**
**Medical Benefits Only (i.e., not Including Drugs)**

| | Adults | % Change | Children | % Change | Total | % Change |
|---|---|---|---|---|---|---|
| **CY11** | $27.1 | 7% | $6.7 | 0% | $33.8 | 5% |
| **CY12** | $29.7 | 10% | $7.7 | 14% | $37.4 | 10% |
| **CY13** | $32.1 | 8% | $7.7 | 1% | $39.8 | 7% |
| **CY14** | $33.0 | 3% | $8.3 | 7% | $41.2 | 4% |
| **CY15** | $33.4 | 1% | $8.4 | 1% | $41.8 | 1% |
| **CY16** | $31.3 | -6% | $9.4 | 12% | $40.7 | -3% |
| **CY17** | $29.6 | -6% | $9.6 | 3% | $39.2 | -4% |
| **CY18** | $30.4 | 3% | $10.2 | 6% | $40.5 | 3% |
| **CY19** | $32.0 | 6% | $10.7 | 5% | $42.7 | 5% |
| **CY20** | $28.2 | -12% | $10.5 | -1% | $38.8 | -9% |
| **CY21** | $30.1 | 7% | $10.7 | 1% | $40.8 | 5% |
| **CY22** | $32.7 | 9% | $10.5 | -2% | $43.2 | 6% |

Wellness benefits incurred in CY23 are not yet complete. Following is a comparison of the adult and child wellness benefits incurred in the 1st nine months of CY19 thru CY23 that were paid by the end of each respective calendar year.

**Wellness Benefits Incurred (January thru September)**

| Incurred Mos 1-9 | Paid By | Adults | Percent Change | Children | Percent Change | Total | Percent Change |
|---|---|---|---|---|---|---|---|
| **CY19** | **12/31/19** | $22,740,297 | | $7,890,740 | | $30,631,038 | |
| **CY20** | **12/31/20** | $19,188,027 | -16% | $7,866,531 | 0% | $27,054,558 | -12% |
| **CY21** | **12/31/21** | $21,176,938 | 10% | $7,994,434 | 2% | $29,171,372 | 8% |
| **CY22** | **12/31/22** | $23,089,645 | 9% | $8,002,472 | 0% | $31,092,117 | 7% |
| **CY23** | **12/31/23** | $24,176,419 | 5% | $7,384,728 | -8% | $31,561,147 | 2% |

### Claims Cost per Member and Trend Rates for Non-Drug Claims

The Table below shows – for non-drug claims – average costs per member per month for medical claims, as well as the resulting trend rates. Results are separated for members who have regular coverage, i.e., for whom the Plan is primary, versus those who have Medicare as primary coverage.

The Table below also shows the extent to which claims costs are complete, by period. For periods which have completion factors well less than 100%, the claims costs shown are heavily dependent on current estimates of the liability for outstanding claims. Therefore, the claims costs and trend rates for those periods should be considered as estimates.

It is useful to review the trends from year-to-year on a calendar year basis because most major Plan benefit and operational changes occur on a calendar year basis. For example,

- In CY11, the negative trend rates were the result of the significant benefit changes in CY11 – primarily the increase in the Plan's deductibles.
- In CY14, the significant negative trend rate was primarily the result of the improvements in network pricing and participation, particularly with respect to out-of-state claims. As of January 1, 2014, the Plan began to participate in the Blue Card Network for out-of-state claims.
- In CY16, the Plan implemented the PCP copay feature on Select coverage. During that feature's development, it was estimated that non-drug claims would increase by about 2.5% due to that Plan change.

Actions taken in response to COVID-19 significantly reduced medical (non-drug) claims costs during the spring of 2020. As delayed services were subsequently provided, and direct costs associated with COVID-19 were incurred, claims costs increased. All of these effects influenced the trend rates in CY20, CY21, and CY22.

Benefit changes were implemented in CY21 and CY22 that were projected to reduce non-drug benefits by about $15.6 million (or 2.9%) in CY21 and $7.0 million (or 1.2%) in CY22.

**Growth in Incurred Claims per Member - NON DRUG**

| | Plan Primary | | | Medicare Primary | | |
|---|---|---|---|---|---|---|
| | Percent Complete | PMPM | Annual Trend | Percent Complete | PMPM | Annual Trend |
| CY14 | 100.0% | $239.34 | -10.7% | 100.0% | $146.18 | -3.6% |
| CY15 | 100.0% | $239.80 | 0.2% | 100.0% | $151.13 | 3.4% |
| CY16 | 100.0% | $253.39 | 5.7% | 100.0% | $152.43 | 0.9% |
| CY17 | 100.0% | $252.60 | -0.3% | 100.0% | $159.72 | 4.8% |
| CY18 | 100.0% | $254.94 | 0.9% | 100.0% | $162.03 | 1.4% |
| CY19 | 100.0% | $262.94 | 3.1% | 100.0% | $168.42 | 3.9% |
| CY20 | 100.0% | $259.40 | -1.3% | 100.0% | $161.11 | -4.3% |
| CY21 | 99.9% | $274.87 | 6.0% | 100.0% | $186.23 | 15.6% |
| CY22 | 99.8% | $264.24 | -3.9% | 99.7% | $201.97 | 8.4% |
| CY23* | 87.0% | $266.62 | 0.9% | 88.1% | $211.96 | 4.9% |

** Based on estimates of outstanding claims.*

# HEALTH INSURANCE EXPERIENCE (Continued)

**CVS Caremark / Value Formulary**

The Plan changed pharmacy benefit managers on 1/1/21 to CVS Caremark from Prime Therapeutics. The Plan changed to the CVS Caremark Value Formulary on 7/1/22.

**Description of Plan Benefits for Prescription Drugs**

Following is a summary of the drug benefits for Select coverage for the last several years:

| Description of Prescription Drug Benefits for Select Coverage | | | | | |
|---|---|---|---|---|---|
| **CALENDAR YEARS:** | **2010<br>2013** | **2014<br>2017** | **2018<br>2019** | **2020<br>06/30/22** | **07/01/22<br>2024** |
| **DEDUCTIBLE** | $75 | $75 | $75 | $75 | $75 |
| **COPAYS** | | | | | |
| Generic (Tier 1) | $12 | $12 | $12 | $12 | $12 |
| Generic (Tier 2) | | | | $30 | * |
| Preferred | $40 | $45 | $45 | $45 | $45 |
| Non Preferred | $65 | $70 | $100 | $100 | * |
| Specialty | $65 | $70 | $100 | $100 | $100 |

** Not applicable under the Value Formulary.*

Drug benefits under Base coverage (High Deductible Health Plan) are also subject to the above copays. Beginning in 2017, certain preventive drugs have been covered under Base coverage subject to the $75 drug deductible; otherwise, drugs under Base coverage are subject to a combined medical and drug deductible, not a separate drug deductible. Effective 1/1/06, Medicare eligible retirees no longer were eligible for drug benefits under the Plan since they were eligible for Medicare Part D drug coverage.

**Performance Guarantee Related to Pricing**

The contract between the Plan and CVS Caremark includes an annual performance guarantee related to drug pricing. The Plan receives an analysis of preliminary results following the end of each quarter, and a final cumulative annual analysis and settlement after the end of the calendar year. The Plan received a payment of $6.2 million from CVS Caremark in June 2022 related to the pricing performance guarantee for CY21 and $4.9 million in July 2023 related to the pricing performance guarantee for CY22. In January 2024 the Plan received a preliminary assessment of the pricing penalty applicable to claims incurred during CY23. That assessment resulted in an estimate of an accrued amount related to CY23 claims of about $3.5 million, and that amount was held as a receivable as of 12/31/2023.

**Drug Claims Incurred in CY23**

**Gross Drug Claims** – Prior to rebates – but after actual and projected payments to the Plan for performance guarantees related to drug pricing – gross drug claims incurred increased from $339.2 million in CY22 to $384.3 million in CY23, an increase of about 13.3%.

**Drug Claim Rebates** – The Plan receives quarterly rebate payments in conjunction with contracts in place between CVS Caremark and various drug manufacturers. Excluding rebate payments from BCBS associated with medical claims, and based on current estimates of rebates receivable, rebates incurred are estimated to have increased from $131.6 million in CY22 to $149.7 million in CY23, an increase of about 13.7%.

### Drug Claims Incurred in CY23 (Continued)

**Net Drug Claims Incurred in CY23** – After estimated incurred rebates and net of actual and projected performance guarantee payments, net drug claims increased from $207.5 million in CY22 to $234.6 million in CY23, an increase of about 13.0%.

### Drug Cost Trends for the Last 10 Calendar Years

**Drug Benefit Costs, per Member per Month**

| | Gross Benefits* | Drug Rebates | Net Drug Benefits* | Year over Year Increase Rates: Gross Benefits* | Drug Rebates | Net Drug Benefits* |
|---|---|---|---|---|---|---|
| CY14 | $78.29 | $6.34 | $71.96 | 10.2% | 33.4% | 8.6% |
| CY15 | $87.04 | $7.01 | $80.03 | 11.2% | 10.6% | 11.2% |
| CY16 | $92.23 | $16.75 | $75.49 | 6.0% | 138.8% | -5.7% |
| CY17 | $97.90 | $20.10 | $77.81 | 6.1% | 20.0% | 3.1% |
| CY18 | $104.70 | $23.73 | $80.97 | 6.9% | 18.1% | 4.1% |
| CY19 | $115.10 | $30.93 | $84.17 | 9.9% | 30.4% | 4.0% |
| CY20 | $124.62 | $35.62 | $89.00 | 8.3% | 15.2% | 5.7% |
| CY21* | $145.81 | $55.71 | $90.10 | 17.0% | 56.4% | 1.2% |
| CY22* | $165.62 | $64.27 | $101.35 | 13.6% | 15.3% | 12.5% |
| CY23* | $189.06 | $73.71 | $115.35 | 14.2% | 14.7% | 13.8% |

** Costs are net of actual and projected performance guarantees related to pricing.*

### Total Health Plan Cost Trends for Non- Medicare Members for the Last 10 Calendar Years

**Monthly Health Insurance Claims Costs for Non-Medicare Members**

| | Medical Benefits | Net Drug Benefits | Total Benefits | Year over Year Increase Rates: Medical Benefits | Net Drug Benefits | Total Benefits |
|---|---|---|---|---|---|---|
| CY14 | $239.34 | $71.96 | $311.30 | -10.7% | 8.6% | -6.9% |
| CY15 | $239.80 | $80.03 | $319.82 | 0.2% | 11.2% | 2.7% |
| CY16 | $253.39 | $75.49 | $328.88 | 5.7% | -5.7% | 2.8% |
| CY17 | $252.60 | $77.81 | $330.41 | -0.3% | 3.1% | 0.5% |
| CY18 | $254.94 | $80.97 | $335.91 | 0.9% | 4.1% | 1.7% |
| CY19 | $262.94 | $84.17 | $347.11 | 3.1% | 4.0% | 3.3% |
| CY20 | $259.40 | $89.00 | $348.40 | -1.3% | 5.7% | 0.4% |
| CY21 | $274.87 | $90.10 | $364.96 | 6.0% | 1.2% | 4.8% |
| CY22 | $264.24 | $101.35 | $365.59 | -3.9% | 12.5% | 0.2% |
| CY23* | $266.62 | $115.35 | $381.98 | 0.9% | 13.8% | 4.5% |

** Based on estimates of outstanding claims as of 12/31/23.*

## HEALTH INSURANCE EXPERIENCE (Continued)

### Analysis of Incurred Medical and Drug Claims Costs by Premium Class

The following is an analysis of incurred claims for the last 5 years. This analysis includes both drug and non-drug claims, including an allocation of drug rebates to each class in proportion to incurred drug claims.

For all classes, this analysis relied on paid data by incurred month and the application of completion factors. This analysis does not include Plan expenses.

As indicated by the ratios of costs by premium class to the active employee cost, the costs by premium class bear a reasonably close relationship from year-to-year.

**Analysis of Incurred Claims Costs by Premium Class**

| | CY19 | CY20 | CY21 | CY22 | CY23* |
|---|---|---|---|---|---|
| **Monthly Cost** | | | | | |
| Employee | $367 | $376 | $402 | $401 | $415 |
| Spouse Only | $658 | $647 | $626 | $604 | $693 |
| Full Family | $757 | $768 | $820 | $817 | $900 |
| Children Only | $382 | $359 | $383 | $401 | $401 |
| Child Only | $203 | $212 | $214 | $218 | $195 |
| Disabled Retiree | $3,043 | $3,205 | $2,330 | $2,707 | $2,765 |
| Early Retiree | $685 | $658 | $650 | $679 | $781 |
| Retiree Spouse (Non-Medicare) | $663 | $630 | $562 | $634 | $716 |
| Retiree/Spouse Combined (Medicare) | $170 | $162 | $188 | $203 | $213 |
| **Annual Rate of Increase** | | | | | |
| Employee | 6% | 2% | 7% | 0% | 4% |
| Spouse Only | -3% | -2% | -3% | -4% | 15% |
| Full Family | -6% | 2% | 7% | 0% | 10% |
| Children Only | 20% | -6% | 7% | 5% | 0% |
| Child Only | -3% | 4% | 1% | 2% | -10% |
| Disabled Retiree | -8% | 5% | -27% | 16% | 2% |
| Early Retiree | 4% | -4% | -1% | 4% | 15% |
| Retiree Spouse (Non-Medicare) | -13% | -5% | -11% | 13% | 13% |
| Retiree/Spouse Combined (Medicare) | 4% | -4% | 16% | 8% | 5% |
| **Ratio to Employee Cost** | | | | | |
| Employee | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 |
| Spouse Only | 2.04 | 1.73 | 1.55 | 1.54 | 1.61 |
| Full Family | 2.20 | 2.11 | 2.02 | 1.99 | 2.13 |
| Children Only | 0.97 | 1.01 | 0.96 | 0.97 | 0.96 |
| Child Only | 0.57 | 0.55 | 0.55 | 0.53 | 0.52 |
| Disabled Retiree | 8.78 | 9.53 | 6.75 | 6.00 | 6.71 |
| Early Retiree | 1.89 | 1.85 | 1.65 | 1.62 | 1.80 |
| Retiree Spouse (Non-Medicare) | 1.95 | 1.80 | 1.58 | 1.44 | 1.58 |
| Retiree/Spouse Combined (Medicare) | 0.47 | 0.45 | 0.44 | 0.49 | 0.51 |

** Based on estimates of outstanding claims as of 12/31/23.*

## HEALTH INSURANCE EXPERIENCE (Continued)

### Retiree & Dependent Rate Subsidies

Historically, premium rates for retirees - and for most active dependent premium classes - have been set below true actuarial cost. In effect, the State subsidizes those premium classes. The experience of the Plan in CY23 was separated by premium class in order to evaluate the amount of those subsidies. In the tables below, Plan expenses were allocated in proportion to the number of employees and retirees; retiree life insurance was allocated to early retirees, i.e., for retirees for whom the Plan is Primary; and all interest income was allocated to active employees.

**CY23 Plan Subsidy Costs**

| | Premiums | Claims | Expenses less Other Income | Gain (Loss) |
|---|---|---|---|---|
| Active Dependents | $134,533,338 | ($151,274,541) | ($4,492,715) | ($21,233,919) |
| COBRA Employees | 3,879,989 | (15,722,861) | (118,796) | ($11,961,668) |
| Disabled Retirees - Plan Primary | 610,406 | (2,871,623) | (19,316) | ($2,280,532) |
| Retirees - Plan Primary | 54,688,598 | (77,973,397) | (205,141) | ($23,489,941) |
| Retirees - Medicare Primary | 56,787,934 | (58,011,599) | (4,209,017) | ($5,432,682) |
| Disabled Retirees - Life Insurance | - | - | - | - |
| Subtotal - Subsidized Classes | $250,500,265 | ($305,854,020) | ($9,044,986) | ($64,398,741) |
| Active Employees | $602,549,827 | ($522,977,330) | ($17,303,989) | $62,268,508 |
| Total Plan | $853,050,091 | ($828,831,350) | ($26,348,975) | ($2,130,233) |

The table below shows the average monthly subsidy cost (a) per active employee for each active employee who purchases dependent coverage and (b) per retiree for each retiree who purchases either retired employee only coverage or both retired employee and dependent coverage. This table illustrates the extent to which monthly premium rates would have to be increased for those employee subgroups in order to eliminate the Plan's subsidy cost. For example, during CY23 an average of 27,927 active employees (or 26.0% of active employees) covered one or more of their dependents. The State incurred an average monthly subsidy cost of $63.36 for each of those active employees. Similarly, the State incurred an average monthly subsidy cost of $269.19 for each early retiree who was not disabled.

**CY23 Plan Subsidy Costs per Active or Retired Employee**

| Employee Subgroup | Average Employee Count | Total Plan Subsidy | Monthly Subsidy per Employee or Retiree |
|---|---|---|---|
| Active Employees with Dependent Coverage | 27,927 | $21,233,919 | $63.36 |
| COBRA Employees | 519 | $11,961,668 | $1,921.86 |
| Disabled Retiree - Plan Primary | 84 | $2,280,532 | $2,253.49 |
| Retirees - Plan Primary | 7,272 | $23,489,941 | $269.19 |
| Retirees - Medicare Primary | 18,377 | $5,432,682 | $24.64 |

## HEALTH INSURANCE EXPERIENCE (Continued)

### Retiree & Dependent Rate Subsidies (Continued)

The table that follows shows the CY23 subsidy costs represented as a *cost per active employee*. This table shows that monthly subsidy costs increased the Plan's monthly cost per active employee by $49.94 in CY23.

**Effect of Plan Subsidy Costs on Active Employee Premium Rate**

| | CY23 | |
|---|---|---|
| | **Annual Costs** | **Monthly Cost per Active Employee** |
| Total Active Employee Costs | $540,281,319 | $418.95 |
| Subsidy Costs for: | | |
| COBRA Employees | 11,961,668 | 9.28 |
| Dependents of Active Employees | 21,233,919 | 16.47 |
| Disabled Retirees - Plan Primary | 2,280,532 | 1.77 |
| Retirees - Plan Primary | 23,489,941 | 18.21 |
| Retirees - Medicare Primary | 5,432,682 | 4.21 |
| Disabled Retirees - Life Insurance | - | - |
| Subtotal - Subsidy Costs | $64,398,741 | $49.94 |
| Total Current Year's Costs | $604,680,060 | $468.88 |
| less Current Costs Funded by Prior Year's Premium | (2,130,233) | (1.65) |
| Total Active Employee Premium Current Year | $602,549,827 | $467.23 |

## PLAN BENEFIT CHANGES

### CY23 Plan Changes

**Select Plan Deductible –** The in network medical deductible for Select coverage for CY23 was increased by $300 from $1,500 to $1,800.

**CY23 SELECT COVERAGE**

| | Separate Medical Plan | | | Separate Drug Plan | | Combined |
|---|---|---|---|---|---|---|
| | *Individual Medical Deductible | *Medical Coinsurance | Individual Coinsurance Maximum | Individual Drug Deductible | Drug Copays Gen/Brand/Spec** | Individual Out of Pocket Limit |
| | | | | $75 | $12/$45/$100 | |
| In Network | $1,800 | 20% | $3,000 | | | $6,500 |
| Out-of-Network | $2,300 | 40% | $4,000 | | | |

* PCP Copay Feature (In-Network Only)
PCP office visit charges are not subject to the deductible.
PCP office visit copay: $25 (applies to the evaluation & management charge)
PCP office visits charges other than the evaluation & management charge: 20% coinsurance

** Drug copays for generic/brand/specialty drugs.

Family Medical Deductibles are limited to 2 times the Individual Medical Deductibles.
Family OOP Limits are limited to 2 times the Individual OOP Limits.

## PLAN BENEFIT CHANGES (Continued)

### CY24 Plan Changes

**Base Family Coverage Deductible –** The deductible for Base Family Coverage is being increased from $3,000 to $3,200 in order to meet the increased minimum deductible requirement in calendar year 2024 for a qualified high deductible health plan under federal law.

**CY24 BASE COVERAGE**

| | Combined Deductible* | Medical Coinsurance | Medical Coinsurance Maximum | Drug Copays Gen/Brand/Spec** | Combined Out-of- Pocket Limit | |
|---|---|---|---|---|---|---|
| **Self Only Coverage** | | | | | | |
| In Network | $1,800 | 20% | $3,000 | $12/$45/$100 | $6,500 | |
| Out-of-Network | $1,800 | 40% | $4,000 | $12/$45/$100 | | |
| **Family Coverage** | | | | | Per Family | Each Person |
| In Network | $3,200 | 20% | $5,500 | $12/$45/$100 | $13,000 | $6,500 |
| Out-of-Network | $3,200 | 40% | $7,500 | $12/$45/$100 | | |

** In 2024, the family coverage deductible will have to be increased to from $3,000 to $3.200.*

* Drugs on the HSA Preventive Drug list are subject only to a separate $75 deductible.

** Drug copays for generic/brand/specialty drugs.

## HISTORICAL HEALTH INSURANCE RATE INCREASES

**Summary of Active Employee Rate Increases from 1986 through January 2024**

| Year | Increase | Effective Date |
|---|---|---|
| 1986 | 0% | |
| 1987 | 0% | |
| 1988 | 0% | |
| 1989 | 6% | July 1, 1989 |
| 1990 | 10% | July 1, 1990 |
| 1991 | 20% | July 1, 1991 |
| 1992 | 25% | February 1, 1992 |
| 1993 | 5% | July 1, 1993 |
| 1994 | 0% | |
| 1995 | 0% | |
| 1996 | 0% | |
| 1997 | 10% | July 1, 1997 |
| 1998 | 4.5% | July 1, 1998 (10% State Plan, 0% School Plan) |
| 1999 | 9% | July 1, 1999 (3% State Plan, 14% School Plan) |
| 2000 | 3% | January 1, 2000 |
| | 12% | July 1, 2000 |
| 2001 | 6% | July 1, 2001 |
| 2002 | 7% | July 1, 2002 |
| 2003 | 4% | July 1, 2003 |
| 2004 | 23% | July 1, 2004 |
| 2005 | 9% | July 1, 2005 |
| 2006 | 11% | July 1, 2006 |
| 2007 | 5% | July 1, 2007 |
| 2008 | 1.5% | July 1, 2008 |
| 2009-2010 | 0% | |
| 2011 | 4% | January 1, 2011 |
| 2012-2018 | 0% | |
| 2019 | 3% | January 1, 2019 |
| 2020 | 3% | January 1, 2020 |
| 2021 | 3% | January 1, 2021 |
| 2022 | 6% | January 1, 2022 |
| 2023 | 6% | January 1, 2023 |
| 2024 | 5% | January 1, 2024 |

As of 1/1/24, the above rate increase history is equivalent to a compound annual rate of:

- 3.8% for the last 20 years
- 2.5% for the last 10 years
- 4.4% for the last 5 years

**Dependent and Retiree Rate Increases**

Rate increases for the last 14 years for dependents and retirees are illustrated in the Table below:

| Average Dependent & Retiree Rate Increases | 2011 | 2012 | 2016 | 2017 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|---|---|---|---|---|
| Dependents of Active EEs | 15% | 0% | 0% | 0% | 3% | 3% | 3% | 6% | 6% | 5% |
| Non-Medicare Retirees | 4% | 0% | 0% | 0% | 3% | 3% | 3% | 6% | 6% | 5% |
| Dependents of Retired EEs | 15% | 0% | 0% | 0% | 3% | 3% | 3% | 6% | 6% | 5% |
| Medicare Retirees | 15% | 2% | -5% | 2% | 2% | 2% | 2% | 2.5% | 6% | 5% |

# FUNDING POLICY

At the 11/30/10 meeting of the Health Insurance Management Board, a formal funding policy for the Plan was adopted by the Board, as follows:

**Funding Policy**

The State and School Employees Health Insurance Management Board shall endeavor to always hold assets sufficient to fully fund all liabilities for incurred administrative expenses, health insurance claims, and life insurance claims of the State and School Employees' Life and Health Insurance Plan. Incurred life and health insurance claims liabilities will include provision both for claims that have been reported and for claims that have not been reported. Claim liability estimates are recomputed on a periodic basis and are based on historical statistics related to the time it takes to fully adjudicate claims, and may be based, in part, on other factors such as inflation and participant counts. Due to the complex nature of the factors involved in the claims liability calculations, actual results may be more or less than the estimate.

Except to the extent that prior accumulated Plan surplus can perhaps be used to offset a portion of current or future costs, the Board shall endeavor to set, for any current or future period, premium rates and benefit structures such that Plan revenues and expenditures are essentially in actuarial balance for such current or future period. To the extent that benefit costs and expenses are in fact being funded by previously accumulated assets and not by premium rates that are sufficient for the remainder of the period to which the premium rates apply, the Plan shall establish a reserve based on actuarial projections for the amount of the premium deficiency.

Recognizing that claims cost estimates for past and future periods are subject to a degree of uncertainty, and therefore may exceed prior estimates, and recognizing that future Plan premium rate and benefit changes may not be able to be implemented on a schedule entirely consistent with the preceding funding objectives, the Board shall endeavor to always hold a reasonable amount of Plan surplus, with Plan surplus measured as the difference in Plan assets and Plan liabilities and reserves. For this purpose, the Board shall endeavor to hold Plan surplus in an amount at least equal to approximately one half (½) of one month's Plan expenses (based upon the average monthly expenses for the last twelve months).

*At its meeting on 6/22/22, the Board voted to increase the Plan's stated funding objective for Plan surplus from one half (½) of one month's Plan expenses to one full month of Plan expenses, effective 7/1/22.*

It should be noted that the funding policy described above does not address the issues raised by the implementation of GASB accounting rules applicable to postemployment life and health insurance benefits. In evaluating the extent to which existing or projected surplus of the Plan is necessary or even sufficient, this Report should be reviewed in conjunction with the most recent version of the GASB Statement No. 74 Report that has been submitted to the Health Insurance Management Board by Cavanaugh Macdonald.

# PLAN PROJECTIONS

### Basic Projection Approach

Incurred medical and drug claims rates were projected forward on a semi-annual basis – by premium class – using assumptions for annual non-drug benefit trend and annual drug benefit trend. See the Appendix of this Report for a more detailed description of those and other assumptions used in these projections.

### Non-Drug Benefit Trend

The basic annual trend assumption, prior to benefit changes, for non-drug benefits was 3% for non-Medicare premium classes and 5% for Medicare primary premium classes.

### Drug Benefit Trend

Prior to any Plan or benefit changes, the basic annual trend assumption for drug benefits, net of rebates, was 10%. The same trend assumption was made for Plan payments before rebates, rebates, and drug benefits after rebates.

### Discussion of Assumptions and their Effect on the Projections

These projections are based on cost trends and other assumptions that are difficult to predict and are subject to change due to unanticipated benefit changes or other fundamental changes that affect future costs. This is particularly true during and following the throes of a global pandemic. There may also be elevated risk that health care costs could increase at higher rates than in prior years simply as a result of higher general inflation; no specific provision has been included for this contingency.

It is noted that current trend assumptions are considerably less than those that were actually experienced just a few years ago. However, the annual cost trend assumptions being used are consistent with the cost trends experienced in those recent years in which significant operational or benefit changes did not occur. To that extent, these assumptions appear to me to be reasonable.

It is also noted that the Plan has periodically taken action to reduce costs. For example, in CY11 deductible and other benefit changes were implemented to reduce Plan costs. In CY14, significant cost reductions were achieved thru the introduction of the Blue Card network for out-of-state claims and enhancements in the AHS network for in-state claims.

Future operating results could be worse – or better – than projected. If experience worsens, rate increases higher than those shown in future years, or other Plan changes, could be required. If these projections prove to be conservative, future rate increases could perhaps be reduced or delayed, or Plan surplus in excess of that projected could still exist at the end of any of the projection periods shown.

## PLAN PROJECTIONS (Continued)

### Projections

The projections appearing in this Report are consistent in most material respects with the preliminary projections presented at the meeting of the Board on 2/28/24. The projections in this Report assume current benefits and assume rate increases of 5% on 1/1/24 and 5% on 1/1/25.

Summary projections appear below and detailed projections appear on the pages that follow.

Under the assumptions and rate increases used in these projections, the Plan is expected to experience close to break-even results each year throughout the projection period, and Plan surplus is expected to meet the Plan's revised stated funding objective throughout the projection period.

**SUMMARY PROJECTIONS (in Millions)**

**Assumes Current Benefits and the Rate Increase Assumptions Indicated Below**

**Does Not Yet Include the Affect of Any Pending Legislation**

| | Health Premium | Health Claims | Health Expense | Life Ins Interest & ACA Fees | Total Gain (Loss) | Gain (Loss) as a % of Premium | ARPA Payment | Year End Projected Surplus | Surplus Objective | Rate Increase |
|---|---|---|---|---|---|---|---|---|---|---|
| **Actual** | | | | | | | | | | |
| CY16 | $720 | ($704) | ($35) | ($2) | ($21) | -2.8% | | $254 | | 0% |
| CY17 | $723 | ($717) | ($37) | $6 | ($25) | -3.4% | | $229 | | 0% |
| CY18 | $722 | ($733) | ($35) | $7 | ($40) | -5.5% | | $189 | | 0% |
| CY19 | $747 | ($766) | ($33) | $7 | ($45) | -6.0% | | $145 | | 3% |
| CY20 | $768 | ($768) | ($33) | $2 | ($32) | -4.2% | | $113 | | 3% |
| CY21 | $777 | ($802) | ($30) | $1 | ($53) | -6.8% | | $60 | | 3% |
| CY22 | $811 | ($797) | ($29) | $1 | ($14) | -1.7% | $60 | $106 | | 6% |
| CY23 | $853 | ($829) | ($29) | $3 | ($2) | -0.2% | $31 | $135 | | 6% |
| **Projected** | | | | | | | | | | |
| CY24 | $894 | ($871) | ($30) | $4 | ($4) | -0.4% | | $131 | $77 | 5% |
| CY25 | $938 | ($917) | ($31) | $4 | ($5) | -0.6% | | $126 | $81 | 5% |

**TREND ASSUMPTIONS**

| | Plan Primary | | | Medicare |
|---|---|---|---|---|
| | Medical | Drugs-Net | Total | Primary |
| CY24 | 3.0% | 10.0% | 5.1% | 5.0% |
| CY25 | 3.0% | 10.0% | 5.2% | 5.0% |

**RATE INCREASE ASSUMPTIONS**

| | Plan Primary | Medicare Primary |
|---|---|---|
| 01/01/24 | 5% | 5% |
| 01/01/25 | 5% | 5% |

## PROJECTED ASSETS, LIABILITIES, & FUNDING STATUS

**Based on Rate Increases of 5% on 1/1/24 and 5% on 1/1/25**

| Mo | Yr | Total Plan Assets | Total Plan Liabilities | Assets less Liabilities |
|---|---|---|---|---|
| 12 | 23 | 230,170,800 | 95,091,340 | 135,079,459 |
| 1 | 24 | 220,378,856 | 75,266,988 | 145,111,869 |
| 2 | 24 | 253,770,199 | 101,226,365 | 152,543,835 |
| 3 | 24 | 242,634,716 | 88,928,914 | 153,705,802 |
| 4 | 24 | 234,518,738 | 74,300,909 | 160,217,829 |
| 5 | 24 | 257,460,897 | 101,374,314 | 156,086,583 |
| 6 | 24 | 245,212,629 | 93,850,225 | 151,362,403 |
| 7 | 24 | 230,581,504 | 78,067,518 | 152,513,986 |
| 8 | 24 | 253,494,134 | 104,790,420 | 148,703,714 |
| 9 | 24 | 239,758,395 | 87,957,926 | 151,800,469 |
| 10 | 24 | 223,293,270 | 75,244,915 | 148,048,355 |
| 11 | 24 | 247,437,189 | 106,340,615 | 141,096,574 |
| 12 | 24 | 225,958,361 | 94,554,416 | 131,403,945 |
| 1 | 25 | 215,214,952 | 73,419,503 | 141,795,449 |
| 2 | 25 | 255,021,052 | 105,505,028 | 149,516,024 |
| 3 | 25 | 242,432,904 | 91,920,139 | 150,512,765 |
| 4 | 25 | 233,129,798 | 75,998,431 | 157,131,367 |
| 5 | 25 | 257,031,545 | 104,432,473 | 152,599,072 |
| 6 | 25 | 239,564,341 | 92,082,098 | 147,482,243 |
| 7 | 25 | 223,495,265 | 74,874,923 | 148,620,342 |
| 8 | 25 | 248,672,941 | 104,181,533 | 144,491,408 |
| 9 | 25 | 233,453,136 | 85,873,707 | 147,579,429 |
| 10 | 25 | 215,209,013 | 71,718,771 | 143,490,242 |
| 11 | 25 | 241,844,716 | 105,728,267 | 136,116,449 |
| 12 | 25 | 218,459,042 | 92,544,236 | 125,914,806 |

## PROJECTED PLAN LIABILITIES

### Based on Rate Increases of 5% on 1/1/24 and 5% on 1/1/25

| Mo | Yr | Health Claims Incurred But Not Reported | CVS Caremark Drug Pricing Adjustment | PBM Drug Rebates Receivable | Health Claims Payable | Life Claims Incurred But Not Reported | Life Claims Payable | Advance less Due Premium | PCORI Fees Accrued & Payable | Expenses Payable |
|---|---|---|---|---|---|---|---|---|---|---|
| 12 | 23 | 85,957,768 | -3,540,424 | -38,766,401 | 34,152,752 | 168,666 | 1,573,727 | 12,470,591 | 573,608 | 2,501,052 |
| 1 | 24 | 78,036,371 | -3,540,424 | -50,720,025 | 34,152,752 | 168,666 | 1,573,727 | 12,470,591 | 624,276 | 2,501,052 |
| 2 | 24 | 77,412,125 | -3,540,424 | -24,187,070 | 34,152,752 | 168,666 | 1,573,727 | 12,470,591 | 674,945 | 2,501,052 |
| 3 | 24 | 78,298,784 | -3,540,424 | -37,421,848 | 34,152,752 | 168,666 | 1,573,727 | 12,470,591 | 725,614 | 2,501,052 |
| 4 | 24 | 76,280,341 | -3,540,424 | -50,082,079 | 34,152,752 | 168,666 | 1,573,727 | 12,470,591 | 776,283 | 2,501,052 |
| 5 | 24 | 79,907,032 | -3,540,424 | -26,686,034 | 34,152,752 | 168,666 | 1,573,727 | 12,470,591 | 826,951 | 2,501,052 |
| 6 | 24 | 82,503,091 | 0 | -40,397,275 | 34,152,752 | 168,666 | 1,573,727 | 12,470,591 | 877,620 | 2,501,052 |
| 7 | 24 | 80,990,090 | 0 | -54,144,041 | 34,152,752 | 168,666 | 1,573,727 | 12,470,591 | 354,681 | 2,501,052 |
| 8 | 24 | 82,323,933 | 0 | -28,805,652 | 34,152,752 | 168,666 | 1,573,727 | 12,470,591 | 405,349 | 2,501,052 |
| 9 | 24 | 79,557,210 | 0 | -42,922,092 | 34,152,752 | 168,666 | 1,573,727 | 12,470,591 | 456,018 | 2,501,052 |
| 10 | 24 | 81,859,539 | 0 | -57,988,100 | 34,152,752 | 168,666 | 1,573,727 | 12,470,591 | 506,687 | 2,501,052 |
| 11 | 24 | 84,893,462 | 0 | -29,976,992 | 34,152,752 | 168,666 | 1,573,727 | 12,470,591 | 557,356 | 2,501,052 |
| 12 | 24 | 88,052,318 | 0 | -44,972,715 | 34,152,752 | 168,666 | 1,573,727 | 12,470,591 | 608,024 | 2,501,052 |
| 1 | 25 | 80,012,683 | 0 | -58,121,702 | 34,152,752 | 168,666 | 1,573,727 | 12,470,591 | 661,733 | 2,501,052 |
| 2 | 25 | 79,425,739 | 0 | -25,502,941 | 34,152,752 | 168,666 | 1,573,727 | 12,470,591 | 715,442 | 2,501,052 |
| 3 | 25 | 80,345,397 | 0 | -40,061,197 | 34,152,752 | 168,666 | 1,573,727 | 12,470,591 | 769,151 | 2,501,052 |
| 4 | 25 | 78,296,234 | 0 | -53,987,451 | 34,152,752 | 168,666 | 1,573,727 | 12,470,591 | 822,859 | 2,501,052 |
| 5 | 25 | 82,043,754 | 0 | -29,354,637 | 34,152,752 | 168,666 | 1,573,727 | 12,470,591 | 876,568 | 2,501,052 |
| 6 | 25 | 84,722,034 | 0 | -44,437,002 | 34,152,752 | 168,666 | 1,573,727 | 12,470,591 | 930,277 | 2,501,052 |
| 7 | 25 | 83,190,618 | 0 | -59,558,445 | 34,152,752 | 168,666 | 1,573,727 | 12,470,591 | 375,962 | 2,501,052 |
| 8 | 25 | 84,571,291 | 0 | -31,686,217 | 34,152,752 | 168,666 | 1,573,727 | 12,470,591 | 429,670 | 2,501,052 |
| 9 | 25 | 81,737,840 | 0 | -47,214,301 | 34,152,752 | 168,666 | 1,573,727 | 12,470,591 | 483,379 | 2,501,052 |
| 10 | 25 | 84,101,804 | 0 | -63,786,909 | 34,152,752 | 168,666 | 1,573,727 | 12,470,591 | 537,088 | 2,501,052 |
| 11 | 25 | 87,245,373 | 0 | -32,974,691 | 34,152,752 | 168,666 | 1,573,727 | 12,470,591 | 590,797 | 2,501,052 |
| 12 | 25 | 90,502,928 | 0 | -49,469,987 | 34,152,752 | 168,666 | 1,573,727 | 12,470,591 | 644,506 | 2,501,052 |

## PROJECTED PLAN CASH FLOWS

**Based on Rate Increases of 5% on 1/1/24 and 5% on 1/1/25**

| Mo | Yr | Premiums Less Expenses | Health Claims Paid, Net | CVS Caremark Drug Pricing Adjustment | PBM Drug Rebates Received | Interest Income | PCORI Fees Paid | Net Cash Flow |
|---|---|---|---|---|---|---|---|---|
| 1 | 24 | 72,079,739 | -82,246,827 | | 0 | 375,145 | | -9,791,943 |
| 2 | 24 | 72,079,739 | -76,847,013 | | 37,763,822 | 394,795 | | 33,391,343 |
| 3 | 24 | 72,079,739 | -83,628,548 | | 0 | 413,326 | | -11,135,483 |
| 4 | 24 | 72,079,739 | -80,593,014 | | 0 | 397,297 | | -8,115,978 |
| 5 | 24 | 72,079,739 | -86,969,070 | | 37,421,848 | 409,642 | | 22,942,159 |
| 6 | 24 | 72,079,739 | -88,286,977 | 3,540,424 | 0 | 418,546 | | -12,248,269 |
| 7 | 24 | 71,812,219 | -86,266,379 | | 0 | 396,643 | -573,608 | -14,631,125 |
| 8 | 24 | 71,812,219 | -89,699,924 | | 40,397,275 | 403,060 | | 22,912,630 |
| 9 | 24 | 71,812,219 | -85,958,660 | | 0 | 410,702 | | -13,735,739 |
| 10 | 24 | 71,812,219 | -88,662,899 | | 0 | 385,555 | | -16,465,125 |
| 11 | 24 | 71,812,219 | -90,982,341 | | 42,922,092 | 391,949 | | 24,143,918 |
| 12 | 24 | 71,812,219 | -93,685,214 | | 0 | 394,168 | | -21,478,828 |
| 1 | 25 | 75,724,231 | -86,834,978 | | 0 | 367,338 | | -10,743,409 |
| 2 | 25 | 75,724,231 | -81,282,382 | | 44,972,715 | 391,537 | | 39,806,100 |
| 3 | 25 | 75,724,231 | -88,726,579 | | 0 | 414,200 | | -12,588,148 |
| 4 | 25 | 75,724,231 | -85,423,309 | | 0 | 395,972 | | -9,303,106 |
| 5 | 25 | 75,724,231 | -92,291,808 | | 40,061,197 | 408,128 | | 23,901,747 |
| 6 | 25 | 75,724,231 | -93,604,920 | | 0 | 413,485 | | -17,467,204 |
| 7 | 25 | 75,442,259 | -91,289,379 | | 0 | 386,068 | -608,024 | -16,069,076 |
| 8 | 25 | 75,442,259 | -95,094,731 | | 44,437,002 | 393,146 | | 25,177,676 |
| 9 | 25 | 75,442,259 | -91,063,502 | | 0 | 401,437 | | -15,219,806 |
| 10 | 25 | 75,442,259 | -94,059,955 | | 0 | 373,574 | | -18,244,122 |
| 11 | 25 | 75,442,259 | -96,401,419 | | 47,214,301 | 380,561 | | 26,635,702 |
| 12 | 25 | 75,442,259 | -99,211,200 | | 0 | 383,267 | | -23,385,674 |

## PROJECTED PLAN CASH FLOWS

### Based on Rate Increases of 5% on 1/1/24 and 5% on 1/1/25

| Mo | Yr | Premiums Less Expenses | Health Claims Paid, Net | CVS Caremark Drug Pricing Adjustment | PBM Drug Rebates Received | Interest Income | PCORI Fees Paid | Net Cash Flow |
|---|---|---|---|---|---|---|---|---|
| 1 | 24 | 72,079,739 | -82,246,827 | | 0 | 375,145 | | -9,791,943 |
| 2 | 24 | 72,079,739 | -76,847,013 | | 0 | 363,325 | | -4,403,949 |
| 3 | 24 | 72,079,739 | -83,628,548 | | 37,763,822 | 381,804 | | 26,596,816 |
| 4 | 24 | 72,079,739 | -80,593,014 | | 0 | 397,192 | | -8,116,083 |
| 5 | 24 | 72,079,739 | -86,969,070 | | 37,421,848 | 409,536 | | 22,942,054 |
| 6 | 24 | 72,079,739 | -88,286,977 | 3,540,424 | 0 | 418,440 | | -12,248,374 |
| 7 | 24 | 71,812,219 | -86,266,379 | | 0 | 396,537 | -573,608 | -14,631,230 |
| 8 | 24 | 71,812,219 | -89,699,924 | | 40,397,275 | 402,955 | | 22,912,525 |
| 9 | 24 | 71,812,219 | -85,958,660 | | 0 | 410,596 | | -13,735,845 |
| 10 | 24 | 71,812,219 | -88,662,899 | | 0 | 385,449 | | -16,465,231 |
| 11 | 24 | 71,812,219 | -90,982,341 | | 42,922,092 | 391,843 | | 24,143,812 |
| 12 | 24 | 71,812,219 | -93,685,214 | | 0 | 394,061 | | -21,478,934 |
| 1 | 25 | 75,724,231 | -86,834,978 | | 0 | 367,232 | | -10,743,515 |
| 2 | 25 | 75,724,231 | -81,282,382 | | 44,972,715 | 391,430 | | 39,805,994 |
| 3 | 25 | 75,724,231 | -88,726,579 | | 0 | 414,093 | | -12,588,255 |
| 4 | 25 | 75,724,231 | -85,423,309 | | 0 | 395,865 | | -9,303,213 |
| 5 | 25 | 75,724,231 | -92,291,808 | | 40,061,197 | 408,020 | | 23,901,639 |
| 6 | 25 | 75,724,231 | -93,604,920 | | 0 | 413,378 | | -17,467,311 |
| 7 | 25 | 75,442,259 | -91,289,379 | | 0 | 385,960 | -608,024 | -16,069,184 |
| 8 | 25 | 75,442,259 | -95,094,731 | | 44,437,002 | 393,038 | | 25,177,568 |
| 9 | 25 | 75,442,259 | -91,063,502 | | 0 | 401,329 | | -15,219,914 |
| 10 | 25 | 75,442,259 | -94,059,955 | | 0 | 373,466 | | -18,244,231 |
| 11 | 25 | 75,442,259 | -96,401,419 | | 47,214,301 | 380,453 | | 26,635,594 |
| 12 | 25 | 75,442,259 | -99,211,200 | | 0 | 383,159 | | -23,385,782 |

## CY24 PROJECTED PLAN EXPERIENCE

**Based on Current Benefits**

**Based on Rate Increases of 5% on 1/1/24 and 5% on 1/1/25**

| CLASS | Active/ Retired | Avg Count 01/01/24 12/31/24 | Prem Rate* 01/01/24 | Rate Incr 01/01/24 | Prem Rate* 07/01/24 | Rate Incr 07/01/24 | Premiums | Claims | Plan Expenses | Gain (Loss) | Gain (Loss) Rate |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Employee | Active | 107,987 | $479 | 4.8% | $479 | 0.0% | 635,009,487 | -564,775,573 | -19,998,299 | 50,235,614 | 8% |
| Spouse Only | Active | 3,632 | $571 | 5.0% | $571 | 0.0% | 24,321,853 | -31,698,760 | -765,966 | -8,142,873 | -33% |
| Full Family | Active | 5,452 | $834 | 5.0% | $834 | 0.0% | 53,700,761 | -61,703,426 | -1,691,193 | -9,693,858 | -18% |
| Children Only | Act/Ret | 8,707 | $402 | 5.0% | $402 | 0.0% | 40,642,156 | -43,718,654 | -1,279,940 | -4,356,438 | -11% |
| Child Only | Act/Ret | 10,847 | $201 | 5.2% | $201 | 0.0% | 24,420,348 | -26,524,956 | -769,068 | -2,873,676 | -12% |
| Disabled Employee | Retired | 84 | $550 | 4.8% | $550 | 0.0% | 556,600 | -2,936,245 | -19,137 | -2,398,782 | -431% |
| Employee | Retired | 7,272 | $550 | 4.8% | $550 | 0.0% | 47,993,000 | -71,509,425 | -1,423,100 | -24,939,524 | -52% |
| Spouse Only | Retired | 899 | $657 | 5.0% | $657 | 0.0% | 7,086,731 | -8,107,436 | -161,345 | -1,182,050 | -17% |
| Full Family | Retired | 228 | $959 | 5.0% | $959 | 0.0% | 2,624,304 | -2,923,521 | -58,181 | -357,398 | -14% |
| Family (1 On Medicare) | Retired | 62 | $425 | 5.2% | $425 | 0.0% | 313,863 | -374,912 | -7,461 | -68,511 | -22% |
| Spouse Only (Medicare) | Retired | 2,839 | $224 | 5.2% | $224 | 0.0% | 7,629,888 | -7,721,620 | -557,933 | -649,665 | -9% |
| Employee (Medicare) | Retired | 18,377 | $224 | 5.2% | $224 | 0.0% | 49,396,480 | -49,215,535 | -3,612,100 | -3,431,156 | -7% |
| Total Health Insurance | | | | | | | 893,695,469 | -871,210,064 | -30,343,723 | -7,858,318 | -0.9% |
| RECAP BY SUBGROUP | | | | | | | | | | | |
| Active Employees | | | | | | | 635,009,487 | -564,775,573 | -19,998,299 | 50,235,614 | 8% |
| Dependents Of Active Employees | | | | | | | 143,085,118 | -163,645,796 | -4,506,167 | -25,066,845 | -18% |
| Disabled Retirees (Regular) | | | | | | | 556,600 | -2,936,245 | -19,137 | -2,398,782 | -431% |
| Retirees & Dependents (Regular) | | | | | | | 58,017,897 | -82,915,294 | -1,650,087 | -26,547,484 | -46% |
| Retirees & Spouse Only (Medicare) | | | | | | | 57,026,368 | -56,937,155 | -4,170,033 | -4,080,821 | -7% |
| Total Health Insurance | | | | | | | 893,695,469 | -871,210,064 | -30,343,723 | -7,858,318 | -0.9% |
| Life Insurance Gain | | | | | | | | | | 0 | |
| Interest Income | | | | | | | | | | 4,790,827 | |
| less PCORI Fees | | | | | | | | | | -608,024 | |
| Total Gain (Loss) | | | | | | | | | | -3,675,515 | -0.4% |
| Beginning Surplus (Prior to Any Applicable Premium Deficiency Reserve) | | | | | | | | | | 135,079,459 | |
| Change In Surplus | | | | | | | | | | -3,675,515 | |
| Ending Surplus (Prior to Any Applicable Premium Deficiency Reserve) | | | | | | | | | | 131,403,945 | |
| Active Employee Premium Summary | | | | | | | | | | | |
| Employer Contributions | | | | | | | 591,936,957 | | | | |
| Employee Contributions | | | | | | | 39,961,820 | | | | |
| COBRA Premiums | | | | | | | 3,110,710 | | | | |
| Total Active Employee Premium | | | | | | | 635,009,487 | | | | |

* The active employee premium rate shown is for Legacy employees who choose Select coverage. Dependent rates shown are for Select coverage.

## CY25 PROJECTED PLAN EXPERIENCE

**Based on Current Benefits**

**Based on Rate Increases of 5% on 1/1/24 and 5% on 1/1/25**

| CLASS | Active/ Retired | Avg Count 01/01/25 12/31/25 | Prem Rate* 01/01/25 | Rate Incr 01/01/25 | Prem Rate* 07/01/25 | Rate Incr 07/01/25 | Premiums | Claims | Plan Expenses | Gain (Loss) | Gain (Loss) Rate |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Employee | Active | 107,987 | $502 | 4.8% | $502 | 0.0% | 666,800,185 | -594,700,064 | -20,603,089 | 51,497,032 | 8% |
| Spouse Only | Active | 3,632 | $600 | 5.1% | $600 | 0.0% | 25,539,940 | -33,355,920 | -789,144 | -8,605,124 | -34% |
| Full Family | Active | 5,452 | $876 | 5.0% | $876 | 0.0% | 56,379,330 | -64,822,338 | -1,742,034 | -10,185,042 | -18% |
| Children Only | Act/Ret | 8,707 | $422 | 5.0% | $422 | 0.0% | 42,641,717 | -45,767,040 | -1,317,563 | -4,442,886 | -10% |
| Child Only | Act/Ret | 10,847 | $211 | 5.0% | $211 | 0.0% | 25,608,709 | -27,741,167 | -791,269 | -2,923,727 | -11% |
| Disabled Employee | Retired | 84 | $577 | 4.9% | $577 | 0.0% | 583,924 | -3,089,462 | -19,714 | -2,525,252 | -432% |
| Employee | Retired | 7,272 | $577 | 4.9% | $577 | 0.0% | 50,349,020 | -75,278,049 | -1,465,967 | -26,394,997 | -52% |
| Spouse Only | Retired | 899 | $690 | 5.0% | $690 | 0.0% | 7,442,685 | -8,537,484 | -166,259 | -1,261,059 | -17% |
| Full Family | Retired | 228 | $1,007 | 5.0% | $1,007 | 0.0% | 2,755,656 | -3,071,347 | -59,812 | -375,503 | -14% |
| Family (1 On Medicare) | Retired | 62 | $446 | 4.9% | $446 | 0.0% | 329,371 | -399,864 | -7,787 | -78,280 | -24% |
| Spouse Only (Medicare) | Retired | 2,839 | $235 | 4.9% | $235 | 0.0% | 8,004,570 | -8,112,748 | -574,751 | -682,929 | -9% |
| Employee (Medicare) | Retired | 18,377 | $235 | 4.9% | $235 | 0.0% | 51,822,200 | -51,676,802 | -3,720,979 | -3,575,581 | -7% |
| Total Health Insurance | | | | | | | 938,257,307 | -916,552,286 | -31,258,368 | -9,553,346 | -1.0% |
| RECAP BY SUBGROUP | | | | | | | | | | | |
| Active Employees | | | | | | | 666,800,185 | -594,700,064 | -20,603,089 | 51,497,032 | 8% |
| Dependents Of Active Employees | | | | | | | 150,169,697 | -171,686,465 | -4,640,010 | -26,156,778 | -17% |
| Disabled Retirees (Regular) | | | | | | | 583,924 | -3,089,462 | -19,714 | -2,525,252 | -432% |
| Retirees & Dependents (Regular) | | | | | | | 60,876,732 | -87,286,744 | -1,699,825 | -28,109,838 | -46% |
| Retirees & Spouse Only (Medicare) | | | | | | | 59,826,770 | -59,789,550 | -4,295,730 | -4,258,510 | -7% |
| Total Health Insurance | | | | | | | 938,257,307 | -916,552,286 | -31,258,368 | -9,553,346 | -1.0% |
| Life Insurance Gain | | | | | | | | | | 0 | |
| Interest Income | | | | | | | | | | 4,708,713 | |
| less PCORI Fees | | | | | | | | | | -644,506 | |
| Total Gain (Loss) | | | | | | | | | | -5,489,139 | -0.6% |
| Beginning Surplus (Prior to Any Applicable Premium Deficiency Reserve) | | | | | | | | | | 131,403,945 | |
| Change In Surplus | | | | | | | | | | -5,489,139 | |
| Ending Surplus (Prior to Any Applicable Premium Deficiency Reserve) | | | | | | | | | | 125,914,806 | |
| Active Employee Premium Summary | | | | | | | | | | | |
| Employer Contributions | | | | | | | 621,598,286 | | | | |
| Employee Contributions | | | | | | | 41,935,458 | | | | |
| COBRA Premiums | | | | | | | 3,266,441 | | | | |
| Total Active Employee Premium | | | | | | | 666,800,185 | | | | |

* The active employee premium rate shown is for Legacy employees who choose Select coverage. Dependent rates shown are for Select coverage.

## FY25 PROJECTED PLAN EXPERIENCE

**Based on Current Benefits**

**Based on Rate Increases of 5% on 1/1/24 and 5% on 1/1/25**

| CLASS | Active/ Retired | Avg Count 07/01/24 06/30/25 | Prem Rate* 07/01/24 | Rate Incr 07/01/24 | Prem Rate* 01/01/25 | Rate Incr 01/01/25 | Premiums | Claims | Plan Expenses | Gain (Loss) | Gain (Loss) Rate |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Employee | Active | 107,987 | $479 | 0.0% | $502 | 4.8% | 650,943,113 | -579,266,487 | -20,301,222 | 51,375,404 | 8% |
| Spouse Only | Active | 3,632 | $571 | 0.0% | $600 | 5.1% | 24,941,380 | -32,505,266 | -777,857 | -8,341,743 | -33% |
| Full Family | Active | 5,452 | $834 | 0.0% | $876 | 5.0% | 55,050,947 | -63,207,085 | -1,716,896 | -9,873,034 | -18% |
| Children Only | Act/Ret | 8,707 | $402 | 0.0% | $422 | 5.0% | 41,639,022 | -44,684,502 | -1,298,613 | -4,344,093 | -10% |
| Child Only | Act/Ret | 10,847 | $201 | 0.0% | $211 | 5.0% | 25,012,956 | -27,113,414 | -780,089 | -2,880,547 | -12% |
| Disabled Employee | Retired | 84 | $550 | 0.0% | $577 | 4.9% | 570,910 | -3,017,170 | -19,439 | -2,465,699 | -432% |
| Employee | Retired | 7,272 | $550 | 0.0% | $577 | 4.9% | 49,165,300 | -73,273,358 | -1,444,556 | -25,552,615 | -52% |
| Spouse Only | Retired | 899 | $657 | 0.0% | $690 | 5.0% | 7,267,241 | -8,305,390 | -163,738 | -1,201,887 | -17% |
| Full Family | Retired | 228 | $959 | 0.0% | $1,007 | 5.0% | 2,689,032 | -2,989,451 | -58,936 | -359,355 | -13% |
| Family (1 On Medicare) | Retired | 62 | $425 | 0.0% | $446 | 4.9% | 321,633 | -385,792 | -7,606 | -71,765 | -22% |
| Spouse Only (Medicare) | Retired | 2,839 | $224 | 0.0% | $235 | 4.9% | 7,816,349 | -7,933,183 | -566,306 | -683,140 | -9% |
| Employee (Medicare) | Retired | 18,377 | $224 | 0.0% | $235 | 4.9% | 50,602,284 | -50,564,232 | -3,666,210 | -3,628,158 | -7% |
| Total Health Insurance | | | | | | | 916,020,164 | -893,245,329 | -30,801,467 | -8,026,632 | -0.9% |
| RECAP BY SUBGROUP | | | | | | | | | | | |
| Active Employees | | | | | | | 650,943,113 | -579,266,487 | -20,301,222 | 51,375,404 | 8% |
| Dependents Of Active Employees | | | | | | | 146,644,305 | -167,510,267 | -4,573,454 | -25,439,417 | -17% |
| Disabled Retirees (Regular) | | | | | | | 570,910 | -3,017,170 | -19,439 | -2,465,699 | -432% |
| Retirees & Dependents (Regular) | | | | | | | 59,443,204 | -84,953,991 | -1,674,835 | -27,185,622 | -46% |
| Retirees & Spouse Only (Medicare) | | | | | | | 58,418,633 | -58,497,415 | -4,232,516 | -4,311,298 | -7% |
| Total Health Insurance | | | | | | | 916,020,164 | -893,245,329 | -30,801,467 | -8,026,632 | -0.9% |
| Life Insurance Gain | | | | | | | | | | 0 | |
| Interest Income | | | | | | | | | | 4,772,737 | |
| less PCORI Fees | | | | | | | | | | -626,265 | |
| Total Gain (Loss) | | | | | | | | | | -3,880,160 | -0.4% |
| Beginning Surplus (Prior to Any Applicable Premium Deficiency Reserve) | | | | | | | | | | 151,362,403 | |
| Change In Surplus | | | | | | | | | | -3,880,160 | |
| Ending Surplus (Prior to Any Applicable Premium Deficiency Reserve) | | | | | | | | | | 147,482,243 | |

| Active Employee Premium Summary | |
|---|---|
| Employer Contributions | 606,806,986 |
| Employee Contributions | 40,951,155 |
| COBRA Premiums | 3,184,972 |
| Total Active Employee Premium | 650,943,113 |

* The active employee premium rate shown is for Legacy employees who choose Select coverage. Dependent rates shown are for Select coverage.

# POSTEMPLOYMENT BENEFITS

## Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions

Under the present State law that governs the Plan, all retirees are required to pay 100% of their premiums.

The premium rates and benefit costs for Medicare eligible retiree coverage are essentially in actuarial balance. There is no provision in the present law, as it relates to Medicare eligible retirees, which results in future expected costs to the State for retiree life and health insurance.

However, the premium rates applicable to most retirees who are not yet eligible for Medicare are not high enough to pay for their expected claims costs. For non-Medicare eligible retirees who were initially hired prior to 1/1/06 (referred to by the Plan as "Legacy" employees), the premium rates for their coverage are currently limited by State law to 115% of the premium rates for active employee coverage. Note that the 115% limitation does not apply to retirees who are Horizon employees, i.e., to those employees who are initially hired on or after 1/1/06.

Since early retiree benefit costs greatly exceed 115% of the active employee premiums, an implicit cost subsidy exists with respect to early retiree coverage for Legacy retirees. The Plan currently covers the current year retiree subsidy cost by increasing the premium rate applicable to active employees.

The CY23 Actuarial Report being provided herein does not separately identify and quantify the liabilities and costs that must be reported and recognized by the State, as an employer, under accounting rules established for postemployment benefits by the Governmental Accounting Standards Board. Therefore, Plan surplus – as defined in this Report – does not take into account the liabilities of the State, as an employer, associated with retiree health and life insurance.

The State and School Employees Health Insurance Management Board has retained Cavanaugh Macdonald Consulting, LLC ("Cavanaugh Macdonald") to prepare annual actuarial valuations of the postemployment life and health insurance benefits ("OPEB") provided through the State and School Employees' Life and Health Insurance Plan. The most recent valuation prepared by Cavanaugh Macdonald was as of 6/30/23.

Although there are surplus funds that exist in the Plan, there are much higher liabilities for the State, as an employer, for future retiree benefits that have not been funded. For example, based on current claims liability estimates and prior to recognizing any premium deficiency reserve, the Plan ended CY23 with a Plan surplus of about $135.1 million. Based on results contained in the "GASB Statement No. 74 Report for the Mississippi State and School Employees' Life and Health Insurance Plan Prepared as of June 30, 2023" by Cavanaugh Macdonald, the State's Total OPEB liability associated with retiree benefits provided through the State and School Employees' Life and Health Insurance Plan were about $554 million as of 6/30/23.

In evaluating the extent to which existing or projected surplus of the Plan is necessary or even sufficient, this Report should be reviewed in conjunction with the most recent version of the GASB Statement No. 74 Report that has been submitted to the Health Insurance Management Board by Cavanaugh Macdonald.

# ASSUMPTIONS

### Basic Projection Approach

Incurred medical and drug claims rates were projected forward on a semi-annual basis - by premium class - using assumptions for annual non-drug benefit trend and annual drug benefit trend.

### Non-Drug Benefit Trend after Benefit Changes

The trend rates shown below are based on an underlying pre-benefit change trend rate of 3% for both non-Medicare members and Medicare members.

| | CY24 | CY25 |
|---|---|---|
| Medical Trend, Non-Medicare | 3.00% | 3.00% |
| Medical Trend, Medicare Classes | 5.00% | 5.00% |

### Drug Benefit Trend

Prior to any Plan or benefit changes, the basic annual trend assumption for drug benefits, net of rebates, was 10%. The same trend assumption was made for Plan payments before rebates, rebates, and drug benefits after rebates.

### Enrollment

No enrollment growth assumptions were included in the projections included in this Report. The assumed proportion of active employees that are Horizon employees versus Legacy employees is as follows:

| | Legacy | Horizon |
|---|---|---|
| CY24 1H | 31.3% | 68.7% |
| CY24 2H | 30.0% | 70.0% |
| CY25 1H | 28.8% | 71.2% |
| CY25 2H | 27.6% | 72.4% |

The proportion of active employees selecting Base coverage is assumed to be 24.0% for Horizon employees and 7.2% for Legacy employees.

### Net Cash Flow from Life Insurance

In the projections included in this Report, life insurance coverage was assumed to produce no annual gains or losses to the Plan throughout the projection period.

### Interest

Interest income was assumed to be earned and received at an annual rate of 2% and was based on the sum of the prior month's cash assets and one-half of the net cash flow for the month.

## ASSUMPTIONS (Continued)

**Administrative Expenses**

The projected, allocated expense rates per employee are as follows:

| | |
|---|---|
| CY24 | $18.91 |
| CY25 | $19.48 |

CY24 health insurance expenses are projected to be approximately 3.4% of projected CY24 premium.

## SIGNIFICANT HISTORICAL BENEFIT CHANGES

### CY22 Plan Changes

**Select Plan Deductible –** The in network medical deductible for Select coverage for CY22 was increased by $200 from $1,300 to $1,500.

**CY22 SELECT COVERAGE**

| | Separate Medical Plan | | | Separate Drug Plan | | Combined |
|---|---|---|---|---|---|---|
| | *Individual Medical Deductible | *Medical Coinsurance | Individual Coinsurance Maximum | Individual Drug Deductible | Drug Copays | Individual Out of Pocket Limit |
| | | | | $75 | $12/$30/$45/$100 | |
| In Network | $1,500 | 20% | $3,000 | | | $6,500 |
| Out-of-Network | $2,300 | 40% | $4,000 | | | |

* PCP Copay Feature (In-Network Only)
PCP office visit charges are not subject to the deductible.
PCP office visit copay: $25 (applies to the evaluation & management charge)
PCP office visits charges other than the evaluation & management charge: 20% coinsurance

Family Medical Deductibles are limited to 2 times the Individual Medical Deductibles.
Family OOP Limits are limited to 2 times the Individual OOP Limits.

**Implementation on 7/1/22 of the CVS Caremark "Value" Formulary** – At its 2/23/22 meeting, the Board approved the implementation as of 7/1/22 of a formulary for prescription drugs based on the CVS Caremark "Value" Formulary. In conjunction with the implementation of the Value Formulary, the $30 copay for high-cost generic drugs was eliminated and the $100 brand copay began to apply only to specialty drugs and not to those brand drugs previously covered as "non-preferred" brand drugs.

## SIGNIFICANT HISTORICAL BENEFIT CHANGES (Continued)

**CY21**

**Select Plan Deductible –** The medical deductible for Select coverage in CY21 was increased by $300.

**Coinsurance Maximum –** The coinsurance maximums for both Select and Base coverage in CY21 were increased by $500.

**CY21 SELECT COVERAGE**

| | Separate Medical Plan | | | Separate Drug Plan | | Combined |
|---|---|---|---|---|---|---|
| | *Individual Medical Deductible | *Medical Coinsurance | Individual Coinsurance Maximum | Individual Drug Deductible | Drug Copays | Individual Out of Pocket Limit |
| | | | | $75 | $12/$30/$45/$100 | |
| In Network | $1,300 | 20% | $3,000 | | | $6,500 |
| Out-of-Network | $2,300 | 40% | $4,000 | | | |

* PCP Copay Feature (In-Network Only)
PCP office visit charges are not subject to the deductible.
PCP office visit copay: $25 (applies to the evaluation & management charge)
PCP office visits charges other than the evaluation & management charge: 20% coinsurance

Family Medical Deductibles are limited to 2 times the Individual Medical Deductibles.
Family OOP Limits are limited to 2 times the Individual OOP Limits.

**CY21 BASE COVERAGE**

| | Combined Deductible* | Medical Coinsurance | Medical Coinsurance Maximum | Drug Copays | Combined Out-of- Pocket Limit | |
|---|---|---|---|---|---|---|
| Self Only Coverage | | | | | | |
| In Network | $1,800 | 20% | $3,000 | $12/$30/$45/$100 | $6,500 | |
| Out-of-Network | $1,800 | 40% | $4,000 | $12/$30/$45/$100 | | |
| | | | | | Per Family | Each Person |
| Family Coverage | | | | | | |
| In Network | $3,000 | 20% | $5,500 | $12/$30/$45/$100 | $13,000 | $6,500 |
| Out-of-Network | $3,000 | 40% | $7,500 | $12/$30/$45/$100 | | |

* Drugs on the HSA Preventive Drug list are subject only to a separate $75 deductible.

**CY16 thru CY20:** See the FY16 or CY16 Actuarial Reports.

**CY10 thru CY15:** See the FY16 or CY16 Actuarial Reports.

**CY09 & Prior:** A detailed description of prior changes appears in the CY10 & prior Actuarial Reports.

# FEDERAL HEALTH CARE REFORM

Federal health care reform was enacted into law in March 2010 by the passage of the Patient Protection and Affordable Care Act and its companion legislation, the Health Care Reconciliation Act ("ACA"). This section includes a discussion of certain items that affected benefits and funding.

**Early Retiree Reinsurance Program (ERRP)**

ACA included a temporary reinsurance program for early retirees (eligible retirees aged 55 and over who are not eligible for Medicare and includes their spouses and dependents). This program reimbursed participating plans 80% of a qualified retiree's allowed medical and pharmacy costs between $15,000 and $90,000. Funding for this program was limited to $5 billion and began June 1, 2010. The Plan applied for and was approved to participate in the program. The Plan received ERRP payments totaling $19.9 million ($5.5 million in December 2010, $6.3 million in April 2011, and $8.1 million in October 2011).

**Grandfathered Plans**

Certain of the requirements of ACA do not apply to plans referred to in ACA as grandfathered plans. Under the rules related to grandfathered plans, there are limits on the changes that a plan can make – relative to its status as of March 23, 2010 – and still remain a grandfathered plan. In general, in order to remain a grandfathered plan, the following requirements must be met: 1.) Plan coinsurance rates may not be reduced; 2.) Plan deductibles may not be increased by more than the sum of 15% plus the medical care component of the CPI; 3.) Plan copays may not be increased by more than the greater of $5, or 15% plus the medical care component of the CPI; and 4.) The portion of the costs, by tier, paid for by the plan sponsor may not be reduced by more than 5%. Plan benefit changes implemented by the Plan as of January 1, 2011, prevent the Plan from being considered a grandfathered plan under ACA.

**Benefit and Other Changes Required Under ACA for CY11**

The following requirements of ACA were addressed in CY10 or CY11 as a result of health care reform.

- ACA required that the Plan make coverage available to dependent children up to age 26 regardless of student or marital status, effective January 1, 2011, and encouraged early implementation of this requirement.
- ACA does not allow a plan to exclude coverage for participants under age 19 due to pre-existing conditions.
- ACA does not allow a plan to have a lifetime maximum limit on benefits.
- ACA requires qualified health plans to include "essential" benefits and may not allow annual maximums on certain benefits deemed to be essential benefits. The Plan made changes consistent with those benefit requirements for qualified health plans.

**Benefit Changes Required Under ACA for CY13**

The following expansion of preventive services for adult women was required by ACA, effective January 1, 2013:

- Well-woman visits for preconception and prenatal care for all female participants.
- Human papillomavirus testing.
- Screening for gestational diabetes in pregnant women between 24 and 28 weeks of gestation (and at the first prenatal visit for women at high risk for diabetes).
- Contraceptive methods and counseling, including FDA-approved contraceptive methods, sterilization procedures, and patient education/counseling for all women with reproductive capacity.

## FEDERAL HEALTH CARE REFORM (Continued)

**Benefit Changes Required Under ACA for CY13 (Continued)**

- Breastfeeding support supplies and counseling in conjunction with each childbirth including comprehensive lactation support and counseling by a trained provider during pregnancy and/or postpartum, and coverage of the costs of renting breastfeeding equipment.
- Annual screening and counseling for interpersonal and domestic violence.

**Benefit Changes Required Under ACA for CY14**

The following benefit changes were required by ACA in CY14:

- The Plan will no longer be able to exclude benefits resulting from preexisting conditions.
- The Plan must provide coverage for Vitamin D for adult participants aged 65 years or older.
- The Plan must provide coverage (as a wellness/preventive benefit with no cost-sharing) for one-time screening for hepatitis C virus infection for participants at higher risk for infection and for adult participants born between 1945 and 1965.
- The Plan must limit employee in Network out-of-pocket costs (defined as the sum of all in Network deductibles, coinsurance, and copays) to no more than $6,350 for self only coverage and $12,700 for family coverage. Those limits are subject to change annually.

**Minimum Value** – IRS Notice 2012-31 provides as follows: "Beginning in 2014, eligible individuals who purchase coverage under a qualified health plan through an Affordable Insurance Exchange may receive a premium tax credit under § 36B unless they are eligible for other minimum essential coverage, including coverage under an employer-sponsored plan that is affordable to the employee and provides minimum value. Under § 36B(c)(2)(C)(ii), a plan fails to provide minimum value if "the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs." If the coverage offered by the employer fails to provide minimum value, an employee may be eligible to receive a premium tax credit. An applicable large employer (as defined in § 4980H(c)(2)) may be liable for an assessable payment under § 4980H if any full-time employee receives a premium tax credit." A separate Actuarial Opinion (and an accompanying Actuarial Memorandum) has been provided that both the Plan's Select Coverage and Base Coverage options meet the minimum value requirements under IRS Notice 2012-31.

**Benefit Changes Required Under ACA for CY15**

The following benefit changes are required by ACA in CY15:

- Beginning 1/1/15, the Plan was required to provide 100% benefits for annual screening for lung cancer with low dose computed tomography in adults ages 55 to 80.
- Beginning 1/1/15, the Plan was required to provide 100% benefits for risk reducing drugs, such as Tamoxifen or Raloxifene, for women who are at increased risk for breast cancer and at low risk for adverse medication effects.
- Based on clarifying guidance under ACA, preventive benefits – paid at 100% without cost sharing – for contraceptive drugs are limited in 2015 to generic drugs only. Non-generic contraceptive drugs are still covered, but currently are subject to normal Plan deductibles and copays.
- Based on a revision in the recommendations of the United States Preventive Services Task Force, preventive services (payable at 100% without cost sharing) for screening for gestational diabetes mellitus in pregnant women are limited in 2015 to one screening in asymptomatic women after 24 weeks of gestation. Prior to 2015, the Plan covered two such screenings per pregnancy (one at the first prenatal visit and one between 24-28 weeks).

## FEDERAL HEALTH CARE REFORM (Continued)

### Benefit Changes Required Under ACA for CY16, CY17 and CY18

The Plan is required by ACA to cover all preventive services recommended by the United States Preventive Services Task Force (USPSTF), with no member cost sharing. There are generally some changes in those services each year. For example, during CY16, the Plan began providing 100% coverage for certain brand contraceptives when a generic is not available or when not medically appropriate. During CY15, 100% coverage applied only to generic drugs.

### Fees Imposed by ACA

**Patient-Centered Outcomes Research Institute** – ACA created the Patient-Centered Outcomes Research Institute (PCORI), which according to the PCORI website, "is authorized by Congress to conduct research to provide information about the best available evidence to help patients and their health care providers make more informed decisions. PCORI's research is intended to give patients a better understanding of the prevention, treatment, and care options available, and the science that supports those options."

Provisions of ACA specified that PCORI was to be funded, in part, by fees payable by all insured and self-insured plans, including governmental plans. Those fees were to be based on total Plan enrollment and were payable – under the ACA – only for Plan years 2012-2018, payable the following July. *(Note: The fees required for PCORI were extended for an additional 10 years for 2019 thru 2028 by the "Further Consolidated Appropriations Act, 2020" that was passed by Congress in December 2019.)*

**Three-year Transitional Reinsurance Program** – ACA created a three-year transitional reinsurance program to help stabilize premiums in the individual health insurance market from 2014 to 2016. Provisions of ACA specify that this program shall be funded by fees payable by all insured and self-insured plans, including governmental plans. Those fees are based on Plan primary enrollment and are payable for Plan years 2014 to 2016.

In regulations issued by the Department of Health and Human Services (HHS), HHS established a fee of $63 per covered life for 2014, with 83.33% of the 2014 fee payable in January 2015 and the remainder payable in the 4th quarter of 2015. For 2015, HHS established a fee of $44 per covered life, with 75% of the 2015 fee payable in January 2016 and the remainder payable in the 4th quarter of 2016. For 2016, HHS established a fee of $27 per covered life, with 80% of the 2016 fee payable in January 2017 and the remainder payable in the 4th quarter of 2017.

**Projected Fees Imposed by ACA** – The Plan is expected to have paid in 2013 to 2019 about $25 million in fees imposed by ACA. As shown below, the majority of these fees were payable in 2015 to 2017. *(Note: The table below does not include PCORI fees incurred in 2019 and later years that were imposed by the "Further Consolidated Appropriations Act, 2020".)*

**Projected ACA Imposed Fees Incurred thru 2018 (in Millions)**

| | Incurred Fees | | | Cash Payments By the Plan | | |
|---|---|---|---|---|---|---|
| Plan Year | PCORI | Transitional Reinsurance | Total | PCORI | Transitional Reinsurance | Total |
| 2012 | $0.177 | | $0.177 | | | $0.000 |
| 2013 | $0.350 | | $0.350 | $0.177 | | $0.177 |
| 2014 | $0.363 | $10.589 | $10.953 | $0.350 | | $0.350 |
| 2015 | $0.378 | $7.371 | $7.748 | $0.363 | $10.589 | $10.953 |
| 2016 | $0.397 | $4.590 | $4.987 | $0.378 | $7.371 | $7.748 |
| 2017 | $0.423 | | $0.423 | $0.397 | $4.590 | $4.987 |
| 2018 | $0.435 | | $0.435 | $0.423 | | $0.423 |
| 2019 | $0.000 | | $0.000 | $0.435 | | $0.435 |
| Total | $2.524 | $22.550 | $25.074 | $2.524 | $22.550 | $25.074 |

| RETIREE LIFE RATES PER $1,000 AS OF 1/1/2014<br>Based on Attained Age of Retiree | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Age** | **Prior** | **Revised** | **Age** | **Prior** | **Revised** | **Age** | **Prior** | **Revised** |
| 40 | 0.25 | 0.20 | 60 | 1.63 | 1.50 | 80 | 3.00 | 3.00 |
| 41 | 0.28 | 0.22 | 61 | 1.76 | 1.65 | 81 | 3.00 | 3.00 |
| 42 | 0.30 | 0.24 | 62 | 1.91 | 1.80 | 82 | 3.00 | 3.00 |
| 43 | 0.33 | 0.26 | 63 | 2.08 | 1.95 | 83 | 3.00 | 3.00 |
| 44 | 0.36 | 0.28 | 64 | 2.25 | 2.10 | 84 | 3.00 | 3.00 |
| 45 | 0.40 | 0.31 | 65 | 3.00 | 2.25 | 85 | 3.00 | 3.00 |
| 46 | 0.43 | 0.34 | 66 | 3.00 | 2.40 | 86 | 3.00 | 3.00 |
| 47 | 0.47 | 0.38 | 67 | 3.00 | 2.55 | 87 | 3.00 | 3.00 |
| 48 | 0.53 | 0.42 | 68 | 3.00 | 2.70 | 88 | 3.00 | 3.00 |
| 49 | 0.54 | 0.47 | 69 | 3.00 | 2.85 | 89 | 3.00 | 3.00 |
| 50 | 0.65 | 0.52 | 70 | 3.00 | 3.00 | 90 | 3.00 | 3.00 |
| 51 | 0.71 | 0.57 | 71 | 3.00 | 3.00 | 91 | 3.00 | 3.00 |
| 52 | 0.79 | 0.63 | 72 | 3.00 | 3.00 | 92 | 3.00 | 3.00 |
| 53 | 0.86 | 0.69 | 73 | 3.00 | 3.00 | 93 | 3.00 | 3.00 |
| 54 | 0.95 | 0.76 | 74 | 3.00 | 3.00 | 94 | 3.00 | 3.00 |
| 55 | 1.06 | 0.85 | 75 | 3.00 | 3.00 | | | |
| 56 | 1.16 | 0.94 | 76 | 3.00 | 3.00 | | | |
| 57 | 1.25 | 1.05 | 77 | 3.00 | 3.00 | | | |
| 58 | 1.38 | 1.20 | 78 | 3.00 | 3.00 | | | |
| 59 | 1.50 | 1.35 | 79 | 3.00 | 3.00 | | | |