COLORADO HIGHER EDUCATION INSURANCE BENEFITS ALLIANCE TRUST
CHEIBA TRUST MEETING

A. MEETING LOCATION AND DATE:

The Lodge at Breckenridge
112 Overlook Drive
Breckenridge, CO 80424

July 25, 2016, Meeting begins at 9:00 A.M., Ballroom
July 26, 2016, Meeting begins at 9:00 A.M., Ballroom

B. GENERAL BUSINESS:

1. Call to order

The meeting was called to order by Mike Dougherty, Chair. The following individuals were in attendance:

- Tracy Rogers, Adams State University
- Shannon Heersink, Adams State University
- Blaine Nickeson, Auraria Higher Education Center
- Mike Dougherty, Colorado School of Mines
- Ann Hix, Colorado School of Mines
- Veronica Graves, Colorado School of Mines
- Ralph Jacobs, Colorado State University-Pueblo
- Darren Mathews, Fort Lewis College
- Greg McClurg, Fort Lewis College
- Josh Mackey, Metropolitan State University of Denver
- Amanda Berry, Metropolitan State University of Denver
- Marshall Parks, University of Northern Colorado
- Kim Gailey, Western State Colorado University
- Maria BonDurant, Western State Colorado University
- Michele Moreau, Arthur J. Gallagher & Co.
- Neida de Quesada, Arthur J. Gallagher & Co.
- Karen Eisiminger, Arthur J. Gallagher & Co.
- Les Kohn, Arthur J. Gallagher & Co.
- Paula Wilson, Anthem BCBS
- Desiree Delgado, Anthem BCBS
- Mike Beaton, Anthem BCBS
- Dixon Waxter, Attorney General's Office
- Eddie Eisiminger, Eaglecrest High School
- Dr. Elizabeth Kraft, Anthem BCBS
- AnnMarie Manders, Anthem BCBS
- Bridget Flavin, Anthem BCBS
- Janet Pogar, Anthem BCBS

2. Approval of June Meeting Minutes
A motion was made to approve the June business session minutes as submitted. The motion was seconded and approved (unanimous).

3. Approval of July Business Agenda and Education Session Agendas
Mike D. had one revision under Discussion and Information items. Add agenda item:
H. 8. *CU Trust update Tony De Crosta*

A motion was made to approve the July Business Agenda as revised. The motion was seconded and approved (unanimous).

A motion was made to approve the Education Agenda The motion was seconded and approved (unanimous).

C. PUBLIC COMMENT:

No one appeared for public comment.

D. REPORTS: (Article VI, Sections 2 and 3, Operating Plan)

1. CHEIBA Trust Reports - Medical, Large Claims, Dental, Vision and Life (GBS)

Michele began by going over the CHEIBA Trust Monthly Claims Analysis report, including Stop Loss Reimbursements, through June 2016.

- Combined medical plans HMO/POS, PPO (grandfathered Plan), Custom Plus, Lumenos HSA and Blue Priority referral based HMO product:
  - Through June there is an 83% loss ratio (paid), 91.7% with retention (without PPACA). At the end of 2015, it was 99.1% so we are running below last year. At the last meeting the loss ratio was 89.8% with experience through April.
  - Rx claims are 18.5% of overall total spend and has been at that level for a while.
  - Enrollment is up approximately 3% from 2015, averaging 3,876 employees on the plan. There were 3,768 employees at the end of 2015.
  - PEPM cost (column G) is $939.84 vs. $917.96 through April 2016
  - $394,472 in claims over the pooling point ($350,000). Majority of these claims are on HMO/POS plan. There is a $401,000 claim on PPO plan.
  - YTD overall down about 7.7% from 2015 at this time.

- HMO/POS plan
  - Driving plan with majority of enrollment. As of June, 2,920 employees enrolled with average YTD enrollment of 2,908 employees.
  - 82.8% paid loss ratio vs. 84.1%. claims through April
  - 91.6% loss ratio with retention vs. 92.9% claims through April
  - At end of 2015, paid loss ratio 81.6%, with retention 95.8%.
  - Rx claims are 17.5% of total. This is up from 16.5% the end of 2015. Relative to total experience, there is no change in total Rx claims dollars.
  - Overall expenditures are down 4.3% from last year at this time.

- PPO plan
  - This plan lost enrollment due to employees moving to HSA and POS plans (some did move to the HMO plan as well). 900 employees as of June 2016 vs. 971 employees on December 2015 (average of 905 employees).
  - The plan is running a little better and leveling out but overall has had higher experience in the past.
  - 80.2% loss ratio. It has increased from 71.5% in April. 88.8% loss ratio with retention (column K)
  - Beginning in January 2016, 84% loss ratio with retention vs. 95% last year.
    - February 76% vs. 84% last year
    - March 74.1% vs. 122% last year
    - April 86% vs. 118% last year
    - May 105.8% (up a little bit which is normal for summer) vs. 90% last year.
    - June 107% vs. 121% last year
    - July & August of 2015 there was a 112% loss ratio w/retention. The Plan is running much better this year.
    - Overall expenditures are down on this plan 25.4% from last year

  Blaine asked why CHEIBA has an expense in claim dollars over the pooling level of $472. Desiree explained there is a claim credit for a claimant with a large adjustment of $80,000 plus. Anthem to follow up to see what generated the claim credit.

- Custom Plus plan
  - Grandfathered with no new enrollment. 21 enrollees at start of year, and there are now 18. There were 24 enrollees in 2015.
  - There are no Rx paid claims as those charges are bundled into the claim experience.
  - 138% loss ratio with retention. Don't expect plan to cover its own medical claims. Right about the same as last year with $177,023.

- Lumenos HSA plan
  - New HSA plan in 2016. Plan has $2,500 individual deductible and $5,000 deductible for family. There is no coinsurance after deductible. The out-of-pocket maximums are $2,500 and $5,000.
  - 12 people enrolled--there were 13 in April
  - There are no claim pooling dollars and Rx claims of $337 are also in the med claim amount. Anthem will verify Rx paid claims that look like copays. Confirm with Anthem if $337 of Rx claims are embedded in column A. Which column is correct A or D?

Blaine asked if there was a large claim In May. There is not one listed on the large claim report. Anthem will research this item.

  - The loss ratio with retention is 450%.

- Blue Priority HMO plan
  - New HMO plan in 2016. The plan does require a referral to see a specialist.
  - 26.1% paid loss ratio; 28.4% with retention
  - 26 employees enrolled

- Dental plan
  - Enrollment through June is 3,876; up 7%
  - 87.6% paid loss ratio vs. 88.7% claims through April
  - 100.4% loss ratio with retention vs. 101.5% claims through April
  - 3.5% higher than last year at the same time

- Vision plan
  - Based on presentation from the last meeting, vision exams and full-service claims are combined on one report.
  - Vision plan is running well.
  - 68.1% paid loss ratio and 88.2% with retention
  - Total claims year to date are $123,881

- Life plan
  - There are 6 claims year to date. There were three as of last meeting in June.
  - May and June experience shows an additional three claims totaling $184,117.
  - Total for 2016 year to date is $384,621. In 2015 there were 19 claims for total of $783,500.

- Michele then reviewed the backup data reports. The Summary of Rolling 12 Month Claim & Enrollment Analysis shows employee enrollment by plan.
  - Enrollment is up 2.7%, and PEPM costs are down year to date 2.4%.
  - HMO/POS plan enrollment is up 5.15% through June, and but PEPM costs are up 2.2%.
  - PPO plan enrollment is down 7.4%, and PEPM costs are down 14.6%.
  - Custom Plus plan information is not relative to look at as it is not credible.
  - Neither the Lumenos or Blue Priority HMO plans have comparisons at this time.
  - Dental plan enrollment is up 2.6%, and the PEPM cost is up 5%.
- The final pages of the report show employee and member information. Enrollment from a year ago is up 3% and up about 2% from year end. The PEPM cost is down 8% from last year and down 5.3% from end of 2015. Rolling plan experience is down 6% from year end and 4% down from 2015. HMO/POS plan membership is up 6.6% on an annual basis and up 2.9% since year end. The PEPM cost is down 5.6% from last year. PPO plan membership is down 10.2% from June 2015, and 6.5% since year end. The PEPM cost is down 6.1% from June 2015, and 5.4% since year end. The Custom Plus plan PEPM cost is up 14.8% since end of 2015. Lumenos doesn't have comparison information.
- Dental plan membership is up 3% from a year ago and up 1.9% from year end. The PEPM cost is down less than 1%.

  Mike D. noted that CHEIBA did not take a rate increase last year and finished on the mark. The 12-month rolling claims for December showed $55.87 PEPM, and now for the 12-month period ending in June, the PEPM cost is $55.82. Current plan year shows costs were up 3.5%, so the six-month average is $58.67. There was a high claims month in March and February was low. The plan is actually running below where it was the same time last year.

- Large Claims Report
  - Desiree passed out a revised large claim report because she had removed information for one member. This member was on the previous report highlighted in yellow. $126,000 claim had a large overpayment and was removed from the report. Anthem will look into the claim.
  - There is one new contract (newborn born at 24 weeks) and will require Synagis (used to prevent a serious lung disease caused by RSV in children). The CHEIBA stop loss contract is for claims over $350,000 pooling and this contract is at $355,199.69. There are nine new large claimants through June.
  - 11 claims in anticipated charges column. The majority are cancer related and will continue.
  - Line 15 shows a member claim for substance abuse; services will continue
  - Line 20 member is deceased (kidney failure)

Blaine noted that only three out of 22 contracts are working with case management. Paula said that is not unusual and that more than half are due to case management being unable to reach member. Dr. Kraft said the majority are cancer related, and oncology has its own care managers. Mike D. noted they represent 13.5% of total medical and Rx spend, and this demonstrates the need for and value of case management.

2. Reserve Report (GBS)

Michele began by saying this report shows the close out of the 2015 plan year. Documents used to prepare this report are the RSR settlements for 2015 and the new RSR settlements for the current plan year which Mike B. will review. Michele explained the layout of the reserve report and what each item means for the Trust.

- LTD plan reserve is at zero and the Claims Reimbursement Deposit Account is at $80,000. In 2017, that line will go away because effective November 2015 the Trust moved to a fully insured arrangement. The $80,000 is left in the CRD account for runout activity—year to date there has been no activity. The liability for claims ends in April 2017.
- Medical - 2015 year end Required Basic Reserve at $4,839,796; Excess Reserve at $414,680. Required Basic Reserve and Excess Reserves (encumbered) are items shows in green. At the end of 2015, the Trust had a Plan Reserve (100% owned by the Trust) in the amount of $900,919. There are $6,155,395 in total medical reserves, but the majority are encumbered.
- Dental - 2015 year end Required Basic Reserve at $304,427; Excess Reserve at $200,547. At the end of 2015, the Trust had a Plan Reserve (100% owned by the Trust) in the amount of $601,266. There are $1,106,240 in total dental reserves.
- Life – 2015 year end Required Basic Reserve $309,226; Plan Reserve at $7,368,550 with $7,677,776 in overall reserves.
- The Additional Accounts pages show first page items in more detail. The drop in the Anthem life plan reserve was caused by moving money for the premium holiday.
- Total Encumbered (Required Reserves) for year end 2015 were $6,148,676
- Total reserves available for use $5,076,984. The $2,199,104 premium holiday amount does not need to be subtracted as it has already been backed out.

Josh noted that Footnote Number 6 states $2.1 million for the premium holiday but 2016 has not been taken. Paula responded that not everyone has taken the 2015 premium holiday and that both years are ½ month premium holidays.

Michele then reviewed the Estimated Projection for 2016. This column shows figures as of June 2016.

- For 2016, the LTD plan is the same as 2015 and will remain at those amounts.
- The Medical Required Basic Reserve is $5,256,754. The Excess Reserve dropped to $6,015 because the Trust had to re-supplement to the 10% of overall premium.

Mike D. asked why the reserve grew so much; was it the projection of loss ratio. Mike B. replied that going from $900,919 to $3,500,334 in one year was due to the transfer of $1.1 mill for the premium holiday and true up. Mike D. asked what year end loss ratio Anthem used. Anthem will look into it. Les noted that this reflects the claims year to date with trend. Mike B said that would be plus or minus a half million.

- Dental – Required Basic Reserve is $315,980 for 2016; $192,996 in Excess Reserve
- Mike D noted that the Required Basic Reserve for 2016 is estimated at $315,980. This reflects a 0% increase and no growth in enrollment numbers.
- Life – Required Basic Reserve is $310,891; Plan Reserves at $6,291,467
- Additional Accounts – money market has almost $48,000, Fidelity investment CDs are at $110,000, Wells Fargo account is at $66,807, totaling $224,791. 10% of the total premium has to be replenished each year. Page 2 shows other accounts with $47,984 with interest at .01% as of 6/30/16. Purchased CDs must be $250,000 to be insured.

3. Claims Analytic Detail Review (Anthem/Executive Summary & Recommendations GBS)

Paula reviewed the 2015 Annual Medical Claims Review for CHEIBA report. The time period for this report is the 2015 calendar year, and any prior year reference in the report means 2014 data. Pages 23-30 of the report are reference materials. All Anthem national accounts and large groups are given this report package annually. The Trust has almost $38 million in medical claims.

- Page 3, Executive Summary: Financials – Medical experience PMPM is $385.90 which reflects a 9.4% trend over 2014. If you take out high claimants, adjustment to trend drops down to 2.4% or $159.93. A high cost claimant is any member with claims over $25,000.
  - Overall membership increased 1.4%.
  - In-network utilization is 96.1%. Network discounts totaled 49.8%. Average contract size was 2.2, slightly higher than benchmark of 2.0. 336 claims accounted for 58% of total spend. 56 people accounted for 27.3% of total medical spend.

  Blaine asked if those numbers are consistent with benchmark. Paula said yes and Dr. Kraft said when Anthem looks at what percent of membership drives what percent of business. 1% attributes to 50% of costs. Actually, 1% are 38% of costs for CHEIBA. Focused costs are in smaller percentage, and they are mostly cancer claimants and specialty pharmacy. Interesting trend in what Anthem is seeing.
  - Medical utilization for inpatient admits has gone up 11.7%. Outpatient visits decreased by 0.7%. Professional visits increased 10.3%. Inpatient stays were longer. Outpatient consumes 40% of plan costs.

  Kim noted CHEIBA PMPM is $380.95, and the benchmark is at $273.59. CHEIBA is $100 over benchmark. Benchmark is all of Anthem's book of business.

- Page 4 Executive Summary, Clinical Cost Drivers –
  - Top five health conditions are Musculoskeletal Systems, Injury & Poisoning, Neoplasms-Malignant, Ill-Defined conditions and Health Status. Health status situations screenings, wellness visits, immunizations, newborn birth status, aftercare of chronic illness, encounters for chemo, radiation and rehabilitation therapy. The same conditions are very typical of peer groups.

  Michele commented that musculoskeletal is predominant in all types of clients.
  - A target program for low back pain is not currently in place. Anthem will discuss this.

Someone asked why there are more depression diagnoses? Dr. Kraft said there is less stigma about mental health and there are more benefits available including residential treatment centers. Due to mental health parity legislation, Anthem is seeing more admissions to residential treatment centers (across all lines of business). These tend to have a longer length of stay. Dr. Kraft is not sure if this is a high prevalence for CHEIBA. In offices, Patient Health Questionnaire's 2 and 9 (PHQ-2 and PHQ-9) is a standardized behavioral health screening tool. Most practices have adopted some screening mechanism as part of their visit routine questions. There are no billed codes so Anthem does not track this. This was a practice update based on what is being seen in the field and perhaps with more routine screening, more behavioral health co-morbidity (co-diagnosis) can be identified. 4% of costs are for depression Rx medications. Bridget noted that higher education people are more likely to seek treatment.

- Page 5 Financial and Demographic Highlights, Medical Only
  - 2.3% growth in enrollment year over year.
  - Average age of member is 35.2 consistent with benchmark.

- Page 6 High Cost Claimants $25k+ shows a graph of high cost claimants.
  - Five out of top 10 HCC are million dollar babies. Could these have been avoided (multiple birth babies). Michele asked if Future Moms may have had some impact. Dr. Kraft said looking into clinical scenarios, there is nothing Future Moms could have done. Triplets are high risk and the twins were also high risk. Treatment of that high risk condition was to deliver the babies as the mother was in danger.
  - Other instances of HCC included an accident and some were lifestyle incidents. There were significant co-morbid conditions. Coordinated care is the most important for this type of issue.

  Michele said we need to educate better on programs available such as Future Moms.

- Page 7 Inpatient Facility Metrics – a snapshot of inpatient claims.
  - 22.7% increase PMPM as well as 23.4% increase for length of stay.
  - Inpatient service category shows 4.84 average length of stay

Mike D asked about the information in the second bullet? Paula responded that there are a lot of babies born at this age group. This is not saying there is higher than average cost per baby, just a lot of babies being born.

- Page 8 Emergency Room Summary compared to institution benchmark
  - 55% of emergency room visits were potentially low intensity. This has gone down from 2014 when it was 59.7%.
  - Low intensity emergency room utilization was 19.2% of avoidable emergency room visits. The first category, Dorsalgia, means lower back pain.

  Mike D asked if the average paid per emergency room facility has to do with standalone facilities. Michele said higher acute care is done in emergency room services which means they are going to cost more. Mike D said that urgent care facilities are only open during certain times. When something arises that could have been handled in urgent care, is that considered avoidable because of time of day? Dr. Kraft said Anthem is focusing on enhanced personal care. They would like members to call their PCP first. With claims they can determine day of week of the service. Mike D said if a member calls New West during closed business hours, the PCP will say call 911. Paula said, "Remember members have Live Health Online and 24 hour Nurseline available to use on off hours". They also have Dispatch Health available. Michele said CHEIBA will see cost impact from members going to emergency room for 2016. Paula said avoidable visits for CHEIBA is lower than their peers.

- Page 9 Professional Cost and Utilization Breakdown
  - There is an increase in office/home visits. That is good, rather than members having inpatient visits, etc.
  - Dr. Kraft said therapeutic injections PMPM jumped, and they are seeing that in other lines of business. In looking at the claims, they are for cancer therapy. Les asked if there is a level of redirection for members. Dr. Kraft said cancer in general is not a home therapy but would be specialty pharmacy. On July 18th Anthem started a new program triggered by level of care. This program entails prior authorization of 63 infusion drugs. Do they meet medical necessity and level of care? These 63 drugs are safe to be provided outside of a hospital setting (Remicade is one half the cost in a physician office vs. a treatment center). Anthem will ask clinicians to call in to see if a drug is safe to be given outside of an acute center. Janet said Anthem has been communicating this information for months. Dr. Kraft said pharmacists are connecting the dots between the doctor and Rx. Anthem has been trying to work on this and will be reporting back with data. Michele said the mission is to support the PCP in the educational role to educate the member and to work with specialists and members to go in the right direction.

- Page 10 – Top Five Health Conditions
  - 45.1% of total paid claims.
  - Middle graph shows number of claimants compared to 2014. There were more musculoskeletal, injury and poisonings, and CHEIBA is higher than the benchmark. These charges could not be alleviated as they were true accidental injuries. Josh asked if the top musculoskeletal and injury were actually injuries. Michele said they were injuries (not on-the-job injuries).

- Page 11 Top Health Conditions by Relationship and PMPM. This is a more expansive list of conditions shown by tier.
  - Kim asked if it is an ortho injury does it go in musculoskeletal or injury? Anthem said it depends on how the claim is coded.
  - Anthem said page 18 shows musculoskeletal is a clinical driver for the plan.

- Page 12 Top 3 Health Conditions with Top 3 Diagnoses. Musculoskeletal, Injury & Poisoning and Neopolasms.

- When a member accesses the provider finder and looks for a doctor, they can see who is an enhanced personal health care doctor. Michele asked how a member would know that. Paula said a member would not know; it is an education thing. CHEIBA needs to let people know they can search for enhanced personal health care doctors. They are in all locations except Gunnison, and Janet said they are trying to find providers in Gunnison.
- Kim asked what enhanced personal health care is. Dr. Kraft said it is a team-based approach for primary care. In Colorado when these practices are trained, Anthem saw improvement in quality and service. Anthem pays these practices differently and patients are assigned to the practice. They pay a risk based PMPM for health care coordination. In addition providers are incented with shared savings. For emergency rooms, Anthem is giving the providers a list of low priority emergency room visits and what day of week is the most popular, so the practices can extend their hours. They are aligning quality and utilization and paying providers in a value-based way. Janet said approximately $4 million has been returned to providers.

- Page 13 – Mental health and substance abuse
  - General mental disorders are approximately 3.9% of the total claim spend. Inpatient mental health and substance abuse as well as professional services for these conditions are both above the Anthem benchmark and are approximately 2% of the overall claims cost. From a disease category standpoint, it is higher than musculoskeletal & Injuries. Paula said there are additional tools and resources that members can use such as Behavioral Health, Live Health Online, EAP and 24 hour Nurseline. Mental health disorders is an area that should be looked to evaluate how to improve through engagement.

- Page 14 – Top 5 Targeted Health Conditions. Low back pain.

- Page 15 – Preventive Screenings.
  - Wellness has improved 37.5%. Child well visits decreased. Some people may take child to clinics and not to PCPs. Adult well visits and cancer screenings are up.

  Mike D asked what cancer screenings are. Paula said PSA test, mammogram, colonoscopy and annual exams are adult cancer screenings. Dr. Kraft said technical specifications are uniform across the county (HEDIS standards). Over the years doctors have picked one way to screen (mammograms, stool samples, pap smears) for certain cancers.

- Page 16 Top 10 Lifestyle Conditions.
  - Opportunity for people to do different things to impact their health. 20% of claims are impacted by lifestyle conditions and could be mitigated by lifestyle changes. Low back pain is high in relevance and is same with benchmark.

- Page 17 Lifestyle Conditions Risk Factor Grid

Why is breast cancer under lifestyle conditions? Because obesity and tobacco use cause breast cancer. Anthem recommends members use the Condition Care Program.

- Page 18 Musculoskeletal System.
  - Promotion of the Diabetes Prevention Program has to do with weight loss.
  - Consider bundling program for hips and knees. Janet said Anthem has done hips and knees program bundling. Are implant surgery facilities inpatient or outpatient? Anthem has not yet moved to bundling arthroscopy.
  - Looking at claims history, numbers do not tie in all costs, just facility cost. It would be a huge savings to bundle all costs. Cannot have everyone in network as they need volume of service. Rose and Swedish are willing to do bundles, and there are some freestanding facilities willing to do bundles, but they want Anthem to direct members to their facility. Communication would be necessary. Michele asked if bundling includes assistant surgeon or anesthesiologist. Freestanding facilities will go into extending physical therapy into the bundle. Janet said they include everything for that episode of care. Current program does not include therapy because most members want to go to a

place closer to home or work. Costs are $23,000 vs. $35,000, which does not include professional fees. Paula said Anthem can set up programs where member gets 100% at approved facility vs. member paying regular costs. Is there a travel allowance available from Anthem? Anthem will look into this item.

Marshall asked if Anthem has considered physical therapy options being covered. Are there better medical options? Dr. Kraft said medical policies are reviewed using peer reviewed literature. Specialists that the Anthem committee uses are not Anthem doctors. Marshall said he has employees that have paid out of pocket for treatment and have been very pleased. Dr. Kraft said Anthem wants to manage number of physical therapy visits after surgery: 1. Prior authorization is required for services after surgery. Evidence based criteria for total joint replacement with guidelines where member failed other treatments and now definitely need surgery. 2. Hired specialist to do reviews. Done previously for low back fusions. They currently have 27% denial rate. Specialists can talk peer to peer on reviews. 3. Pre-habilitation component - Physician calls in saying they want to do new knee or hip. Anthem asks physician if there are underlying medical conditions. They are doing discharge planning before surgery occurs. Case managers calling patients. Michele said one of the important things for lower back fusions is that only 50% are successful, and prior authorization on those is critical.

- Page 19 Neoplasms-Malignant (high cost cancers)
  - Breast cancer has the highest volume; second is neuroendocrine tumors. Costs are outpatient related for chemotherapy. Members can use the Cancer Care Program.

- Page 20 Ill-defined conditions
  - Abdominal and pelvic pain are the highest costs and have the most outpatient costs
  - Employees are driving 51% of the costs

- Page 21 Health Status - Occasions when circumstances other than a disease or injury exists that are not classifiable to the other ICD-9 OR ICD-10 categories. This occurs in one of two ways: 1) when a person is not currently sick but encounters health services for some specific purpose, such as organ donation, vaccination, or to discuss a problem which itself is not an injury or disease; 2) some circumstance or problem is present which influences the persons health status but it is not a current illness or injury
  - Health Status is the fifth clinical cost driver with $2.2 million in plan expense

- Page 22 Paid Claims Distribution
  - 57.4% of members had less than $1,000 in paid claims
  - 28% of members had between $1,000 and $4,999 in paid claims
  - 11.3% of members had between $5,000 and $24,999 in paid claims
  - 2.7% of members had between $25,000 and $99,999 in paid claims
  - .6% of members had $100,000 plus in paid claims

- Normalized Claims PMPM Exhibit for Colleges in Colorado-2015 data: CHEIBA is the base number. Other two Colorado university systems data is also shown.

  Mike B began reviewing this exhibit. Anthem will continue to compare PMPM costs for different service areas for inpatient, outpatient and professional services. It is difficult to compare CHEIBA to Anthem benchmark because Anthem benchmark is multi-employer, multi-state and multi-benefits. Anthem tried to normalize the PMPM data to get a better look at what CHEIBA PMPM is current and past normalized to two of the three other large university systems in state. One is a like population and the other has rural locations like CHEIBA.

  Normalization based (assuming age and gender are similar) on plan values (HMO population, PPO population). Other colleges have similar plan values. Normalized plan designs weighted based on number of employees on plan then based on HMO plan. Area cost differences normalized also (Anthem

has narrow and non-narrow networks). Provider network differences were normalized. Normalized from current values to CHEIBA values. Did not normalize prior year benefit changes. Current CHEIBA PMPM for 2015 inpatient is $119.71, outpatient is $127.87 and professional services is $133.37. On the surface it appears CHEIBA compared to college 1 is $65 higher and 5 dollars higher than college 2. By normalizing the figures by 24.6%, it shows CHEIBA at $119.71 and college 1 at $137.08. College 1 went from being under CHEIBA to over CHEIBA because of normalization. College 2 was under and now is very close. CHEIBA now has narrow network (new for 2016) so that is not in calculation. Michele said now CHEIBA knows how they are running in comparison to peers in Colorado. Les noted this report shows CHEIBA is more expensive than college 1.

Mike D asked if the seat of the pants take away is that CHEIBA benefits are richer? Mike B said it is likely. If reversed and CHEIBA adopted plan design of college 1, would we expect to see cost go down? Mike B said yes that is correct.

Marshall asked if there was accommodation made for location as the difference between some of these might be location. Mike B said it is all weighted. Kim said this report is telling us CHEIBA's utilization is on par and costs are on par if everything is normalized. Les said utilization might be better than cost. This would be expected based on location.

4. Health Status Report (GBS)
   Les began the discussion and said GBS is doing follow up from six months ago. There is one change for the cover sheet: the time period on left side should be January 1, 2015 – June 30, 2015.
   Population is broken down by non-claimants (people with no claims), healthy claimant, acute (accidents or conditions treated and done) and chronic conditions compared to benchmark. The benchmark data covers about 1.5 million claimants. This report identifies outliers in chronic related grouping. Green valuations are 20% lower and red valuations are higher than the benchmark.
   - Diabetes green category historically running very well compared to benchmark
   - Same is true with diabetes with hypertension
   - Mental illness is red and higher than the benchmark
   - These numbers are not inconsistent against Anthem's information
   - 8% of non-claimants have undiagnosed hypertension, cholesterol and 3% have undiagnosed diabetes. Mike D asked how we know these conditions were undiagnosed. Les said the study is done by the Centers for Disease Control and Prevention's National Center for Health Statistics. Michele said members were probably diagnosed in the prior year.
   - The most prevalent conditions for chronic claimants are Hypertension, chronic thyroid, depression, chronic join and musculoskeletal. This information is the same as the Anthem claim and Rx information.

5. Dental Utilization Review & Current vs. State Dental Plan Overview (Anthem)
   AnnMarie from Anthem joined the meeting to review the 2015 CHEIBA Dental Utilization Review.
   - Overall Paid Dental Claim Summary for the PPO and PPO plus plans.
     - Diagnostic and preventive claims are making up 78.2% of utilization. Billed charges are $1.65 million.
     - Major restorative makes up 16.6% of claims. Billed charges at $1,286,811. After administration costs and member costs, $738,244 paid.
     - 95% of utilization is for diagnostic and preventive or basic services.
     - Major services have minimum usage at 3.8% over $1 million of billed charges with $369,547 paid
     - Orthodontics at 1.4% of total utilization. Billed charges at $213,038 with $68,022 paid.
     - $4.2 million in billed charges with $2.4 million paid
     - Paid PMPM is $24 and Anthem's book of business is $23.
     - PPO plan has deeper discounts on provider billed charges.

   - PPO Plan

- Diagnostic and preventive claims are making up 77.2% of utilization. Billed charges are $600,995. Paid PMPM is $10 vs. $9 for Anthem's book of business
- Major restorative makes up 17.4% of claims. Billed charges at $489,374. After administration costs and member costs, $254,178 paid.
- Major services have minimum usage at 4%. Billed charges at $401,519 with $129,545 paid
- Orthodontics at 1.4% of total utilization. Billed charges at $104,255 with $21,929 paid.
- Paid PMPM is $20 and Anthem's book of business is $23.
- Utilization across this plan is same for diagnostic and preventive and minor restoration; right in line with last year
- Total Paid is just under $800,000. The figures shown for Anthem's book of business are for a PPO plan only.

➢ PPO +
- Paid PMPM on exams is higher than Anthem's book of business.
- $1 million savings on Billed Charges
- Paid PMPM $26 vs. Anthem's book of business at $23.

Michele asked why the costs are higher in the PPO plus plan. Annmarie responded that costs are higher because of deeper discounts and access to providers in PPO vs. PPO+. The providers charge more.

➢ Dental Network Utilization
- Utilization is up about 3%; last year 57%, now at 60%

➢ Dental Enrollment by Plan & Tier
- 60% in PPO Plus plan and 40% in the PPO plan; highest categories are employee only and employee + family

➢ Dental Plan Highlights
- 78% of claims were for diagnostic and preventive claims; 95% for diagnostic, preventive and basic
- Overall PMPM just about the same as Anthem's book of business ($24 vs. $23)
- In-network utilization increased by 3%

Mike D noted when looking at the dental plans, the benefits are same but in the PPO Plus there are deductibles. Out of network in PPO plan pays 40% vs. 50% in PPO Plus. Why did the Trust set out of network benefits differently between the two plans? Annmarie responded because the PPO has a smaller network of providers; however, people in Denver area can use the smaller network, and it's easier to for them to use in-network providers. Plan design is attempting to incentivize people to go in network vs. the PPO Plus to be used in rural locations. Mike D said in certain areas there is not a network, so members will always be using out-of-network providers no matter what. Anthem does not want to penalize members for being in rural areas.

At the June meeting there was discussion about authorizing a third cleaning. The benefit booklet needs to be revised to say the Trust is allowing a third cleaning per year. Kim said these third cleanings are available for pregnancy, diabetes, head and neck cancer, chemotherapy, transplants and heart conditions.

Annmarie then reviewed the exhibit showing a comparison of the State dental plan vs. Anthem's PPO and PPO Plus plan benefits and pricing impacts to CHEIBA plans if the benefits are changed. This exhibit was produced using the plan design summaries and certificates of coverage. The State of Colorado has a richer plan with Delta.

	State of CO Delta Plan	**CHEIBA**	**Cost Impact to Change CHEIBA Benefit**
Annual Maximum	$3,000	$1,500	12.5%

			To change to a $2,000 annual max - 5%
Orthodontic lifetime maximum	$3,000	$1,000	3.9% To change to a $2,000 annual max – 2.5%
Diagnostic & Preventive	Not included in annual max	Included in annual max	3.8%
Adult Orthodontic	Included	Not included	6%
Bitewings (standard x-rays)	2 per 12 months	1 per 12 months	2.77%
Space maintainers	Through age 19	Through age 12	.5%
Implants	1 per 60 mos.	1 per 10 years	1.5%
Occlusal guard	1 per lifetime	1 per 3 years only if osseous surgery was performed	.5%
Missing tooth	Not included	Included	.95% to remove

The second page shows that making all changes to the CHEIBA plan to match the State plan, there would be a 32% increase.

Mike D asked how many members actually reach the annual maximum. Annmarie replied that 221 people reached the max in 2015, and as of June 2016, there are 87 members.

Mike D asked if instead of changing the annual max per member, what if CHEIBA changed the percent covered on major services. Currently cover 50% on major and 80% on basic. What if that percent became 70% on major. Anthem will research that change in major services to see what the cost impact would be.

Mike B asked how many members hit $1,000 in benefits. Anthem will look into those numbers for the August benefits subcommittee meeting.

Blaine said the classified rates for the Delta plan are $44.30 per month; CHEIBA is at $39 per month (difference is 13.6%), and Anthem is saying the Trust rates would have to go up 32% to get the same benefits. Mike B said you cannot compare different dependent ratios because rates would go higher, and Mike D said we don't know what state has done to push dollars around in tiers. Les said the State may have more people in metro area so that could impact provider utilization. Michele said a 32% increase seems high to add these benefits. Les said he will make call to Delta to get information on plan relationships.

Annmarie said there are a small amount of members meeting the ortho annual max; 60 in 2015 and 38 in 2016. CHEIBA could add a third plan with an annual max of $2,500, an ortho lifetime max of $1,500, diagnostic and preventive would not apply to annual max. It would be a 13% increase for those changes. Michele said she has a couple of school district clients that have done something very similar to that by keeping their regular plan and adding a buy-up max plan (much larger loss ratio). Ann said there is a certain subset of people not getting care because of the limit.

6. Pharmacy Review (Anthem)
   Bridget from Anthem began the review of this packet.

   - Slide 2 – the first bullet states the Rx drug prices increased 10.43% in 2015 and the Consumer Price Index went up 1.4%. The breakdown between tiers shows specialty drugs are not the highest; branded drugs have increased the most and generics have also been increasing in cost. Drivers of trend are new drug impact costs (breakthrough therapies) and generic savings are overall lower. Michele said CHEIBA data shows an 81% usage of generics. Bridget said 85% or above would be good. Anthem would like to see CHEIBA usage go higher.

   - Slide 3 – in depth look at what drives trend down and up. Formulary and network strategies,

- Down
  - Formulary and network strategies
  - Clinical programs and edits
  - Benefit design strategies
  - OTC drugs
  - Rebates
  - Generics
  - Biosimilars
  - Price protection
  - Provider incentives
- Up
  - Specialty drug pipeline
  - Brand and generic AWP increases
  - Generic patent cliff
  - Breakthrough therapies (HepC, PCSK9)
  - Increased utilization
  - Drug waste
  - Gaps in care
  - Wrong site of care

- Slide 4 – pharmacy program summary shows highlights of:
  - plan performance
  - clinical cost drivers
  - Anthem recommendations

- Slide 5 – top line performance metrics
  - Total plan costs $7.5 million in 2015, up 22.8%; $6 million in 2014.
  - Plan costs PMPM rose from $52.78 to $75.63, 20.9% trend, due in part to an increase in specialty drug offerings and costs. The generic fill rate went up by 1.4% so it is going in the right direction (a little bit below where we want to be). Member cost share is 11.0%, right in line with benchmark. It is lower than last year because of increase in specialty drug cost. Specialty drug percent of plan cost is up a bit; not near trend that Anthem is used to seeing. Specialty drug plan cost is $25.86 for 2015, which is below benchmark at $32.71.

- Slide 6 – reviews top 10 indications by cost
  - 55.6% of total drug spend.
  - Hepatitis C drugs show highest trend; there was one in 2014 for CHEIBA
  - 3 members taking Harvoni (preferred product) in 2015. That is why trend is up 218.5% (3 members, 9 prescriptions). Normal course of therapy is 12 weeks, and the three members should be done with treatment.

- Slide 7 – top drugs by cost. Blue print indicates specialty medications, 15 of the top 25, which is typical (usually see about ½ specialty). Data is very similar to last year.
  - 4 of the top 10 are specialty drugs which is lower than benchmark of 5 or 6. Specialty drugs available for inflammatory conditions are Humira, Enbrel and Cimzia
  - MS drugs (higher prevalence of MS in Colorado). The last few years have brought some oral medications, and patients are willing to go on treatment now that there are oral meds.
  - Hepatitis C and cancer drugs are the other top two. Other three conditions are behavioral health (Abilify for mental and neurologic). CHEIBA is seeing high utilization for depression drugs. Other high utilization drug is the generic for Abilfy. Attention deficit disorders utilize Adderal XR; this is a situation where they drive to the branded drug. Kim said CHEIBA has high utilization for depression drugs. Member could have been prescribed multiple meds so utilization looks higher. Ralph asked if

there are instances where Anthem drives the member to a generic drug. Anthem chooses whether they can get a good contract on it. Most of the time generic is better cost. Anthem has not seen the price drop on the generic of Cymbalta.
- Sylatron is a drug for cancer for renal carcinoma in the endocrine diagnosis category.

- Slide 8 – top drugs by utilization
  - 5 depression medications on list. These are the same 5 as last year. There are also thyroid medications on the list. Last year flu vaccines were high, and it is the same for this report.

- Slide 9 – snapshot of clinical and specialty programs for CHEIBA.
  - Retail 90 is a program which members can opt to receive a 90-day supply at a Retail 90 pharmacy. This program is not currently in CHEIBA program.
  - Generic Select is a program where a member on brand name drug is offered a one-time $0 copay to switch. This program saved $1.7 million.

- Slide 10 – benefit design program opportunities
  - New formulary option available
  - New network option available

- Slides 11, 12, 13 – pharmacy related gaps in care mailings.
  - Slide 12 – ADHD member mailings; encouraged 15 in 2015, 14 in 2014
  - Slide 13 – Depression mailings. One mailing is for members on three or more medications. There is also a standard member mailing when someone starts treatment. 385 in 2015 vs. 186 in 2014.

- Slide 14 –Medication Possession Ratio (MPR). This is a calculation to show adherence to taking medications.
  - Anti-Coagulant (new category so there is no 2014 information). The target for MPR is 80%; CHEIBA is at 85%, which is very good.
  - Antidepressants are at 78.4% and Antipsychotics 79.9%, which is excellent adherence. Anthem usually sees around 75%.
  - Asthma medication ratios are good at 54.1%
  - Cholesterol/Lipids went up from last year to 84.6%
  - Diabetes went up to 81%
  - Hypertension went down to 81%
  - Osteoporosis went up to 84.5%

- Narrow network

  Bridget reviewed Anthem's new narrow network, which is a tiered network. The member would not really lose any pharmacies as Anthem is breaking the network into tier 1 and tier 2 pharmacies. There are 20,000 pharmacies in level 1 and the rest in level 2 (really is 100% of all pharmacies with all combined). 7% of members would expect to pay higher copay (this is a general number; not CHEIBA specific). Michele asked if tier-based, would a member pay more if they use a tier 1 pharmacy; rural areas would have to pay more? Mike D said tier 1 pharmacies are CVS, Target, Costco, Safeway and Walmart. Marshall asked if a member goes to a CVS or CVS Target, do they specifically have to go to Target? Anthem will check to see if that is true? Ralph asked what is generally the cost difference between tier 1 and 2 pharmacies? It depends on which drug the member uses. It could be $10 on a copay or 10% more. This is an average savings. Mike D noted that Sam's Club is not mentioned. Anthem will check; they think it is Walmart.

  Blaine said we are talking about $150,000 in savings on $7.5 million. Mike B said yes it is a very small percentage. Mike D said if CHEIBA loses grandfather status because of insurer fee, CHEIBA needs to

make up that percentage. Bridget said there is a lot more savings on the focused formulary; narrow network is not taking away just asking member to go to a specific pharmacy.

- Essential formulary drug list. All Anthem formularies go through same committee. This provides a good balance of savings and production. Closed drug list means some drugs are not on the formulary. It is managed by tier placement. A whole class of over-the-counter drugs have been taken off the list. If a brand drug has a generic equivalent, the brand drug is not covered. Extended release drugs will be covered, combination drugs will not be covered but their individual drugs will be covered. All classes of medications are covered. Mike D asked what an extended release drug is. Bridget replied that Ambien is an extended release drug but is not covered; however, Zolpidem (generic) would be covered.

- Dose optimization program – list of drugs where if member gets both they would only be charged a single copay. There would be a $10.50 savings on essential drug list, but it would cause 10% disruption. Anthem has seen that 15 of the top drugs cause 60% of the disruption. CHEIBA can focus on those members taking those drugs.

  Ann asked if extended release drugs are better. Bridget said it is on a case-by-case basis. In most cases, the patent is about to expire.

  Mike D asked if a member is on a generic equivalent, and they are not tolerating drug, is there an appeal review? There is a process for a non-formulary exception where member has to show they tried two formulary alternatives. Mike D said some generics may have side effects that don't occur in brand drug. Bridget said Anthem sees members being allergic to mostly inactive ingredients. In that case, Anthem would use the exception process. The appeal process would be initiated by the doctor.

- Specialty Split Fill – This program is for a list of medications that patients have difficulty tolerating. In these cases, patients have paid for their pills but have found they are unable to take them. Anthem will give two split fills (two 15-day supplies) for no additional copay. By month two the member will be on their normal medication. All these medications come from specialty pharmacies, so there is not much plan savings; it is more of a preventive cost. There is a need to communicate this to patients because when the doctor gives them the Rx, they can speak to the doctor to see if there are other options.

  Michele asked where Anthem is on not having over-the-counter drugs on the formulary. Bridget said this issue is being taken care of via the essential pharmacy.

- Right Drug Right Channel – this program does not have a lot of savings impact; just affects a few members. This prevents self-injectable medications from being claimed under medical. Self-administered drugs, such as insulin, should be claimed under the pharmacy benefit. Also infused drugs (infusion center) should be claimed under the medical benefit. 94% of self-administered drug claims go through the Rx benefit.

- Preventive Rx program – This is a list of medications that can be offered to a member at a discounted copay or zero copay. It promotes adherence and can help to prevent a big event such as a fracture or blood clot. The 2016 Preventive Rx Drug List now includes asthma medications. This program brings no savings to plan; it can add costs because you are losing cost share. It helps with adherence and prevention as member utilizing 90-day retail supply encourages adherence.

- Retail 90 program is a group of pharmacies where member can have 90-day retail supply rather than using mail order. The member would pay three copays. This can save plan about $1 PMPM.

- Smart 90 subset – Anthem will provide information on their Smart 90 program. The Retail 90 and Smart 90 are new for 2017.

Blaine said the cost of EPI pens is going up? Bridget said that is true because there was previously a generic but now it has gone away. There also used to be single dose boxes but they now only have two dose boxes. Bridget said there are copay cards online for members to receive discounts.

There are a couple of different savings options available for employers. Larger carriers are moving toward some sort of exclusion such as PPI's are now over-the-counter.

- Michele then reviewed the Executive Summary of the Anthem report
  - 5 top health conditions accounted for 45% of claims paid; this is under other higher ed groups. Michele outlined PMPM numbers for CHEIBA vs. the two other CO higher ed systems.
    - Employee PMPM at $407.16 is below college system 1 at $455.91 and above college system 2 at $312.12
    - Spouse PMPM at $449.42 is below college system 1 at $536.54 and below college system 2 at $526.18.
    - Child PMPM at $295.95 is above college system 1 at $139.41 and is up because of newborn costs/HCC.

  - Top 5 health conditions. There were injuries that could not be prevented – face fracture, skull fracture, dislocations. There may be some things that can be done in the musculoskeletal area such as bundling osteoarthritis services as mentioned to Janet earlier; however, Anthem does not currently have osteoarthritis bundling available. The top three musculoskeletal system categories account of 3.6% of total claims expenditure.
    - Considerations in these areas are to implement a bundled knee and hip program, continue routing of care and provider to provider reach out in musculoskeletal and pain management. Anthem offers two buy-up programs: one for lower back pain conditions at a cost of $.47 PEPM; and the other for musculoskeletal management at a cost of $.53 PEPM.
  - Chiropractic and musculoskeletal claims are reviewed year after year. CHEIBA increased the visit limit for chiro from 20 to 30 because many musculoskeletal claims were less acute and could be handled by chiro services. There does not seem to be any reason to increase the chiro benefit at this time. Greg said the HMO plan chiro benefit only has 8 visits, and that needs to be pointed out to members. Michele asked if the Trust wanted to consider lifting that limit to 30. Paula confirmed the HMO members have access to 30 visits, however, the difference in the HMO and PPO products for chiropractic benefits is contractual. For the PPO plans, Anthem has a maximum benefit allowance that has been negotiated with our chiropractic providers and the treatment is not subject to the authorization process as is true for the HMO products. For HMO products, Anthem contracts with Landmark on a capitated basis and the risk for managing that capitation falls entirely to Landmark. Part of Landmark's process is to allow for a certain number of services (6-8) and then require a treatment plan from the provider for any additional services.
  - Plan currently offers value-based pricing for advanced radiology at freestanding vs hospital facilities. The top three neoplasms are breast, brain and endocrine tumors and neoplasms are the third highest category in the list of top 5 conditions. There is really not much that could have been done regarding these claims, except looking at the Rx formulary because there are high dollar oncology drugs.
  - Claims attributed to lifestyle conditions make up 19.5% of total expenditures, which is lower than other CO higher ed groups. For CHEIBA the top lifestyle problems are related to obesity, lack of physical activity, alcohol use and poor nutrition practices. 5.5% of total lifestyle condition claims activity is related to osteoarthritis (except for lower back). CHEIBA's claims for artery disease and lower back problems are above the Anthem benchmark. Stress/Anxiety/Depression are number two in prevalent lifestyle cost conditions.
    - CHEIBA considerations include: Communication campaigns, wellness strategies, National Jewish quit line.
  - CHEIBA claims for inpatient mental health/substance abuse and over all mental health services are above the Anthem benchmark (information reviewed by Anthem).

  - CHEIBA considerations include: promoting Live Health Online (behavioral health online service), State EAP program (6 visit max). The State program is free. Anthem has a buy-up EAP program for an additional $1.55 PEPM. A positive for the Anthem EAP is the providers would be in the Anthem network for continued member service. Standard also has an EAP program at a cost of $.77 PEPM. The CHEIBA booklet does not currently provide information about EAP services. The Trust needs to decide if it is more valuable to promote an Anthem program or promote the State program.
- Emergency room visit costs have increased by 10.3% from the prior period, and CHEIBA does have higher levels of acute ER visits.
  - CHEIBA considerations include: working on member education and communication; utilize the 2017 open enrollment to promote appropriate settings and the differences between settings and costs for urgent vs. emergency care.
- Inpatient facility costs increased 22.7%, admissions are up almost 12%, length of stay increased 23.4%. These statistics are a factor of high claimant activity in 2015. There were 56 high-cost claims over $100,000 representing 27.3% of the total spend. Conditions by paid amount are within the top five overall claim areas: Musculoskeletal $3,845,574; neoplasms $3,559,272; newborn care $2,433,363 of which $2,014,032 were attributed to a premature births. Most of these high claims were not preventable, so no amount of engagement would have changed the costs.
- A CHEIBA consideration for Rx would be a tiered network because there is no downside to any locations.

Anthem information and GBS information needs to be done in three weeks for the benefits subcommittee meeting. Mike B is on vacation the first part of August. There may be more flexibility in plan design because the Trust will probably lose grandfathered status this year.

Paula discussed Anthem programs available to the Trust:

- Condition Care support program (buy up program)
- Lower back pain program. Costs associated $.47 PMPM.
- Musculoskeletal management support program. Cost is $.53 PMPM.

A member asked how Anthem finds the members for these programs. Paula said these are voluntary programs and CHEIBA needs to get people engaged and educated. Paula said a downside for these programs is there is no reporting. Les asked if Anthem has data on the number of members available for this program. Anthem will research and follow up.

7. CBGH Reports (CBGH)

Bob Smith and Lisa Slavinski joined the meeting.to provide an update on their previous presentation, Analyzing Hospital Performance. The previous information was based on national information, and today they will show statistics for CHEIBA hospitals. Their data is gathered using two tools, Leapfrog (self-reporting) and Comparion (medical analytics, drives quality measures down to service line level). We need to know that hospitals can be excellent at one service and not so good at others.

- Slide 2 – hospital quality came into question in the 80's, but in 1998-99 the question of hospital quality came to the forefront. A report from the Institute of Medicine said not only quality was an issue but also waste (over utilization, underutilization, misuse of resources). 98,000 people a year die of medical errors year in and year out; however, the National Quality Forum on Health said that number should be closer to 250,000. 2/3 of the measure haven't changed in about 10 years. Last May Johns Hopkins said there were 250,000 deaths due to medical errors; the third leading cause of death in the US. There is no confidence in Health Grades study because it states there was no differential between highest and lowest graded hospitals in terms of outcomes. There are two models that are useful and statistically justifiable: Leapfrog, founded in 2000, as result of report in 1998, and the Comparion system.

Slides 3 & 4 - Lisa said the Leapfrog hospital survey (they do a hospital survey and hospital safety scoring). There were no hospitals in Colorado that received a score of F. 1,500 hospitals completed the voluntary survey last year, and this year numbers are higher (as of June 30th, 1,667 submitted data). In Colorado there were 37 of the 76 (49%) hospitals that completed the survey, and of those, there are a couple that are not eligible because of their business. 67% of the hospitals are urban and 33% are rural. There were three CHEIBA hospitals that did not report and have never reported: University of Colorado, UC Children's and Platte Valley MC. Blaine said he lives in Brighton, and the Platte Valley MC recently became part of SCL Health. Michele asked if the surveys are voluntary and hospitals knows they will not fare well, what is the incentive to complete it? Lisa said the incentive to complete is pressure from employers and insurance carriers, and also by completing it, they will see areas needed for improvement. Centura and Sky Ridge have always completed the survey. Paula noted that UC hospital accounts for 4.3% of paid claims.

- Slide 5 - Hospital safety scores are calculated from MEDPAR files and assigns grades to more than 2,500 US hospitals. The safety survey is standards based, not achievement based. The A-F scale of grades reflect the hospital's efforts to prevent harm to patients. Hospitals have no choice in participation as their data is publicly reported information including rates of patient infections and medical and medication errors. The safety surveys are done twice a year, in the spring and the fall. They have seen significant improvement on hospitals that had a C grade going up to an A; there have been a few that have dropped down in score. If a hospital receives an A+, that means they have had an A rating for several years. The Safety Survey covers:
  - Basic hospital Information (bed size, teaching status)
  - Computerized Physician order Entry (CPOE) (helps prevent medication errors
  - Evidence-based Hospital Referral (EBHR) (determines hospital performance on national endorsed QOC measures for four high-risk surgical procedures)
  - Maternity Care (C-sections, Episiotomy, early effective delivery and high risk deliveries)
  - ICU Physician Staffing (determines whether or not patients in ICUs are cared for by physicians certified in critical care)
  - Safe Practice Scores (SPS) (determines hospital's adherence to 8 of the 24 NQF safe practices)
  - Managing Serious Errors (demonstrates hospital's performance in preventing hospital-acquired infections and other conditions and evaluates "Never Events" policy)
  - Bar Code Medication Administration (using bar codes to prevent medication error)
  - Readmission for common acute conditions (six readmission measures collected and reported by CMS)

- Slide 6 - The CHEIBA hospitals are not consistent in their charges for C-sections or vaginal births; this is reflective of the All-Payor Claims Database. If they have the highest costs for C-sections, they may not have the highest costs for vaginal deliveries. The C-section data covers all C-sections, not just planned C-sections. C-section deliveries are higher in commercial plans than in Medicaid. 75% of all births in CO are vaginal. The number of C-sections in Colorado are 25% lower than the national average; however, they increase 50% between 1990 and 2012. Reducing C-sections in CO by just 10% or 1,708 procedures could lower overall health care spending in the State by $6.5 million a year. This would be a savings to commercial insurance plans of $4.85 million.

- Slide 7 - There are a lot of A graded hospitals for CHEIBA. Leapfrog did away with the A+ category for this spring's survey. There is data available for the top hospitals that are used the most by CHEIBA members. Lisa has that data and can provide it. Paula said that the top hospitals based on paid amount are the Northern Colorado Medical Center in Greeley and Medical Center of the Rockies. Lisa said she took info from the Anthem report

  The Leapfrog survey is available online. It is most useful for purchasers, not consumers. Castlight and Health Care Blue Book are more useful for consumers.

.

- Slide 8 - Comparion Medical Analytics uses Medicare Provider Assessment and Review (MedPAR). This data can tell you the actual number of deaths per 1,000, complications, Patient Safety Indicators (PSI), inpatient quality indicators (IQI) for all general, acute, non-federal hospitals (VA hospitals are not included).

- Slide 9 – Comparion uses a variety of regression models to determine where the risk adjusted indices are for mortality, complications, PSI and IQI and to get the expected mortality vs. the actual mortality.

- Slide 10 – Overall Hospital Performance for CHEIBA hospitals (dollar ranking). Composite quality score showing mortality, complication, patient satisfaction, and two or three other measures. St Joseph scored in the 95th percentile out of 3,500 hospitals. The top three hospitals are where CHEIBA is spending the most money. Red flag is for Parkview in Pueblo which scored in the 5th percentile nationally. RACI (risk adjusted complication index) shows what the expected complication rate is vs. actual. If the actual and expected are the same, the RACI score will be a 1.0. If it's less than one, such as St. Joeseph at .94, which means they do 6% better on complications. Poudre Valley scored 32% better than expected. Mercy Durango is 60% better on complication rates. Parkview complication rate is 40% higher than expected.

- Slide 11 – Hospital Performance – School of Mines. Composite overall quality scores showing major cardiac surgery excluding bypass and joint (knees and hips) replacement. Swedish has a 77.5 cardiac surgery score and a 19.8 joint replacement score. So would recommend Swedish for cardiac surgery but not for knee or joint replacement surgery. St. Anthony score of 98.4 for joint replacement probably reflects they have a dedicated ortho hospital within the hospital.

- Slide not included in presentation handout – There are two strategies for addressing both supply and demand: 1. Shift hospital performance. 2. Shift consumer choice by steering employees toward safer care. Design employer strategies for attaining safe, higher quality hospital care for employees and their values. Develop a purchaser value network of three or four coalitions and put a manual together on how to buy specified services of care--advocate for transparency /accountability.

- Slide 12 - Suggested actions:
  1. Send letters to hospitals to encourage Leapfrog group survey participation.
  2. Define the opportunities. Determine composite score for 3-4 highest dollar-volume services. CBGH will look at other college data to see highest cost services and see what opportunities there are.
  3. Be transparent. If you have an insurance committee, share outcomes. Discuss as a quality of care issue. Get input.
  4. Engage Your Suppliers - fix problems not place blame. There are always issues with data reporting so challenge data from the suppliers.
  5. Pilot a quality improvement project - could look at either which hospital do you use or just one organization, or look at data for one to three organizations to see which hospital is used the most. There is an $850,000 spend for Mines at Swedish; more than the next three or four altogether. Focus on the interaction between buyer and seller.
  6. Educate your employee/consumer - employee engagement is the wonder drug of the 21st century.
  7. Plan for value-based payments – blended payment plan for C-Sections. If a hospital has a C-Section rate of 23%, and the hospital agrees to obtain a target of 17%. We will pay you one fee for delivery at blended rates. For a vaginal delivery, a percentage would be added to bring to the agreed-upon price. Paula asked if there are discussions with hospitals regarding blended payments, how does that affect the physician rates?
  8. Phase in Value-based insurance design - not all providers provide the same value or services. If we provide benefits as if they were basically what we are doing is undervaluing services like primary care. Think about 3-4 years engaging hospitals. Not in favor of narrow networks. Believes in consumer choice. If we want to use top facilities, say you will give them 90/10 vs. 70/30 because there is a certain degree of consumer demand. Les said the agreements could be made by facility or by procedure; this could be very complex administratively. Physicians like to see their scores, and so they provide feedback on a blind basis. They have seen that physicians on the bottom of a list will work harder to improve their outcome scores.

- Slide 14 - Questions you may have
  1. Is it about hospital or physicians? Hospitals control the hygiene factor; they have to put methods and systems in place for doctors to be successful. If the hospitals don't do it, physicians can't do it. Hospitals do not generally resent employer involvement. If an employer is sitting at the table with Anthem and a hospital administrator, the hospital will be more open to the discussion. CBGH can help and will discuss how to engage your local hospital?

  Ann asked if CBGH is seeing bundling of maternity services. Not in CO but other states are bundling with OB doctors and hospitals. Paula said Anthem does have a maternity package billing hospital and provider together. CO PERA just did bundles for knee surgeries.

Kim asked if you have to be a member for the Comparion website. Yes, and the Gunnison hospital is not participating in the Leapfrog survey. CBGH can provide the Gunnison data.

E. 2015 FINAL ACCOUNTING:

1. 2015 RSR Overview Medical, Dental and Life (Anthem)
   - Medical

   Mike B began his review of the January 1, 2015, to December 31, 2015, Final-Health paid through June 2016. Mike B reviewed the report line by line.

   This report has been reviewed twice before, once last year and once in January. Now this is the final report with the six-month runout. The first section shows premium paid and the ½ month premium holiday. Upper section shows as if all premium was paid. Actuaries bring in prior years run-in claims of approximately $3.7 million of $45 million. Actual amount of run-in was $3.3 million (line 4 is a Final number even though it says Estimate). Line 6 is large claims written off for claims incurred in 2015 and paid in 2015. Line 7 shows adjusted incurred claims of $43 million. There was a gain of $707,108 for 2015 (premium minus claims minus charges). Line 10a shows premium reduction amount for the premium holiday. $6.15 million is the ending balance for 2015. This amount will transfer to 2016 and reapportioned to buckets.

   Mike D noted the total amount of lines 8 – 8c is $4.577 million. This is 10% of premium as reserve. We are also reserving 10% of the retention paid to Anthem. Premium covers both claims paid and pays Anthem for administering the plan. The Basic Reserve is designed to be a cushion for claims payment that exceeds the projections. $450,000 of the Basic Reserve is essentially a risk pool against Anthem cost of doing business. This means that there is an 11% Basic Reserve covering claims risk.

   January 1, 2016, to December 31, 2016, Full year 2016 Medical Estimate-paid thru 6/2016
   Mike B explained this report is calculated using six months of data projected and reviewed the report line by line. There are two errors on this report (right hand calculations are correct; just notations are incorrect):

   1. Line 8a. Chargeable Expenses - commission amount should be $3.09 PMPM.
   2. Line 8b. Chargeable Expenses – pooling charge should be $13.28 PMPM.

   Line 10e shows $1.1 million that was transferred from the life reserves in order to cover the premium holiday. $3.5 million is an actionable number. It is above the premium holiday amount of $2.3 million. The Trust would still have $1.2 million for rate mitigation, etc. Mike D said there is no interest on the basic reserve. Mike B said he did not see that in prior calculations and will check to be sure. Mike B believes all plans include interest on reserves.

- Dental

  Mike B then reviewed the January 1, 2015, to December 31, 2015, Final-Dental paid thru 6/2016. This report has also been reviewed prior to this final report and includes the amount of the dental one-half month premium holiday. Mike B reviewed the report line by line.

  The basic reserve is 10% of premium, which includes claims and retention. Excess reserve grew because the basic bucket didn't need any money and the Excess grew by interest amount as well.

  Mike B then reviewed the January 1, 2016, to December 31, 2016, Estimate-Dental paid thru 12/2016 line by line. The excess reserve can be used for premium holiday or rate mitigation.

The next RSR reports do not come until January 2017, so these are the reports CHEIBA will have to make renewal decisions. Les asked if Anthem will do a final renewal with claims data through September. Mike B said no, but numbers will be available through August so there will be an additional two months of data.

F. PRELIMINARY PLAN RENEWALS:

1. Anthem
   - Preliminary Rate Renewal

     Mike B reviewed the Medical Preliminary renewal line by line. Line 4 shows essentially a 0% increase because of large claims that have dropped off. Line 5 for this particular period (paid claims in 2016) shows write offs are $716,425 (prior year $2.6 million). Line 7 Reserve Adjustment is inflated at $3.84, and Mike B will work with the actuary to get a revised number. Claims for the two new plans are immature, and there are not really a lot of people enrolled. The new number should be about $2.25 (capitation last year was $2.14). Mike B expects annual trend to uptick to nearly 8 or slightly over 8 annual (currently 7.3%). The retention amount was a no change request at $28.60. This is also true for pool charge at $13.28. Blaine said he thought they agreed that the GBS commission should increase 3% per year. Mike D said he thought this change should be requested by GBS. The Trust needs to let Mike B know before he finalizes the sheet.

     Anthem, as part of a co-op for the State of CO, had to sign an agreement that should there be any losses Anthem would have to absorb those losses. The Colorado Co-op became insolvent in 2015. Regulatory language was adopted in spring 2016 so that members would not lose coverage if any insurance company became insolvent. The mandate is that insurance companies will recoup that loss. Assessment is $5.35 per contract per month for five to six years for PPO products only that are fully insured. Ralph asked if CHEIBA was self-funded, would they have been impacted. Anthem said no they would not be. CO co-op fee can be passed through on to the rates.

     Renewal with ACA fees included is listed at minus 2.4%. Les suggested the Trust use a 1% increase rather than a decrease. Mike D asked if the Trust loses grandfather status would the change be a 4.2% increase. The PPACA 3.6% insurer fee is statutory fee, not regulatory. It currently does not apply but could come back on in 2018. It is unknown if the insurer fee will later be applied to self-funded plans also. The totals do not match 2015 RSR amounts; they are just free flowing 12 months of claims accumulation. On the Renewal Worksheet, the amount over $350K pool column is for illustration only.

     Mike B then reviewed the Dental Preliminary Renewal sheet. These figures do not have pooling charges in them. There were $2,574,367 in paid claims and a small reserve adjustment of $28,318. Dental calculations are based on 3% annual trend; 5% was used in prior years. There are no ACA fees for 2017. Final required rate adjustment calculation is -4%.

     Mike B. then reviewed line by line the Life Experience Refund Report for January 1 through June 30, 2016. This report is not a year-end projection--six months only reflecting $800,447 in premium received. There is not a 2016 line renewal as the rates are guaranteed until December 31, 2017.

- Actuarial Equivalency by Demographics and Plan Design
  Mike B stated this exhibit shows updated first-blush plan decrements should the Trust need to become non-grandfathered. Shows copays, deductibles, office visits, Rx copay values for certain plans at different percentages. GF status update. There is no room for contribution or benefit changes for the Trust to not lose grandfathered status. Losing grandfathered status costs 4.3% but without a plan design change, it is considered a benefit upgrade. The Transition numbers are the same as 2017. HMO is different because out-of-pocket accumulation is different. New HMO and Lumenos plans are non-grandfathered. The Custom Plus plan is not applicable.

  Mike B then reviewed the June 2016 Demo Factor by Product (shows average age for each plan and age difference based on products). Age is a contributor to the higher loss ratio in the Prime plan because the average age is 15 % higher. There is a potential savings of $1.92 million if the group went self-funded if the Insurer Fee in 2018 is at 3.6%.

  Mike D noted in the top section of this exhibit for Office Visit copay it shows the current benefit level at $20/$20 and the new benefit level at $30/$40; however the benefit value is minus -.07% for both benefit levels. Mike B will look at his notes to see if the new benefit level should be $30/$30.

  Mike D said on the RSR final projection for 2016 it shows the Basic Reserve needing $4.8 million and an estimated insurer fee of $1.9 million assuming the Trust is not self-funded. If the Trust moves to self-funding would they own all reserves that are not in the Basic Reserves. Michele said the Trust would own 50% of the basic reserve and would be handing back to Anthem $2.6 million that would be partially offset by now paying the $1.9 million Insurer Fee.

- Other Renewing Contracts

  1. Mutual of Omaha
     Neida said the Trust received a rate pass from Mutual, and the contact has been extended for two years.

  2. HealthSmart
     Neida said the Trust received a rate pass from HealthSmart for one year

  3. CHUBB
     Neida is working on gathering information for Chubb in order to get the renewal information.

- **Appointment of Plan Design Subcommittee**
  Tracy Rogers, Marshall Parks, Blaine Nickeson, Mike Dougherty, Josh Mackey, Darren Mathews.

G. OLD BUSINESS:

GBS Update

1. Client Service Plan
   Mike D sent this document out to the Trustees for any questions or comments and none were received.

A motion was made to adopt the CHEIBA Trust Client Service Plan for 2016. The motion was seconded and approved (unanimous).

2. Communication Project (Pepper Krach)
   Pepper joined the meeting via conference call to present CHEIBA Trust WFE Aggregated Results exhibit. This is part one of a three or four stage process. Pepper, Michele and Neida have been conducting interviews with each institution and have completed seven of the nine institutions. Results of the interviews will be shared at the next meeting.

- Slide 3 provides the total census count by institution for a total population of 4,321.
- Slide 4 provides an overview of the discovery process of collecting data with a breakdown of the census by: gender, tenure, compensation, and life stages.
- Slide 5 – the work force evaluation breaks down life stages into four levels: Entry Level, Mid-Career (young families), Established and Pre-Retiree (age 55 and older). Pepper reviewed the areas of importance for each category.
- Slide 6 provides a breakdown of the CHEIBA population by life stage. Mid-Career, ages 30-45, represent the highest percentage at 39%. Entry Level and Mid-Career, assuming people are under three years of tenure, together make up the majority of population (approximately 50%).
- Slide 7
  Blaine asked if the terms Gen-Y and millennials are used interchangeably. For this evaluation, they are not. The identifiers are:
  - Entry Level ages 20-30
  - Mid-Career ages 30-45
  - Established ages 45-55
  - Pre-Retiree age 55+
- Slide 8 provides a high level overview of the annual US Employee Benefits Trends Study done by MetLife. It shows employees' financial fears and worries as they relate to where they are in their life. For example, pre-retirees are concerned with outliving their retirement savings, while entry level employees are worried about not having enough money to cover out-of-pocket medical costs that are not covered under their plan (i.e. premiums, deductibles and copayments.) This is somewhat the core that drives offering very strong benefits to your employee population. CHEIBA institution interviews indicated that the benefits are very widely received and respected within the organizations.
- Slide 9 provides an overview of demographics for CHEIBA. There is almost a 50/50 split between men and women. This information is important from the standpoint of communication and retention.
- Slide 11 (1st—there were two slides with number 11) – provides breakdown by age and percent male and female by each life stage. Interesting this insight shows almost a 50/50 split between under age 44 and Established/Pre-Retiree. Darren said it is interesting to see that males are a small minority now and may become a bigger minority in the future. Males are leaving at a quicker rate than those that are coming in—will be interesting to see what the numbers would be in a few years.
- The WFE project is working towards satisfying a broad range of needs at different stages of life.

There are different focuses of interest as we move through different courses of life. Part of the communication strategy will be to consider the interest of each of the four groups and start to focus communications to the areas of interest for each category. One way to do that is through the website and having resource libraries for the different age levels. Michele said the challenge is how to communicate to each stage in life; there will be different channels and methods for this broad audience. Many interviews indicated that people are retiring and moving on.

The second part of the communication strategy will be to focus on people who have less than three years' experience at the institutions. They need more support and the better that is achieved, the better retention rates will be.

Michele said the benefits package has been one of the topics in interviews, and as far as recruitment, most of the CHEIBA institutions that were interviewed say the benefits package has a higher regard than the pay itself. In most higher education institutions, the benefits package represents 29-40% of compensation, depending on salary range. Josh said that the schools are not using the website for recruitment, but potential employees need to get the information.

- Slide 11 (2nd) Workforce Distribution by Tenure
  Less than three years tenure has largest percentage 32.8% or 1,400 employees. This population needs the most communication to help support them to determine which plan is right for their family. With the addition of two plans, employees are struggling to see which plan is right. Tenured employees are comfortable with the PPO or POS plans they are enrolled in. New employees need to find out the differences between each plan, and we need to be sensitive to that and the communication we are providing. If you add in the 3-5 year tenured employees, that adds another 13% to the 32.8% of employees which require more education in order to make decisions. Tenure is based on the years of employment (data showed date of hire for each employee).

- Slide 12 Workforce Distribution by Compensation
  This slide shows breakdown of compensation by male and female. Also shows that 38% are making less than $50,000. The workforce evaluation can identify a break off for key employees, but all institutions would have to come to an agreement as to what a key employee is to extract that group and have a separate breakdown if that would be important to CHEIBA. Michele said the census did have that breakdown and a couple of schools provided their key employees.

  This information tells us that employees making less than $50,000 are most concerned about being able to afford benefits, specifically contributions for medical. Each school has their own contribution strategy, so this is affecting 1,600 employees. Now that the Trust is offering four medical plans, they need to make sure contributions are reflective of benefits employees are receiving. The Trust needs to help guide employees to help them make the best benefit plan decisions based on their different income levels.

  There was also some discussion about total compensation statements. Some schools are contributing a large percent of total medical cost, and that is getting lost as employees are not seeing the investment schools are making on their behalf. Need to include medical costs employers are paying on behalf of the employee showing them that it is a true value.

- Slide 13 Workforce Distribution by Compensation
  This slide shows compensation broken out by the four life stages. Entry level people are making lowest amount, and the colleges are seeing the highest turnover in that entry level category of under $40,000. What can be done to best help them with contributions and making decisions? Les asked if the value of cash vs. benefits is being discussed in the interviews. Do people care more about money or benefits? Michele said they have found in the interviews that benefits are a big draw for retention; no one has said compensation is not important. Most people feel there should be communication around total value of benefits and compensation. Michele said there is a bigger discrepancy between males and females in the Mid-Career and Entry Level stages.

- Slide 14 Enrollment Distribution by Tier
  This slide shows breakdown of male vs female in each of the tiers and how many are not covered by the plan and total percent in each tier. There is 4% enrollment in the Employee/Children tier which is interesting because, assuming the two highest categories of entry level and mid-career, they are the ones potentially in the lower income--surprising you don't see more enrollment there.

- Slide 15 Enrollment Distribution by Plan
  Shows how enrollment fell in each plan by each school. Largest percent of population is in the Blue Advantage POS plan.

These slides provide a base of a benchmark for future years. It will show success in communication and how employees may migrate to other plans based on actual need, gender and stage of career.

Les asked if there is higher turnover for the people who are not covered by the Trust benefits. Trust - Most are covered by spouse's plan or military plan. They are seeing more employees still covered by their parent's insurance. Mike D said the most curious number is the number that is not covered. Josh said it would be helpful to see enrollment by tier by stages of life.

- Slide 16 same information as slide 15 but in a different graph. Shows how total enrollment is making up the entire enrolled population.

- Next steps
  Over the next week interviews will be completed and will begin correlating the findings. Interviews are going well--people are being candid and sharing. It is helping with enrollment material and usage of the booklet. Feel this will help with direction of communications moving forward. Michele will set a meeting with Anthem regarding their communication campaigns for 2017.

  Mike D asked what the end goal is. Michele said communication strategy is never ending. We want to make the program work with the life stages and to meet the needs of the audience. We need to provide a long term communication campaign but also address immediate needs through the step process.

  Pepper said the first part is short term goals for open enrollment. Second part is determining what we want to communicate; such as Telemedicine for employees in the HDHP. Best in class employers are those meeting bottom line goals by paying close to their audience. Better engagement of employees at different life stages helps them to appreciate and understand the large investment institutions are making on their behalf. Michele said we will also be providing benefits through Castlight, but for now, we are trying to educate employees in consumerism.

- Workforce Evaluation Demographics
  Communication campaign will not be identical for every campus; will have to be tailored to each institution. Pepper said there are multiple channels of distribution. One way is to create a poster campaign and have a series of 4 posters. Each poster would have an identifier that people in different life stages could identify with. Post card mailings can be used to target specific ages and spouses, and then that would be reinforced with posters with images similar to the post cards. Social media aspect, if the Trust is interested, could gain a lot of traction. Communication will vary by campus. The workforce evaluation will give a specific story for each entity. Once the interviews are complete, could have meetings to show what applies to particular institutions. This information can be provided one the interviews are completed.

3. Amendment 69
   Mike D said we should see information in September. Governor Hickenlooper in a currently running television ad is encouraging voting NO saying that the exchanges are just getting going. Les said behind the scenes polling shows millennials are 2/3 against and 1/3 in favor.

   Mike D said he received an email from Senator Kefalas sent to people (including Rebecca Weiss) discussing preliminary state meeting to discuss free standing emergency room centers. The Email list included the original house member in the Republican Party who was the cosponsor of the bill (HB1374) introduced in the house but withdrew her sponsorship. Talk about additional info CIVHC (state repository of data) all payers claims data base. The original legislation did pass the House, and in the Senate, it was sent to the state Veterans Affairs (kill committee). Mike D spoke to Senator Woods noting that the bill was designed simply to study the issue. Appointment of group to bring recommendations back to the Senate. Michele asked if CHEIBA would like her to attend? Mike D asked that she reach out to senator's office. Mike D will forward the email to Michele.

Anthem Update

1. Premium Holiday (Meeting minutes confirmation)
   Mike D said Anthem has confirmed that when the Trust makes and records a motion in the minutes, that will be sufficient notice for Anthem to move forward with the premium holiday. The decision for 2017 will be made in November.

2. Vision Reporting
   Annmarie reviewed the vision reporting exhibit. Paula said this reporting shows people are using the plan, and this is the first report of what will be provided on a semi-regular basis. If the Trust would like more reporting, please let Anthem know.

   - Slide 1 shows Vision Utilization Benefit Savings – The majority of charges are from exams with a member savings of $132,770 on exams only. Darren asked if these figures are minus the premium expense. Annmarie said these figures represent billed charges only. Josh asked if Anthem can total each column. Annmarie will total the columns for the next report.

     Annmarie reviewed the utilization by Age Break section and noted that utilization of the frames benefit for ages 41-55 increased 7.2%, single vision lens benefit increased 4.7% for ages 19-26 and 4.6% for ages 27-40. Multi-Focal Lined lens benefit utilization is consistently going up for ages 41-55.

   - Slide 2 Vision network Utilization. This slide shows that 75.6% of exam expenses were for independent providers, 97.1% of members are using in-network providers with network saving of 48.5%. Of those 25.1% are retailers, 72% are independents and 2.9% are out of network. Kim asked which providers are included in the Other Retail category. Annmarie will check to see.

Michele said the retention percentage is higher on vision and asked if the value is lessening. Michele also noted that none of the exam and material claims are part of the medical plan. Annmarie confirmed they do not go into the medical claims.

Paula commented that Metro, Auraria and Mines are going to be doing onsite clinics for vision and everything is on schedule and moving forward.

Mike D said there are billing issues, inconsistencies and problems; the process is not quite seamless. If there are adjustments they are working on, budgets, etc., these issues can affect their numbers. Kim said the billings have been a real headache. Anthem said they are working with individual colleges, and there is a lot of learning to do. Dawn from Anthem is working to get things fixed for everyone. Greg said when employees are charged for the exams as part of the medical plan, it is very hard to reconcile. Mike D asked if as business strategy for Anthem, could they integrate vision exams as part of the medical.

Michele said we need to determine how to communicate better and asked the Trust to send ideas to her or Neida and they can set up a call. We will try to get ahead of things to make it clearer for the employees.

Kim said Western had a couple of retroactive claim adjustments back to October or November on families where the claim was adjudicated and then Anthem came back and said the employee didn't have coverage and owed money. Desiree said Anthem processing made an error and retroactively termed the old PPO contract and caused adjudication to come back on claims. This situation has been fixed.

LiveHealth Online - Desiree spoke about the two handouts included in the packet. The program went into effect January 1, 2016, for physician online visits and 23 employees have used it. There are also behavioral health visits available to members. She is not sure if anyone has used that service as no communication has been sent out on the EAP portion. Registration is encouraged prior to using the service due to credit card registration, etc. Top five Diagnoses, Top five Rx numbers, Usage by day, Where would they have gone if they didn't use LiveHealth Online, Utilization by age, and Visits by time of day were provided on the report. This service is less costly for the member. The majority of users were CO based members, some in FL. Mostly spouse/dependents utilized the service. Ralph asked if they can get usage report by campus. Desiree will put that request in and provide the detail to each institution. Mike D noted that on the back page of flyer it shows cost of physician only. Desiree said the cost is $49 but CHEIBA would have a discount using copay or coinsurance—members on the HDHP will have a $49 copay. So, the flyer cannot be used for all members. Anthem can customize flyer by plan and it can be posted on Anthem's website.

H. DISCUSSION AND INFORMATION ITEMS:

1. Treasurer's Report
   Blaine said the total investment for the Fidelity account is at $158,003.07, and the Operating account is at $65,198.10 for a total of $223,201.

2. Annual Budget (Article VI, Section 5, Operating Plan)
   Blaine began the discussion and said the current year budget is $184,000. The Trust is close to running out of easily liquid cash; this will probably have to be addressed next year. At some point around the end of 2017, the rest of the Standard CRD account will be closed out and can hope for good news from Anthem for performance guarantee. Then the Trust will have to decide if they want to draw from unencumbered reserves (i.e., life) and/or assess some type of PMPM overhead charge per institution. Blaine said he does not see the need to continue the Fidelity account as there is no influx of cash to invest.

Budget for this year was $165,000, and Blaine added an additional $15,000 for the communication project to this year's budget. The Trust had previously decided to go through phase 1 at a cost of $15,000. A Trustee asked if there is a phase 2 and what is that cost. The contingency amount in the budget is $25,000 which could cover additional costs. Kim asked if the $15,000 is for GBS consulting. Blaine said it is for the workforce evaluation, interviews and collaborating with Anthem.

Darren asked if there needed to be $20,000 in the budget for booklet printing. Blaine said the costs have gone up because the booklet became longer (added 8 pages). Institutions can look at the number of booklets they need and perhaps costs could be reduced by reducing the number of booklets printed. Darren said with the website redesign, the Trust could use that rather than having the booklet.

Darren made a motion to accept the 2016-2017 budget as presented. The motion was seconded and approved. Blaine abstained.

- Income and Expense Report
  This item was not discussed.

3. Contract Update
   Dixon provided an update on the Anthem medical dental and vision, HealthSmart, Chubb, Mutual of Omaha and GBS contracts are to be completed. Marshall asked if the Anthem renewal is complicated this year. Dixon replied that it is going well.

4. Annual Review of GBS Services
   Mike D proposed that he circulate the same set of questions that he has used in the past. He will ask for input from the Trustees, and once all responses are received, will summarize the findings. He will provide the evaluation in September.

   - Appoint Subcommittee
     Tracy and Mike will be the subcommittee for the review of GBS services.

5. Benefit Booklet
   - Appoint Subcommittee
     Ann Hix, Shannon Heersink, Susan Benesch, Maria Bondurant, Amanda Berry will be on the subcommittee. Neida will be providing information to the members to get the process started. These subcommittee members will also be on the website committee.

6. Calendar of Meetings
   The calendar of meetings for 2016-2017 was discussed and the following meetings are scheduled:

Date	**December 1-2, 2016**
Location	GBS office
Type	Face-to-face meeting (tentatively) may be phone meeting
Date	**January 26-27, 2017**
Location	Metropolitan State University of Denver
Type	Face-to-face meeting
Date	**April 3-4, 2017**
Location	University of Northern Colorado
Type	Face-to-face meeting (tentatively) may be phone meeting
Date	**June 1-2, 2017**
Location	Western State Colorado University
Type	Face-to-face meeting
Date	**July 26-28, 2017**
Location	The Lodge at Breckenridge – Annual Planning & Educational Meeting
Type	Face-to-face meeting
Date	**September 28-29, 2017**
Location	Fort Lewis College
Type	Face-to-face meeting

7. Election of CHEIBA Officers
   Marshall said the nominating committee found great appreciation for current officers.

A motion was made to nominate the current Trust officers to serve for another year. Josh seconded. The motion passed unanimously.

8. Tony DeCrosta, University of Colorado Health and Welfare Trust
   Tony DeCrosta from CU Trust joined the meeting at 4:00 pm. He explained that the Trust is a self-insured trust with four employers, 67,000 members with health, vision, HSA and FSA. The CU Trust recently did an RFP for Rx, and they now have their Rx coverage with ESI through Anthem and went from an open formulary to a closed formulary. The CU Trust employs pharmacists and expected a big uproar, but they just had one appeal. They have realized a $7 million savings. CHEIBA would be 20% of total claims applied to the CU numbers. They have mandatory mail order with in-house pharmacy. This has saved a lot of money with rebates given back to the health plan. The CU Trust focuses on prevention and launched a prevention program with their wellness program. They put out a magnet (age and gender specific), did preventive screenings, and did monthly mailers around prevention. This has evolved into a business-to-business model, writing script for the employers. The CU Trust launched their first prevention program in 2013 by removing all barriers for diabetes (no copay and no coinsurance). They have now launched a new study on diabetes with the School of Public Health. Three years into program, medical adherence is up but it is a wash—not saving or losing.

   Michele asked if they removed all barriers between medical and pharmacy. Tony replied that if a member goes for a diabetes check only, there is no copay but if there is anything else there is a copay charged. They have now launched a prediabetes program focusing on the prediabetes population. Through biometric screening, they can find A1c scores and see immediate risks. In person and online services have been

expanded through partnership with Omada, a virtual lifestyle change program. Omada provides help through online coaching and counseling. The program is aimed at any person with a chronic disease, namely prediabetes, hypertension and heart disease who would benefit from weight loss.

BeColorado is the name to capture healthy image and wellness and preventive programs. They have a Move Exercise incentive program providing employees only with a $25 (taxable) a month incentive if they move 30 minutes 12 days per month. This App compatible (similar to Fitbit app), and the information goes to employers and then to payroll. There is an honor system so information can be entered manually. They are discussing buying down premiums as an incentive because many employers have HDHP or are seeding the HSA. Mike asked what the process is if you have disabled employee. The program is built around any person physically moving. Next iteration is to make the program app agnostic. Then all employees could upload their information into one place.

Paula asked how they decided on the $25 incentive. Tony commented this was arbitrary. They have had an increase in members going from 3,600 in 2014 to 4,500 in 2015. Majority of members are female using the app. PEPM costs were $1.84 in 2014 and $2.40 in 2015. About a 26% lower PEPM cost over the participants in two years. Next iteration is personalized incentives. For morbidly obese, that may not incent them.

There is value in "bigger is better" as the CU Trust has negotiating power. They meet quarterly to talk about financials and are running at $17 million net reserve. They invest their money very conservatively. They have an internal actuary and everything is validated by Mercer who does exterior actuarial valuation. This year they went in with .9% rate increase, which was brought up to 2.2%. Michele asked if someone could purchase the programs outside of being in the trust. Tony said yes and ad hoc programs are also available. Les asked about the cost, and Tony said he would talk with Mike or GBS about costs.

I. PLANNING DISCUSSION:

1. Grandfather Status

Mike B began the discussion by saying if CHEIBA wants to go to a non-grandfathered status, there is a 4% adjustment to the HMO plan and 4.9% adjustment to the PPO plan for blended enrichment of benefits for the two main plans of 4.3%. Deductibles, copays and Rx copays will accumulate towards the out-of-pocket max. CHEIBA can adjust the rates accordingly for each plan and then make decisions to adjust benefits to any amount (zero to unlimited). Blaine asked what if the Trust doesn't want to make a plan design change. Mike B said there is no benefit to changing benefits. GBS will verify if they can enrich the plan and retain grandfathered status. If you make a benefit change to lessen the benefit, you would lose grandfathered status. Michele suggested the Trust look at adjusting copays on Rx. Blaine said the Trust has spent much time protecting grandfathered status. Mike D said the Trust had a 4.2% bump to the rates previously when considering grandfather status and have previously decided not to make the transition to non-grandfathered status. Michele said the Trust can do different things to the plan designs to absorb the 4.3%. The Trust has to comply and state in their open enrollment materials if the plans available are grandfathered or non-grandfathered. Mike B said on the Anthem system the plan names change to state whether a plan is grandfathered or non-grandfathered.

Mike B said the decrements changed slightly. Blaine asked if the .8% decrement is just on the HMO plan? Mike B said yes it is just to the HMO product only. Ann asked about an employer copay change. Mike B said the benefit committee can determine those changes.

- Required Changes
  Copays and deductible amounts apply to the out-of-pocket maximum.

- Possible alternative plan decrements to offset Impact

HMO Plan	Current Benefit	New Benefit	Benefit Value
Inpatient Copay	$400	$800	-.80
OOP Max Single	$2,000	$4,000	-2.40
Office Visit Copay	$20/$20	$30/40	-.70
Outpatient Surgery	$85	$185	-.20
Rx copay	$15/30/45	$15/45/60	-.80

PPO Plan	Current Benefit	New Benefit	Benefit Value
Deductible	$400	$800	-2.80
OOP Max Single	$1,150	$2,150	-1.60
Rx copay	$15/30/45	$15/45/60	-.80

Blaine and Marshall said that if we are looking at a -2% renewal and have to add 4% for grandfathered status, we are at a 2% renewal. Based on the budget, that is far below what we have to work with. Inclination would be to make benefit changes that incentivize behavior and trying to keep cost of care down, not so much renewal rates. Mike D said unless the Trust goes self-funded, it is looking at a 3.6% increase next year due to the resumption of the insurer fee. Marshall said the Trust needs to target things that change behavior and things that make 3-4% movement; makes sense to stay off that. Blaine said he would like to see generic adoption rise from 81% to 85%. Mike D said that would mean a copay change. Mike D asked if there are other behaviors to target. Blaine suggested looking at emergency room copay, urgent care copay and Rx generic.

Mike D asked what the Trust can do to encourage individuals to utilize certain facilities. If a member is having knee replacement surgery, can we build plan designs so members go to top facilities, the Trust pays for travel or for outlying areas, tell members if you go to certain places, your costs will be less. Tracy mentioned that we need to be careful about politics and making the hospitals mad. We want to hold hospitals accountable to report your data if you're so good or get your grades up or we will drive business away. Michele asked if there could be provider contract issues. Paula said steerage should not be an issue. Another question is can this be done on a fully insured group? Paula said there are things Anthem can get special pricing on. Les asked Anthem what procedures are high on list and for ideas on imaging, infusion, physical therapies to get people out of hospital (drive employees to outpatient facilities). Paula said imaging is handled by AIM so there is steerage. Behavioral change involves a dollar change so the Trust needs to determine what it would take to drive employee behavior ($20 copay). Darren said Durango and Gunnison members would need more incentive to drive to Denver. Kim asked Anthem to include introducing essential formulary to their iterations. The Trust needs to see difference between current and essential pricing. What is covered now and wouldn't be covered.

CHEIBA benefit valuation PPO vs. HMO - With new load of actuarial pricing for benefits there was a significant change between previous benefit values for HMO/PPO. The previous valuations have been within 1% (tolerant). This year's valuation with new load was more than 5%, meaning that the PPO benefit was valued five points higher than the HMO. Mike B thinks the actuarial programs are changed yearly, and it's possible the valuation could reverse next year (don't want to go 15 years of steady comparison and then jump at one year's valuation). Based on unique change in actuarial program they would be valued the same for 2017 and reevaluate in 2018. Should the actual valuation in 2018 comeback differently, he would present what the value is and make a decision at that time. If Trust wants to, we could say this is an aberrant year of pricing and stick with pricing. Blaine asked if we mess with pricing, will it change the value and make the problem worse (shed more healthier people to HMO plan). If you make the price different by 5%, you are likely to shed healthier people into the HMO or Lumenos plans.

Blaine said enrollment has been dropping in the PPO plan and asked if there is a chart on average age of members? Mike B said that information is not available. Michele said there has been a drop in PPO plan enrollment and the loss ratio has gotten better so sick people may have moved already. Mike D asked if the PPO is 5% more valuable than the HMO plan and Mike replied that it is. Mike D asked if you pay 100% premium for both plans, for that 100% in the PPO, you are getting 5% more value? Mike B said actuaries are looking at utilization and those benefits are driving those claims. Mike D said underlying utilization means certain members use certain benefits. Les said there are better deals with the HMO plans and that could mean the provider contracts are driving.

Mike D asked if Anthem is starting to see an imbalance in membership between HMO docs and PPO docs. Paula said she will ask Janet to see if there is tracking. Most doctors are contracted with both PPO and HMO. Get split on which docs are in enhanced personal care. Mike B said you also have to consider area codes--Denver is higher for HMO than the PPO. The combination of the rate seed (claim basis) and the area code create a premium range for an individual. If they are in high cost region because of provider reimbursement, costs are higher.

Mike D asked what the .7 means. Mike B said it is an adjustment to the claim rate to determine premium (the higher the number the worse). All networks used to be on same contract but now payments are different to providers based on plan. Mike B said the same valuation has been used in the prior years. Paula said payments to doctors in enhanced personal health care is higher. Mike D asked the Trustees if they would like Mike B to balance these plans out on an actuarial basis to see what needs to be done this year or leave it this year and decide next year. Marshall said the Trust is moving in opposite direction; not a pricing issue. We have a common rate and try to keep the plan design for members to be comparable. Clearly value of HSA plan is different. People are leaving the PPO plan and moving to the HMO plan. That would seem to contradict calculation that there is more value in the PPO plan. He believes the Trust should not do anything at this time and pay attention to see what happens. Ann said at Mines they have seen the shift of membership from the PPO plan to the HMO plan (80% HMO).

Darren said the Trust has made efforts to keep plans at comparable value but has now changed by introducing two new plans. If we recognize it is a real thing that happens, one year doesn't make a trend. If Anthem is willing to not change pricing, the Trust can take advantage of that and see what happens. If the Trust breaches the grandfather status, we have the opportunity to work on the plan designs.

Mike B will present this same exhibit next year, updating in the 3rd quarter for January and should have something for the September meeting.

2. EAP Program

Neida reviewed the spreadsheet comparing EAP plans (State, Anthem, Standard). She polled all institutions to find out who currently uses the State EAP. All plans are comparable and there would be some advantages to Anthem in that providers in their EAP network are part of their provider network. This would give continuity for those who seek help. The State program has information on the EAP in the State booklet, but CHEIBA does not provide that information in their booklet. Does the Trust want to move in the direction of a full standalone EAP program or communicate the State program information to members that the resource is out there for their use? Ann asked if the State EAP covers everyone.

- Darren said they have an office on their campus
- Tracy said they are in their office once a week
- UNC uses their own counseling center
- Ann said they receive complaints that people don't want to drive downtown
- Marshall said they had four or five visits to the EAP and now have 125 now that they have their own center (easy access with appointments).
- Darren contracts with another group at Mercy Hospital.

Les said the communication campaign would have to be very specific. Michele said the Trust needs to promote EAP services, and if campus is currently happy that is ok, but if a campus would like to outsource these services, please let GBS know. Mike commented that the spreadsheet was very well done.

3. 2017 Open Enrollment Strategy

- Anthem Microsite
  Paula presented a handout on the Anthem microsite. Anthem can put the microsite URL on the employee ID cards. The microsite is a big electronic file cabinet where employers can post plan design changes links to other carriers, flyers. Anthem needs 45 days in total to bring the site up, so to be operational in mid-October, need to begin the process mid-August, beginning of September. Campuses don't relate to CHEIBA, so Anthem can build a separate file cabinet for each institution. They could have special items for each campus, even though some may be the same. Michele noted that developing this site takes 45 days, and there would be no cost to the Trust. If CHEIBA would be going the individual campus route, Anthem would need all documents in PDF format.

  Les asked what is the redundancy vs the Web Benefits website? Neida said it should be one or the other. The benefits subcommittee will discuss this item. Marshall said the Trust does not want to change methods each year. Michele said the Anthem website does not have enroll options, but Web Benefits does but will take time to build the site. Blaine noted that if employees are looking for information on other coverages, they would not be inclined to go to an Anthem site. Josh said if the Trust is working on a communication strategy, they don't want to steer people in a bunch of different directions.

- Web Benefits Design
  Steve Herman from WBD joined the meeting at 9:00 am on July 26.

  Steve began by showing the old version of the website. What WBD found is that the website can get convoluted and information can be confusing for the end user. New interface is much more user friendly and makes it easier to use for Trustees and employees. Nothing has been removed from the site, just reordered or put in a new location. He then brought up the new website and started showing some of the features. There is a side by side benefit comparison feature. All the forms that were available are still on the system. The website is a work in progress, and we can still make tweaks before it is rolled out to employees. Images can be revised; we can send new images over to WBD to be uploaded. There is a video library w/150 videos explaining health care plans, FSA, etc. Each institution website can be built out, and it is all permission based. ABC institution will log in and those employees will only see their info. There can also be an admin log in to control what can and can't be seen when people enroll.

  Blaine asked what the source of the video content is. It is created by WBD production studio. Brought actors and actresses in to read the content WBD created. They can do custom videos and have HR people shoot videos that can be placed on the system. Other video content provided by us or a vendor in mp4 it can be posted on their system.

  FSA page has a calculator for employees to see how much they are saving. There is also a calculator for dependent care. A listing of expenses that are covered and not covered and the guideline behind those is also provided.

  WBD is open to any suggestions the Trust has. They will reorganize data, change buttons on home page, change links to different areas. They can flip the switch quickly when we notify them. Logins will be the same.

Marshall said they are only using the website now for benefit administrators. How do we get access for all employees? Each institution can have their own login. Right now permissions are for employee only or for HR departments. WBD can expand on the logins, but login permissions are going to be based on each institution, not down to each individual employee.

Mike D asked what is the purpose/gain of having individual campus logon. Maybe there is an initiative at a campus and not at another; perhaps a wellness program. WBD can hide the information that doesn't pertain to certain users. Mike D asked if the side-by-side comparison can show campus specific rates. Rates would be on a separate drop down page and the builders would advise on the best way to do this.

Website changes can typically be turned around in 24 to 48 hours. Marshall asked if modifications to individual sites can be made by the universities. All modifications are done by WBD. Can they include benefits that aren't part of the trust? You have the option to do that but the physical labor would be managed by WBD; they will control the upload of the docs.

Michele said this web portal was designed as a repository for documents, but the capabilities have grown. The Trust is discussing a long-term education campaign, and for this open enrollment, we thought stage 1 could be utilizing this website and then work on others. Colorado School of Mines is currently the only campus that does tell their employees about the website.

Mike D said this is becoming a resource that could reduce the number of links by campus. Michele said the benefit booklet committee could also review the website.

Paula said this website may be a better solution than the Anthem Microsite. She would like to put the WBD link on their Anthem ID card. We could explore that and it may be a possibility. Anthem will check to see if that is possible. A suggestion was made that the Trust could buy a domain for a landing site and then they would able to go to schools. This option would not be secure.

- Targeted Communications

  Michele said out of the communication campaign and following the interviews and putting individual workforce evaluation into play, we will come up with strategy for targeted communication (targeting products or behavioral changes). May see targeted communication on the institution level.

  Neida asked for this open enrollment, do we promote this at the health fair or on website. Do we want to actively promote these items? How should we do it through the website or benefit booklet. What are the specific things your employees would be interested in for this open enrollment? Michele said these items can be discussed by the subcommittee. Mike said there are elements that are not well communicated. It would make sense to promote Dispatch Health at Metro but not for Alamosa. The subcommittee will make recommendations or develop items that may be helpful at the open enrollments. Les said it is incumbent on GBS to ask each institution what is most important to them and what we should focus on. Blaine said Auraria would like to have Dispatch Health at their health fair. Don't necessarily have to give information on all supplemental programs, but pick up programs we want to communicate and spread that out. Les said communication should have an extended life and become part of culture and what employees regularly see. Open enrollment is a good launching pad as people pay attention at that time. Tracy suggested freebies with a purpose, like Live Health Online coupons.

  Ann asked if a benefit administration call could be set up like last year once all changes are decided on. Neida will set up the call in early October.

4. Online Enrollment
   Tabled – open discussion for future strategies.

5. Bundled Pricing (Anthem Hips/Knees) Next Generation
   Anthem will work internally to bring back information on this topic.

6. Self-Funding
   Mike D asked that this agenda item be left on. If CHEIBA were to go self-funded, they could still be grandfathered and be in total compliance. Looking forward to 2018, right now the 3.6% insurer fee is coming back to fully insured plans in some form. HHS can't by fiat make the insurer fee cover self-funded plans—not sure if 3.6% is in PPACA or if it is a number that the HHS secretary has the ability to modify. Les will look back at the regulations and check with GBS compliance. Mike suggests everyone pay attention to the election as it could flip the makeup of the Senate, House of Representatives and Presidency. If everything flips to the same as when PPACA passed, may see insurer fee being passed on to self-funded plans. If it doesn't, Trust could avoid 3.6% rate increase (approximately $2 million) by being self-funded.

   Blaine said the IRS page states the insurer fee is passed on to Anthem and then comes to CHEIBA. Les said that CHEIBA as a self-funded plan, is exempted as a non-ERISA governmental plan. Josh said it would be helpful to have a conversation to layout the pros and cons of self-funded and grandfathered status so he could communicate the information to his college leadership. Michele said she sent the GBS information to Josh but hasn't reviewed it with him. Michele to make an appointment with Mike, Josh and Blaine to go over the presentations. Blaine briefly went through pros and cons. Pro is saving on insurer fee. There are lots of things CHEIBA gets as add ons being fully insured with Anthem. The net benefit was $1.4 million but a lot more work. Josh ask if there has been a conversation beyond financials. Blaine said yes regarding control of plan design. Marshall said not much has changed since last discussion and keep an eye on the politics of things this fall. The additional work and added risk did not put them over the top. It would cause CHEIBA to buy overhead and staff positions. One of Marshall's concerns was with the Trust staying together. As this changes in the fall, the Trust will be ready to look at that again to see if something is different.

   Mike D said CHEIBA could not go self-funded and entertain entering the CU trust at the same time. CHEIBA would lose control of some aspects and that may become a big deal for schools that don't have access to the CU health system. Michele said the meeting with the CU trust was a strategic discussion. Trust did their due diligence to see what other options exist. Josh said he is not sure their leadership has background in this item. Mike said CU is not the only opportunity for CHEIBA. CSU is an option, and CSU-Pueblo and Global are part of that system. CCCS is another option, and they are all over the state. Les said if CHEIBA were using the Anthem network, that will not change whether part of CSU or CCCS. There would be a smaller admin fee and the Trust could maybe save 1%, but is that worth it to lose autonomy.

Updated Parking Lot document in packet

1. Colorado Care, Amendment 69. This is funded with 10% payroll tax. Also another 10% tax on other earned income. GBS will update for next meeting.
2. Medical claims audit - done 10-12 years ago. If the Trust were self-funded, an audit would have to be performed about every 3-5 years.

Dependent eligibility audit - done 3 years ago. There are dependent eligibility changes coming this year, so the Trust may want to consider this again. Some concerns did come up during interviews such as forgetting to take off spouses. Also, the Trust will not be covering domestic partners anymore.

Darren said Fort Lewis has two employees go through the Exchange and they have been awarded subsidy. Fort Lewis needs to file an appeal and they are wondering if there is language available to use to show that the plans meet minimum essential coverage. GBS will check with compliance department to see if there is a template available with language for our clients.

EXECUTIVE SESSION - The Trust may convene in executive session pursuant to §24-6-402(3)(a)(II), C.R.S., to confer with the Trust's attorneys for the purpose of receiving legal advice.

J. ADJOURNMENT

Meeting adjourned at 3:55 pm.

A motion was made to adjourn the meeting. The motion was seconded and approved.