POSTEMPLOYMENT BENEFITS

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

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

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

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

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

The CY22 Actuarial Report being provided herein does not separately identify and quantify the liabilities and costs that must be reported and recognized by the State, as an employer, under accounting rules established for postemployment benefits by the Governmental Accounting Standards Board. Therefore, Plan surplus – as defined in this Report – does not take into account the liabilities of the State, as an employer, associated with retiree health and life insurance.

The State and School Employees Health Insurance Management Board has retained Cavanaugh Macdonald Consulting, LLC ("Cavanaugh Macdonald") to prepare annual actuarial valuations of the postemployment life and health insurance benefits ("OPEB") provided through the State and School Employees' Life and Health Insurance Plan. The most recent valuation prepared by Cavanaugh Macdonald was as of 6/30/22.

Although there are surplus funds that exist in the Plan, there are much higher liabilities for the State, as an employer, for future retiree benefits that have not been funded. For example, based on current claims liability estimates and prior to recognizing any premium deficiency reserve, the Plan ended CY22 with a Plan surplus of about $102 million. Based on results contained in the "GASB Statement No. 74 Report for the Mississippi State and School Employees' Life and Health Insurance Plan Prepared as of June 30, 2022" by Cavanaugh Macdonald, the State's Total OPEB liability associated with retiree benefits provided through the State and School Employees' Life and Health Insurance Plan were about $494 million as of 6/30/22.

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

ASSUMPTIONS

Basic Projection Approach

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

Non-Drug Benefit Trend after Benefit Changes

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

	CY23	CY24	CY25
Medical Trend, Non-Medicare	3.00%	3.00%	3.00%
Medical Trend, Medicare Classes	3.00%	3.00%	3.00%

Drug Benefit Trend

Prior to any Plan or benefit changes, the basic annual trend assumption for CY23 thru CY25 for drug benefits, net of rebates, was 10%. However, the Plan implemented the CVS Caremark Value Formulary as of 7/1/22, and trend rates are expected to be lower for the 1st half of CY23 versus the 1st half of CY22 as a result of this change. A 5% assumption was used for the 1st half of CY23 and a 10% assumption for the 2nd half of CY23. The same trend assumption was made for drug benefits before rebates, rebates, and drug benefits after rebates. These assumptions produce an increase in net drug claims in CY23 of about 7.5%, followed by increases in CY24 and CY25 of about 10%.

Enrollment

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

	Legacy	Horizon
CY23 1H	33.7%	66.3%
CY23 2H	32.6%	67.4%
CY24 1H	31.4%	68.6%
CY24 2H	30.2%	69.8%
CY25 1H	29.0%	71.0%
CY25 2H	27.8%	72.2%

The proportion of active employees selecting Base coverage is assumed to be 22.5% for Horizon employees and 6.5% for Legacy employees.

Net Cash Flow from Life Insurance

In the projections included in this Report, life insurance coverage was assumed to produce annual gains to the Plan of about $600,000.

Interest

Interest income was assumed to be earned and received at an annual rate of 1% and was based on the sum of the prior month's cash assets and one-half of the net cash flow for the month.

ASSUMPTIONS (Continued)

Administrative Expenses

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

CY23	$18.93
CY24	$19.49
CY25	$20.08

CY23 health insurance expenses are projected to be approximately 3.6% of projected CY23 premium.

SIGNIFICANT HISTORICAL BENEFIT CHANGES

CY20 Plan Changes

Drug Copays for Generic Drugs – Beginning 1/1/20, there are 2 tiers of copays applicable to generic drugs. Tier 1 generic drugs are subject to a $12 copay. Tier 1 generally applies to generic drugs which have an ingredient cost for a 1-month supply of less than $20. Tier 2 generic drugs are subject to a $30 copay. This Plan change is expected to reduce Plan costs in CY20 by about $4.4 million. (NOTE: Under special Plan rules, the Tier 1 generic copay also generally applies to preferred brand drugs for insulin and other diabetic supplies.)

CY19 Plan Changes

Telemedicine Benefit Applicable to Behavioral Health Services – Behavioral health services are now available via telemedicine at the regular Plan benefits subject to the applicable deductibles and coinsurance.

Modifications to Wellness/Preventive Benefits – Effective January 1, 2019, coverage for vitamin D as a wellness/preventive benefit was removed. The vaccine benefits language was also revised to include coverage of the appropriate shingles vaccination beginning at age 50 or above.

Modified Coverage for Non-surgical Treatment of Obesity – The Weight Management Program participation mandate for bariatric surgery has been modified and the obesity treatment exclusion was removed and modified to provide for limited weight management coverage under wellness/preventive benefits for services by providers participating in the Plan's obesity treatment network.

Cognitive Therapy – Coverage for cognitive therapy was removed as a listed Plan exclusion.

CY18 Plan Changes

Drug Card Copays – Effective January 1, 2018, the copay for non-preferred drugs and specialty drugs was increased from $70 to $100.

Elimination of the Visit Limit for Dietitian Services – Previously, visits for nutritional counseling with an in-network registered dietitian were limited to four visits per calendar year. Effective January 1, 2018, this limit was eliminated. Based on current and anticipated utilization and allowable charges, the projected cost for removing the limit is expected to be minimal.

Telemedicine Benefit to Include Registered Dietitians – Previously, benefits provided for telemedicine services were limited to basic primary care services. Effective January 1, 2018, benefits are also provided for telemedicine services provided by a registered dietitian. Benefits are subject to a $10 copayment, with such being subject to the deductible for Base Coverage, but not subject to the deductible for Select Coverage.

100% Coverage in 2018 for a Generic Statin – The United States Preventive Services Task Force (USPSTF) recommends that adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke) use a low to moderate dose statin for the prevention of CVD events and mortality when all of the following criteria are met:

(1) They are ages 40 to 75 years.
(2) They have one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension or smoking); and
(3) They have a calculated 10-year risk of a cardiovascular event of 10 percent or greater.

The Plan now provides 100 percent coverage for a generic statin (Lovastatin) to comply with the ACA-mandated coverage.

SIGNIFICANT HISTORICAL BENEFIT CHANGES (Continued)

CY17 Plan Changes

Select & Base Coverage Out-of-Pocket Limits – Effective January 1, 2017, Base Coverage and Select Coverage were modified as generally described in the charts below. Both coverage options now have a $2,500 in-network medical coinsurance maximum and a $6,500 combined in-network out-of-pocket limit (deductible(s), coinsurance, and copays).

CY17 BASE COVERAGE

	Combined Deductible*	Medical Coinsurance	Medical Coinsurance Maximum	Drug Copays	Combined Out-of- Pocket Limit	
Self Only Coverage						
In Network	$1,800	20%	$2,500	$12/$45/$70	$6,500	
Out-of-Network	$1,800	40%	$3,500	$12/$45/$70		
					Per Family	Each Person
Family Coverage						
In Network	$3,000	20%	$5,000	$12/$45/$70	$13,000	$6,500
Out-of-Network	$3,000	40%	$7,000	$12/$45/$70		

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

CY17 SELECT COVERAGE

	Separate Medical Plan			Separate Drug Plan		Combined
	*Individual Medical Deductible	*Medical Coinsurance	Individual Coinsurance Maximum	Individual Drug Deductible	Drug Copays	Individual Out of Pocket Limit
				$75	$12/$45/$70	
In Network	$1,000	20%	$2,500			$6,500
Out-of-Network	$2,000	40%	$3,500			

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

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

Preventive Wellness Services – The Plan is required by ACA to cover all preventive services recommended by the United States Preventive Services Task Force (USPSTF), at no member cost sharing. Recently, the USPSTF removed or modified their recommended services, and the Board voted to change the list of preventive services that the Plan covers, at no member cost sharing, to conform with the recommended list (to the extent that the recommended changes are not inconsistent with other State law). The services removed or modified are still eligible for benefits, subject to the same rules and benefit provisions as other services. The Plan anticipates a savings of approximately $1.6 million as a result of these changes.

SIGNIFICANT HISTORICAL BENEFIT CHANGES (Continued)

CY17 Plan Changes (Continued)

Base Coverage Preventive Drugs – Except for those drugs that are classified as preventive under ACA and are therefore covered at 100%, all other drugs under Base Coverage were previously subject to the combined medical and drug deductible of $1,800 for Self Only Coverage and $3,000 for Family Coverage. Effective January 1, 2017, drugs that appear on the Prime Therapeutics "HSA Preventive Drug" list (that do not also appear on the ACA Preventive Drug list) are not subject to the full combined medical and drug deductible. Rather, they are subject to a separate $75 preventive drug deductible and normal drug copays. In 2017, Base and Select drug coverage are the same for these preventive drugs.

Telemedicine – The Plan added coverage for Telemedicine services beginning January 1, 2017. Basic Telemedicine services are subject to a $10 copayment. Telemedicine is not subject to the deductible on Select coverage, but is subject to the deductible on Base coverage, as required by IRS rules for a qualified high deductible health plan.

CY16 Plan Changes

Pre-certification Requirements for Outpatient MRI's and CT scans – Pre-certification for outpatient MRI's and CT scans are no longer required. Instead, the Plan's medical policy will apply.

Chiropractic Benefit – The calendar year limit for chiropractic services has been removed and replaced with a 30 visit per calendar year limit.

Primary Care Physician (PCP) Copay Feature for Select Coverage (Effective 1/1/16) – Previously, all office visits were subject to the calendar year deductible and applicable coinsurance. Effective January 1, 2016, Select coverage includes a copay feature applicable to office visits to an In-Network Primary Care Physician (PCP).

Details of the new PCP copay feature are as follows:

- Primary Care Physician (PCP) includes: Family Practice, General Practice, Gynecology, Internal Medicine, Pediatrics, Registered Dietitians, and Nurse Practitioners.
- Visits to an In-Network PCP are not subject to the calendar year deductible.
- An office visit copay applies to the In-Network PCP's charge for evaluation and management, and applicable coinsurance applies to any additional charges for other services provided in the PCP's office.
- PCP Office Visit Copay, In-Network: $25
- Out-of-Network: Office visits to an Out-of-Network primary care physician will continue to be subject to normal Out-of-Network deductibles and coinsurance.

Maternity Management Program – In an effort to increase engagement and help improve maternity outcomes, the Plan changed the previous benefit of 100% coverage for physician maternity services to be limited to only those participants who participate in the maternity management program. For any participant choosing to not engage in the program, regular Plan benefits will apply.

Contraceptive Coverage – During CY16, the Plan began providing 100% coverage without cost-sharing for certain brand contraceptives when a generic is not available or when not medically appropriate. During CY15, 100% coverage applied only to generic drugs.

SIGNIFICANT HISTORICAL BENEFIT CHANGES (Continued)

January 1, 2010, thru January 1, 2015

See the FY16 or CY16 Actuarial Reports.

January 1, 2009 & Prior

A detailed description of prior changes appears in the CY10 & prior Actuarial Reports.

FEDERAL HEALTH CARE REFORM

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

Early Retiree Reinsurance Program (ERRP)

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

Grandfathered Plans

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

Benefit and Other Changes Required Under ACA for CY11

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

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

Benefit Changes Required Under ACA for CY13

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

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

FEDERAL HEALTH CARE REFORM (Continued)

Benefit Changes Required Under ACA for CY13 (Continued)

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

Benefit Changes Required Under ACA for CY14

The following benefit changes were required by ACA in CY14:

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

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

Benefit Changes Required Under ACA for CY15

The following benefit changes are required by ACA in CY15:

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

FEDERAL HEALTH CARE REFORM (Continued)

Benefit Changes Required Under ACA for CY16, CY17 and CY18

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

Fees Imposed by ACA

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

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

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

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

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

Projected ACA Imposed Fees Incurred thru 2018 (in Millions)

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

RETIREE LIFE RATES PER $1,000 AS OF 1/1/2014
Based on Attained Age of Retiree

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

Agenda Item 3
Wellness Incentive Program
Ms. Cindy Bradshaw

Description

The Plan's single Base Coverage deductible is $1,800 and $3,000 for family coverage. Employees completing the incentive requirements in 2022 received a $300 deductible credit for Base Coverage and a $600 deductible credit for Select Coverage to be applied for the calendar year 2023 benefit period. The board approved spouse participation in the incentive program at the November 2022 board meeting.

The IRS historically announces the minimum deductibles for qualified High Deductible Health Plans in April or May for the following year. The current minimum deductible under federal law is $1,500 for single coverage and $3,000 for family coverage. It is anticipated that the IRS will increase the deductible.

The Plan's current single Base Coverage deductible is $1,800 and the family deductible is $3,000. The wellness incentive is currently a reduction in the deductible which creates a compliance issue if the IRS increases the minimum deductible.

Staff recommends that the Wellness Incentive Program only be applied to the Select Coverage for 2023. Activities completed during the 2023 Program will earn a $600 deductible incentive credit for employees and a $600 deductible incentive credit for spouses, to be applied for the 2024 calendar year benefit period.

Action

Board approval of incentive criteria.

Agenda Item 4
Financial Statements
Mr. Chris Shaman

Description

The previous month's financial statement for the State and School Employees' Life and Health Insurance Plan is included in this section.

Action Requested

None

STATE AND SCHOOL EMPLOYEES' LIFE AND HEALTH INSURANCE PLAN
STATEMENT OF CASH RECEIPTS, DISBURSEMENTS, AND BALANCE
February 28, 2023

	CURRENT YEAR			LAST YEAR		
	MONTH ENDING February 28, 2023	FY2023 YEAR TO DATE	CY 2023 YEAR TO DATE	MONTH ENDING February 28, 2022	FY2022 YEAR TO DATE	CY 2022 YEAR TO DATE
RECEIPTS:						
PREMIUMS RECEIVED:						
HEALTH INSURANCE	$71,684,731.63	$547,263,888.86	$140,728,003.86	$68,472,298.29	$524,470,638.53	$128,675,591.31
LIFE INSURANCE	1,753,435.57	13,167,354.68	3,464,849.09	1,571,579.86	12,543,505.43	3,011,488.59
REFUNDS OF CLAIM OVERPAYMENTS	6,515.48	62,211.54	7,806.43	36,122.12	141,960.83	52,952.83
SUBROGATION RECEIPTS	70,443.92	681,619.80	251,268.19	159,384.30	902,327.55	537,169.56
LATE FEES RECEIVED	0.00	6,354.00	0.00	4,375.56	18,537.81	7,748.29
INTEREST RECEIVED	280,669.73	1,103,744.03	506,313.02	50,463.63	456,942.44	98,710.70
PHARMACY REBATE	9,840.89	71,669,085.32	1,686,333.72	0.00	58,138,163.98	0.00
ARPA PAYMENT	0.00	60,000,000.00	0.00	0.00	0.00	0.00
TOTAL RECEIPTS	$73,805,637.22	$693,954,258.23	$146,644,574.31	$70,294,223.76	$596,672,076.57	$132,383,661.28
DISBURSEMENTS:						
NON-ADMINISTRATIVE:						
CLAIMS PAID-MEDICAL	44,537,819.68	404,404,203.93	95,506,346.12	47,736,297.37	417,820,293.08	101,300,556.41
CLAIMS PAID - PHARMACY	28,907,595.18	203,702,152.23	49,697,477.84	28,418,536.58	206,284,143.21	55,397,967.47
CLAIMS PAID - LIFE	1,645,441.55	10,386,741.28	3,122,106.55	1,421,126.00	10,732,482.98	2,817,421.00
PREMIUM REFUNDS	38,730.00	429,377.90	84,726.30	39,423.30	302,980.61	40,057.30
SUBTOTAL NON-ADMINISTRATIVE	$75,129,586.41	$618,922,475.34	$148,410,656.81	$77,615,383.25	$635,139,899.88	$159,556,002.18
ADMINISTRATIVE AND COST CONTAINMENT FEES:						
ADMINISTRATIVE EXPENSE - STATE	89,603.33	815,754.27	222,654.96	107,500.09	886,631.98	257,057.09
FORVIS - AUDITOR	0.00	74,000.00	0.00	3,000.00	74,000.00	6,000.00
CTI - MEDICAL CLAIMS/PERFORMANCE AUDIT	0.00	0.00	0.00	0.00	740.25	740.25
PILLAR- PHARMACY CLAIMS/PERFORMANCE AUDIT	0.00	8,885.94	0.00	0.00	0.00	0.00
CAVANAUGH MACDONALD - ACTUARY	0.00	30,000.00	7,500.00	0.00	15,000.00	0.00
LYNN TOWNSEND - ACTUARY	30,245.00	127,756.50	33,006.50	24,192.00	120,181.25	32,128.00
SEGAL - CONSULTANT	0.00	9,360.00	0.00	11,537.50	38,606.25	17,217.50
BLUE CROSS BLUE SHIELD OF MISSISSIPPI - TPA	1,615,980.00	10,704,692.60	3,159,510.00	1,558,652.50	10,962,735.00	3,117,523.50
CVS CAREMARK-PHARMACY NETWORK	0.00	1,931,757.72	306,030.31	314,772.70	1,924,792.09	566,707.10
MINNESOTA LIFE - LIFE INSUROR	79,863.45	580,373.08	164,985.09	81,450.60	558,535.68	163,161.19
ACTIVEHEALTH - WELLNESS PROMOTION	0.00	1,445,314.90	488,736.25	270,272.07	1,858,966.63	799,539.24
KEPRO-UTILIZATION MANAGEMENT	0.00	1,139,634.78	379,425.75	188,902.45	1,296,146.36	378,511.22
HDMS - DECISION SUPPORT	20,153.17	141,072.19	40,306.34	20,153.17	141,072.19	40,306.34
TRUSTMARK - BANK SERVICES	2,235.79	14,778.37	4,342.68	2,110.52	14,535.92	4,148.36
PCORI FEES	1,459,069.00	1,459,069.00	1,459,069.00	0.00	0.00	0.00
SUBTOTAL ADMINISTRATIVE	$3,297,149.74	$18,482,449.35	$6,265,566.88	$2,582,543.60	$17,891,943.60	$5,383,039.79
TOTAL DISBURSEMENTS	$78,426,736.15	$637,404,924.69	$154,676,223.69	$80,197,926.85	$653,031,843.48	$164,939,041.97
NET INCREASE (DECREASE) FOR PERIOD	($4,621,098.93)	$56,549,333.54	($8,031,649.38)	($9,903,703.09)	($56,359,766.91)	($32,555,380.69)

STATE AND SCHOOL EMPLOYEES' LIFE AND HEALTH INSURANCE PLAN
STATEMENT OF ESTIMATED UNOBLIGATED CASH
February 28, 2023

	CURRENT YEAR at 2/28/2023	LAST YEAR at 2/28/2022	VARIANCE
CASH AND CASH EQUIVALENTS:			
TREASURY FUND 3153	144,578,081.85	83,536,096.00	61,041,985.85
CLAIMS BANK ACCOUNT - NET (LESS OUTSTANDING CHECKS)	29,830,192.22	35,048,394.05	(5,218,201.83)
TREASURY FUND 3154	8,961,015.11	4,073,407.72	4,887,607.39
TREASURY FUND 3144	371,323.98	207,484.87	163,839.11
RETIREE INSURANCE TRUST (OPEB) - TREASURY FUND 3645	1,058,137.46	1,047,432.40	10,705.06
TOTAL CASH AND CASH EQUIVALENTS	$184,798,750.62	$123,912,815.04	$60,885,935.58
ESTIMATED OBLIGATIONS:			
OUTSTANDING CLAIMS - HEALTH (INCURRED BUT NOT REPORTED)	(15,610,054.74)	(16,831,517.00)	1,221,462.26
OUTSTANDING CLAIMS - LIFE (INCURRED BUT NOT REPORTED)	(364,302.00)	(297,233.00)	(67,069.00)
OUTSTANDING CLAIMS - HEALTH (INCURRED BUT NOT PAID)	(27,400,251.00)	(19,648,251.00)	(7,752,000.00)
ADVANCE PREMIUMS	(10,156,954.00)	(9,023,969.00)	(1,132,985.00)
FORVIS - AUDITORS	0.00	0.00	0.00
CTI - MEDICAL CLAIMS/PERFORMANCE AUDIT	0.00	(10,358.00)	10,358.00
PILLAR-PHARMACY CLAIMS/PERFORMANCE AUDIT (FEBRUARY)	0.00	0.00	0.00
CAVANAUGH MACDONALD - ACTUARY (FEBRUARY)	0.00	0.00	0.00
WM. LYNN TOWNSEND - ACTUARY (FEBRUARY)	(29,193.00)	(25,000.00)	(4,193.00)
GALLAGHER - CONSULTANT (FEBRUARY)	0.00	0.00	0.00
SEGAL - CONSULTANT (FEBRUARY)	0.00	(23,790.00)	23,790.00
BLUE CROSS BLUE SHIELD OF MISSISSIPPI - TPA (FEBRUARY)	(1,611,636.00)	(1,559,941.00)	(51,695.00)
CVS -CAREMARK -ADMIN (FEBRUARY)	0.00	(262,898.00)	262,898.00
MINNESOTA LIFE - LIFE CLAIMS/FEES (FEBRUARY)	(1,585,500.00)	(1,501,043.00)	(84,457.00)
ACTIVE HEALTH - WELLNESS PROMOTION (JANUARY, FEBRUARY)	(534,223.00)	(267,467.00)	(266,756.00)
KEPRO-UTILIZATION MANAGEMENT (JANUARY, FEBRUARY)	(381,788.00)	(188,085.00)	(193,703.00)
HDMS - DECISION SUPPORT SYSTEM (FEBRUARY)	(20,153.00)	(20,153.00)	0.00
TRUSTMARK - BANK SERVICES (FEBRUARY)	(2,100.00)	(2,000.00)	(100.00)
TOTAL ESTIMATED OBLIGATIONS	($57,696,154.74)	($49,661,705.00)	($8,034,449.74)
TOTAL ESTIMATED UNOBLIGATED CASH	$127,102,595.88	$74,251,110.04	$52,851,485.84

PROJECTED SURPLUS PER CY22 ACTUARIAL REPORT AS OF 02/28/2023	$121,091,012.37
PROJECTED SURPLUS PER CY22 ACTUARIAL REPORT AS OF 12/31/2023	$97,718,644.65

***NOTE: OTHER THAN AMOUNTS LISTED IN THE RETIREE INSURANCE TRUST (OPEB) - TREASURY FUND 3645 SHOWN ABOVE, THE ESTIMATED UNOBLIGATED CASH AMOUNT DOES NOT INCLUDE ANY ADDITIONAL RESERVES FOR THE $493,733,000 UNFUNDED ACTUARIAL ACCRUED LIABILITY FOR CURRENT AND FUTURE RETIREE LIFE AND HEALTH INSURANCE BENEFITS.**

Agenda Item 5
General Schedule
Mr. Chris Shaman

Description

A general schedule of major activities associated with the Plan and actions to be taken by the Board in the next few months is included in this section.

Action Requested

None

State and School Employees Health Insurance Management Board
General Schedule
March 2023

April	Board proposes potential benefit changes for Calendar Year 2024 Third Party Medical Claims Administrator Claims and Performance Audit Report Performance Audit of PBM
May	Staff and consultants evaluate proposed benefit changes for calendar year 2024 Performance Audit of PBM
June	Staff and consultants evaluate proposed benefit changes for calendar year 2024 Pharmacy Benefit Manager Claims and Performance Audit Report