COOK COUNTY/FOREST PRESERVE
ANNUITY AND BENEFIT FUND
MEETING OF THE HEALTH BENEFITS COMMITTEE

REPORT OF PROCEEDINGS had at the audio/video meeting of the above entitled matter, held at 70 West Madison Street, Suite 230, in the City of Chicago, County of Cook, State of Illinois, on Tuesday, May 18, 2021, commencing at the hour of 9:00 a.m.

APPEARANCES

TRUSTEES OF THE COMMITTEE:
- **CHAIRMAN PATRICK MCFADDEN**
- **DIAHANN GOODE**
- **STEPHEN HUGHES**
- **BILL KOURUKLIS**
- **KEVIN OCHALLA**
- **LAWRENCE WILSON**

OTHER TRUSTEES PRESENT:
- **JOHN BLAIR**
- **JOSEPH NEVIUS**

STAFF:
- **REGINA TUCZAK, Executive Director**
- **MARGARET FAHRENBACH, Legal Advisor**
- **RACHELLE HOWLIET, Senior Health Benefits Specialist**
- **GARY LEDONNE, Director of Benefits Administration**
- **BRENT LEWANDOWSKI, Director of Member Services**
- **JODI WEINSTEIN, IT Administrator**

ATTORNEY FOR THE BOARD:
BURKE, BURNS AND PINELLI, LTD.
BY: MS. MARY PATRICIA BURNS

ALSO PRESENT:

CVS HEALTH
- **MICHAEL HECK**
- **KATHY GOERGES**
- **JAMES HOGAN**

UNITED HEALTHCARE
- **CRAIG BARTHOLOMEW**
- **BETHANY BUMP-WHITE**
- **PATTI PRINCE**
- **MIKE WALL**

SEGAL
- **DAN LEVIN**
- **THOMAS WYSZOMIRSKI**

TRUSTEE MCFADDEN: I hereby convene this Health Benefits Committee meeting of the Cook County and Forest Preserve District Annuity and Benefits Fund for May 18, 2021.

The Committee is adhering to the guidance provided by the Governor's April 30th 2021 disaster proclamation. The Governor's Executive Order number 2021-9, as well as the provisions of the Public Act 101-0640.

There may not be a quorum of trustees physically present at the meeting location. Some trustees however are present at the public meeting location as is the Executive Director and Fund counsel. For the record, the public has received notice of this meeting and of their ability to participate by video conference or to be physically present at the meeting. In addition, the Fund is recording this meeting and a transcript of the proceedings will, after future approval by the Board, be made available on the Fund's website.

TRUSTEE MCFADDEN: Peggy, please call the roll.

MS. FAHRENBACH: Trustee Goode.

TRUSTEE GOODE: Present.

MS. FAHRENBACH: Trustee Hughes.

TRUSTEE HUGHES: Present.

MS. FAHRENBACH: Trustee Kouruklis.

MS. FAHRENBACH: Trustee McFadden.

TRUSTEE MCFADDEN: Here.

MS. FAHRENBACH: Trustee Ochalla.

TRUSTEE OCHALLA: Here.

MS. FAHRENBACH: Trustee O'Rourke.

MS. FAHRENBACH: Trustee Wilson.

MS. FAHRENBACH: Trustee Blair.

TRUSTEE BLAIR: Here.

MS. FAHRENBACH: Trustee Nevius.

TRUSTEE MCFADDEN: May I ask you? So, we have seven?

MS. TUZCAK: Yes, they are saying that we are missing Trustee O'Rourke, Trustee Wilson and Trustee Kouruklis but we have a quorum because we have Trustee Hughes.

TRUSTEE MCFADDEN: Which one of those belongs on the Committee?

MR. LEDONNE: Those three.

MS. FAHRENBACH: The committee includes trustees…

TRUSTEE MCFADDEN: That is not here.

MS. TUCZAK: Those that I mentioned. Trustee O'Rourke, Trustee Wilson and Trustee Kouruklis are all on the committee and they are not present. Trustee Nevius and Trustee Blair are not on the committee but they are present.

TRUSTEE MCFADDEN: Okay. Thank you, Gina. Consistent with Public Act 91-0715 and reasonable constraints determined by the Board of Trustees, at each meeting of the Board, members of the

public may request a brief time to address the Board on relevant matters within its jurisdiction.

Are there any requests for public comment today? If any member of the public wants to speak, please identify yourself for the record.

Hearing none, we will proceed to the public business matters. The first item on the agenda is review and approval of the minutes of August 18, 2020 Health Benefits Committee Meeting.

TRUSTEE MCFADDEN: May I have a motion to approve?

Trustee Ochalla: So moved.

Trustee Goode: Second.

TRUSTEE MCFADDEN: Moved by Trustee Ochalla second by Trustee Goode.

All in favor? Any discussion?

Please call the roll, Peggy.

MS. FAHRENBACH: Trustee Goode.

TRUSTEE GOODE: Aye.

MS. FAHRENBACH: Trustee Hughes.

TRUSTEE HUGHES: Aye.

MS. FAHRENBACH: Trustee McFadden.

TRUSTEE MCFADDEN: Aye.

MS. FAHRENBACH: Trustee Ochalla.

TRUSTEE OCHALLA: Aye.

TRUSTEE MCFADDEN: The motion carries and the minutes have been approved.

The next item on the agenda is the CVS Pharmacy Benefit Plans provider's performance review. There are two portions. The first we will cover is Medicare and the second will be the Non-Medicare.

Gina? Could you please introduce these people for us? Get them going.

MS. TUCZAK: Absolutely. We have CVS representatives on the teams meeting. We have Michael Heck that will provide the overview of the Medicare performance and we also have Kathy Goerges who's a clinical specialist, she will also assist and James Hogan that will assist on the non-Medicare piece.

MR. HOGAN: I'm going to need your help for just a minute while I get this speaker situation figured out. I know you can hear me, but I cannot hear anybody in the room, so I'm working on it.

MS. TUCZAK: OK, well Mike Heck is going to be first anyways, right Mike?

MR. HECK: Just taking myself off mute. Yes, I am going to start, Gina, sorry.

MS. TUCZAK: Thank you. We've asked that the presentations be no longer than 20 minutes apiece to keep the meeting moving efficiently as possible, especially with the Board meeting

scheduled for 10:30 AM. So with that, I'll turn it over to Mike Heck. If you want to begin your presentation, you all have the materials in front of you. The CVS packet is the first packet in the materials.

MR. HECK: Good morning everyone and thank you very much for the opportunity to review the Cook County Pension Fund pharmacy benefit for the 2020 plan year for both non Medicare and Medicare lines of business. My name is Michael Heck; I am the strategic account executive for the Medicare line of business. I live here in Chicago. This is my first time with the Committee so I very much appreciate your time today. Without further ado, I'll go ahead and jump in, but if there are any questions while I'm presenting, please feel free to interrupt. I'm happy to answer as we go.

So first, let's take a look at slide number 3, which I feel tells a very good story about our financial journey for 2020. As you can see on the top line, we start with our total gross costs. This is how much we spent on medication that went up 13.9% year over year from $46.3 million to $52.8 million. The next line you'll see our rebates. As your pharmaceutical benefits manager, we pass those rebates through to the Fund and those also went up 21.1% year over year from about $11 million flat in 2019 to $13.3 million in 2020. When we take those rebates out of the total gross costs, we have our total gross

costs after rebates, in 2019, $35.3 million up 11.6% to $39.4 million in 2020.

The next factor we want to consider in our costs is the member component. So the member costs went up year over year from $3.48 million in 2019 to $3.66 million in 2020. The member cost share as a percentage went down from 7.5% to 6.9%. So when we take that member cost share into consideration, we have our total net cost after the rebates in member share and that went up 12.3% from $31.8 million to $35.8 million.

The last piece that we want to consider are our EGWP offsets and subsidies or Medicare Part D subsidies and offsets. Those went up 12.6% year over year from $18.7 in 2019 to almost $21 million flat in 2020. When we factor in the rebates, the member cost share and the offsets and subsidies and we come to a total plan cost increase year over year of 11.9% from $13.145 million in 2019 to $14.705 million in 2020. Before I move on to the first of our two key metric slides, do we have any questions?

TRUSTEE HUGHES: Michael, this is Trustee Hughes.

MR. HECK: Yes, sir.

TRUSTEE HUGHES: The total plan cost going up by 11.9%, does that correspond to say your book of business? Are there any fair comparisons to make in that regard?

MR. HECK: There is. I've seen across our book of business. I don't have apples to apples comparison in this presentation, but this is a little bit above our book of business benchmark. I've been seeing for other clients and other EWGP plans anywhere between 6 and 12%, so this is on the higher end of that spectrum, Sir.

TRUSTEE HUGHES: Okay, alright. Thank you.

MR. HECK: You're welcome, Sir. Great question.

Let's move on to the first of our two key metrics slides. At the top, we're going to see some membership numbers, and you can see that year over year from 2019 to 2020, our membership grew a bit from 9,293 in 2019 to 9,419 in 2020. The percentage of folks who are actually utilizing the plan went down a little bit year over year from 71.5 to 70.5, and at this point I'll call attention to the last column on the right, our book of business numbers. That is our whole EGWP line of business, so it's not specified whether it's government or employer, but it's all of our EGWP clients, all of our Medicare Part D clients if you will. And average eligible member age stayed fairly flat at 76, which is right in line with our book of business.

The next section is going to tell a very, very similar story to what we saw in the first slide. Our gross costs with our rebates removed, our gross costs with the rebates, member costs.

TRUSTEE MCFADDEN: Excuse me, Mike?

MR. HECK: Yes, Sir.

TRUSTEE MCFADDEN: You pointed out that the book of business figures are very much the same for the age and the utilization.

MR. HECK: Yes, sir. That's correct.

TRUSTEE MCFADDEN: Is that your whole universe of customers?

MR: HECK: This is our whole universe of Medicare Part D customers, sir.

TRUSTEE MCFADDEN: Right. Well, on the prior page are you comparing referencing the book of business figures for the same? You haven't disturbed the book of business base that you're referring comparing us to. Have you?

MR. HECK: The book of business base that I spoke of in the previous slide and this slide is all of our EGWP or Medicare Part D business.

TRUSTEE MCFADDEN: Regardless of whether it's a government pension or…..?

MR. HECK: That is correct, Sir,

TRUSTEE MCFADDEN: Okay.

MR. HECK: It can be a union or can be an employer. Unfortunately, on the commercial side, we do have the ability to break them out by, you know, type of plan but on the EGWP side we don't have that ability, so it's the whole universe of EGWP or Medicare Part D plans.

TRUSTEE MCFADDEN: Thank you.

MR. HECK: You're welcome, Sir.

So as I mentioned, the second section here is going to tell very similar story. The numbers are going to match up to the first page, though, there. So, I will kind of glaze over those. That brings us down to that 11.9% increase. But what I really want to focus on is the PMPM figures at the bottom of the page. PMPM is per member per month, and gross cost per member per month did increase year over year from $415.87 in 2019 to $467.26 in 2020. So that put us just above the book of business benchmark there, which is the whole universe of EGWP clients. The member cost per member per month went up a bit from $31.21 in 2019 to $32.44 in 2020. That is a step above our book of business benchmark as well. And then, when you consider those member cost shares, the net cost went from $384.66 in 2019 to $434.82 in 2020, and that is still right in the neighborhood but a little bit above our book of business benchmark there.

TRUSTEE OCHALLA: Excuse me, Mike?

MR. HECK: Yes, sir.

TRUSTEE OCHALLA: Do you have a, in your numbers, have you gotten a reason as to why ours have gone up outside of your whole universe?

MR. HECK: Ultimately, there are many factors that you can that go into it as you can imagine, but ultimately it is

utilization and specialty trend, which we're going to look at in the next slide, is a huge driver of overall trend. So what we've seen is some, you know, some strong specialty trend for the Fund which has affected negatively, obviously, the overall cost increase.

TRUSTEE OCHALLA: Okay. I may have more questions on that after you get through the next part. Thank you.

MR. HECK: You're welcome Sir.

So lastly, we look at our rebates per member per month and that went up 19.5% year over year from $98.82 in 2019 to $118.06 in 2020 and that gives us a bottom line per member per month increase of 10.4% from $117.88 to $130.10. Obviously, that's a little bit below that 11.9% that you see a few lines above, but increased membership help bring that number down a little bit per member per month.

The next slide we'll look at some more key metrics. These are more targeted towards what types of medications were filled, where were they filled at? So starting at the top, you can see that single source brands went up just a tiny bit from 11.6% to 11.8%, still within our book of business at 12.2%. Multi source brand same story there, went up just a tiny bit but stayed within our book of business benchmark there. Generic dispensing rate, that portion of our medications that we're dispensing are generics, we're doing a great job there even though we saw a

little tick down from 87.1% in 2019, 86.8% in 2020. We're still doing a good job there in comparison with our book of business in terms of dispensing generics. Last line in this section, the substitution rate for generics still remains high, it ticked down just a little bit, but still remains above our book of business, which is great news.

Next, we'll look a little bit about utilization in the next section. You can see that total prescriptions fell about 0.2%, probably about 500 prescriptions in there, we lost. So it stayed relatively flat prescriptions per member per month dropped from 2.3 to 2.2 year over year, and then next week we can see where these prescriptions were filled. So in 2019, our members filled 45.5% via retail. In 2020, they filled about 43.2% via retail, a drop of 5.2% which is good because the best pricing for the Fund is via the mail and maintenance choice channels. So ultimately, we want to see the retail prescriptions decrease preferably, and the mail and maintenance choice prescriptions increase because that's how the Fund gets the best or deepest discount on those medications. You can see the next two lines, the mail prescriptions, they went up just a tiny bit but remained flat. The good news here is that those maintenance choice prescriptions went up significantly. Now, there's a little definition of maintenance choice over on the right there. That's the ability of a member to obtain a 90 day supply at a retail

pharmacy for the same price as the mail pharmacy. The good news is, the fund gets the same discount, so it's a win win for everyone. Last in this section, we will look at days' supply per member per month. That went up just a tick from 138.45 in 2019 to 141.01 in 2020. Just a little bit above our book of business there at 134.06.

Lastly, let's look at specialty. I mentioned this on the previous page. This is a major driver for all clients in the EGWP space. We're seeing, you know, anywhere from the teens up into the mid-20s of specialty trend upward in year over year. For the Fund, it went from $18.4 million in 2019 to $22.3 million in 2020. Those utilizers, especially utilizers as a percentage of our membership base did go up as well, so we gained some utilizers there and went up from 4.7% to 4.8%. The specialty gross cost per member per month went from $165.66 to $197.75 year over year, which took us a little bit further away from our book of Business Benchmark there at the $161.82. As a percentage of our total gross cost went up as well, 6.2% from 39.8% to 42.3%, a little bit above our book of business there as well, and as a percentage of our total prescriptions, 1% is a very common number to see across the EGWP client base. We've ticked above that just a little bit to 1.2%. Specialty member cost share stayed relatively flat 0.5% which is a little bit below our book of business at 0.7%. So as I mentioned

previously, this is a major driver of why we're seeing that upward trend overall, specialty is a major driver behind that.

Next slide we will look at our top ten therapeutic classes and this is for the Med D benefit. So this is what processes through both the primary and supplemental benefits, which we'll discuss in a moment. But these are the top 10 classes of medications that are processed through the Med D benefit, and we're not seeing anything out of the ordinary here. And honestly, I want to call attention to the left hand side where you see book of business rank. That's going to be where it ranks for our EGWP Book of Business. Prior rank is where it was in 2019 for the Fund and current rank is where it was in 2020 for the Fund. So we didn't see a lot of shuffling in that top seven or eight. What we saw was cardiovascular agents come from below the top 10 into the top 10 and I'm going to show you on the next slide, the major driver behind that. But as you can see, there's not a lot of movement in the top ten. It's remained fairly static and when we move to a more detailed slide that's next. You can see in the middle I want to point out the therapeutic class. That therapeutic class ties back to the previous slide and where that therapeutic class is ranked.

TRUSTEE MCFADDEN: Michael, I have a question on slide 6. The assorted classes - medications with more than one indication they treat.

MR. HECK: Yes, Sir.

TRUSTEE MCFADDEN: Your book of business is markedly different than our experience. And the reason I'm talking about this one is because of the amount of money attributed to the limited number of RXs and the number of people utilizing.

MR. HECK: I see, so the cost per member or the cost per prescription. So these are generally newer to market medications and the reason we put them in their own class is because there are certain medications that are being used to treat immune diseases and other indications. And, these medications generally tend to be more expensive overall so they generally tend to be more price per prescription, which is why you're seeing less total RXs, but still a very high cost.

MS. GOERGES: Yes, and Mike, I just wanted to add that there will be more explanation of that on the following page where you see your top 25 drugs. So under the assorted classes, it is a select few as to how, it's not how CVS Caremark designates these products, but how we obtained the therapeutic classes. So, it's a product called Revlimid that's really driving the cost in that assorted classes. And Revlimid, even though it's not necessarily considered a cancer drug, it falls into another class, but its primary indication is for the treatment of cancer - it treats multiple myeloma and that's where you're seeing the cost because that one product alone is $3 million. And as you can see for

your assorted classes in total, it's $3.2 million. So that's the primary driver of the cost, in there and that is for the treatment of myelomas, which is a type of cancer.

TRUSTEE MCFADDEN: Thank you,

MS. GOERGES: Certainly.

MR. HECK: Thank you very much Kathy for the added background.

MS. GOERGES: Sure.

MR. HECK: So if you do go to slide seven, you can see that Revlimid is on top there and you'll see that as Kathy mentioned, it's about $3 million of that $3.2 million in the assorted classes there. So that's the major driver there, and I want to point out on the very right hand side the gross cost per prescription. You can see that's most second most expensive on the list, but it's an expensive per prescription medication.

So the next thing I want to call out on this top 25 slide, on slide seven, I want to call out when we looked at the previous slide, we saw that cardiovascular agents jumped into the top 10 and that's driven by Adempas. If you look at the current number 10, Adempas, that's going to be the driver behind that cardiovascular agents category coming up into the top 10. And the other major thing I wanted to point out on this slide is that we've had some major movers within the diabetic space. We can look at Trulicity which went from 14 to 8. We can look at

Jardiance, which is a current 18, came up from 44. We can look at that Ozempic, which is at 25 now, but it came up from 66. So, those antidiabetics are really new treatments for type 2 diabetes and recently, the American Diabetes Association stated that these medications should be part of a regimen for patients with diabetes and cardiovascular disease or chronic kidney disease in order to reduce the cardiovascular risk. So while we're seeing increased utilization of these, the good news is we do have all of the possible utilization management protocols in place. So prior authorizations, quantity limits, that sort of thing. We have all that in place to make sure that utilization is appropriate.

TRUSTEE BLAIR: I just have one question, if I could. Back to page 6, the antidiabetics, you know your book of business is number one across the table. Is there going to be a change in cost for those Novolog, Levemir, Ozempic and the other antidiabetics? Because wasn't there something done at the federal or national level with changing the price point of those medicines?

MR. HECK: Fantastic question and I did see those efforts, but I believe and I don't know if you heard about some other changes they were attempting to make in the Medicare space like the point of sale rebate rule. Those were proposed but they had not been put in place. So the Biden administration and I'm not

sure of the current status of the insulin proposal, but I know that the point of sale rebate proposal has been tabled until 2023. So I believe the same thing has happened with the insulin proposal. I know that both the Trump administration and the Biden administration had it high on their list to address the cost of insulin. So while, I know that there were some proposed measures, changes that CMS would make to mandate you know, a cap on spending or you know, change the pricing. I believe that's been tabled to 2023, but I believe we'll see that bubble up again in the next 6 to 8 months.

TRUSTEE BLAIR: Thank you.

MR. HECK: You're welcome, Sir. Thank you for the question. It was a good one.

So the last one I really want to call out on this top 25 slide, slide 7 is Otezla that's, you know, an analgesic and that is the only other one that really moved significantly into our top 25.

If there are no more questions on the top 25 here, I'll move on to the next top 10 slide and this is the top 10 or top eight because we only have 8. So this is the top eight for the enhanced benefit coverage, and I think the best visual representation I can give of how the enhanced benefit works, it used to be called "the wrap". And for lack of a better analogy, if this is your Med D benefit, supplemental benefit kind of

wrapped around that and provided an extra layer of benefit for some of the items you see in the top eight here. Now, Part D non-formulary. Part D non-formulary are Med D approved medications that are not on our formulary. So the Funds formulary covers let's say about 87% of Med D approved drugs. Of that other 13%, those will still process via the enhanced benefit and we'll look in more detail at the top 25 for the enhanced benefit next and correlate the same way it goes with the Part D non-formulary categories. Number 2 on this list is diabetic supplies. Lancets meters test strips that sort of thing. Number 3 is non-part D enhanced drugs. There are some definitions down at the bottom. You can include allergy treatments, vaccines, other oral chemotherapy, that sort of thing. And then at number 4, we have benign prostatic hyperplasia that is BPH otherwise known as. And that is treated with erectile dysfunction drugs. Now, the Fund covers these erectile dysfunction drugs but only for the treatment of BPH. That's number 4 on our list and rounding out the top eight Anorexients (diet aides). Two types of vitamins, single entity and multi that have to be prescription and cough and cold.

So, as we move to the next slide and look at the top 25 again, therapeutic class in the center column that will correlate to the previous slide to show you which category each of these items falls into.

TRUSTEE MCFADDEN: So, Michael.

MR. HECK: Yes, Sir.

TRUSTEE MCFADDEN: Could you get for us an estimate of what the erectile dysfunction medications would cost us now, since that drug has been, is now generic? So, based upon our experience from when we did cover it to now, what would the annual expense be?

MR. HECK: Absolutely, sir. I can get with our analytics team, potential utilization.

TRUSTEE MCFADDEN: Thanks, thanks.

MR. HECK: Absolutely.

TRUSTEE MCFADDEN: I'm sorry I interrupted you.

MR. HECK: You know the one thing I don't like about this presentation is talking at people for 20 minutes, so I appreciate your participation as well as all the other questions we've gotten.

So as you can see, you know down our list, there are a couple that moved into the top 25 that weren't even listed before that's because those are new. Trodelvy and Kathy, keep me honest here. Trodelvy is used to treat cancer?

MS. GOERGES: Correct.

MR. HECK: And you know, I'm going to ask for help on the Budesonide at number 20.

MS. GOERGES: Sure. That could be utilized for asthma or chronic obstructive pulmonary disease as well, so it's an inhaler.

MR. HECK: And the last new one here is at 21, the T:Slim. That's going to be diabetic supplies. That's an insulin pump. So this really breaks down the top 25 items that are on your enhanced benefit. And again, it wraps around that Part D benefit to provide one benefit to the member. The Member doesn't see two plans. It operates as one, but it's a way for you to provide a more robust benefit than the bare bones Med D coverage. So that brings me to the end of my presentation. I did want to point out in our appendix here. There is a top ten specialty by gross cost slide. There is also a corresponding top 25 for just specialty. So if you want to dig into specialty a little more, those are your two slides and then lastly, a summary of our digital adoption. How are members doing in terms of using caremark.com? Are they active up there because we know that members who are digitally engaged will be more adherent as well.

So with that, I'm going to just give you my sincere thanks for your engaging questions and your time and maybe put aside a few minutes for questions if there's anybody that have any.

TRUSTEE OCHALLA: I might be able to take this answer offline. I don't want to waste everybody's time in here, but I know that we had talked about at one point, a system that the

County has for its members for active employees on the diabetic front with free meters, test strips, lancets and things like that in order to kind of catch problems before they become major problems and you know more of a prevention stage. Are we utilizing something like that in both Medicare and non-Medicare for our plan? And if not, is there a way to maybe implement that with a minimum cost?

MR. HECK: It's a fantastic question.

MS. TUCZAK: You know what, Mike, if you don't mind, I'm going to take that one for a minute? It's that we are in the midst of setting up discussions with CVS and UHC to investigate these diabetic programs that might assist the members with some of the costs of these products. But we don't have anything in place right now.

TRUSTEE OCHALLA: Okay.

MS. TUCZAK: But if you want him to discuss more, but we haven't implemented anything.

TRUSTEE OCHALLA: Yeah if you, I mean, it is their program that you're talking about?

TRUSTEE MCFADDEN: We'll wait until the staff fleshes this out with the two or more providers, possible providers.

TRUSTEE OCHALLA: Is it an outside provider, Gina? Outside of CVS, or is it?

TRUSTEE MCFADDEN: It could be CVS or it could be United Healthcare?

MS. TUCZAK: And then there is an outside provider, Livongo, that would be unrelated to either two that we can certainly solicit.

TRUSTEE OCHALLA: Okay, how far along are you?

MS. TUCZAK: Yes, we're just starting.

TRUSTEE OCHALLA: Okay. That's fine, well I'll hold off until another time since there seems to be a time crunch today and some issues can be discussed offline. Thank you.

MR. HECK: Yes, absolutely.

If any of the members have questions that you haven't been able to get to now, please pass them on to me through Gina. I'm more than happy to research whatever you need. So with that, thank you very much for your engagement and time and I'll pass it over to James Hogan for the non-Medicare portion of our presentation.

MR. HOGAN: Great, thank you Mike and can everybody hear me okay?

MR. HECK: Yes, sir.

MR. HOGAN: Okay, very good.

MS. TUCZAK: Great, thank you. Okay. James, do you want to get started? I know we are at about 25 minutes, so if you don't mind getting started on the non-Medicare presentation which is

in the same deck as of the other one and if you could get started, that would that be great.

MR. HOGAN: Thank you, very good.

Thanks Gina and thank you Mike.

Where I'd like to begin for the team here is if we can move to slide 18 and I would just like to reorient the group here that we are focused on the non-Medicare benefit and we have the slide here from the high level financial perspective broken down to show a couple of key indicators from a cost perspective and how the Fund invested in this section of the benefit.

I'll start everybody at the top row, the total gross cost. We have $14.6 million. At the top right hand corner of this slide for the total gross cost in 2020. From there, we generated nearly $4.3 million in rebates which is the next row down. A 21.5% increase from the last period. This is due to the alignment to formulary by the Fund and as CVS Health grows and gains negotiating power with pharma, we pass that rebate on to the Fund. We have a total net cost after rebates of $9.4 million, a 1% decrease from the prior period. Members contributed in the next row down, 2% more than they did in 2019 for a total of $925 thousand. And the member cost share overall was down about 2%. So your members contribute 6.3% of the total cost of the medication. And this is only their copays. That brings us to a total net cost, so net net, how much did the Fund

invest in the non-Medicare component of the plan coverage? $13.7 million at the bottom right hand corner of this slide.

Any questions on this? Okay, very good.

I'd like to draw your attention to Slide 19. Very similar to the information Mike had detailed. No reason to go line by line, but there's a few key indicators of note here. You'll notice the 2nd row from the top, the average monthly utilizers as a percentage of members, staying relatively consistent. So you've got about half of your members using the plan. Average age for the non-Medicare segment is 59, the next row down. And then this is where we break down those cost indicators. And I'll draw your attention to that next section, downward says cost with rebates. This is where you can observe your PMPM cost for the plan with a net cost PMPM of $230.81, which is the 2nd row from the bottom of that section. And then we also have the member cost share indicator, next row down of 6.3%. So that's how those two slides tie together from a financial perspective. From a drug mix lens, Mike had mentioned the generic dispensing rate. We have that same metric here in the next area down of nearly 87%. And then substitution rate at about 99%. So two good indicators on that front. Now, you'll see total prescriptions in the utilization section went down a little bit, but that was absorbed largely because of the shift to 90 days supplies. So each 30 day

prescription counts as 1 prescription. So to get to 90 days, that's three prescriptions.

Where we normalize for that to show exactly how much medication was used by the Fund members, we want to look at that bottom row of that utilization section. This is the clean view of the total scope of medication used that Days' Supply PMPM. So the Fund is up 3% at nearly 92%. Specialty at the bottom. Well, I know on the Medicare side and non-Medicare side we spend a lot of time, but I'll show you why as we get down here. It's a large number. It's an investment by the Fund in high cost medications for a smaller number of your people. So it's only 3% of your population using specialty medications, but it's a healthy investment at $5.7 million. Any questions on this slide?

TRUSTEE MCFADDEN: Jim? Back at the drug mix, the two last items, the dispensing rate and the substitution rate. Of the whole universe, 87% of what's RX is generic?

MR. HOGAN: Correct.

TRUSTEE MCFADDEN: And, so where? Expand a little bit on the substitution rate, where does that, who's substituting it, who's taking the initiative?

MR. HOGAN: Sure. So, Mr. McFadden now I'll use your prior definition of the dispensing rate, which is a good one. The whole universe is 87% of all of your medication, but not all medication has a generic substitution available. So that leads

into that next metric of the substitution rate. So what we're saying is, when there is a direct generic available and that is when a brand medication loses its patent protection, generic manufacturers bring products to market. It is legally allowed to switch a brand name drug with a generic. The pharmacist is allowed to do that legally. If there's no generic available, a pharmacist cannot switch out for example, a brand high cholesterol medication that has no generic with another generic in the class. That's not legally allowed, so that's where you get the distinction Mr. McFadden on why that rate is so high. Oftentimes, that substitution happens automatically, and most benefit plans do have structures in place to incentivize the member, like the Fund does, to have lower copay on generics and to have substitution happen automatically. That is done by the pharmacist.

TRUSTEE MCFADDEN: Thanks.

MR. HOGAN: You're welcome.

Anything else on this slide before we move on?

Alright, very good.

Where that daily supply becomes important is the next slide 20. What we're measuring here are the percentage of your members who are adherent to their medication by class. Therapeutic classes are lifted pardon me, listed on the left hand side of the slide. And then as we move to the right, we see your non-

Medicare population. So 81.5% of your diabetics are adherent to their medication. That rate exceeds those of the benchmarks that we have moving to the right of our average CVS health customers in the 50th percentile. Other plans with mandatory Maintenance Choice like the Fund has in place and then the 90th percentile are those plans that are the best of the best. So, nearly across the board, diabetes and hypertension for sure, the Fund is exceeding all benchmarks and even in the hyperlipidemia space, the Fund has a very good adherence rate to medication. The only benchmark it is not exceeding is that 90th percentile. So the point here is that the Fund is investing in this plan. The takeaway is members are using their medication. They have easy access to care with the pharmacy network and with 90 day supplies where you can go into CVS or get your mail order script from Mount Prospect Pharmacy. The copays are set to a level where they are only contributing 6.3% of the total cost of the drug, so the barriers have been removed by Fund leadership who allow members to take their medication at a lower cost and with easy access. And it's all coming together on this page where you're getting a return on your investment because members are actually taking their medication as prescribed by their physician. Any questions on this?

TRUSTEE MCFADDEN: Just a thought. Would there be a substantive payback if we chased these 20% that are not taking their medication regularly.

MR. HOGAN: I think, Mr. McFadden there could be. Should that extra 20% move into the adherent range by 1 means or another, whether it be incentivized or otherwise, by Fund leadership, there would likely be a payback because members may avoid some type of medical complication. I will say that with these figures, reaching 100% is often not feasible, so the reason is, there could be legitimate reasons why a Member might not continue on with their medication as prescribed. They might be switching to another medication within the class, or might be weaned off of a medication for a while as they are under physician observation. So, there could be some reasons why we don't see our plans even the 90th percentile ever reach much above 80. But to answer your question, yes. If we could get people more of your people into that adherent bucket, there would be value to the Fund. How we would do that though, would not. I don't believe, be low hanging fruit. I think there's probably a reason why that 18.5% has missed a refill here and there.

TRUSTEE MCFADDEN: Thank you.

MR. HOGAN: You're welcome.

Alright, I will move on to the next slide and I will pass this over to Kathy Goerges. Kathy would you call out the key highlights on this page, please?

MS. GOERGES: Sure.

MR. HOGAN: Kathy, I'm having some trouble hearing you.

MS. GOERGES: I paused because I heard Gina speaking so I didn't know.

MS. TUCZAK: Thank you, Kathy. Yes, we're just tight on time so anything you can do to tighten this presentation would be appreciated. I know Jim is about 13 minutes in. Thank you.

TRUSTEE MCFADDEN: We apologize for pressing you a little bit genuinely, but the circumstances since the meeting was set have changed.

MS. GOERGES: Oh, absolutely. No problem.

With this particular slide really, the very important highlight, is that if you look back at previous reviews that we have held with you. There is a different dynamic that we have now incorporated into our analysis and that is when you're looking at this analysis you'll see additional breakouts and what I mean by additional breakouts is when you're looking under the specialty class, so the first column, you'll notice that will have psoriatic arthritis. You'll see rheumatoid arthritis which we have had in the past. You'll see Crohn's disease, that's new, and you also see psoriasis. So basically what we've

been able to do now is break apart. Before you would see rheumatoid arthritis, you would see psoriasis, and now we're actually able to break out those therapeutic classes by indication. So that is a uniqueness to this analysis that was created for this year and then going forward. And then within those breakout sets, where you somewhat see because there is an increase in utilization of these types of products that are utilized for these particular diseases and the medications to treat those, actually do have multitude of indications for them now. Where before it was just rheumatoid arthritis. Now, they've branched out into a variety of different diagnosis.

TRUSTEE MCFADDEN: For the Crohn's disease, where it more than doubled this is because it's simply being broken up.

MS. GOERGES: Broken out and increasing in utilization because these therapies now are available for those that do suffer from Crohn's.

TRUSTEE MCFADDEN: So.

MS. GOERGES: It could be a compilation of both items because.

TRUSTEE MCFADDEN: This is not real helpful because we don't know that.

MR. LEVIN: It went from three to seven people so it's a small, very small number. It makes it look like a big percentage increase.

TRUSTEE MCFADDEN: That's helpful. Thank you.

MS. GOERGES: So increase of four utilizers year over year.

TRUSTEE MCFADDEN: Okay, so that arithmetic makes a little sense. Okay, great. Thank you.

MS. GOERGES: Sure. Any other questions on this and please when you have opportunity to review this, if you have additional questions just email us, we'll get back to you.

TRUSTEE MCFADDEN: Thank you.

MS. GOERGES: And then on the next time slide is really, you know, that's therapeutic classes of your specialty and what not. Now, we're really looking at your top 25 drugs overall.
So this is what you're seeing within the plan, and we're up at the top of the page again. These are by gross costs, not by utilization. And this is where you see, on the therapeutic class, you'll see numerous anti-diabetic agents and for the same reasons that Mike mentioned about the indications of these diabetic medications, the increase in the American Diabetic Association guidelines we'll continue to see an increase in these types of products being utilized and possibly, even indications outside of diabetes. And then, you'll see a mix in of antineoplastic because again, it's by gross cost so those would notably be seen. Any additional questions on this particular slide?

Next, then, is looking at your top therapeutic classes. And here, there wasn't, you know, again, year over year, there weren't too many significant changes to the environment of which the non-Medicare place. There were not too many nuances in between the two years. So not much, not many changes. And then just a note like antineoplastic, those are oncology medications. And then the psychotherapeutic and neurological agents that you see here at number 6, that's where like multiple sclerosis can fall, Alzheimer's medications may fall on here smoking cessation, sleeping disorders that's where that's the category of which that falls. Any questions?

Well, that's really it on the on the clinical side. And again, I could do a deep dive. I'm just very, you know, aware of the time that we have and I want to have it most useful of your time.

MS. TUCZAK: Thank you very much, Kathy.

TRUSTEE MCFADDEN: Thank you.

MS. GOERGES: Sure.

MR. HOGAN: So that concludes our non-Medicare portion of the presentation. Gina and team, was there anything that you would like our team to cover before we wrap?

MS. TUCZAK: No, I think that's great unless there's any question from any of the trustees. Great.

MR. HOGAN: Well, thank you very much for having us today. We appreciate the opportunity.

TRUSTEE MCFADDEN: Thank you.

TRUSTEE BLAIR: Thank you.

MS. GOERGES: Thank you, everyone. Have a great day.

TRUSTEE MCFADDEN: Next is UnitedHealthcare, Gina. Could you introduce?

MS. TUCZAK: Certainly. UnitedHealthcare will provide the next presentation. There's a materials in front of you. They provide the medical benefits for the plan, and there are four members of the UnitedHealthcare Service team to assist with this presentation. I think I'll start the presentation by turning this over to Craig Bartholomew, the Executive Director, UnitedHealthcare for our account. So Craig, if you want to begin? Again, we really appreciate your assistance in keeping this to 20 minutes. We are under a time constraint that we did not anticipate when we scheduled this meeting some time ago. Thank you.

MR. BARTHOLOMEW: We will do that and thank you very much for having us here. We're going to go through the material. Please ask us questions in whatever format you would like in terms of we can have follow up, we can have data available to answer your questions live. Anything that we cannot answer live right now, we will get back to you. So thank you again for your

business and your partnership. I will turn it over to Patty Prince.

MS. PRINCE: Thank you, Craig. I actually was just going to say the same thing. We wanted to start off by thanking you for your partnership over the years and thank you for continued business for 2021 and into the future. We've prepared a presentation to meet the expectations that were set, so I'm going to actually turn it over to Bethany Bump-White to jump right in with data.

MS. BUMP-WHITE: Great, thank you Patti.

I'm going to start on page 2 and just cover a couple data parameters before we jump into the actual information. So the current time period that we're covering today is incurred claims in 2020, with one month of run out, so claims were paid through the end of January of 2021. The prior period does mirror that incurred in 2019 also with one month of run out. We're going to talk a little bit later on the depth about catastrophic cases. We identify a catastrophic case as an individual with $100,000 or more in medical spend.

And with that, I'm going to move on to Page 3 to cover the executive summary. So at the very top of the page, we have a table that just highlights the historical performance for the total population as well as the three breakouts that we're going to talk about today - Medicare, the non-Medicare under 65 and

then the non-Medicare over 65. And so this is looking at their per member per month or PMPM rate from 2017 to 2020. And then when we start focusing in on the change from 2019 to 2020, we see that the Medicare cost on a per member per month basis decreased about 7.2% from the prior period. We see that the non-Medicare under 65 population decreased about 10% in the prior period and then the third population the non-Medicare over 65, their costs increased about 17.1% from the prior period. This cost increase was driven primarily by Neoplasm or cancer diagnosis, as well as conditions related to the digestive system. 2020 was really an interesting year because of COVID. We did see significant declines in utilization across our entire book of business and within your population we saw significant decreases in the use of inpatient admissions. We saw significant declines in the use of the emergency room and we also saw a reduction in outpatient surgeries. Neoplasms or cancer is your number one cost driver. It's impacting about 24% of your overall population. Another impact of COVID was a reduction in the number of surgeries, specifically spine and joint surgeries. They decreased about 19.9% compared to the prior time period. And one of the things that are really coming out of the pandemic is really an increased use of telehealth. We see about 16.8% of all your office visits, a combination of your medical and behavioral health visits occur via telehealth. Kind of diving

into that a little bit deeper, about 42.7% of behavioral health office visits were done via telehealth, about 19.4% of primary care visits were done via telehealth, and then finally about 13.2% of specialty office visit occurred via telehealth.

Any questions with the executive summary? If not, let's move on to Page 4.

Just to talk a little bit about demographics, what we have on this page is we've outlined for your whole population the number of annuitants on the plan, as well as the number of members as well as the average age and then the rows below then break out the three parts of your population; the non-Medicare over and under 65 as well as the Medicare population. So when we look at your overall population, we saw your population was relatively stable. You had just about a 0.6% increase in the number of annuitants, so 9,709 annuitants in 2020 and then about a 0.3% increase in the number of members so it's at 12,840. On the non-Medicare over 65, we saw a decrease in their population, non-Medicare under 65 actually increased both in the number of annuitants and number of members and then finally, Medicare. We saw a small reduction in the number of annuitants and in the number of members compared to 2019.

And then if we move on to Page 5, this kind of just highlights some financial metrics. Again, looking at your overall population and then the three breakouts. We're actually

giving you two metrics on this page. The first one where it says allowed PMPM, this is looking at the allowed cost on a per member per month basis, so that looks at what the plan paid plus what the member's paying out of pocket. So that's the first block in each of the rows, and then the second block is the paid PMPM. So this is just looking at the per member per month costs that the pension fund has paid so this is what we calculate your trend off of. So when we look at the very top line looking at the overall population, we saw that the plan paid amount actually decreased about 3.7% and then the rows underneath just highlight the trend numbers that we saw in the executive summary. The increase in over 65 of 17%, the under 65 decreased 10% and the Medicare decreasing 7.2% compared to 2019. Any questions about the financial metrics? If not, we'll move on to Page 6.

Kind of breakdown the trend that we're seeing in our population. So as I mentioned, the overall trend we're seeing is negative 3.7% so costs declined compared to what we saw in 2019. If we look at the graph on the far left hand side of the page, this is looking at what's impacting your population from a points of trend perspective, so some of the bars are shifting to the left, so those are going to be your trend mitigator so that's helping out your trend. So things like the decreased use of emergency room, the decrease in inpatient admissions, the

decrease in the number of surgeries and then the overall reduction in the benefit utilization. Those are all helping out your trend. The two bars that are shifting to the right are going to be your catastrophic cases, that's going to be an increase in the number of members hitting that $100,000 or more threshold, so that's pushing up your trend. And then the cost associated with those catastrophic members is also increasing compared to what we saw in 2019. So at higher number of catastrophic cases, a higher number hitting that threshold and a higher amount of spend for those particular cases, that sort of offsetting some of the decreased costs that we saw in your population in 2020. And then we shift over to the right hand side of the page, the top two boxes break out the percent change in the per member per month cost for your non-catastrophic population. Those costs decreased about 12.1% and then on the catastrophic side we saw an increase of about 16.2%. And then finally, the box at the bottom looks at the clinical categories that were having the largest impact on your trend. The number one category is what we call infectious and parasitic diseases, that increased about 100% compared to the prior time period. The biggest driver of that is going to be expenses related to COVID. And then, we did see decreases in musculoskeletal, other conditions, genitourinary, which is really kidney failure, and then we saw the increases in neoplasms or cancer spend.

TRUSTEE MCFADDEN: Are they also because of the COVID and people not acting on their ailments?

MS. BUMP-WHITE: In your population we did see some members with a chronic disease that did avoid care. Things like hemoglobin, A1C testing, lipid screening, which is cholesterol screening. We did see a decline in those activities. The one really positive thing that we saw, which was unusual, in your population is we saw actually a steady use of Wellness visits. Most other customers that we looked at had a significant decline in members seeking that Wellness visit. You actually held relatively steady, which was great to see.

TRUSTEE MCFADDEN: Thank you.

MS. BUMP-WHITE: You're welcome.

So we move on to Page 7. This just takes a high level look at the impact of COVID directly. This data is through April 6 of this year, and what we've seen is a total expenditure of about $3.3 million that are directly tied to confirmed COVID cases. About $13,000 of which is tied back to cost related to the vaccines. As of April 6 we saw about 4% of the population was partially or fully vaccinated. Now, this is going to be an undercount because this is only going to be based on claims data that was paid by the Pension Fund plan. So if a member for example, sought a vaccine through like a County Health Department, for example, we might not have a claim to be able to

count that member. So we would expect your true vaccination rate to be much higher than 4%.

Any questions about the COVID data? If not, we'll move on to Page 8.

As I mentioned, 2020 was an unusual year because of COVID. We did see significant declines in utilization across our entire book of business and we saw similar declines in your population specifically. So some of the metrics on the left hand side of the page highlight some of the impacts due to COVID. We saw about an 11.6% decline in the use of inpatient admissions. We saw about a 19% decline in outpatient surgeries, we saw about a 26% decline in the use of the emergency room. But as I mentioned in the metric in the first column, the very bottom, the use of Wellness visits per thousand, we actually saw a 2% increase in your population using Wellness visits. So that's fantastic to see. So members really valued and understood the value of getting that Wellness visit done and they continue to get some of that care despite the pandemic going on. One of the silver linings that we're seeing coming out of pandemic is really members embracing telehealth. If you look at the graph over on the right hand side of the page, we've actually looked at the difference in utilization between in person care, which is the dark blue color of the bars, and then the gold color which represents telehealth. And you can see starting around April, we

really saw a significant amount of the care happening via telehealth. About 50% of the visits in that one month are happening via telehealth. We see some drop off as the year goes on but we still see a relatively good portion of telehealth care even happening through December, the end of the year.

TRUSTEE BLAIR: I have a question about the telehealth. Do you think that's going to be a standard moving forward?

MS. BUMP-WHITE: I think in the behavioral health space in particular, I think people really have embraced telehealth much more so than we've seen in the medical. I still think there will be a portion of medical care that will happen via telehealth. I don't think telehealth is going away. I think we'll see a proportion of members keep utilizing it, but I think behavioral health will continue to see higher levels. I think people really like to be able to get the care in the, you know, in the comfort and the safety of their own home. So I think that will be, I think, a trend to see as a high proportion of visits and behavioral health happening via telemedicine.

TRUSTEE BLAIR: Thank you.

MS. BUMP-WHITE: You're welcome.

Any other questions with the COVID impact? If not, we'll look at page 9.

Looking at some of the clinical drivers. Where's the money going? What we have here is we've looked at your top five sorts

of broad clinical categories. Looking at the percent of spend that's impacted by each of these categories. And there's a line towards the bottom, it's kind of smaller print that says percent CC content. That's going to indicate the percent of spend in each of these categories driven by those high cost catastrophic cases. So for example, your number one clinical driver is Neoplasms or cancer. It's about 17% of your spend in 2020. In about 64% of the $10 million spent on cancer is due to those catastrophic cases. That specifically looking at you know, chemotherapy and radiation treatment, breast cancer, and secondary malignancy, those are the top drivers in the cancer category. And then as you move to the right, the cost decreased slightly. So circulatory is your number 2 category at about 15% of your spend. Musculoskeletal is third at about 11% of spend. Genitourinary is 8% of your spend in 2020, and then the final category is Injuries and Poisonings which is about 8% of spend in 2020. The big drivers in this category are some complications related to some surgeries. You had a major head injury and then a fracture of the lower limb that was complicated and required multiple surgeries to correct.

And then if we move on to page 10, what we've done here is sort of just narrowed the focus in a little bit for the clinical categories. Now, we're looking at individual conditions versus those big broad categories. So your number one condition in

terms of prevalence is hypertension or high blood pressure. About 38.3% a member on your population had that high blood pressure diagnosis, and the cost has increased compared the prior time period. Diabetes is your number 2 condition in terms of prevalence, about 28.4% of the population has a diabetes diagnosis. A little bit lower than the prior time period, but not a huge drop. Your third condition is back pain. About 8.4% of the population has a back pain diagnosis in 2020. That's about a 13% decline compared to the prior time period. And then your fourth most prevalent condition is what we call osteoarthritis, this is related to the joints. About 15.4% of the population has a joint related diagnosis in 2020 and we did see a slight uptick in the paid per claim amount for osteoarthritis.

Any questions on any of the clinical categories?

TRUSTEE MCFADDEN: The osteoarthritis, the cost per claim was at the average I guess $6,828.00, but the number of people using it is down and those are two separate figures, they stand alone?

MS. BUMP-WHITE: Correct.

TRUSTEE MCFADDEN: So the cost hasn't gone up because of the fewer bodies?

MS. BUMP-WHITE: Correct. So what sometimes happens is when prevalence drops like that, the people that are left are the

sicker individuals so that can cause that cost per person to increase slightly even though the number of people in the population has gone down.

TRSUTEE MCFADDEN: What is the percentage of the population in the whole country that's diabetic that would fall into this column?

MS. BUMP-WHITE: So about 10 to 11% of the country is diabetic so we're going to see an elevated number of members with diabetes in your population because your average age is going to be higher, so as age increases, we're going to see increased numbers of diabetic members.

TRUSTEE MCFADDEN: Taking into account the age, are we in the neighborhood of what the rest of the country is?

MS. BUMP-WHITE: You're probably a little bit higher than what we would expect based on the age mix of your population.

TRUSTEE MCFADDEN: A little. Okay, thank you.

MS. BUMP-WHITE: You're welcome.

So moving on to page 11, this now focuses in on those catastrophic cases, those individuals that had $100,000 or more in spend in 2020. This is really a very small subset of your population, so 105 individuals hit that catastrophic threshold, so it's about 0.8% of the population. But yet these 105 individuals are driving about 36% of the overall medical spend in 2020. The good news is, that we're reaching a very high

proportion in our clinical programs that Mike's going to talk about here in a minute. About 83% of the catastrophic cases were engaged in some kind of a clinical program. So these are individuals that are working with our nurses to try to improve their care and help reduce their spend. When we look over to the far right hand side of the page, this is looking at the top clinical categories that are driving spend for these 105 individuals. So the number one category is neoplasms or cancer and that increased to about $35 per member per month. And then your second category of circulatory system, injuries and poisoning, genitourinary, and in the final category is that infectious and parasitic diseases which is really driven by COVID.

And then if we move on to page 12, this is looking at the use of Wellness visits and looking at the use of cancer screenings. So if we look at the very first wheel at the very top left hand side of the page. This is looking at the percent of members that had a Wellness visit, so 72.4%. As I mentioned, you're holding relatively steady. Only about a 0.1 percentage change compared to the prior time period, which is great to see. Most customers that I look at when I look at this number, I've seen significant declines compared to prior data, so that's great to see that you're holding relatively steady. When we look at your mammography screening rates, they are at 81.3%. Again,

relatively steady compared to the prior time period. Cervical cancer screenings – here, we did see a bit of a drop off. Your down to about 47.6% that's down about 4% points. And then finally, colorectal cancer screenings that are at 51.1%. Here, we did see an increase of about 1.3 percentage points. So it's great to see that members are gravitating to getting that Wellness visits. We really do see, as we see higher rates of compliance around cancer screenings, we do see lower costs to the plan and we see better management of chronic conditions. Questions about the Wellness or cancer screening information? If not, I'll hand over to Mike Wall.

MR. WALL: Thank you, Bethany.

I'm going to just take a few minutes to talk about our clinical programs both from the moment that people call us. That's our advocacy category as noted on Page 13 to then the outbound calls that we make to the high risk members and then the targeted mailings we do. So 41% of your households are actually calling us, which we welcome because that's an opportunity for us to connect those calling with clinical programs that could be of value. Almost 24,000 total interactions and we count the emails, we count the mailings, and we count the phone calls both inbound as well as outbound. So our live, you know conversations telephonic, actually increased, which is good, particularly during a challenging year. We also saw an increase in just email

communication. Again, this is secure email where we get the Member's consent to communicate with them via email.

Yes, Mr. McFadden, did you have a question?

TRUSTEE MCFADDEN: I haven't seen an EOB in the mail in I can't remember. Now, isn't that part of our arrangement and if I am not mistaken and you have stopped doing it, can you speak to that please? Putting EOB's in the mail to the member.

MR. WALL: Yes, Mr. McFadden. I was really focused on the connections that we make on clinical programs. Patti, if you wanted to address the EOB's?

TRUSTEE MCFADDEN: Did you stop doing EOBs?

MS. PRINCE: No. So by registering on myuhc.com you may have at one point, agreed to go green, in which case you would have everything sent to you electronically versus receiving paper EOB's.

TRUSREE MCFADDEN: Okay. Thank you, Patti.

MS. PRINCE: No problem.

MR. WALL: So we really try and connect with members who are at high risk. So Bethany talked about the expensive conditions in your population, diabetics, people with cancer. And over 1000 people are now working with our Care Manager on a plan of care. Making sure they're, you know, identifying any symptoms that they're feeling, raising that with their doctors, so that we can prevent unnecessary admissions and emergency room visits. So

this is a really high rate of engagement by phone. We really appreciate the collaboration with Gina and her team to promote why United Healthcare is calling. And then we're also going to send mailings, and these mailings are very targeted based off the claims data that we have where we see a gap in care. And let me just give you an example of a gap in care. So if you're diabetic, you really should have an A1C test twice a year. And if we don't see 2 A1C tests within the 12 months, we will send a letter to you, very friendly, saying you know, it's important that you follow up and get tested and as Bethany indicated, some of the A1C tests were down. We're also going to send a letter from our Medical Director to their treating providers that we have on record and together, the members, annuitants, working with the providers, close the gap in care. And that gap closure rate was measured at 38% again, down slightly in 2020, which is consistent with our book of business, but not that much. But certainly, when you can close that gap in care you can prevent downstream medical costs. And then we also will send reminders on preventive screenings, primarily with Women's Health, in your population, 642 individuals. And then finally, helpful mailings on heart disease, diabetes, those are all programs within disease management where somebody is at low or moderate risk. They're doing all the all the right things. They don't need outreach from our care managers, but certainly keeping health in

their mind and giving them helpful reminders. So that's our member connections. If there are no questions, I'd like to focus on the next page.

TRUSTEE GOODE: Question.

MR. WALL: Sure.

TRUSTEE GOODE: About the 5% of individuals receiving 100% for Women's Health and that's the 642 individuals, is as a whole population that you have mailed, had the mailings go to?

MR. WALL: Right. And those who by virtue of their age and gender, needed a reminder around mammography's and cervical cancer screenings.

TRUSTEE GOODE: Okay, thank you.

MR. WALL: Yes, Thank you for your question.

If there are no further questions, I just wanted to focus on cancer, which was your top cost driver. And as Bethany indicated, it was a range of cancers from breast and lung to some rare cancers like head and neck and pancreas. Those rare cancers, however, can be expensive to treat, and so they often have, these members have specific needs related to their care and the Pension Fund has our Cancer Support program in place. These are Oncology-trained nurses, specialized in cancer who are outreaching and engaging with your members. 112 members received outreach and 74 are working with our care managers on their

cancer treatment. Again, focusing on those on active cancer treatment.

So I'm just going to move to the next slide if there are no questions. Touch a little bit about on diabetes slide number 15. So as Bethany indicated diabetes is number 2 in terms of the number of cases in your population. It is slightly higher than what we see given the age of your population. It's important to know that those people with diabetes also have other comorbidities - Heart disease, Hypertension, High Cholesterol. So we really want to address the whole person when we reach out to them and engage them with our programs both with phone and email. And you can see we made over 175 member connections. And then for those in end stage renal disease, we have a kidney resource services program. So again, those are folks on dialysis. 21 individuals, 17 enrolled in our programs where they're getting support from a trained nurse in dialysis. I appreciate the extra minutes, but I did want to spend a couple minutes on behavioral health. Bethany highlighted the shift to telehealth services. You can see that's well represented in the far right of slide 16 but with both the yellow and orange bars, we believe that telehealth, particularly from able health conditions is here to stay. There was an increase in anxiety in your population, understandable, given all the challenges during the last year. And, we want to really encourage, seeking our

behavioral health specialists because we know when early signs of anxiety and stress substance use disorder are addressed, it will mitigate longer term costs. Your overall spend is roughly about $7.00 PMPM, up slightly. Again, we view this as good spend to address concerns of the whole person and when you can address emotional health, behavioral health issues, we know it has a direct tie in to how you manage your physical health, your diabetes, and your heart disease. So I know I moved pretty quickly, but if there are any questions I'm happy to field any questions now.

TRUSTEE MCFADDEN: Thank you.

MR. WALL: Thank you.

So I'll now turn it to Craig who will close our presentation.

MS. TUCZAK: Great.

MR. BARTHOLOMEW: Thank you again for your time. We will be happy to answer any of the questions you send to us as follow ups and once again, we appreciate your partnership and working with you.

TRUSTEE MCFADDEN: Thank you. Thank you and I'm sorry, we pushed you a little faster than maybe you would have liked.

MR. BARTHOLOMEW: That's quite Okay.

MS. PRINCE: We appreciate your time. Thank you. Have a wonderful day.

TRUSTEE MCFADDEN: Thank you.

MR. BARTHOLOMEW: Take care.

MR. WALL: Goodbye.

TRUSTEE MCFADDEN: Dan from Siegel is here and he needs like 10 minutes. We're due upstairs at 10:30 AM, so we could ask him to come back during a regular meeting and summarize the year or we can do it now? There's a lot of us here, maybe it would be worthwhile to do it now.

TRUSTEE GOODE: Yes, I agree.

TRUSTEE MCFADDEN: If we keep someone waiting, it will only be the President.

MS. TUCZAK: President Wilson is on the Teams. Everybody is here except Trustee O'Rourke.

TRUSTEE MCFADDEN: Okay.

MR. LEVIN: So do you want me to do the 5 minute version?

TRUSTEE MCFADDEN: Yes, Dan.

MR. LEVIN: No problem, no problem.

So basically what we do with the April/May meetings, we do two things. We look at how the prior year came in comparative to what we originally projected and then we look at where our preliminary look at what the budget rate increases would have to be for 2022. So again, doing the five minute version we turn to Page 4, that is our look at the actual versus our projected and not surprisingly, you can see that things were more favorable than expected by about the $7.3 million, actual was $91 million,

after offsetting for all the rebates and government subsidies and everything, while projections were $98.2 million or 7.4% favorable difference and most of that is because of the COVID and you can see that very clearly if you look at the very first column called UnitedHealthcare Medical claims and you go down to April and May, you can see that those two months are very low compared to all the other months. And so that is the biggest portion of the difference. Then, when you also look and say, okay, let's say just for the number of contracts, which was a little bit smaller than we projected, it turns out to be a difference of 8.6% bottom line on the page. And again, that's mostly because of the COVID. So, you'll notice that there's a shaded area for that last quarter of rebates, it's yellow and bolded, informally $4,289,107. The reason that's shaded, what's actually being shown is equal to the third quarter number because we cannot find numbers for that so we could come in, you know, as much as a few $100,000 higher than that.

MR. WYSZOMIRSKI: Dan, I will stop you right there. We have received that by now, and the figure represents a 5% increase from what is illustrated on here. It should be about $4.5 million.

MR. LEVIN: $4.5. Okay. Alright, so there you have it. We will send out a corrected version as soon as we get the final numbers from CVS. But, bottom line is things came in more

favorable than expected because of the low utilization due to COVID.

TURSTEE MCFADDEN: What's an average contract?

MR. LEVIN: That's the number of contracts that you have that had coverage during the 2020 calendar year on average. It's different each month as people leave and go, but that's the average number you have.

TRUSTEE MCFADDEN: Contract, define?

MR. LEVIN: Oh, contract? It's an annuitant's, so they may have dependent or they may not have dependents.

TRUSTEE MCFADDEN: Are they "contacts"?

MR. LEVIN: No, as opposed to a belly button. So, in other words, you could be one contract, but would be 2 belly buttons if you have a spouse.

MS. TUCZAK: You're one contract.

TRUSTEE BLAIR: People utilizing the health plan?

MS. TUCZAK: Annuitants who elect health care coverage to our plan.

TRUSTEE MCFADDEN: So, why don't we just stick with contacts? No? Okay.

TRUSTEE BLAIR: It does not matter.

TRUSTEE MCFADDEN: You, guys?

MS. BURNS: Well, no I mean if you guys…

TRUSTEE MCFADDEN: Well, I mean, I've never seen it characterized like this or use the word contracts like that. That's not the connotation that it has so let's stick with contacts and then put an asterisk next to it if we have to expand on that a little. Okay?

MR. LEVIN: Okay.

So on the next page, the question everybody wants to hear is, well, what are we projecting for increases preliminarily on the gross rate for next year. That's on page 5. And remember that there's 4 different buckets we rate, and so there's the Medicare and non-Medicare and there's the Choice and the Choice plus plans. If you go over to the right under percent change in the next to last column of the table there, things are actually looking pretty good. The non-Medicare Choice Plan is a 3.7% increase, Medicare 0.7%. Choice Plus a little bit higher but still, not too bad. 6.1% for non-Medicare which is still lower than industry trend and then Medicare is 3.4%. So, everything is under four except for that Choice Plus non-Medicare, although that does only have 275 individuals covered in it, so it affects the least amount of people. Again, this is preliminary. We're going to have another five months of data when we do this in August. And again, this is the increase in the total rate, not the increase in what an annuitant or survivor pays. You know, those will change based on the proposal that was made at the

committee last year to gradually increase the cost-share percentages.

If there are any questions I know you're in a time crunch, submit them to Gina and I can make sure they get answered.

TRUSTEE MCFADDEN: Thank you, Dan.

TRUSTEE BLAIR: Thank you.

TRUSTEE MCFADDEN: Everyone, okay?

TRUSTEE BLAIR: Thanks for asking.

TRUSTEE MCFADDEN: Yeah, then we can, we could adjourn and head upstairs? There's a big turn out here. So, we're good now, Dan, right? Thank you.

Gina has an item. Could you speak to that please, Gina?

MS. TUCZAK: Certainly, yes. There is a specialty drug Imcivree, I hope I got that right, which is a new therapeutic class of pharmacy benefits. So it's the first drug of its kind and CVS has reached out to us for a decision on whether we want to include or exclude this drug from our pharmacy benefit program. The specialty drug is the first of its kind where it links a rare genetic condition, three rare genetic conditions to weight obesity. And, it's estimated by CVS that there are 150 to 2000 US residents that might have this condition. It's a specialty drug. So one year of usage is about $360,000 per person.

TRUSTEE GOODE: What's it called again?

MS. TUCZAK: Imcivree.

TRUSTEE MCFADDEN: Do you know if the weight gets down to where the doctor wants, is that the end of the expense or is it a maintenance drug too?

MS. TUCZAK: I can verify that. It's a maintenance drug. Genetic, it's a genetic condition.

MR. LEVIN: Yes, it's a maintenance drug.

TRUSTEE MCFADDEN: Well, okay. Thank you.

MS. TUCZAK: So, the therapeutic class is called rare genetic adipose tissue disorder and this is a situation that we had about six years ago. There was a new high cholesterol drug, a very specialized drug that came out and the same thing, it was the first of its class for a new therapeutic class. And, what was done at that time, which is what I recommend we do here, is that the plan exclude it. CVS can provide me some time, maybe end of the year, if we've had any members that have requested this drug to be filled. And, we can kind of assess if there's an interest in it, and by that time we'll have more information in terms of utilization, other information that might help us make a decision. This is a newly approved drug by the FDA. It is very expensive.

PRESIDENT WILSON: Gina? This is Lawrence, forgive me. I just wanted to jump in. I think I missed what diagnosis would this be prescribed for?

MS. TUCZAK: It's a rare genetic condition to manage weight obesity.

TRUSTEE MCFADDEN: Okay, Lawrence?

PRESIDENT WILSON: Yes.

MS. BURNS: It's called Adipose tissue disorder.

PRESIDENT WILSON: Okay, thank you.

MS. TUCZAK: In talking to Dan, many of his clients are electing to exclude it at this time and then just have a little bit more time pass and understand more of the utilization of the drug, how it's going to be, how it'll be commercialized and make a decision later to include it back in if that's the pleasure of the Fund. So, that's what I'm recommending at this time is that we go ahead and exclude it. I can revisit this, at the end of the year, see what type of other information's available and then we can make a decision to put it in if we'd like to do so.

TRUSTEE OCHALLA: At this time, we don't have a member that's asking for the doctors prescribing for this? This is just coming up as this is now available.

MS. TUCZAK: Right. That's correct.
They told me, CVS told me that in their entire book of business, they had 14 people in the State of Illinois, their entire book of business requests the drug.

MS. BURNS: One of the legal reasons why it would be prudent to exclude it at this point is because you do cover weight loss

drugs, you don't want confusion. You don't want members to think it's a weight loss drug versus it's a genetic drug. So if you give a clear direction that it's excluded, you can always deal with people that encounter that decision. You don't want confusion.

MR. LEVIN: Yes, statistically it's unlikely you're going to have any members that end up requesting this, but to the extent that you do that, you can investigate their genetic component in the medical necessity at that time which ever you recommend at that time.

TRUSTEE BLAIR: Reasonable.

TRUSTEE MCFADDEN: Okay, good?

TRUSTEE OCHALLA: Do you know if there is a time frame for this condition that I would hate there to be complications if we all of a sudden do decide to address it and then the member has complications because we have to go through our processes? Do you know the specific of that, or is that better suited for Dan?

MR. LEVIN: So prior to anyone being approved to get this drug, they would have to undergo genetic testing even if you did cover it. So, you know, they're going to have to get to a point where they do that genetic testing and show that they have it, the condition, and if they show that, then I think that would be what the committee would want to consider and determine whether it's covered. But what you don't want to do is just say you're

covering it, and then you know possibly have it used by people that don't actually have the condition.

TRUSTEE OCHALLA: Got it, okay.

TRUSTEE MCFADDEN: Okay, do we finish?

Please, motion to adjourn.

MS. BURNS: Maybe just to make the record clear, the motion to exclude that Imcivree as a specialty drug for the reason presented.

TRUSTEE MCFADDEN: Well, I would rather have a motion not to include.

MS. BURNS: Okay. Good, just so it's clear.

TRUSTEE GOODE: Motioned.

TRUSTEE MCFADDEN: Trustee Goode motioned, second by Trustee Ochalla.

TRUSTEE OCHALLA: I didn't second it, but I will.

(Chorus of ayes)

TRUSTEE MCFADDEN: We're going to put it down as a roll call. Everyone approved. Okay, please.

TRUSTEE GOODE: Motion to adjourn.

TRUSTEE MCFADDEN: Trustee Goode motions that we adjourn the meeting, second by Trustee Kouruklis.

All in favor of that idea.

(Chorus of ayes)

Thank you.