AGENDA
State and Public School Life and Health Insurance Board

September 20, 2016
1:00 p.m.

EBD Board Room – 501 Building, Suite 500

I. Call to Order ..........................................................Carla Haugen, Chairman

II. Approval of August 16, 2016 Minutes.......................Carla Haugen, Chairman

III. ASE-PSE Financials August, 2016...................... Marla Wallace, EBD Fiscal Officer

IV. Benefits Sub-Committee Report ... Shelby McCook, Board & Benefits Comm. Mbr.

V. EBD Wellness/AR Works PCP Visit Req....... Dr. Joseph Thompson, Director ACHI

VI. DUEC Discussion of Nasal Steroids .......................Dr. Geri Bemberg, UAMS

VII. Cost Effectiveness .................................................. Dr. Bradley C. Martin, Pharm D.

VIII. Director’s Report................................................. Chris Howlett, EBD Executive Director

Upcoming Meetings

October 18, 2016; November 15, 2016

NOTE: All material for this meeting will be available by electronic means only
ethel.whittaker@dfa.arkansas.gov. Notice: Silence your cell phones. Keep your personal
conversations to a minimum. Observe restrictions designating areas as “Members and
Staff only”
The 163rd meeting of the State and Public School Life and Health Insurance Board (hereinafter called the Board), met on September 20, 2016, at 1:00 p.m. in the EBD Board Room, 501 Woodlane, Suite 500, Little Rock, AR 72201.

**MEMBERS PRESENT**
- Carla Haugen - Chairman
- Katrina Burnett
- Shelby McCook
- Lori Freno-Engman
- Dr. Andrew Kumpuris
- Dan Honey – Vice-Chairman
- Dr. Joseph Thompson
- Angela Avery - Teleconference
- Dr. Tony Thurman

**MEMBERS ABSENT**
- Robert Boyd
- Janis Harrison
- Dr. John Kirtley
- Renee Mallory

Lori Eden, EBD Deputy Director, Employee Benefits Division

**OTHERS PRESENT:**
- Geri Bemberg, Dwight Davis, Brad Martin, UAMS; Ethel Whittaker, Matt Turner, Marla Wallace, Cecilia Walker, Lori Eden, Janna Keathley, Terri Freeman, Sherry Bryant, EBD; Kristi Jackson, Jennifer Vaughn, ComPsych; Pam Lawrence, AHH; Sylvia Landers, Minnesota Life; Drew Crawford, Sebco; Marc Watts, ASEA; Ronda Walthall, Wayne Whitley, AR Highway & Transportation Dept; Jessica Akins, Takisha Sanders, Health Advantage; Martha Hill, Mitchell Williams; Karyn Langley, Qual Choice; Mark Adkison, Stephen Carroll, Allcare; Andy Davis, Arkansas Democrat-Gazette; Allison Drennon; Insurance Advantage; Liz Tullos, WageWorks; Steve Althoff, Greg Jones, MTI; Sam Smothers, Astra Zeneca; Scott McRae, APSRC; David Kissia, AEA; Sean Seago, Merck; Martha Carlson, ABCBS; Elizabeth Whittington, Mike Motley, ACHI; Robyn Keene, AAEA; Randy Loggings, ACHI

**CALL TO ORDER:**
Meeting was called to order by Carla Haugen, Chairman
I. **APPROVAL OF MINUTES:** *by Carla Haugen, Chairman*

The request was made by Haugen to approve August 16, 2016, minutes.

**McCook made the motion to adopt the minutes. Freno-Engman seconded; all were in favor.**

Minutes approved.

II. **FINANCIALS:** *by Marla Wallace, EBD Fiscal Officer*

Wallace reported financials for August 2016. For August PSE, four (4) weeks of medical and pharmacy claims were paid. The FICA savings for the month is $468,971. There was a net gain of $2.09 million for the month, and $25.2 million year-to-date. Net assets available are $56.3 million.

For ASE for the month of August, four (4) weeks of medical and pharmacy claims were paid. The net gain was $2.09 million. The year-to-date net gain is $17.06 million. Net assets available are $17.4 million.

III. **Benefits Sub-Committee Meeting:** *by Shelby McCook, Benefits Committee Member*

**Topics Discussed:**

- August Financials
- EBD Wellness/Arkansas Works PCP Requirements

IV. **EBD Wellness/Arkansas Works PCP Requirements:** *by Dr. Joseph Thompson, Director, ACHI*

Language from the Arkansas Works Legislation on Wellness Visit Requirements is to promote health, wellness, and healthcare education about appropriate healthcare-seeking behaviors. In the legislation, 23-61-1005, as it was passed there are requirements for increased personal responsibility for individuals in the program to take steps to improve their health.

The legislation requires those above the federal poverty level have premiums to pay, and all persons will need to have a wellness visit with their primary care provider to receive additional benefits beyond the standard essential health benefit.

Dr. Thompson reported the Board has discussed over the past three (3) years, developing financial incentives to have individuals take more responsibility and seek preventive and wellness care to reduce their future health risk and the cost of the plan.
In the navigation of the Legislation process for continuation of the Medicaid expansion converting from the health-care independence program to the Arkansas Works Program; the legislation would possibly provide lower-income Arkansans with an incentive for themselves to have a wellness visit and preventive care. As a result, there is the potential to receive additional benefits. The legislation discussed the possibility of dental coverage as an added benefit.

Dr. Thompson reported a group of health-care professionals recently met to review the best possible strategies for the wellness programs. There were several options discussed.

The Board is in review for the 2018 plan year to decide if the premium differential would be continued or not, and what would be necessary to get a bonus incentive for taking the responsibility to improve your health.

To provide the best possible solution for the member's the following strategies were discussed:

- In addition to the on-line health risk appraisal, any contact with a clinical provider would serve as a wellness visit. The member would receive a premium discount. (EBD)
- Restrict the visit to only a primary care provider.
- Contact with the Attributing Primary Care Provider, which is selected by the Third Party Administrator.
- Require the member to provide a signed document from the physician that a wellness assessment was performed. This scenario could provide the most accurate result. However, administratively the most difficult to administer.
- There are a set of codes under the Affordable Care Act where co-pays are not assessed for a wellness visit.
- Biometric Screening (UALR)
- Establish new claims codes (Medicare)
- Create a new code for wellness only (South Carolina)
- Financial Incentives for additional benefits (Medicaid)

McCook has concerns regarding developing a new contract with a third-party administrator to manage the wellness plan.

Dr. Thurman reported the plan is not incentivizing for the wellness exam and members are penalized for not participating. Dr. Thurman also has concerns that members are waiting several days for responses to inquiries.
ARBenefits Plan Goals for Wellness Program/Visit Requirement

- Purpose:
  - "Created to reduce ever-increasing claims costs and encourage participants of the ARBenefits Plan to actively engage in their health and well-being."
- Background:
  - Wellness program was implemented in 2014
    - Members eligible for monthly premium incentive with completion of online health risk assessment and wellness visit
    - In 2015, only member was required to complete wellness requirements; As of 2016, covered spouses also must complete requirements
  - $75 monthly premium incentive was in place for 2015 and 2016 plan years; Board determines amount of wellness discount annually

V. DUEC UPDATES: by Dr. Geri Bemberg, UAMS

HIV Medications:

Dr. Bemberg reported previously two HIV medications Edurant and Complera, were not discussed at the last Board meeting. Dr. Bemberg recommended to continue coverage but remove the PA requirement. Dr. Kumpuris motioned to approve. Feno-Engman seconded; after discussion, all were in favor.

Motion approved.

Nasal Steroids:

Dr. Bemberg reported there are currently three nasal steroids available over the counter, with only one available for purchase on this plan. The previous proposal presented to DUEC recommended excluding all nasal steroids and azelastine from the formulary, resulting in a savings of $80,000/quarter or $320,000 per year. However, after conversations concerning azelastine, the recommendation was amended to continue covering azelastine products at Tier 1, resulting in a cost savings of $40,000/quarter. This was not passed by DUEC.

Based on current information, the recommendation is being amended again. Our new proposal is to continue coverage of this class and revisit in 6 months. Concerns include a large amount of member disruption with little savings, as well as the potential to shift members to a higher cost medication. The committee will reevaluate the class of medications in 6 months.

VI. Cost-effectiveness of Healthcare Interventions: by Dr. Bradley C. Martin, Pharm D.

<table>
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<tr>
<th>DOES COST EFFECTIVENESS REALLY MATTER?</th>
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<tbody>
<tr>
<td>- Guideline Developers Considering Cost Effectiveness</td>
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</tbody>
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Page | 4
Board Meeting
September 20, 2016
Surveys indicate 40-75% of plans use or plan to use cost-effectiveness in aiding decisions (Garber 2004, Bryan, 2009).

- National Institute for Clinical Effectiveness (NICE) in UK
  - They do not pay for drugs that cost more than £20,000-£30,000
- Canada and many other European countries consider cost effectiveness
- Medicare and PCORI are prohibited from using cost/QALY

**USING COST EFFECTIVENESS DATA**

Option 1. Establish a willingness to pay threshold or thresholds, which, if exceed would warrant lack of coverage of a medical intervention

Option 2. Allow reported and evaluated cost-effectiveness data to be presented, alongside clinical data, for coverage determination.
  - Weigh ICER information more for high budgetary impact medications

Option 3. Ignore cost-effectiveness considerations in decision-making

**WHAT IS A GOOD VALUE?**

- Technologies that DOMINATE others are CLEAR WINNERS
- Always choose LOWER COST and HIGHER EFFECT Technologies

- Most often a NEW Technology is MORE EXPENSIVE and MORE efficient

- Interpret the Incremental Cost Effectiveness Ratio (ICER)
  a. Very High Value
  b. $50k – 100 k/QALY
  c. High Value
  d. $50k – 150k/QALY
  e. Low Value
  f. >$150,000/QALY

- Who suggest three times the GDP per capita (~$150,000 per QALY in U.S.)

McCook has concerns that opiates could be over prescribed and contributing to new drug addictions. McCook questions should the Board have concerns and is there an action that needs to be applied? Dr. Thompson will provide legislative information relating to the issue at the next Quality of Care meeting.

Dr. Bemberg reported agencies are reviewing how you can limit the number of pills prescribed. Dr. Bemberg will provide additional information at the next Quality of Care meeting.
VII. DIRECTOR’S REPORT: by Lori Eden, EBD Deputy Director

Medical Management is in review at the legislative level. Active Health is the new vendor.

Open enrollment for State Employees concluded September 15, 2016. The division processed 2,280 enrollment forms, 4,600 phone calls, and assisted 88 walk-ins.

Public Schools open enrollment will kick-off October 1st and go through October 15th.

The Director continues to review options for the 2018 plan design and will provide an update at a future meeting.

Dr. Thurman questioned how many employees were available to process 4,600 calls? Eden reported there are twelve (12) call-center employees. In addition, employees of the accounting department assisted members who paid premiums.

Dr. Thompson motioned to adjourn. Haugen seconded; all were in favor.

Meeting adjourn.
### REVENUES & EXPENDITURES

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<th>Category</th>
<th>EMPLOYEE ONLY</th>
<th>EMPLOYEE + DEPENDENTS</th>
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<td>Funding</td>
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**Expenses**

- Medical Expenses
  - Claims Expense: $12,640,165
  - Claims IBNR: -
  - Medical Administration Fees: $1,075,952
  - Refunds: -
  - Employee Assistance Program (EAP): $55,580
  - Life Insurance: $54,233
- Pharmacy Expenses
  - RX Claims: $5,881,230
  - RX IBNR: -
  - RX Administration: $171,673
- Plan Administration: $341,330

**Total Expenses**: $20,220,163

**Net Income/(Loss)**: $3,941,469

### BALANCE SHEET

**Assets**

- Bank Account: $17,130,179
- State Treasury: $81,282,008
- Due from Cafeteria Plan: $5,195,886
- Due from PSE: $99
- Receivable from Provider: -
- Accounts Receivable: $1,119,712

**Total Assets**: $102,606,875

**Liabilities**

- Accounts Payable: $7,040
- Deferred Revenues: -
- Due to Cafeteria: $39,040
- Due to PSE: -
- Due to Federal Government ($44 fee): $119,712
- Health IBNR: $24,700,000
- RX IBNR: $1,800,000

**Total Liabilities**: $27,626,802

**Net Assets**: $74,980,072

**Less Reserves Allocated**

- Premiums for Plan Year 1/1/15 - 12/31/15 ($6,260,000 + $5,400,000): $(3,886,667)
- Premiums for Plan Year 1/1/16 - 12/31/16 ($3,600,000 + $12,600,000): $(16,200,000)
- Premiums for Plan Year 1/1/17 - 12/31/17 ($7,560,000): $(7,560,000)
- Premiums for Plan Year 1/1/18 - 12/31/18 ($5,040,000): $(5,040,000)
- Catastrophic Reserve (2015 $10,400,000): $(10,400,000)

**Net Assets Available**: $31,893,406

Fifth Week of Claims $0
### Arkansas State Employees (ASE) Financials - January 1, 2016 through August 31, 2016

#### EMPLOYEE ONLY

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<th>Plan Type</th>
<th>Actives</th>
<th>Retirees</th>
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#### EMPLOYEE + DEPENDENTS

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#### REVENUES & EXPENDITURES

**Funding**

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<th>Source</th>
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<th>Year to Date (8 Months)</th>
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<td>1 State Contribution</td>
<td>$14,702,184</td>
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<td>2 Employee Contribution</td>
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<td>3 Other</td>
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<td>4 Allocation of Reserves</td>
<td>$1,350,000</td>
<td>$10,800,000</td>
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<td><strong>Total Funding</strong></td>
<td>$24,074,746</td>
<td>$201,194,828</td>
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**Expenses**

- **Medical Expenses**
  - Claims Expense: $14,757,836, $115,496,288
  - Claims IBNR: $1,021,588, $8,694,702
  - Medical Administration Fees: $142,367, $9,194,272
  - Refunds: $1,350,000, $10,800,000

- **Pharmacy Expenses**
  - RX Claims: $5,496,320, $50,123,760
  - RX IBNR: $184,306, $1,510,593
  - RX Administration: $391,453, $4,030,751

- **Total Expenses**
  - $21,983,997, $184,131,693

**Net Income/(Loss)**: $2,090,750, $17,063,135

#### BALANCE SHEET

**Assets**

- Bank Account: $8,358,214
- State Treasury: $91,037,313
- Due from Cafeteria Plan: $5,018,599
- Due from PSE: $177,363
- Receivable from Provider: $5,018,599
- Accounts Receivable: $(563,221)

**Total Assets**: $104,028,267

**Liabilities**

- Accounts Payable: $1,253
- Deferred Revenues: $664,295
- Due to Cafeteria Plan: $28
- Due to PSE: $84
- Due to Federal Government ($27 fee): $664,295
- Health IBNR: $28,000,000
- RX IBNR: $1,700,000

**Total Liabilities**: $30,365,660

**Net Assets Available**: $73,662,608

- Premiums for Plan Year 1/1/16 - 12/31/16 ($3,600,000 + $12,600,000) = $(5,400,000)
- Premiums for Plan Year 1/1/17 - 12/31/17 ($7,560,000 + $13,770,000) = $(21,330,000)
- Premiums for Plan Year 1/1/18 - 12/31/18 ($5,040,000 + $8,262,000) = $(13,302,000)
- Premiums for Plan Year 1/1/19 - 12/31/19 ($5,508,000) = $(5,508,000)
- Catastrophic Reserve (2016 $10,700,000) = $(10,700,000)

**Fifth Week of Claims $0**
### Public School Employees (PSE) Financials - January 1, 2015 through August 31, 2015

#### REVENUES & EXPENDITURES

<table>
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<th>Funding</th>
<th>Current Month</th>
<th>Year to Date (8 Months)</th>
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<td><strong>$206,098,591</strong></td>
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#### Expenses

- **Medical Expenses**
  - Claims Expense | $15,552,738 | $111,358,983 |
  - Claims IBNR | - | - |
  - Medical Administration Fees | $1,496,529 | $12,453,683 |
  - Refunds | - | $(66,503) |
  - Employee Assistance Program (EAP) | $73,388 | $612,835 |
- **Pharmacy Expenses**
  - RX Claims | $3,819,840 | $30,320,007 |
  - RX IBNR | - | - |
  - RX Administration | $230,370 | $2,273,777 |
  - Plan Administration | $339,664 | $5,510,519 |
| **Total Expenses** | **$21,512,530** | **$162,463,301** |

Net Income/(Loss) | $668,921 | $43,635,290 |

#### BALANCE SHEET

**Assets**

- Bank Account | $10,286,315 |
- State Treasury | $88,679,540 |
- Receivable from Provider | - |
- Accounts Receivable | $8,344,102 |
- Due from ASE | - |
| **Total Assets** | **$107,309,958** |

**Liabilities**

- Accounts Payable | $983 |
- Due to ASE | $99 |
- Deferred Revenues | $577 |
- Due to Federal Government ($44 fee) | $1,613,216 |
- Health IBNR | $28,000,000 |
- RX IBNR | $1,400,000 |
| **Total Liabilities** | **$31,014,874** |

Net Assets | $76,295,083 |

Less Reserves Allocated

- Premiums for Plan Year 1/1/15 - 12/31/15 ($20,000,000 rec'd from Dept. of Education) | $(6,666,667) |
- Premiums for Plan Year 1/1/16 - 12/31/16 ($9,600,000) | $(9,600,000) |
- Premiums for Plan Year 1/1/17 - 12/31/17 ($5,760,000) | $(5,760,000) |
- Premiums for Plan Year 1/1/18 - 12/31/18 ($3,840,000) | $(3,840,000) |
- Premium Assistance (FICA Savings) | $(3,747,244) |
- Catastrophic Reserve (2015 $10,900,000) | $(10,900,000) |
| **Net Assets Available** | **$35,781,172** |

Fifth Week of Claims $0
Public School Employees (PSE) Financials - January 1, 2016 through August 31, 2016

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<td><strong>Funding</strong></td>
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<tr>
<td>Per Participating Employee Funding (PPE Funding)</td>
</tr>
<tr>
<td>Employee Contribution</td>
</tr>
<tr>
<td>Department of Education $35,000,000 &amp; $15,000,000 &amp; Other Funding</td>
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<tr>
<td>Other</td>
</tr>
<tr>
<td><strong>Total Funding</strong></td>
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| **Expenses** |
| Medical Expenses |
| Claims Expense | $16,689,049 | $128,873,475 |
| Claims IBNR | -$ | $2,000,000 |
| Medical Administration Fees | $1,585,694 | $13,111,411 |
| Refunds | -$ | |
| Employee Assistance Program (EAP) | $73,828 | $613,970 |
| Pharmacy Expenses |
| RX Claims | $3,700,481 | $32,525,296 |
| RX IBNR | -$ | $(300,000) |
| RX Administration | $257,927 | $2,179,252 |
| Plan Administration | $390,828 | $5,228,958 |
| **Total Expenses** | $22,697,807 | $184,232,362 |

| **Net Income/(Loss)** | $2,088,664 | $25,227,301 |

| BALANCE SHEET |
| Assets |
| Bank Account | $15,392,607 |
| State Treasury | $109,089,802 |
| Receivable from Provider | $-
| Accounts Receivable | $3,942,815 |
| Due from ASE | $84 |
| **Total Assets** | $128,425,308 |

| Liabilities |
| Accounts Payable | $2,889 |
| Due to ASE | $177,363 |
| Deferred Revenues | $303 |
| Due to Federal Government ($27 fee) | $1,010,826 |
| Health IBNR | $30,000,000 |
| RX IBNR | $1,100,000 |
| **Total Liabilities** | $32,291,381 |

| Net Assets | $96,133,927 |
| Less Reserves Allocated |
| Premiums for Plan Year 1/1/16 - 12/31/16 ($9,600,000 + $20,000,000 DOE + 18,100,000 DOE) | $(15,900,000) |
| Premiums for Plan Year 1/1/17 - 12/31/17 ($5,760,000) | $(5,760,000) |
| Premiums for Plan Year 1/1/18 - 12/31/18 ($3,840,000) | $(3,840,000) |
| Premium Assistance (FICA Savings) | $(3,881,786) |
| Catastrophic Reserve (2016 $10,500,000) | $(10,500,000) |
| **Net Assets Available** | $56,252,140 |

| Fifth Week of Claims | $0 |
Packet Contents

I. Arkansas Works Wellness Visit Requirements...............................................................p. 3
II. EBD Wellness Program Background.............................................................................p. 5
III. ARBenefitsWell Program Components.......................................................................p. 6
IV. Preventative Wellness Services/AHRQ Widget Screenshot.........................................p. 7
V. Private Option Interim Report Graph.............................................................................p. 9
VI. PCMH Attribution Methodology....................................................................................p. 11-13
VII. Medicare Annual Wellness Code................................................................................p. 15
VIII. South Carolina Example.............................................................................................p. 16
IX. Potential Options..........................................................................................................p. 17
Arkansas Works Wellness Visit Requirements
23-61-1005. Requirements for eligible individuals.

(a)(1) To promote health, wellness, and healthcare education about appropriate healthcare-seeking behaviors, an eligible individual shall receive a wellness visit from a primary care provider within:

   (A) The first year of enrollment in health insurance coverage for an eligible individual who is not a program participant and is enrolled in employer health insurance coverage; and

   (B) The first year of, and thereafter annually:

       (i) Enrollment in an individual qualified health insurance plan or employer health insurance coverage for a program participant; or

       (ii) Notice of eligibility determination for an eligible individual who is not a program participant and is not enrolled in employer health insurance coverage.

(2) Failure to meet the requirement in subdivision (a)(1) of this section shall result in the loss of incentive benefits for a period of up to one (1) year, as incentive benefits are defined by the Department of Human Services in consultation with the State Insurance Department.

Language from Arkansas 1115 Waiver Extension Application
https://www.medicaid.state.ar.us/Download/general/comment/ARWorksAppFinal.pdf

Incentivizing Timely Premium Payment and Completion of Healthy Behaviors

Arkansas seeks to encourage personal responsibility and further the objectives of the State’s Healthy, Active Arkansas initiative. Under Arkansas Works, Arkansas will create a new incentive benefit (e.g., dental services) for the new adult population. This benefit will only be available to enrollees who make timely premium payments (if required) and achieve healthy behavior standards.

- **Arkansas Works enrollees with incomes above 100% FPL.** Arkansas Works enrollees with incomes above 100% FPL who make three consecutive months of timely premium payments (i.e., within a 90-day grace period) will be eligible to receive an incentive benefit. To retain this incentive benefit, these enrollees must pay all premiums timely and must visit a primary care provider (PCP) during each calendar year (assuming at least six months of enrollment in Arkansas Works during that calendar year). For individuals covered through QHP premium assistance, carriers will monitor whether enrollees are paying premiums timely and whether individuals have visited a PCP. In the event that an individual enrolled in QHP coverage has failed to pay premiums timely or failed to see a PCP, carriers will inform Arkansas Medicaid. For individuals covered through ESI premium assistance, premiums will be paid through a paycheck.
EBD Wellness Program Background
ARBenefits Plan Goals for Wellness Program/Visit Requirement

• Purpose:
  o “Created in an effort to reduce ever-increasing claims costs and encourage participants of the ARBenefits Plan to actively engage in their own health and well-being.” (From EBD Website)

• Background:
  o Wellness program was implemented in 2014
    ▪ Members eligible for monthly premium incentive with completion of online health risk assessment and wellness visit
    ▪ In 2015, only member was required to complete wellness requirements; As of 2016, covered spouses also must complete requirements
  o $75 dollar monthly premium incentive was in place for 2015 and 2016 plan years; Board determines amount of wellness discount annually
<table>
<thead>
<tr>
<th>Wellness Visit Requirements</th>
<th>Eligible Screening Providers</th>
<th>Timeframe for Completion</th>
<th>Member Incentive</th>
<th>If Requirements Not Completed</th>
<th>Additional Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>An visit with PCP or specialist <strong>and</strong> completion of online health assessment; Must be conducted in office setting</td>
<td>PCPs can include specialists, APNs, PA’s, and other providers if they are in-network for the plan</td>
<td>Each wellness plan year is November 1 through October 31 for Jan. 1 effective date</td>
<td>Monthly premium incentive ($75)</td>
<td>No monthly premium incentive (both wellness visit and health assessment criteria must be met)</td>
<td>Health management program opportunities (American Health = Case Management Vendor, ComPsych = EAP/Wellness Coaching Vendor)</td>
</tr>
<tr>
<td>If an employee and covered spouse had an office visit between November 1, 2015—October 31, 2016 this counts as their wellness visit for 2017</td>
<td></td>
<td>Enrollment = Within 60 days hire or during open enrollment begins in September</td>
<td></td>
<td>Rate setting takes place by July of each year (for next calendar year)</td>
<td>Referrals to these programs determined based on claims data and</td>
</tr>
</tbody>
</table>
Preventative Wellness Services

It is the intent of the ARBenefitsWell program to encourage members to be actively engaged with their health care and specifically preventive services. The preventive services recommended by the United States Preventive Services Task Force are specific to age, gender, and certain risk factors such as tobacco use and sexual activity. Appropriate recommended preventive services are covered by ARBenefits at no cost to members (no deductible, co-pay, or co-insurance). Please use the widget below to find the services recommended to you and bring the list of "A" and "B" recommendations to your primary care physician. We also suggest bringing a copy of the results page from your Health Assessment provided by GuidanceResources®, and a list of medications currently prescribed to you.
Private Option Interim Report Graph
Table 4 compares utilization of ER measures for Medicaid and QHP enrollees in both the General Population and the Higher Needs population. Emergent and non-emergent ER visits were compiled using a commonly used New York University (NYU) algorithm. Unassigned ER visits include visits that the algorithm did not assign as emergent or non-emergent (including ER visits for psychiatric, alcohol and substance abuse, etc.).

On three of the four ER measures, a lower proportion of visits were made by QHP enrollees in the General Population and Higher Needs population compared to Medicaid enrollees. These include total ER visits (13.2 percent lower in the General Population and 50.8 percent lower in the Higher Needs population), non-emergent emergency room visits (58.1 percent lower in the General Population and 63.6 percent lower in the Higher Needs population), and unassigned ER visits (9.4 percent lower in the General Population and 67.0 percent lower in the Higher Needs population). For emergent ER visits, QHP enrollees had a higher proportion of use than Medicaid enrollees (122.1 percent higher in the General Population and 51.9 percent higher in the Higher Needs population).
PCMH Attribution Methodology
AR BCBS Patient Panel Attribution Methodology

From the PCMH Provider Manual 2016:

2c. Attribution of Patients (Patient Panel) Fully insured members will be assigned to a physician based on an attribution methodology that will include but not be limited to factors such as claims containing specific evaluation and management CPT codes (99201-99499), assignment through recent dates of service, the total allowed amount of the paid claims and a member PCP selection process.

If a member cannot be assigned based on paid claims or the member declines to select a PCP that member may be assigned to a participating clinic based on geographic proximity to the participating clinic. Members assigned to participating clinics but who have not established care at that clinic (no paid claims for E&M codes 99201-99499) will not be included in the patient panel of attributed members until the participating clinic is paid for an eligible E&M service code (99201 – 99499). For those members, care coordination payments will not be begin until the member has established care and the participating clinic has been paid for an eligible E&M service code (99201-99499).

Self-insured employers will independently choose to participate or not participate in the PCMH program. They will also choose the Care Coordination Payment amount for their members.
CMS Medicare FFS Patient Attribution Methodology

From CPC+ Request for Practice Applications: https://innovation.cms.gov/Files/x/cpcplus-rfa.pdf

Appendix E: Attribution Methodology
Beneficiaries will be aligned with the practice that either billed for the plurality of their primary care allowed charges, or that billed the most recent claim (if that claim was for CCM services) during the most recently available 24-month period. If a beneficiary has an equal number of qualifying visits to more than one practice, the beneficiary will be aligned to the practice with the most recent visit.

To be eligible for this initiative and aligned with a practice, beneficiaries must:

- Have both Medicare Parts A and B;
- Have Medicare as their primary payer;
- Not have end stage renal disease (ESRD) or be enrolled in hospice;
- Not be covered under a Medicare Advantage or other Medicare health plan;
- Not be institutionalized;
- Not be incarcerated;
- Not be enrolled in any other program or model that includes a shared savings opportunity with Medicare FFS initiative;
- Reside in one of the regions selected for this model;

For all beneficiaries who meet the criteria above, claims with the following qualifying CPT codes will be selected for the look-back period (the most recent 24 months) when the physician or practitioner specialty is internal medicine, general medicine, geriatric medicine, family medicine:

<table>
<thead>
<tr>
<th>Service</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office/Outpatient Visit E&amp;M</td>
<td>99201-99205</td>
</tr>
<tr>
<td></td>
<td>99211-99215</td>
</tr>
<tr>
<td>Complex Chronic Care Coordination Services</td>
<td>99487-99489</td>
</tr>
<tr>
<td>Transitional Care Management Services</td>
<td>99495-99496</td>
</tr>
<tr>
<td>Home Care</td>
<td>99341-99350</td>
</tr>
<tr>
<td>Welcome to Medicare and Annual Wellness Visits</td>
<td>G0402, G0438, G0439</td>
</tr>
<tr>
<td>Service</td>
<td>Code</td>
</tr>
<tr>
<td>-------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Chronic Care Management</td>
<td>99490</td>
</tr>
<tr>
<td>Services</td>
<td></td>
</tr>
</tbody>
</table>

The following information will be needed to conduct beneficiary alignment.
For a practice:
- Practice name;
- Practice Address (street, city, state, zip);
- Group Provider Transaction Provider Number (PTAN) (Group Provider Identification Number (PIN));
- Group National Provider Identifier (NPI) (If the practice is a solo practitioner, relevant Billing P-Tan or Individual Billing P-Tan/PIN information would be needed);
- Tax ID.

For each individual practitioner:
- Practice affiliation;
- Practice name;
- Individual NPI,
- Effective start date of participation;
- Effective termination date of participation.

CMS will provide each practice with a list of its claims-based aligned patients prior to the start of the initiative and each performance year. In addition, the beneficiary assignment algorithm will be run every three months with reports provided to the practice within 15 business days of the end of the look back period and applicable to payments starting 30 days after the end of the look back period.

Practices will be required to inform their patients in writing of their involvement in this initiative, and the changes their practice has made or is undertaking to provide comprehensive primary care and better serve their needs. Patients may opt out of data sharing.

At all times during the initiative, though Medicare beneficiaries will be attributed to a practice, they will remain free to select the providers and services of their choice and will continue to be responsible for all applicable beneficiary cost-sharing. CPC+ does not include any restrictions on or changes to Medicare FFS benefits, nor does it include provisions for beneficiaries to opt out of alignment with a participating practice for purposes of expenditure calculations and quality performance measurement.
Medicare Annual Wellness Visit Codes
Lung Cancer Screening Counseling and Annual Screening for Lung Cancer with Low Dose Computed Tomography


Coding, Diagnosis, and Billing

Coding

Use the following Healthcare Common Procedure Coding System (HCPCS) codes when filing claims for AWVs.

AWV HCPCS Codes and Descriptors

<table>
<thead>
<tr>
<th>AWV HCPCS Codes</th>
<th>Billing Code Descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0438</td>
<td>Annual wellness visit; includes a personalized prevention plan of service (PPPS), initial visit</td>
</tr>
<tr>
<td>G0439</td>
<td>Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit</td>
</tr>
</tbody>
</table>

Diagnosis

Since CMS does not require a specific diagnosis code for the AWV, you may choose any appropriate diagnosis code. You must report a diagnosis code.

Billing

Medicare Part B covers AWV if performed by a:

- Physician (a doctor of medicine or osteopathy);
- Qualified non-physician practitioner (a physician assistant, nurse practitioner, or certified clinical nurse specialist); or
- Medical professional (including a health educator, registered dietitian, nutrition professional, or other licensed practitioner), or a team of such medical professionals who are working under the direct supervision of a physician (doctor of medicine or osteopathy).

Who Can Get the AWV?

Medicare covers an AWV for all beneficiaries who are no longer within 12 months after the effective date of their first Medicare Part B coverage period and who have not gotten either an IPPE or an AWV within the past 12 months (that is, at least 11 months have passed following the month in which the IPPE or the last AWV was performed). Medicare pays for only one first AWV per beneficiary per lifetime and pays for one subsequent AWV per year thereafter.

Frequently Asked Questions (FAQs)

Is the AWV the same as a beneficiary's yearly physical?

No. The AWV is not a “routine physical checkup” that some seniors may get every year or so from their physician or other qualified non-physician practitioner. Medicare does not cover routine physical examinations.

Are clinical laboratory tests part of the AWV?

No. The AWV does not include any clinical laboratory tests, but you may make referrals for such tests as part of the AWV, if appropriate.

Do deductible or coinsurance/copayment apply for the AWV?

No. Medicare waives both the coinsurance or copayment and the Medicare Part B deductible for the AWV.

Can I bill an electrocardiogram (EKG) and the AWV on the same date of service?

Generally, you may provide other medically necessary services on the same date of service as an AWV. The deductible and coinsurance/copayment apply for these other medically necessary services.
2016 Preventive Screening Voucher

Employees, retirees, COBRA subscribers and their covered spouses, whose primary coverage is the State Health Plan, are eligible for one free preventive screening in 2016. If you are unable to attend a worksite or regional screening event, take this voucher and your State Health Plan ID card to a participating provider. For a list of providers, visit www.PEBAperks.com.

Present this voucher along with your State Health Plan insurance card to one of the participating providers and ask for the preventive screening. In addition to measuring your height, weight and blood pressure, the screening will also include a lipid panel (total cholesterol, HDL, LDL, triglycerides); chemistry profile (BUN and creatinine, glucose and electrolytes); and hemogram (red and white blood cell, hemoglobin and hematocrit). There will be no cost to you and test results will be mailed to your home within 14 business days.

Note to Provider: This screening is covered in full without member cost share for employees, retirees and spouses whose primary insurance is the State Health Plan. Please bill code 99420. If you have any questions, please contact BlueCross BlueShield of South Carolina at 800.444.4311.

EXPIRES DECEMBER 31, 2016

www.PEBAperks.com
Potential Options

1. Any outpatient contact with NCQA code or
2. Restrict only to primary care providers with NCQA code
3. Qualified health plans must attribute relationships and assess assigned provider/site
4. Only allow CPC/PCMH sites to be eligible; any visit would count towards requirement
5. Determine new wellness code to be used across both programs
6. From 9/16 meeting with Medicaid, QHPs, EBD and other stakeholders: Utilize ACA mandated preventive service codes (covered at no-cost to beneficiaries) as requirement for wellness visit.
COST EFFECTIVENESS OF HEALTHCARE INTERVENTIONS
BRADLEY C MARTIN, PHARM.D., PH.D.

DOES COST EFFECTIVENESS REALLY MATTER?

- Guideline Developers Considering Cost Effectiveness
  - ACC/AHA Task Force On Practice Guidelines
- AMCP Dossier
  - Includes Cost Effectiveness Evidence
  - Surveys indicate 40-75% of plans use or plan to use cost effectiveness in aiding decisions (Garber 2004, Bryan, 2009)
- National Institute of Clinical Effectiveness (NICE) in UK
  - They do not pay for drugs that cost more than £20,000 - £30,000 per QALY
- Canada and many other European countries consider cost effectiveness
- Medicare and PCORI are prohibited from using cost/QALY
TYPES PHARMACOECONOMIC AND HEALTH CARE TECHNOLOGY ASSESSMENT (HTA) STUDIES

- Budget Impact
  - Estimate plan or population expenditures with adoption of new technology

- Cost Effectiveness (CEA)
  - Cost Utility Analysis (CUA)

- Cost Minimization (CMA)

- Cost Benefit Analysis (CBA)

COST EFFECTIVENESS ANALYSIS

- Study Comparing the Costs and Effects of at Least Two Alternatives

Important Considerations

- Measure of Effectiveness
- Perspective
  - Who's Costs Do We Consider?
    - Payer or Society
- Time Frame
  - Lifetime, Year(s), Episode such as a hospitalization
- Study Methodology
  - Modeled Estimates Projected from Clinical Trials
  - Cost Effectiveness Alongside Clinical Trials
QUALITY-ADJUSTED LIFE-YEAR (QALY) OFFERS A COMMON CURRENCY IN ASSESSMENT OF HEALTH GAIN

Cost Effectiveness Models


Copyright © American Heart Association, Inc. All rights reserved.
Interpreting Effectiveness:
Considering clinical efficacy, safety and tolerability, estimate effectiveness (QALYs)

EBM: Does a new technology improve relevant patient outcomes?

Now Consider Costs

Cost ($) vs Effectiveness

Inferior: Higher Cost
Lower Effect

Higher Cost
Higher Effect

Lower Cost
Lower Effect

Superior: Lower Cost
Higher Effect
Effectiveness

Cost ($)

High extra cost
Low gain

Low extra cost
High gain

CE Threshold

Effectiveness

INCREMENTAL COST-EFFECTIVENESS RATIOS (ICERS)

Cost ($)

High extra cost
Low gain

Low extra cost
High gain

CE threshold

Effectiveness
WHAT IS A GOOD VALUE?

- Technologies that **DOMINATE** others are **Clear Winners**
  - Always Choose **Lower Cost** and **Higher Effect** Technologies
- Most Often a NEW Technology is **More Expensive and More Effective**
  - Interpret the Incremental Cost Effectiveness Ratio (ICER)
- **Very High Value**
  - <$50,000/QALY
- **High Value**
  - $50K-100K/QALY
- **Moderate Value**
  - $100K-$150K/QALY
- **Low Value**
  - >$150,000/QALY
- WHO suggests 3 times the GDP per capita (~$150,000 per QALY in U.S.)

INTPRETING COST EFFECTIVENESS RESULTS

<table>
<thead>
<tr>
<th>Table 2. Base Case Costs, Quality-Adjusted Survival, NMB, and ICERs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy</strong></td>
</tr>
<tr>
<td>---------------</td>
</tr>
<tr>
<td>Adjusted dose warfarin</td>
</tr>
<tr>
<td>Rivaroxaban</td>
</tr>
</tbody>
</table>

Abs dom indicates absolutely dominated; Ext dom, extendedly dominated; ICER, incremental cost effectiveness ratio; NMB, net monetary benefits; and QALY, quality-adjusted life years.
# CAUTIONS

- Most Cost Effectiveness Studies Use Models
  - Often take trial results of 6 months to a couple years and simulate lifetime costs and effects
  - Very few models are externally validated
  - Most models are a simplified representation of reality
    - Assumptions!!!
  - Models are only as good as the data they are based on
- Uncertainty
  - Sensitivity Analyses
  - Be mindful of comparator(s)
  - Proprietary driven studies and publication bias

# USING COST EFFECTIVENESS DATA

**Option 1:** Establish a willingness to pay threshold or thresholds, which, if exceed, would warrant lack of coverage of a medical intervention

**Option 2:** Allow cost effectiveness data to be presented, alongside clinical data, for coverage determination.

  *Weigh ICER information more for high budgetary impact medications*

**Option 3:** Ignore cost effectiveness considerations in decision making
## Nasal Steroids

<table>
<thead>
<tr>
<th>Product</th>
<th>Current Tier Placement</th>
<th>Proposed Tier Placement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veramyst (fluticasone)</td>
<td>Excluded</td>
<td>No change</td>
</tr>
<tr>
<td>Fluticasone</td>
<td>Tier 1</td>
<td>No change</td>
</tr>
<tr>
<td>Flonase Allergy Relief</td>
<td>RBP</td>
<td>No change</td>
</tr>
<tr>
<td>Triamcinolone Nasal</td>
<td>Excluded</td>
<td>Continue Exclusion</td>
</tr>
<tr>
<td>Nasacort Allergy 24Hr</td>
<td>Excluded</td>
<td>Continue Exclusion</td>
</tr>
<tr>
<td>Nasacort Allergy 24 Hr Children</td>
<td>Excluded</td>
<td>Continue Exclusion</td>
</tr>
<tr>
<td>Rhinocort Allergy</td>
<td>Excluded</td>
<td>Continue Exclusion</td>
</tr>
<tr>
<td>Budesonide Nasal</td>
<td>Excluded</td>
<td>Continue Exclusion</td>
</tr>
<tr>
<td>Astepro 0.15%</td>
<td>BPC</td>
<td>No change</td>
</tr>
<tr>
<td>Azelastine 0.1%</td>
<td>Tier 1</td>
<td>No change</td>
</tr>
<tr>
<td>Azelastine 0.15%</td>
<td>Tier 1</td>
<td>No change</td>
</tr>
<tr>
<td>Flunisolide</td>
<td>Tier 1</td>
<td>No change</td>
</tr>
<tr>
<td>QNasl</td>
<td>RBP</td>
<td>No change</td>
</tr>
<tr>
<td>QNasl Childrens</td>
<td>Excluded</td>
<td>Continue Exclusion</td>
</tr>
<tr>
<td>Beconase AQ</td>
<td>RBP</td>
<td>No change</td>
</tr>
<tr>
<td>Nasonex</td>
<td>RBP</td>
<td>No change</td>
</tr>
<tr>
<td>Mometasone</td>
<td>RBP</td>
<td>No change</td>
</tr>
</tbody>
</table>

## Histamine Antagonist

<table>
<thead>
<tr>
<th>Product</th>
<th>Current Tier Placement</th>
<th>Proposed Tier Placement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Astepro 0.15%</td>
<td>BPC</td>
<td>No change</td>
</tr>
<tr>
<td>Azelastine 0.1%</td>
<td>Tier 1</td>
<td>No change</td>
</tr>
<tr>
<td>Azelastine 0.15%</td>
<td>Tier 1</td>
<td>No change</td>
</tr>
</tbody>
</table>

## Cost Comparison

<table>
<thead>
<tr>
<th>Product</th>
<th>Rx Cost</th>
<th>OTC Cost w/o RBP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veramyst (fluticasone)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluticasone</td>
<td>$15</td>
<td></td>
</tr>
<tr>
<td>Flonase Allergy Relief</td>
<td></td>
<td>$22.47 (#120 sprays)</td>
</tr>
<tr>
<td>Triamcinolone Nasal</td>
<td></td>
<td>$122.53</td>
</tr>
<tr>
<td>Nasacort Allergy 24Hr</td>
<td></td>
<td>$17.96 (#120 sprays)</td>
</tr>
<tr>
<td>Nasacort Allergy 24 Hr Children</td>
<td></td>
<td>$12.94 (#60 sprays)</td>
</tr>
<tr>
<td>Rhinocort Allergy</td>
<td></td>
<td>$18.64 (#120 sprays)</td>
</tr>
<tr>
<td>Budesonide Nasal</td>
<td></td>
<td>$14.99 (#120 sprays)</td>
</tr>
<tr>
<td>Astepro 0.15%</td>
<td>AWP: $185.64</td>
<td></td>
</tr>
<tr>
<td>Azelastine 0.1%</td>
<td>$15</td>
<td></td>
</tr>
</tbody>
</table>
### Revised Proposal:

There are currently 3 nasal steroids available over the counter, with only one available for purchase on this plan. The previous proposal presented to DUEC recommended excluding all nasal steroids and azelastine from the formulary, resulting in a savings of $80,000/quarter or $320,000 per year. However, after conversations concerning azelastine, the recommendation was amended to continue covering azelastine products at Tier 1, resulting in a cost savings of $40,000/quarter. This was not passed by the DUEC.

Based on current information, the recommendation is being amended again. Our new proposal is to continue coverage of this class, and revisit in 6 months. Concerns include a large amount of member disruption with little savings, as well as the potential to shift members to a higher cost medication.

<table>
<thead>
<tr>
<th>Product</th>
<th>Plan:</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azelastine 0.15%</td>
<td>$21.81</td>
<td>$15</td>
</tr>
<tr>
<td>Flunisolide</td>
<td>$44.49</td>
<td>$15</td>
</tr>
<tr>
<td>QNasal</td>
<td>$103.94</td>
<td>$15</td>
</tr>
<tr>
<td>QNasal Childrens</td>
<td>Excluded</td>
<td></td>
</tr>
<tr>
<td>Beconase AQ</td>
<td>$26</td>
<td>$234.94</td>
</tr>
<tr>
<td>Nasonex</td>
<td>$26</td>
<td>$215.66</td>
</tr>
<tr>
<td>Mometasone</td>
<td>$26</td>
<td>$180.13</td>
</tr>
</tbody>
</table>