AGENDA

State and Public School Life and Health Insurance Board

March 31st, 2020

1:00 p.m.

EBD Board Room – 501 Building, Suite 500

I.	*Call to Order*	*Carla Haugen, Chair*
II.	*Approval of February Minutes*	*Carla Haugen, Chair*
III.	*EBD Financials*	*Bonnie Casey, EBD Comptroller*
IV.	*DUEC Report*	*Dr. Hank Simmons, DUEC Chair*
V.	*Quality of Care Subcommittee Report*	*Dr. John Vinson, QoC Chair*
VI.	*Diabetic Supplies/Options*	*Dwight Davis and Micah Bard, UAMS EBRx*
VII.	*Plan Update*	*Paul Sakhrani, & Courtney White, Milliman*
VIII.	*Director's Report*	*Chris Howlett, EBD Director*
IX.	*Adjournment*	*Carla Haugen, Chair*

2020 Upcoming Meetings:

April 14th, May 19th, June 17th

NOTE: All material for this meeting will be available by electronic means only

Notice: Silence your cell phones. Keep your personal conversations to a minimum.

STATE AND PUBLIC-SCHOOL LIFE AND HEALTH INSURANCE BOARD MEETING MINUTES

198th meeting of the State and Public-School Life and Health Insurance Board (hereinafter called the Board), met on March 31, 2020, at 1:00 PM via teleconference

Date | *time* 3/31/2020 1:00 PM | *meeting called to order by Carla Haugen, Chair*

Attendance

Members Present

Cindy Allen
Stephanie Lilly-Palmer
Greg Rogers
Dori Gutierrez
Cindy Gillespie
Dr. Terry Fiddler
Melissa Moore
Carla Haugen – Chair
Renee Mallory - Vice-Chair
Amy Fecher
Dr. John Kirtley
Dr. Lanita White
Lisa Sherrill
Herb Scott
Cynthia Dunlap
Chris Howlett, Employee Benefits Division Director

Members Absent

OTHERS PRESENT:

Rhoda Classen, Theresa Huber, Stella Greene, Shalada Toles, Laura Thompson, EBD; Oktawia DeYoung, Micah Bard, Dwight Davis, UAMS EBRX; Takisha Sanders, Jessica Akins, Jim Bailey, Health Advantage; Mike Motley, ACHI; Stephen Carroll, AllCare Specialty; Courtney White, Paul Sakhrani, Milliman; Frances Bauman, Novo Nordisk; Sean Seago, MERCK; John Vinson, APA; Jill Johnson, Sidney Keisner, UAMS; Todd Forwood, ConnectYourCare; Jim Chapman, Abbvie; Suzanne Woodall, Brent Flaherty, Medimpact; Nima Nabavi, Amgen; Charles Hubbard, ASP; Mitch Rouse, TSS; Robin Keene, AAEA; Daniel Faulkner; Sam Smothers, Endo Pharmaceuticals; Laurel Walrath; Mallinckrodt Pharmaceuticals

Approval of Minutes by Carla Haugen, Chair

MOTION by Dr. Kirtley:

Motion to accept the February 24, 2020 minutes.

DRAFT

Dr. White seconded; all were in favor.

Minutes Approved.

DUEC Report by Dr. Hank Simmons, DUEC Chair

The following report pertains to the DUEC meeting at 1:00 PM on Monday, March 2nd, 2020, with Dr. Hank Simmons presiding.

I. Old Business

A. DCWG Update: *Dr. Sidney Keisner, UAMS*

1. Lutetium Lu 177 dotatate (Lutathera)

FDA approved indication: Treatment of somatostatin receptor-positive gastroenteropancreatic neuroendocrine tumors (GEP-NETs), including foregut, midgut, and hindgut neuroendocrine tumors in adults.

Potential off-label uses: Treatment of somatostatin receptor-positive pheochromocytoma/paraganglioma

***Recommendation: Add PA to Lutathera. Cover only midgut NETs vs. all GEP NETs.**

The DUEC voted to adopt the recommendation as presented.

2. Androgen deprivation therapy

The DCWG looked at all agents for androgen deprivation therapy and found no evidence showing one agent to be superior to another for any disease state. Lupron, Zoladex, and Trelstar are the most commonly utilized agents (prostate and breast cancer).

No official recommendation, but the outcome of DCWG was to look at potential rebate opportunities in this class of agents.

DRAFT

B. Formulary Cleanup: *Dr. Micah Bard, UAMS*

1. Mupirocin

Label Name	Generic Name	Utilizing Member Count	Rx Count	Plan Pd/Rx	Mbr Paid/Rx	Plan Pd/Unit	Total Savings
Mupirocin 2% Ointment	Mupirocin	1,394	1,489	$1.37	$7.24	$0.06	
Mupirocin 2% Cream	Mupirocin	51	54	$241.90	$16.35	$10.25	$12,989
Totals					**Quarterly Savings**		**$12,989**
	Affected Members	**51**			**Annual Savings**		**$51,956**

***Recommendation: Exclude Mupirocin 2% Cream**

2. Tazarotene

Label Name	Generic Name	Utilizing Member Count	Rx Count	Plan Pd/Rx	Mbr Paid/Rx	Plan Pd/Unit	Total Savings
Tazorac 0.1% Gel	Tazarotene	1	1	$1336.46	$40	$13.36	$1,203.68
Tazorac 0.05% Cream	Tazarotene	7	7	$503.41	$56.50	$11.75	$2,594.41
Tazarotene 0.1% Cream	Tazarotene	9	15	$132.78	$35.20	$4.00	
Totals					**Quarterly Savings**		**$3,798.09**
	Affected Members	**8**			**Annual Savings**		**$15,192.36**

***Recommendation: Exclude brand-name Tazorac.**

3. Ketoconazole

Label Name	Generic Name	Utilizing Member Count	Rx Count	Plan Pd/Rx	Mbr Paid/Rx	Plan Pd/Unit	Total Savings
Xolegel 2% Gel	Ketoconazole	1	1	$582.49	$145.62	$12.94	$549.36

DRAFT

Ketoconazole 2% Cream	Ketoconazole	300	331	$33.13	$17.40	$0.64	
Ketoconazole 2% Shampoo	Ketoconazole	329	384	$9.65	$14.46	$0.08	
Totals					**Quarterly Savings**		**$549.36**
	Affected Members	**1**			**Annual Savings**		**$2,197.44**

***Recommendation: Exclude Xolegel 2% Gel**

4. Clobetasol

Label Name	Generic Name	Utilizing Member Count	Rx Count	Plan Pd/Rx	Mbr Paid/Rx	Plan Pd/Unit	Total Savings
CLOBETASOL PROP 0.05% FOAM	Clobetasol	11	15	$325.50	$19.76	$3.76	$3,544.05
CLOBETASOL EMOLLNT 0.05% FOAM	Clobetasol	1	2	$267.13	$15	$5.34	$355.80
CLOBETASOL PROP 0.05% SPRAY	Clobetasol	10	12	$256.35	$49.28	$2.27	$2005.44
CLOBETASOL 0.05% TOPICAL LOTN	Clobetasol	6	6	$211.79	$49.48	$3.08	$735.36
CLOBETASOL EMOLLIENT 0.05% CRM	Clobetasol	11	12	67.94	$33.48	$1.94	
CLOBETASOL 0.05% OINTMENT	Clobetasol	171	193	105.59	$17.43	$2.04	
CLOBETASOL 0.05% CREAM	Clobetasol	159	180	84.55	$19.90	$1.61	
CLOBETASOL 0.05% SOLUTION	Clobetasol	115	143	77.55	$22.33	$1.19	
CLOBETASOL 0.05% GEL	Clobetasol	2	3	$106.04	$15	$2.65	
Totals					**Quarterly Savings**		**$6,640.65**
	Affected Members	**28**			**Annual Savings**		**$26,562.60**

***Recommendation: Exclude Clobetasol Foam, Spray, and Lotion.**

5. Potassium Chloride

Label Name	Generic Name	Utilizing Member Count	Rx Count	Plan Pd/Rx	Mbr Paid/Rx	Plan Pd/Unit	Total Savings
POTASSIUM CL 20% (40 MEQ/15ML)	Potassium Chloride	3	5	$791.87	$21.00	$0.97	$3,871.62
POTASSIUM CL 20 MEQ PACKET	Potassium Chloride	7	9	$463.69	$46.79	$6.62	$4,072.20

DRAFT

POTASSIUM CL 10% (20 MEQ/15ML)	Potassium Chloride	19	36	$360.16	$17.90	$0.55	$12,716.63
POTASSIUM CL ER 10 MEQ CAPSULE	Potassium Chloride	531	983	$17.03	$18.51	$0.24	
POTASSIUM CL ER 10 MEQ TABLET	Potassium Chloride	945	1644	$10.72	$17.17	$0.17	
POTASSIUM CL ER 10 MEQ TABLET	Potassium Chloride	349	618	$10.71	$17.25	$0.18	
POTASSIUM CL ER 20 MEQ TABLET	Potassium Chloride	1260	2311	$9.76	$16.64	$0.16	
POTASSIUM CL ER 20 MEQ TABLET	Potassium Chloride	226	375	$8.72	$18.62	$0.16	
Totals					**Quarterly Savings**		**$20,660.45**
	Affected Members	**29**			**Annual Savings**		**$82,641.80**

***Recommendation: Reference Price Potassium Chloride solution and powder packs to tablets. The package insert of tablets provides instructions for dissolving in a glass of water.**

The DUEC voted to adopt the recommendations as presented.

C. Second Review of Drugs: *Dr. Micah Bard, Dr. Oktawia DeYoung, UAMS*

1. Lurasidone (Latuda):
   New evidence shows a lowered risk of hospitalization for certain patients with bipolar depression or schizophrenia with QT prolongation.

   ***Recommendation: Add to coverage T3PA**

2. Pegfilgrastim/Filgrastim:
   100% PA approval rate

   ***Recommendation: Remove PA requirement**

The DUEC voted to adopt the recommendations as presented.

II. New Business

A. New Drugs*: by Dr. Jill Johnson and Dr. Sidney Keisner, UAMS*

Brand	Generic	Recommendation
Non-Specialty Drugs		
(1) CONSENSI	AMLODIPINE BESYLATE/CELECOXIB	Exclude, Code 13
(2) TALICIA	OMEPRAZOLE/AMOXICILL/RIFABUTIN	Exclude, Code 12 & 13

DRAFT

(3) ABSORICA LD	ISOTRETINOIN, MICRONIZED	Exclude, Code 13
(4) CAPLYTA	LUMETEPERONE TOSYLATE	Exclude, Code 1
Specialty Drugs		
(1) GIVLAARI	GIVOSIRAN SODIUM	N/A Medical
(2) OXBRYTA	VOXELOTOR	Exclude, Code 1 & 10
(3) VYONDYS-53	GOLODIRSEN	Exclude, Code 1
(4) SECUADO	ASENAPINE	Exclude, Code 13
(5) PADCEV	ENFORTUMAB VEDOTIN-EJFV	Exclude, Code 2
(6) ENHERTU	FAM-TRASTUZUMAB DERUXTECN-NXKI	Exclude, Code 1 & 2
(7) ZIRABEV	BEVACIZUMAB-BVZR	Exclude Pharmacy; N/A Medical
(8) UBRELVY	UBROGEPANT	T4PA
(9) ESPEROCT	FVII REC, B-DOM TRUNC PEG-EXEI	T4PA
(10) AYVAKIT	AVAPRITINIB	Exclude, Code 1 & 2
(11) TEPEZZA	TEPROTUMUMAB-TRBW	Exclude, Code 8

The DUEC voted to adopt the recommendations as presented.

MOTION by Dr. Kirtley:

I motion to approve the recommendations as presented.

Dr. Fiddler seconded; all were in favor.

Motion Approved.

Quality of Care Subcommittee Update by Dr. John Vinson, Quality of Care Chair

Dr. Vinson provided an update on the Quality of Care meeting from March 10, 2020. There were two recommendations made by the Quality of Care committee, but they will be deferred until the wellness discussion at a later date.

Benefits Topics Discussed:
- Approval of Minutes
- ACHI Follow-up Update
- Director's Report

Discussion:

Haugen: I want to touch base on the motion to include the flu vaccination requirements as part of the wellness program. Are we going to bring this to benefits or right to the committee, the whole committee?

Howlett: The wellness discussion will take place between the Benefits and then the Board.

Haugen: In light of all that's going on right now, and not having a quorum for the last Benefits meeting, if there is not a quorum, can we bring this straight to the Board?

DRAFT

Howlett: Yes ma'am, that can be done.

Lilly-Palmer: Pharmacies do not participate in the Flu Shot Clinics. Are the shots that are no cost to most employees, at this time, with benefits? Even with other benefits, they are typically covered.

Dr. Vinson: There are certain places in the state where they've not been able to and other places where they regularly do. That was part of the discussion that some pharmacies have not been able to do that, because they've been told that the Health Departments are already doing that for us. While that's great, there might be opportunities to have multiple clinics if they're willing to do so to get those percentages up from 38%. And to the second part, yes, they are available at zero copays and billed through the state employees' benefit.

Diabetic Supplies/Options by Dwight Davis & Micah Bard, UAMS EBRx

Dr. Davis provided a presentation on the diabetic supply coverage policy evaluation.

Recommendations:

- Move coverage of all diabetes supplies (blood glucose test strips, lancets, syringes, pen needles) to the community pharmacies. (***Projected annual savings between $2,200,000 - $2,900,000***).
- Maintain monthly quantity limits on the blood glucose strips. (Currently, the quantity limit = 153 test strips/month)
- Require a contingency edit on blood glucose test strips: 120-day lookback period to identify antidiabetic medications before the supplies will be reimbursed. Otherwise, a prior authorization request is needed.
- Move the Dexcom products out of the medical (DME) benefit into the pharmacy benefit. Prior authorization policy will govern access. (***Projected annual Plan savings between $64,000 - $315,000 – depending on the level of member copayment applied***)
- Apply a copay of $80/30-day supply for Dexcom sensors.
- The implementation date of June 1, 2020

Discussion:

Haugen: Just so I have it clear, you're telling us that we have to provide the same supplies and rebate them to reduce the cost by 75%.

Dr. Davis: Yes.

Haugen: Okay, the Dexcom part, is that to reduce it close to zero almost?

Dr. Davis: It wouldn't be zero, but it would be significantly less than what we are currently paying.

Haugen: On the copay of $80, what are the members paying out of pocket now? I remember $350.

Dr. Davis: On the Dexcom, according to the data we have, it looks like the average copay or the out of pocket that the patients were paying was $350 per claim.

Haugen: So, now, it would be only $80 for a thirty-day supply.

Dr. Davis: That's correct.

Haugen: Would this affect the members on the retiree plan as well?

DRAFT

Dr. Davis: Yes, this would be non-Medicare. The people with prescription drug coverage under the plan, this would apply to them with an $80 copays or whatever copay you want to set. The retired teachers that are on Medicare would probably need to be left where they are, just because you have to be set up to be billed Medicare claims.

Scott: Are we talking about doing a duel system, or will this be a phased out Kannact system if we go over to the tier one implementation date?

Howlett: This would be a replacement of Kannact moving forward, basically doing more with less. This would bring down the cost. We spent about $2.9 million a year right now on the Kannact with the diabetics. We can serve more diabetics as well as have the diabetic supplies cost less. We can take the coaching and run that back through our relationship with HealthAdvantage, and have the disease management programs support that. While they are supporting that, typically, those with diabetes have other conditions, and they can pick up some other integrated healthcare for no additional cost.

Haugen: So now, instead of those who are enrolled and not enrolled, all will be connected under the same umbrella?

Howlett: That would be correct. It would be through a point of sale at the pharmacy, as well.

Scott: From my understanding, you could have an option of either no copay or possibly could set an appropriate amount.

Haugen: Right, if we set the copay at $80, what I understood Dr. Davis to say is that it would be less out of pocket than what they have now because the average right now is about $350. So, it would actually be lower for them on the copay side to have a copay.

Howlett: There are two parts to this, the Lancet supplies, needles, and all that was part one. There was a piece to that if it would be the pleasure of the Board, was to vote for a $15 copay, that would basically erase that $718,000 and put it at a complete wash. Part two with the Dexcom, with the utilizers represented on the chart, the part where on average, claim around $352 a month, and that was member responsibility. The two scenarios that Dr. Davis had given was a $40 scenario as a copay and an $80 copay in the scenario. So, the ask on the first part would be Lancet supplies and whether that would be the pleasure of the Board to adopt that. Then it would be to assign a $15 copay or not. It is the Board's choice on that and the same with the Dexcom on part two. That would be a $40 copay or an $80 copay.

Dunlap: The third recommendation is to require a contingency edit on blood glucose test strips. Can you explain what that testing is an antidiabetic medications? It says otherwise they wouldn't be eligible for reimbursement, and that's assuming that all diabetics are taking diabetic medication.

Dr. Davis: One of the reasons we would recommend the presence of an antidiabetic agent is one of the things that we've noticed, or I guess many of you may have noticed signs at intersections that say we buy diabetic test supplies. Strips are a valuable commodity, and we know that sometimes health plans that just pay for these things without any controls at all, they wind up on Craig's list or whatever the case might be for sale. We wanted to prevent or at least reduce the risk to the plan for people just buying these and reselling them. So, we wanted some type of an edit in place that they're on an antidiabetic agent that would be legitimately used or if the physician wants them testing for whatever reason and they're not on medication, then at least that's communicated to us, and we can do a prior authorization. We want to put them in the hands of the people who need them just to have some type of control built-in.

DRAFT

Dunlap: I was just asking because I know every diabetic does not take medication, but still have to do testing.

Dr. Davis: That's correct, not every diabetic will use those, but at least we would have some type of way to control the access to it.

Dr. Kirtley: I am just sitting here absorbing. I didn't realize that some of those meters were going completely through the medical side. I thought that we had almost all that in the Kannact system. The only thing that I would even wonder what the results from the Kannact approach are. Have they sent us an update of what they feel like they have accomplished?

Howlett: We have. There was some information provided to the Quality of Care, Benefits, and I believe the Board. When you look at the overall value, we saw that a lot of the individuals were using Kannact to order supplies. They were calling and counting a kind of a rudimentary coaching session to be able to order the supplies, and then we looked at their own definitions for participation, and we had under a thousand (under a third basically) of the population that was participating in the program actively. When you started looking at the numbers, that's where we started to get concerned. Dr. Davis and Dr. Bard started looking at how to leverage opportunities for the health plan for the participants that were not participating with Kannact. As they built that piece, we had several thousand outside of Kannact that did not want to participate. It was following through the normal plan design, but as we saw what we could do there, we started comparing the two numerically and for effect effectiveness, and we saw that this would be a more viable option for the health plan.

Dr. Kirtley: I know we had originally discussed the trial with the Kannact program. We had an issue in our plan that it was basically any kind of strips that you wanted. If we are going to take that on-again, limiting to strips that we know are a good value, for services overpaying for specific supplies, is going to be a big issue for us.

Dr. Davis: That was one of the issues that really wasn't what initiated this evaluation, but we were hearing that some patients were from Kannact were testing twenty times per day. We knew that wasn't the case, but what we found was that the quality of the supplies that we're requiring, such as needles not being sharp enough or the Lancets weren't able to do their job, and the strips were Bluetooth strips that were paired to the actual meter. So, there was just a lot of things that, from a supply standpoint, just didn't make sense. We thought we could optimize the value to the plan on at least exploring our own pathway. We didn't really even evaluate, at least for our portion, whether Kannact was what type of coaching they were doing or the effects of that. We were just trying to unwind those supplies from the coaching because we knew that there was a significant amount of money that could come back to the plan and we can also offer what I would consider the best in class supplies. One other thing is a newly diagnosed patient with diabetes winds up in the pharmacy with a new prescription for insulin or whatever the case is, the pharmacist wants to spend time with them to educate them on how to administer the insulin and then do the proper testing and then they can't even provide the testing supplies. It was kind of a continuity of care issues as well.

Dr. White: To understand this, if we did this, we would be offering the Accu-chek testing strips, is that correct?

Dr. Davis: Yes.

Dr. White: What would be the plan for those patients that don't have and Accu-chek meter? Is there a payment or a copay for them to get the new meter, or is that included?

DRAFT

Dr. Davis: No, there is no copay, and the meters are free.
Dr. White: Okay, so they would get that meter also at the pharmacy.
Dr. Davis: Yes.
Dr. White: Are those are in, you may or may not know this, but are those in good supply at this time where we wouldn't have to worry about back orders or unavailability of the meter?
Dr. Davis: We have no indication that there is a supply issue, but I think it's going to be key for us to implement some kind of wait until this pandemic is passed before we actually pull the trigger on it so that the supply issues won't be there.
Dr. White: It's actually a very good meter; about ten years ago, the VA switched all of their patients to those meters. They're very good, reliable meters, but I just wanted to make sure I understood moving our patients from what they have to an Accu-chek meter and how that would happen.
Haugen: I know this would take a vote. Do we want to have further discussion in another meeting, or do we want to try and make a decision here today?
Howlett: Today, the plan's request was to bring it to the Board for a vote.
Scott: Did I misunderstand, I thought you said something about sending this out to the Benefits to review as well?
Haugen: I think what I was asking on the Benefits side was if we needed to send this to the Benefits to discuss. Since we haven't been able to get a quorum in Benefits, I didn't know if we could do a joint meeting and invite them on a call to discuss it before bringing it to a vote. It will be dependent on whether we want to start this sooner or later since this is the first time, we're seeing this, I don't want to jump right in unless everybody is comfortable with it.
Fecher: I agree with what you're saying, and I believe that with the pandemic going on right now, it might be best to table this to get more information for the Board members.
Haugen: I agree, I think we have time to look at this. We are about to make decisions on a new plan year and stuff, that we could mix this in with some of our plan changes.
Dr. White: That seems like a reasonable proposal to me. I understand hesitation with what's happening in the nation and the world, but do we think anything would change our minds? What more information would we want to get?
Dr. Fiddler: Didn't he say that we would need to vote on it at this time to make things move on?
Haugen: Yes, we would have to vote on it at this time for them to move forward. We are going to start looking at the plan for the next year. So, my recommendation would be to hold this, but I can't make the motion.
Dr. Kirtley: I am with you; I think it's a little bit difficult for us to really look at this without it being in front of us to really pilfer through. I think even if we voted today, we're looking at a delay in the implementation for some time. I take from the Board of Pharmacy; we're watching some critical shortages on some medications and supplies that if we did try to throw this together in thirty days and say we had five hundred people that needed these meters. I don't really know what capacity there is for that, but I think it might be a little bit more conducive for us to get this presentation and be able to look at it further in-depth.
Haugen: Am I taking that as your motion to hold it?
Dr. Kirtley: Yes.
Scott: I will second that.
Dr. Fiddler: I will say that I am fine with this, but I don't think it will be a lack of equipment. I think it will be the distribution, because I just ordered forty to fifty and got them within three or for days, but that was three weeks ago. I am okay withholding it.

DRAFT

Howlett: We can table this if the Board members would send other questions to explore. The only other request that the plan would have, as we get through this pandemic, Lord willing we get through it sooner rather than later. That could actually increase the availability for people to be able to go out to the pharmacies and get the supplies. But in the meantime, we can table this as we go into rates and different things between now and the summer. The only request I would have from the plan perspective is that we not wait until 1-1-2021 to put it into effect as we could see some significant value and the cost savings for this.

Haugen: I am not saying we need to hold it until then, but we can bring it with the other discussions going forward. As you are monitoring this, if you or Dr. Davis see anything that the Board should come back and meet before our next meeting, then we have the opportunity to call emergency meetings.

Howlett: Yes ma'am, and we can also bring it back up to the Benefits subcommittee as well to entertain that motion. So, as I'm understanding, we are going to table this until a later date?

Haugen: I say bring it back to next month's agenda unless there are more pending items.

MOTION by Dr. Kirtley

I make a motion to table this until a later date.
Scott seconded. All were in favor.
Motion Approved.

Dr. Davis: I do have one other thing that is a COVID-19 issue. I wanted to at least explore having conditional approval by the Board. Since this thing has taken shape since the last DUEC meeting, one of the drugs that we anticipate significant use of in the treatment of respiratory illness is albuterol. It's a bronchodilator, and it's most commonly used in an inhaler or an updraft, but our plan covers albuterol in the form of ProAir. That's the brand that we cover on formulary, and we also cover generic albuterol inhalers. We have heard that there can be an anticipated shortage of albuterol inhalers. Since we cover only ProAir, as a brand, and a generic, there are two or three other brands, and also a product called Levalbuterol, or Xopenex. I have checked with Teva Pharmaceuticals, who makes ProAir, and they indicate that they're not aware of any shortage currently, but the concern is the supply chain going from the manufacturer to the wholesaler to the pharmacies. We are not currently receiving calls into our call center that have voiced concern over these shortages, but we're just trying to at least prepare for them. So, what we are asking is for approval to open the coverage up to any brand of albuterol inhaler. So, we could potentially pay for some of the brands that are not receiving rebates, but at least we wanted to make the supply available to our members if they absolutely needed, if the shortage occurs. The other thing is that we do not currently have a limit or a monthly supply limit on these inhalers. I know the Medicaid program has a two-inhaler per month (30-day limit). We would recommend that we place a two-inhaler per month limit on our albuterol inhalers to prevent stockpiling, but it would also provide adequate supplies for anyone who needs it. Beyond this recommendation, that could be something that we could keep in place from now on because of it being clinically appropriate. The second thing would be on opening up the formulary to allow any other albuterol product to be dispensed would be a temporary thing that we could assess as the COVID-19 situation improves.

Dr. Fiddler: I would so move to do that. But with that, do we cover inhaled corticosteroids?
Dr. Davis: Yes, we do.
Dr. Fiddler: I think they are not recommended to use on those with the Coronavirus and I just want to make sure that it doesn't go out there as an option yet, unless we are completely okay with that particular medication.

MOTION by Dr. Fiddler:
I would make a motion to take any generic that is market recognizable to use and make it available for our members.

Dr. Kirtley: I would say it's not just necessarily generics available. Due to supply chain issues and what the Pharmacist Association, the Board of Pharmacy, governor's office, the Department of Health, the Medical Society, and even some of the asthma allergy doctors are saying, if there's only one albuterol or Levalbuterol available, that we are all fine with the automatic substitution of that product, because there's really similar generics available. This stuff is getting snapped up quickly, so is the supply chain on this, this is the first product we've seen that is so stressed that if you've got any of them in some places, that's what you are going to have to go with. So, if you wouldn't mind an amendment.

Amended Motion by Dr. Fiddler:
Any of the albuterol products, no matter what the brand name is, we would accept that. Dr. Kirtley seconded.

Dunlap: Are we including the two-inhaler limit, or will that be a second motion, because I have a question on that.
Dr. Kirtley: It should still be the limit.
Dunlap: So, is that going to be two, and you said that you would want to extend that even beyond to make that a permanent change, or is it just because of the pandemic?
Dr. Kirtley: This should just be during the epidemic we face where we are having supply chain issues. With Dr. Davis at UAMS and the pharmacies, we should be able to tell when those issues resolve. I would not anticipate more than one fill of the alternative product. If they're having to use more than two inhalers within the month or two that we expect the supply chain to stabilize, they've got a bigger problem.
Dunlap: Well, the only reason I ask that is because if you were to go beyond just this period, people with children or people who travel, if they lose an inhaler or are out of town and they need an emergency inhaler and how would they be able to get on. Also, would they have to have an authorization from the doctors to get one?
Dr. Kirtley: They would be in the exact same shape they were in before this. This would allow them to get any other therapeutically equivalent product when there's a shortage of whatever product they may be seeking. But if they need another one later, they are going to have to come back to the pharmacy.
Dunlap: But in the past, you didn't have a limit on the inhaler, right?
Dr. Kirtley: I thought we had a two-inhaler limit.
Dr. Davis: No, John, we don't.
Dr. Kirtley: We should.
Dr. Fiddler: So, if I had been a member of this thing and I came back to the pharmacy once or twice a week, and I did that three or four weeks in a row, I could still fill out four or five inhalers for me per week if I so chose to get it?
Dr. Davis: No, the day supply would be stopped for an early refill, but if your physician allowed you to get three albuterol per month or something like that, or routinely, there is not a limit in

place to stop that. A standard of care with asthma would be an inhaled corticosteroid, and that should reduce the demand for albuterol. So, if you're required two hundred actuations per month, we have a bigger problem. 99% of the patients on this plan are sticking within one inhaler per thirty days. So, we don't have a widespread abuse. We primarily wanted to put that limit to prevent any stockpiling during this period of time.

RESTATING OF MOTION

MOTION by Dr. Fiddler:

I make a motion that whatever albuterol inhaler that would be available by the market for the patient would be allowable up to two inhalers for a thirty-day period for this plan. Dr. Kirtley seconded. All were in favor.
Motion Approved.

Plan Update by Courtney White & Paul Sakhrani, Milliman

Sakhrani and White provided an educational piece on claims payment processes and an update on plan experience for ASE and PSE.

ASE

- 2020 & 2021 projections updated to incorporate claims data incurred from January 2019 to December 2019 and paid through February 2020

- 2020 projected plan experience
  - Allocated reserves for 2020 is $25.1M
  - Estimated deficit of $9.6M
  - End of Year Assets: $62.0M
  - No plan changes / 5% increase in employee contributions
- 2021 plan experience
  - No additional funding ($14.5M allocated assets)
  - Projected deficit: $32.0M
  - End of Year Assets: $15.6M
  - No plan design or contribution changes
  - Increased membership based on historical patterns
  - Baseline trends (medical: 5%, pharmacy: 8%)

PSE

- Projections updated to incorporate claims data incurred from January 2019 to December 2019 and paid through February 2020

- 2020 plan experience
  - Allocated reserves for 2020 is $25.3M
  - Estimated deficit of $18.2M
  - End of Year Assets: $105.6M
  - No plan changes / 0% increase to employee contributions

DRAFT

- 2020 plan experience
    - No additional funding ($15.5M allocated assets)
    - Projected deficit: $57.1M
    - End of Year Assets: $33.1M
    - No plan design or contribution changes
    - Increased membership based on historical patterns
    - Baseline trends (medical: 7%, pharmacy: 8%)

Discussion:

Dr. Kirtley: It's going to be fascinating to see how COVID-19 and the lack of elective procedures, and a lot of other stuff, and how that's going to affect this in the long run versus people that are getting treated acutely for potential COVID-19 symptoms.

White: I think that's going to have an impact on 2020 and lessen the impact on 2021.

Director's Report by Chris Howlett, EBD Director

Howlett provided an update on what the plan has been doing related to COVID-19 and trying to support the governor's and secretary Smith's initiative in leading our state through this pandemic.

From the plan perspective, dealing with pharmacy, we have extended prior authorizations that were due to expire that would have some negative effect to our members. Those prior authorizations for some of the pharmaceuticals or the drugs would be extended April, May, and June, and part of that would bleed into July as well. What that would do is any drug that would need prior authorization for them to be able to get that drug, if they were to expire, then you'd have to go to your doctor and establish that. A lot of times, it's a lot more time to get that done than the simple request of signing the form and doing that. So, we made a decision to help the membership in that. A couple of other things; there's an early refill override. So, with that, typical drugs that you're trying to get filled a little bit too soon on some of the maintenance drugs and otherwise, we have overwritten that and anytime there is a member that goes into a pharmacy and tries to fill a drug, they would be able to fill that. Our support for that mechanism would be back in the EBRx call center where they handle a lot of the front-line questions, PA's, and all the other things related to the pharmacy benefit for the members. The last piece on the pharmacy is there's a signature log law that exists in a lot of states. We have one and found a provision in that that allows us to relax the signature law requirement as people venture out and go curbside or to a drive-thru window to decrease the potential exposure to the population in those settings. There's a code that Medimpact, our pharmacy benefits manager, has coded into the system, and when the script is being filled, they can enter that particular code in, and that will allow us to track what's being done. It will still allow the member to receive their medications and be medically compliant. On the medical side, we have worked very hard in and around increasing access to the membership with telemedicine options. As everyone's aware, we have the request for elected procedures to be decreased or not done. We have the opportunity to allow individuals not to be in the hospital or physician's office settings, to be able to still get assessed, treated, or evaluated. With that, we took our traditional telemedicine option that we have, and we worked out a relaxed piece that allows a decrease or elimination or relaxing of the patient and doctor relationship. This allows and affords the membership opportunities to be able to receive care via standard telemedicine, which is with a digital or videography or just the telephonic, which is handset to handset. Of course,

DRAFT

we also have opportunities that the governor and secretary Smith have put out, as well as EBD's own secretary, secretary Fecher, and several others in support of the UAMS initiative, and the Department of Health's initiative to get people assessed and checked out, or have questions answered via the website, the 800 number that's been provided, and/or the drive-thru testing that they're performing onsite.

MOTION by Scott:

I motion to adjourn the meeting.

All were in favor.

Meeting Adjourned.

DRAFT

State and Public School Life and Health Insurance Board
Drug Utilization and Evaluation Committee Report

The following report pertains to the DUEC meeting at 1:00 p.m. on Monday, March 2nd, 2020 with Dr. Hank Simmons presiding.

I. Old Business

A. DCWG Update: *Dr. Sidney Keisner, UAMS*

1. Lutetium Lu 177 dotatate (Lutathera)

FDA approved indication: Treatment of somatostatin receptor-positive gastroenteropancreatic neuroendocrine tumors (GEP-NETs), including foregut, midgut, and hindgut neuroendocrine tumors in adults.

Potential off-label uses: Treatment of somatostatin receptor-positive pheochromocytoma/paraganglioma

***Recommendation: Add PA to Lutathera. Cover only midgut NETs vs all GEP NETs.**

The DUEC voted to adopt the recommendation as presented.

2. Androgen deprivation therapy

The DCWG looked at all agents for androgen deprivation therapy and found no evidence showing one agent to be superior to another for any disease state. Lupron, Zoladex, and Trelstar are the most commonly utilized agents (prostate and breast cancer).

No official recommendation, but outcome of DCWG was to look at potential rebate opportunities in this class of agents.

B. Formulary Cleanup: *Dr. Micah Bard, UAMS*

1. Mupirocin

Label Name	Generic Name	Utilizing Member Count	Rx Count	Plan Pd/Rx	Mbr Paid/Rx	Plan Pd/Unit	Total Savings
Mupirocin 2% Ointment	Mupirocin	1,394	1,489	$1.37	$7.24	$0.06	
Mupirocin 2% Cream	Mupirocin	51	54	$241.90	$16.35	$10.25	$12,989
Totals					**Quarterly Savings**		**$12,989**
	Affected Members	**51**			**Annual Savings**		**$51,956**

***Recommendation: Exclude Mupirocin 2% Cream**

2. Tazarotene

Label Name	Generic Name	Utilizing Member Count	Rx Count	Plan Pd/Rx	Mbr Paid/Rx	Plan Pd/Unit	Total Savings
Tazorac 0.1% Gel	Tazarotene	1	1	$1336.46	$40	$13.36	$1,203.68
Tazorac 0.05% Cream	Tazarotene	7	7	$503.41	$56.50	$11.75	$2,594.41
Tazarotene 0.1% Cream	Tazarotene	9	15	$132.78	$35.20	$4.00	
Totals					**Quarterly Savings**		**$3,798.09**
	Affected Members	**8**			**Annual Savings**		**$15,192.36**

***Recommendation: Exclude brand-name Tazorac.**

3. Ketoconazole

Label Name	Generic Name	Utilizing Member Count	Rx Count	Plan Pd/Rx	Mbr Paid/Rx	Plan Pd/Unit	Total Savings
Xolegel 2% Gel	Ketoconazole	1	1	$582.49	$145.62	$12.94	$549.36
Ketoconazole 2% Cream	Ketoconazole	300	331	$33.13	$17.40	$0.64	
Ketoconazole 2% Shampoo	Ketoconazole	329	384	$9.65	$14.46	$0.08	
Totals					**Quarterly Savings**		**$549.36**
	Affected Members	**1**			**Annual Savings**		**$2,197.44**

***Recommendation: Exclude Xolegel 2% Gel**

4. Clobetasol

Label Name	Generic Name	Utilizing Member Count	Rx Count	Plan Pd/Rx	Mbr Paid/Rx	Plan Pd/Unit	Total Savings
CLOBETASOL PROP 0.05% FOAM	Clobetasol	11	15	$325.50	$19.76	$3.76	$3,544.05
CLOBETASOL EMOLLNT 0.05% FOAM	Clobetasol	1	2	$267.13	$15	$5.34	$355.80
CLOBETASOL PROP 0.05% SPRAY	Clobetasol	10	12	$256.35	$49.28	$2.27	$2005.44
CLOBETASOL 0.05% TOPICAL LOTN	Clobetasol	6	6	$211.79	$49.48	$3.08	$735.36
CLOBETASOL EMOLLIENT 0.05% CRM	Clobetasol	11	12	67.94	$33.48	$1.94	
CLOBETASOL 0.05% OINTMENT	Clobetasol	171	193	105.59	$17.43	$2.04	
CLOBETASOL 0.05% CREAM	Clobetasol	159	180	84.55	$19.90	$1.61	
CLOBETASOL 0.05% SOLUTION	Clobetasol	115	143	77.55	$22.33	$1.19	
CLOBETASOL 0.05% GEL	Clobetasol	2	3	$106.04	$15	$2.65	
Totals					**Quarterly Savings**		**$6,640.65**
	Affected Members	**28**			**Annual Savings**		**$26,562.60**

***Recommendation: Exclude Clobetasol Foam, Spray, and Lotion.**

5. **Potassium Chloride**

Label Name	Generic Name	Utilizing Member Count	Rx Count	Plan Pd/Rx	Mbr Paid/Rx	Plan Pd/Unit	Total Savings
POTASSIUM CL 20% (40 MEQ/15ML)	Potassium Chloride	3	5	$791.87	$21.00	$0.97	$3,871.62
POTASSIUM CL 20 MEQ PACKET	Potassium Chloride	7	9	$463.69	$46.79	$6.62	$4,072.20
POTASSIUM CL 10% (20 MEQ/15ML)	Potassium Chloride	19	36	$360.16	$17.90	$0.55	$12,716.63
POTASSIUM CL ER 10 MEQ CAPSULE	Potassium Chloride	531	983	$17.03	$18.51	$0.24	
POTASSIUM CL ER 10 MEQ TABLET	Potassium Chloride	945	1644	$10.72	$17.17	$0.17	
POTASSIUM CL ER 10 MEQ TABLET	Potassium Chloride	349	618	$10.71	$17.25	$0.18	
POTASSIUM CL ER 20 MEQ TABLET	Potassium Chloride	1260	2311	$9.76	$16.64	$0.16	
POTASSIUM CL ER 20 MEQ TABLET	Potassium Chloride	226	375	$8.72	$18.62	$0.16	
Totals					**Quarterly Savings**		**$20,660.45**
	Affected Members	**29**			**Annual Savings**		**$82,641.80**

***Recommendation: Reference Price Potassium Chloride solution and powder packs to tablets. Package insert of tablets provides instructions for dissolving in a glass of water.**

<u>The DUEC voted to adopt the recommendations as presented.</u>

C. <u>Second Review of Drugs: *Dr. Micah Bard, Dr. Oktawia DeYoung, UAMS*</u>

1. Lurasidone (Latuda):
   New evidence shows lowered risk of hospitalization for certain patients with bipolar depression or schizophrenia with QT prolongation.

   ***Recommendation: Add to coverage T3PA**

2. Pegfilgrastim/Filgrastim:
   100% PA approval rate

   ***Recommendation: Remove PA requirement**

<u>The DUEC voted to adopt the recommendations as presented.</u>

II. New Business

A. New Drugs: *by Dr. Jill Johnson and Dr. Sidney Keisner, UAMS*

Brand	Generic	Recommendation
Non-Specialty Drugs		
(1) CONSENSI	AMLODIPINE BESYLATE/CELECOXIB	Exclude, Code 13
(2) TALICIA	OMEPRAZOLE/AMOXICILL/RIFABUTIN	Exclude, Code 12 & 13
(3) ABSORICA LD	ISOTRETINOIN, MICRONIZED	Exclude, Code 13
(4) CAPLYTA	LUMETEPERONE TOSYLATE	Exclude, Code 1
Specialty Drugs		
(1) GIVLAARI	GIVOSIRAN SODIUM	N/A Medical
(2) OXBRYTA	VOXELOTOR	Exclude, Code 1 & 10
(3) VYONDYS-53	GOLODIRSEN	Exclude, Code 1
(4) SECUADO	ASENAPINE	Exclude, Code 13
(5) PADCEV	ENFORTUMAB VEDOTIN-EJFV	Exclude, Code 2
(6) ENHERTU	FAM-TRASTUZUMAB DERUXTECN-NXKI	Exclude, Code 1 & 2
(7) ZIRABEV	BEVACIZUMAB-BVZR	Exclude Pharmacy; N/A Medical
(8) UBRELVY	UBROGEPANT	T4PA
(9) ESPEROCT	FVII REC, B-DOM TRUNC PEG-EXEI	T4PA
(10) AYVAKIT	AVAPRITINIB	Exclude, Code 1 & 2
(11) TEPEZZA	TEPROTUMUMAB-TRBW	Exclude, Code 8

The DUEC voted to adopt the recommendations as presented.

Meeting Adjourned.

Respectfully submitted,

Henry F. Simmons, Jr., MD
Chair, DUEC

***New Drug Code Key:**

1	Lacks meaningful clinical endpoint data; has shown efficacy for surrogate endpoints only.
2	Drug's best support is from single arm trial data
3	No information in recognized information sources (PubMed or Drug Facts & Comparisons or Lexicomp)
4	**Convenience Kit Policy** - As new drugs are released to the market through Medispan, those drugs described as "kits will not be considered for inclusion in the plan and will therefore be excluded products unless the product is available solely as a kit. Kits typically contain, in addition to a pre-packaged quantity of the featured drug(s), items that may be associated with the administration of the drug (rubber gloves, sponges, etc.) and/or additional convenience items (lotion, skin cleanser, etc.). In most cases, the cost of the "kit" is greater than the individual items purchased separately.
5	**Medical Food Policy** - Medical foods will be excluded from the plan unless two sources of peer-reviewed, published medical literature supports the use in reducing a medically necessary clinical endpoint. A medical food is defined below: A medical food, as defined in section 5(b)(3) of the Orphan Drug Act (21 U.S.C. 360ee(b)(3)), is "a food which is formulated to be consumed or administered eternally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation." FDA considers the statutory definition of medical foods to narrowly constrain the types of products that fit within this category of food. Medical foods are distinguished from the broader category of foods for special dietary use and from foods that make health claims by the requirement that medical foods be intended to meet distinctive nutritional requirements of a disease or condition, used under medical supervision, and intended for the specific dietary management of a disease or condition. Medical foods are not those simply recommended by a physician as part of an overall diet to manage the symptoms or reduce the risk of a disease or condition, and all foods fed to sick patients are not medical foods. Instead, medical foods are foods that are specially formulated and processed (as opposed to a naturally occurring foodstuff used in a natural state) for a patient who is seriously ill or who requires use of the product as a major component of a disease or condition's specific dietary management.
6	**Cough & Cold Policy** - As new cough and cold products enter the market, they are often simply re-formulations or new combinations of existing products already in the marketplace. Many of these existing products are available in generic form and are relatively inexpensive. The new cough and cold products are branded products and are generally considerably more expensive than existing products. The policy of the ASE/PSE prescription drug program will be to default all new cough and cold products to "excluded" unless the DUEC determines the product offers a distinct advantage over existing products. If so determined, the product will be reviewed at the next regularly scheduled DUEC meeting.
7	**Multivitamin Policy** - As new vitamin products enter the market, they are often simply re-formulations or new combinations of vitamins/multivitamins in similar amounts already in the marketplace. Many of these existing products are available in generic form and are relatively inexpensive. The new vitamins are branded products and are generally considerably more expensive than existing products. The policy of the ASE/PSE prescription drug program will be to default all new vitamin/multivitamin products to "excluded" unless the DUEC determines the product offers a distinct advantage over existing products. If so determined, the product will be reviewed at the next regularly scheduled DUEC meeting.
8	Drug has limited medical benefit &/or lack of overall survival data or has overall survival data showing minimal benefit
9	Not medically necessary
10	Peer -reviewed, published cost effectiveness studies support the drug lacks value to the plan.
11	**Oral Contraceptives Policy** - OCs which are new to the market may be covered by the plan with a zero dollar, tier 1, 2, or 3 copay, or may be excluded. If a new-to-market OC provides an alternative product not similarly achieved by other OCs currently covered by the plan, the DUEC will consider it as a new drug. IF the drug does not offer a novel alternative or offers only the advantage of convenience, it may not be considered for inclusion in the plan.
12	Other
13	Insufficient clinical benefit OR alternative agent(s) available

State and Public School Life and Health Insurance Board
Quality of Care Subcommittee Summary Report

The following report resulted from a meeting of the Quality of Care Subcommittee meeting on Tuesday, March 10, 2020.

Topics Discussed:

- Approval of Minutes
- ACHI Follow-up Update
- Director's Report

Follow-up Update: Elizabeth Montgomery & Mike Motley, ACHI

Motley addressed follow-up questions from the last meeting and discussed the upcoming update of Health Wasted Calculator analysis.

Recommendations to the Board

MOTION by Brown:

I would like to make a motion that we recommend the Board that they include the flu vaccination requirement as part of the wellness program criteria and that the Board will determine at what level.
Bushmaier seconded. All were in favor.
Motion Approved.

MOTION by Brown:

I make a motion that we expand mass flu clinic access by expanding that beyond the Department of Health.
Murtha seconded. All were in favor.
Motion Approved.

Director's Report: Terri Freeman, EBD Operations Manager

Freeman stated that they had nothing to report.

Employee Benefits Division
Benefits Subcommittee

Diabetes Supply Coverage Policy Evaluation

April 10, 2020

Diabetes Test Supplies – Coverage Policy

- For members enrolled in EBD's "Diabetes Management Program", whether previously administered through Active Health Management or Kannact;
  - Type 1 or Type 2 diabetes diagnosis
  - Blood glucose strips, glucometer, lancets, syringes and pen needles covered with no copay
  - With prior program, all products were obtained through the member's pharmacy. With the Kannact program, all products are mailed directly to the member.
  - Both programs include some level of coaching.

- For members *not* enrolled in the program;
  - With the prior program, all products could be purchased at the pharmacy for a copay.
  - With the current model, only test strips can be purchased at the pharmacy for a copay. Other products (syringes, pen needles, and lancets) are excluded from coverage.

Plan Expenditures for Diabetes Supplies

- **Prior Program** -
  - In the last full 12-month dataset (CY 2018), the **total cost** of diabetes supplies (syringes, needles, lancets, test strips, glucometers) amounted to **$1,045,000** and involved approximately 1,100 members.
  - Of the total cost of $1,045,000, the total cost of test strips amounted to $487,445 with the EBD Plan paying $267,480 and members paying $220,000.
  - Prior program provided some level of coaching, but the fees associated with the coaching were included in the blended disease management charge.

- **Current Program** -
  - Through Kannact, all supplies are included in the monthly per-participant fee. EBD pays a monthly fee based on condition of member; $59.00, $69.00, or $79.00/month. Most participants are $79.00/month.
  - This cost includes supplies and coaching.
  - Currently 3,118 members enrolled with Kannact. Total current annual cost = $2,844,000 (~$76/participant/month)

Results of the Rebate Contract Bid Evaluation

Part One:

- Accu-Check Test Strips (Roche) chosen as the exclusive covered blood glucose strip. Blood glucose monitors are provided at no cost.
- TruePlus insulin syringes and pen needles chosen as the exclusive syringe/pen needle products.

Part Two:

- Dexcom brand chosen as the exclusive Continual Blood Glucose Monitoring (CGM) device.

Financial Impact to the Plan (rebate modeling) – Part One

Per-Utilizing-Member-Per-Month Cost for Diabetes Supplies			
Before		**After**	
Blood Glucose Test Strips	Blood Glucose Test Strips	Blood Glucose Test Strips w/free meter	Blood Glucose Test Strips w/free meter
Lancets	Lancets	Lancets	Lancets
Syringes	Pen Needles	Syringes	Pen Needles
$70.35	**$78.84**	**$16.53**	**$19.26**

The blended Total Cost per utilizing member ***before*** considering the rebate bid was approximately $78/month.

The blended Total Cost per utilizing member ***after*** considering the rebate bid is $19/month.

The net savings per utilizing member resulting from the rebate bid is $59/month.

Summary of Rebate Impact – Part One

Current Program - Kannact	
Number of participants	3,118
Total Annual Plan Cost (includes supplies & counseling and is based on $59, $69, or $79 per participant per month, depending on condition)	$2,844,000
Total Annual Member Cost	$0.00
Rebate / discount to Plan	$0.00
Net Annual Plan Cost	**$2,844,000**

Option #1 (Move supplies to local community pharmacy)	
Number of participants	3,118
Annual Supply Cost (assume $78 / utilizing member/month)	$2,918,000
Counseling Cost (through Health Advantage)	$0.00
Total Member Cost (no copay)	$0.00
Rebate / discount to Plan (Savings) Pre-rebate PMPM = $78 vs. Post-rebate PMPM = $19	$2,200,000
Net Annual Plan Cost	**$718,000**

Option #2 (Includes Option #1 PLUS)	
Add Co-pay for Supplies	Up to $15/Rx
Projected Annual Copay collected (Additional Savings)	$718,000
Net Annual Plan Cost	**$0.00**

Summary of Rebate Impact – Part Two

Current Coverage of Dexcom	
Number of utilizing members	522
Total # of Claims	2,472*
Total Plan Paid	$548,400 ($222/claim)
Total Member Paid	$869,000 ($352/claim)
Total Cost	**$1,417,400 ($574/claim)**

* Claims volume indicates extremely low compliance to sensor use

Note:

1. Dexcom is a wearable device classified as a continual blood glucose monitor (CGM).
2. Dexcom involves three (3) components; sensors, transmitter, and a receiver.
3. Dexcom is currently obtained through the medical benefit (durable medical equipment).

Option #1 – Move from Medical to Pharmacy Coverage	
Number of utilizing members	522
Total # of Claims	6,264*
Total *Projected* Plan Cost	$2,501,400
Total *Projected* Member Cost	$0.00
Net *Projected* Plan Cost (net of rebates)	**$1,604,000**

* Projected claims volume reflects 100% compliance to sensor use

Option #2 (Includes Option #1 PLUS)	
Add Co-pay of $40/30-day supply Net Plan Cost after co-pay	$250,500 **$1,354,500**
Add Co-pay of $80/30-day supply Net Plan Cost after co-pay	$501,100 **$1,103,000**
Total *Projected* Annual Member Savings	**$368,000 - $619,000**
Total *Projected* Annual Plan Savings (assuming a copayment is required)	**$64,000 - $315,000**

Recommendations:

- Move coverage of all diabetes supplies (blood glucose test strips, lancets, syringes, pen needles) to the community pharmacies. (***Projected annual savings between $2,200,000 - $2,900,000***).
- Maintain monthly quantity limits on the blood glucose strips. (Currently, the quantity limit = 153 test strips/month)
- Require a contingency edit on blood glucose test strips: 120-day lookback period to identify antidiabetic medications before the supplies will be reimbursed. Otherwise, a prior authorization request is needed.
- Move the Dexcom products out of the medical (DME) benefit into the pharmacy benefit. Prior authorization policy will govern access. (***Projected annual Plan savings between $64,000 - $315,000 – depending on level of member copayment applied***)
- Apply a copay of $80/30-day supply for Dexcom sensors.
- Implementation date of July 1, 2020 (*or at a reasonable future date given the current circumstances*)

Questions??

State of Arkansas Employee Benefits Division

Interim Monitoring Report

Through February 29th

State and Public School Life and Health Insurance Board of Directors

Courtney White, FSA, MAAA
Paul Sakhrani, FSA, MAAA

31 MARCH 2020

Milliman

Agenda

- Education – Claims Payment Process
- Arkansas State Employees (ASE)
  - Plan Experience
- Public School Employees (PSE)
  - Plan Experience
- Appendices
  A. Plan summary
  B. Assumptions / methodology
  C. Limitations & caveats

Claim Types

Incurred Claim

A claim for a procedure or service that has already occurred. Incurred claims are not always reported immediately.

Paid Claim

A claim that has been reported and paid.

Dollar Definitions

Billed Amount
- Amount charged by provider for care

Allowed Amount
- Maximum amount paid by insurer for care

Out-of-Pocket Cost
- Amount paid by insured for their care

Paid Amount
- Amount paid by insurer for care

Claims Processing

Incurred Claim

A person receives care from a provider and presents their insurance card.

Reported Claim

The provider bills the insurer for their services.

Paid Claim

The insurer pays the claim and bills the patient for any remaining balance.

Claim Payment – Example: Explanation of Benefits

Sally broke her foot and required surgery.

Her benefits:

- $1,000 deductible
- 20% coinsurance
- $6,000 out-of-pocket maximum

Description of Service	Billed	Contracted Rate	Deductible	Coinsurance / Copay	Total Patient Paid	Plan Paid
Surgical Center	$80,000	$20,000	$1,000	$3,800	$4,800	$15,200
Surgery	$10,000	$5,000	-	$1,000	$1,000	$4,000
Anesthesiologist	$2,000	$1,200	-	$200	$200	$1,000
Total	**$93,000**	**$26,200**	**$1,000**	**$5,000**	**$6,000**	**$20,200**

Claims Payment Processing - Considerations

Trend Analysis

Analyze trends using allowed / paid dollars on an incurred / paid basis

Cash Flow Projections

Determine future financial savings / costs using paid dollars

Plan Design Impact

Identify impact on benefits due to change in paid to allowed ratio

Incurred But Not Reported (IBNR)

Estimate future paid claims that have not been reported yet

Arkansas State Employees (ASE)

Executive Summary

- 2020 & 2021 projections updated to incorporate claims data incurred from January 2019 to December 2019 and paid through February 2020
- 2020 projected plan experience
  - Allocated reserves for 2020 is $25.1M
  - Estimated deficit of $9.6M
  - End of Year Assets: $62.0M
  - No plan changes / 5% increase in employee contributions
- 2021 projected plan experience
  - No additional funding ($14.5M allocated assets)
  - Projected deficit: $32.0M
  - End of Year Assets: $15.6M
  - No plan design or contribution changes
  - Increased membership based on historical patterns
  - Baseline trends (medical: 5%, pharmacy: 8%)

Total Plan Experience

Funding	2019	2020	2021
State Contribution	$ 173.61	$ 172.24	$ 172.24
Employee Contribution	97.45	99.66	100.34
Other	23.47	21.65	21.80
Total Income	$ 294.53	$ 293.55	$ 294.38
Medical Claims	$ (194.59)	$ (219.01)	$ (222.43)
Pharmacy Claims	(86.58)	(97.99)	(106.68)
Administration Fees	(18.30)	(17.35)	(17.47)
Plan Administration	(2.90)	(2.81)	(2.91)
Total Expenses	$ (302.37)	$ (337.16)	$ (349.48)
Program Savings	$ -	$ 8.96	$ 8.70
Net Income / (Loss) Before Reserve Allocation	$ (7.84)	$ (34.64)	$ (46.41)
Allocation of Reserves	$ 21.70	$ 25.08	$ 14.46
Net Income / (Loss) After Reserve Allocation	$ 13.86	$ (9.56)	$ (31.95)

Average Membership			
Active Employees / Pre-65 Retirees	47,720	46,897	46,897
Post-65 Retirees	13,346	13,829	14,243
Total Enrolled	61,067	60,725	61,140

Total Income PMPM[1]	$ 431.54	$ 437.27	$ 420.94
Total Expenses PMPM[2]	$ (412.62)	$ (450.38)	$ (464.49)

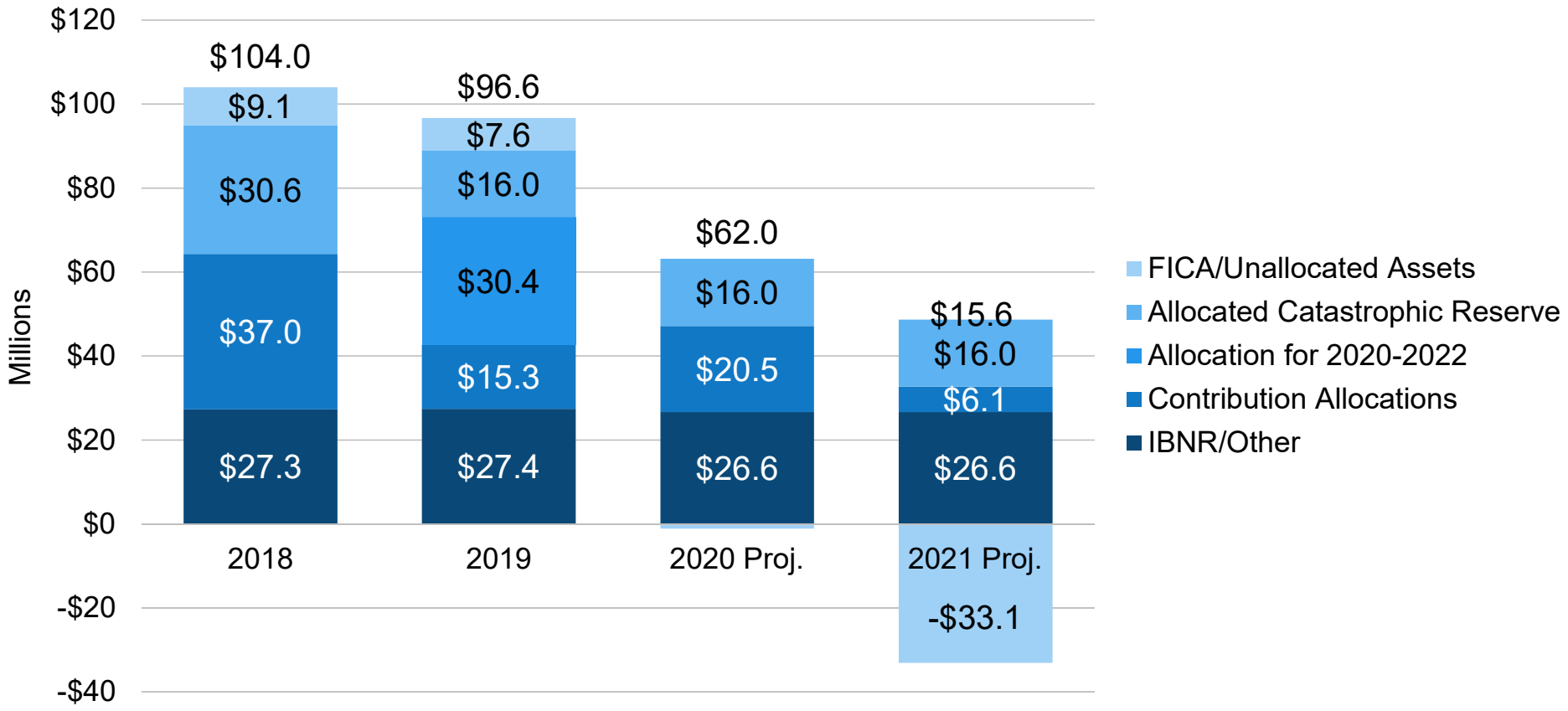
[1] Allocation of Reserves included in Total Income

[2] Total Expenses offset by Pharmacy Program

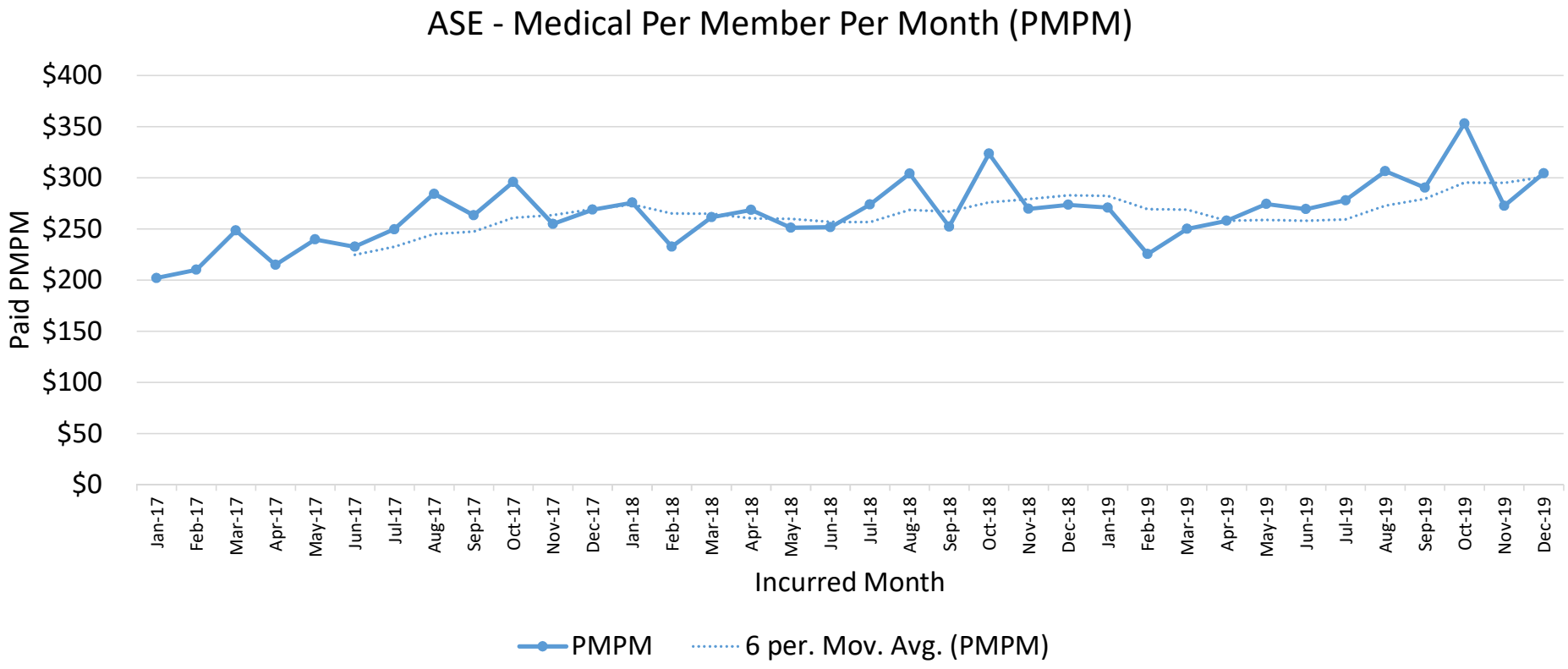
Projected Assets: 2019 – 2021

Development of 2021 End-of-Year Assets			
(a)	2019	End-of-Year Assets	$96.6
(b)	2020	Total Income	$293.6
(c)		Total Expenses	($328.2)
(d)		Allocated Assets	$25.1
(e) = (b) + (c) + (d)		Total Surplus / (Deficit)	($9.5)
(f) = (a) - (d) + (e)		End-of-Year Assets	$62.0
(g)	2021	Total Income	$294.4
(h)		Total Expenses	($340.8)
(i)		Allocated Assets	$14.5
(j) = (g) + (h) + (i)		Total Surplus / (Deficit)	($31.9)
(k) = (f) – (i) + (j)		End-of-Year Assets	$15.6

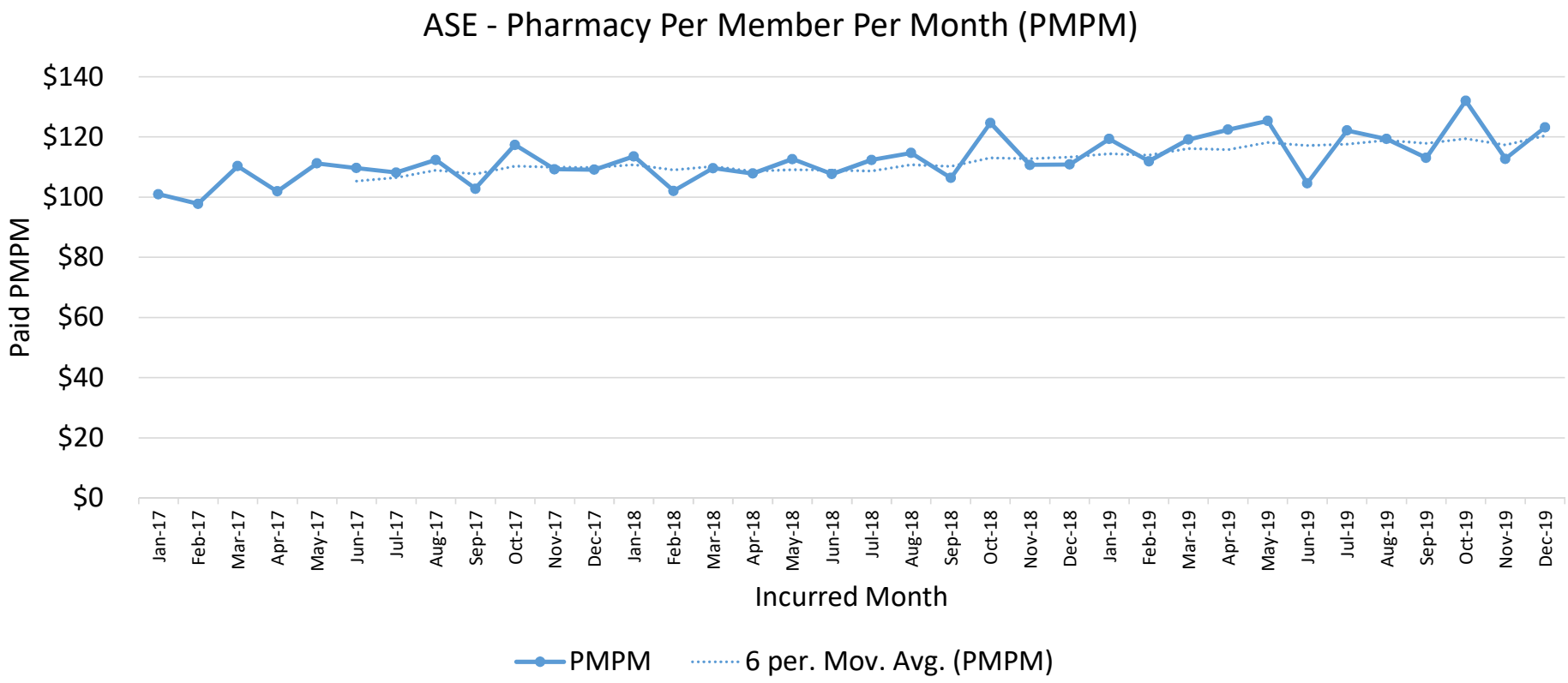
End of Year Assets



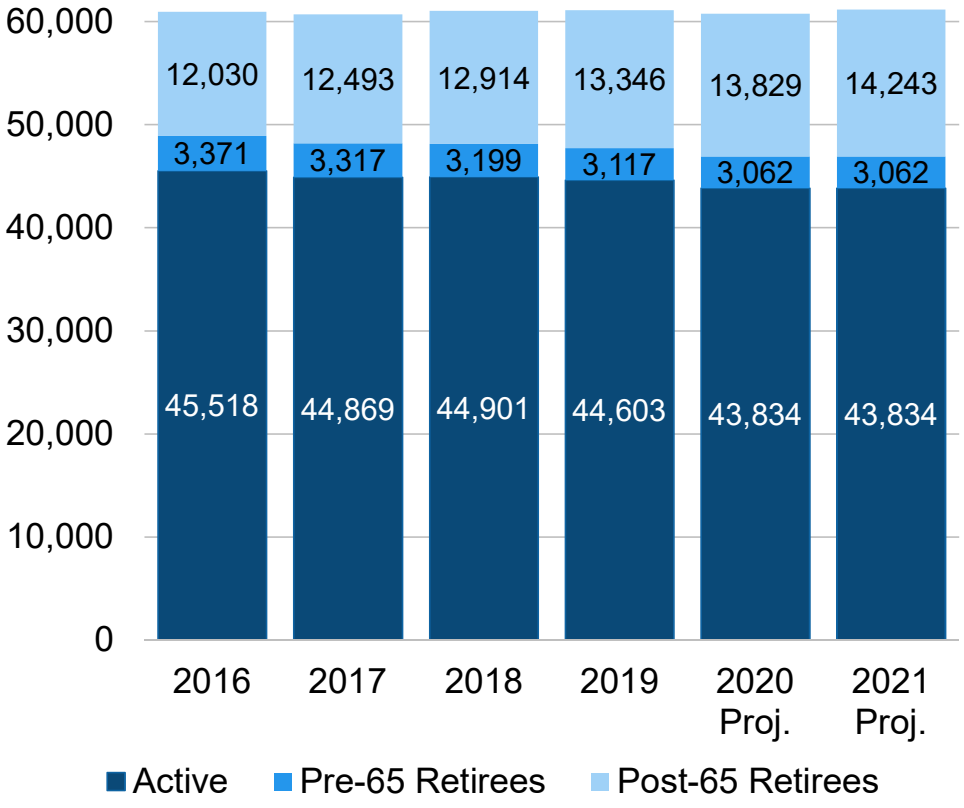
Monthly Trend - Medical

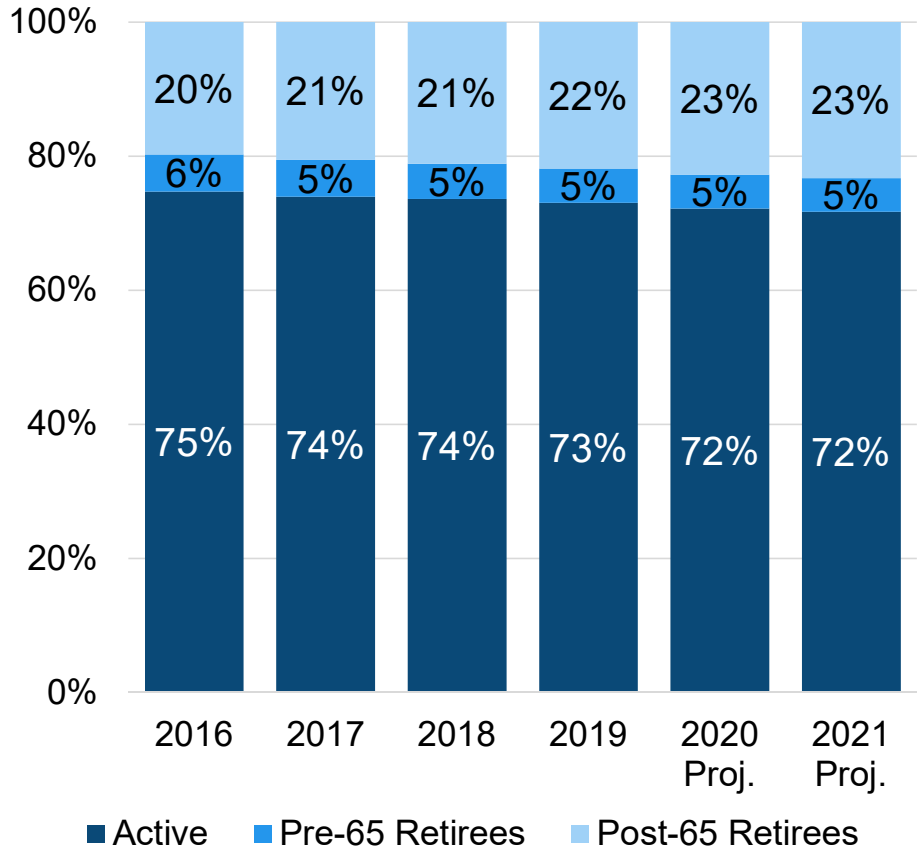


Monthly Trend - Pharmacy

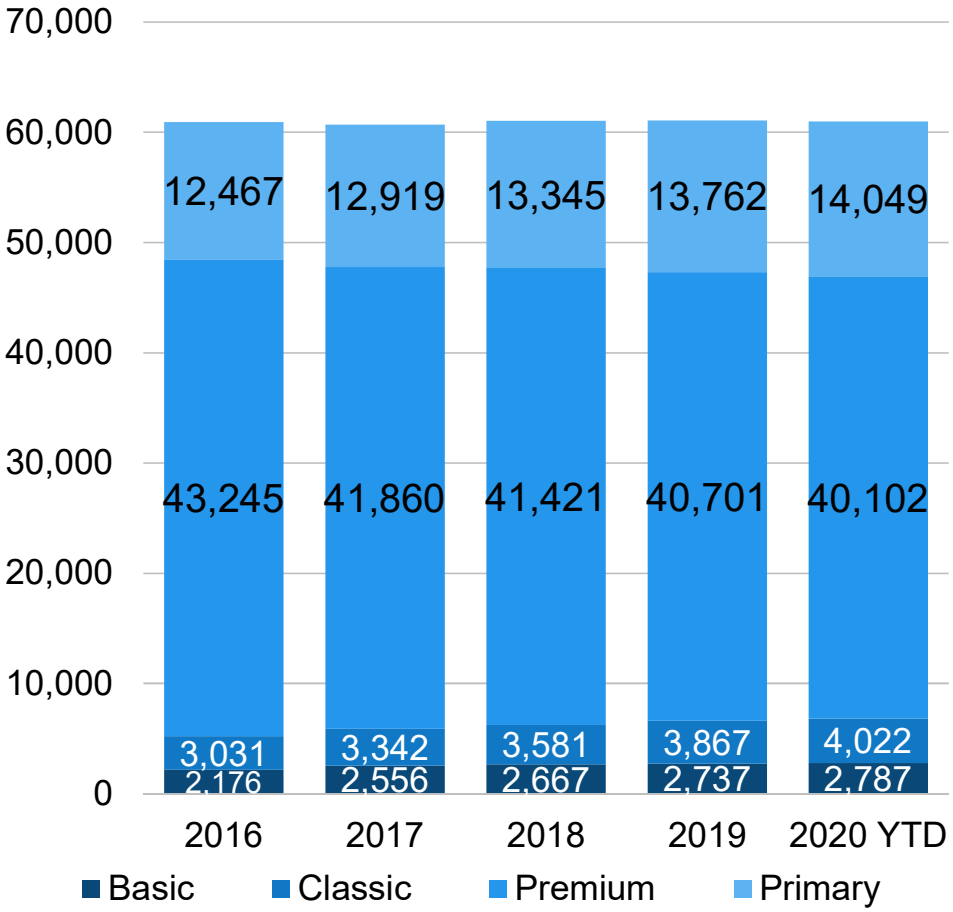


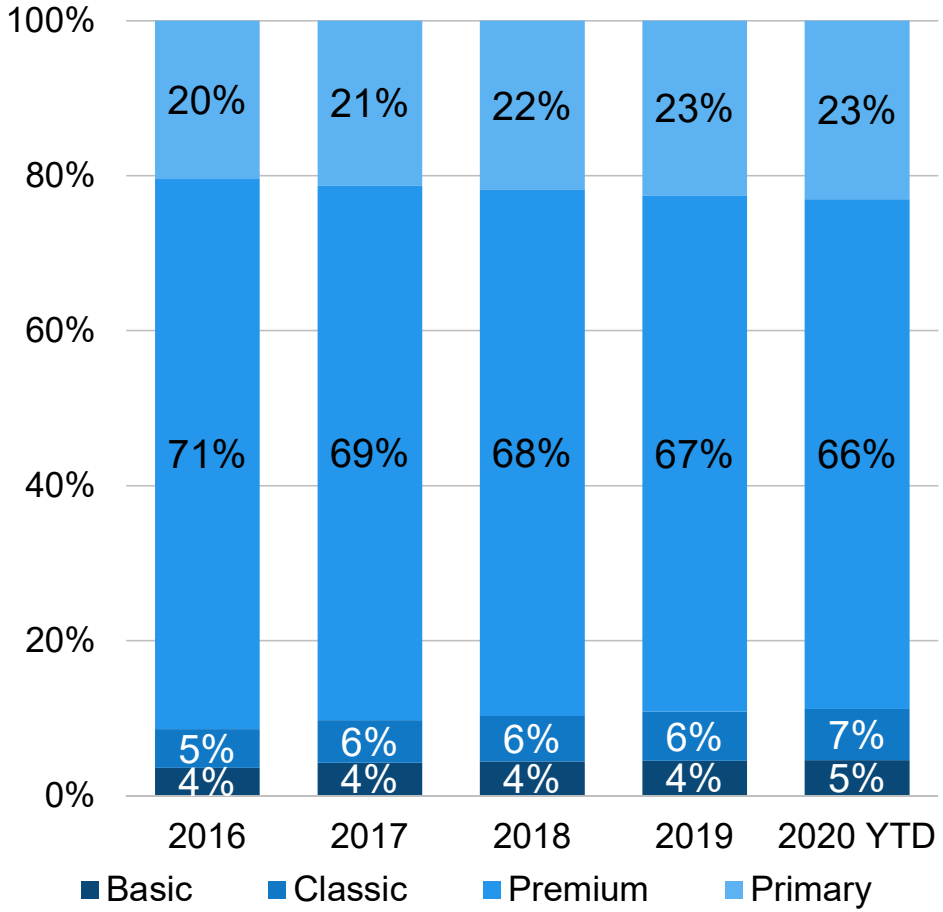
ASE - Average Membership by Status





ASE - Average Membership by Plan





Public School Employees (PSE)

Executive Summary

- Projections updated to incorporate claims data incurred from January 2019 to December 2019 and paid through February 2020
- 2020 plan experience
  - Allocated reserves for 2020 is $25.3M
  - Estimated deficit of $18.2M
  - End of Year Assets: $105.6M
  - No plan changes / 0% increase to employee contributions
- 2021 projected plan experience
  - No additional funding ($15.5M allocated assets)
  - Projected deficit: $57.1M
  - End of Year Assets: $33.1M
  - No plan design or contribution changes
  - Increased membership based on historical patterns
  - Baseline trends (medical: 7%, pharmacy: 8%)

Total Plan Experience

Funding	2019	2020	2021
PPE Funding	$ 102.39	$ 105.28	$ 108.80
Employee Contribution	121.12	124.10	128.24
Dept of Ed Funding	88.10	88.10	88.10
Other	15.02	14.88	15.38
Total Income	$ 326.64	$ 332.37	$ 340.52
Medical Claims	$ (247.11)	$ (281.55)	$ (310.50)
Pharmacy Claims	(60.87)	(70.13)	(77.33)
Administration Fees[2]	(28.46)	(27.96)	(28.88)
Plan Administration	(2.61)	(2.55)	(2.63)
Total Expenses	$ (339.06)	$ (382.18)	$ (419.35)
Program Savings	$ -	$ 6.42	$ 6.30
Net Income / (Loss) Before Reserve Allocation	$ (12.42)	$ (43.40)	$ (72.52)
Allocation of Reserves	$ 12.66	$ 25.25	$15.48
Net Income / (Loss) After Reserve Allocation	$ 0.24	$ (18.15)	$ (57.05)

Average Membership			
Active Employees / Pre-65 Retirees	82,317	84,194	86,602
Post-65 Retirees	14,280	15,115	16,021
Total Enrolled	96,597	99,308	102,623

Total Income PMPM[1]	$ 292.71	$ 300.09	$ 289.08
Total Expenses PMPM[2]	$ (292.50)	$ (315.32)	$ (335.40)

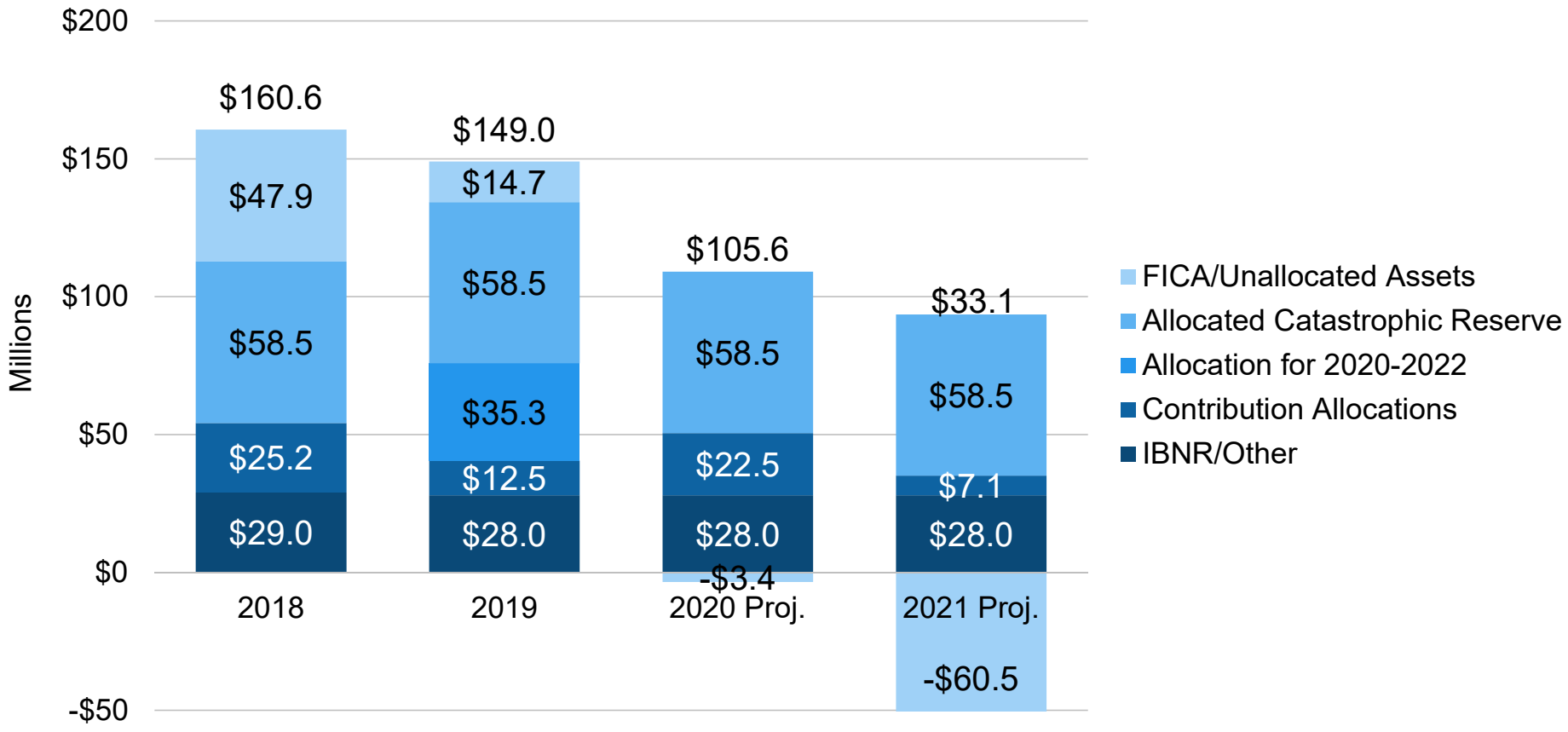
[1] Allocation of Reserves included in Total Income

[2] Total Expenses offset by Pharmacy Program

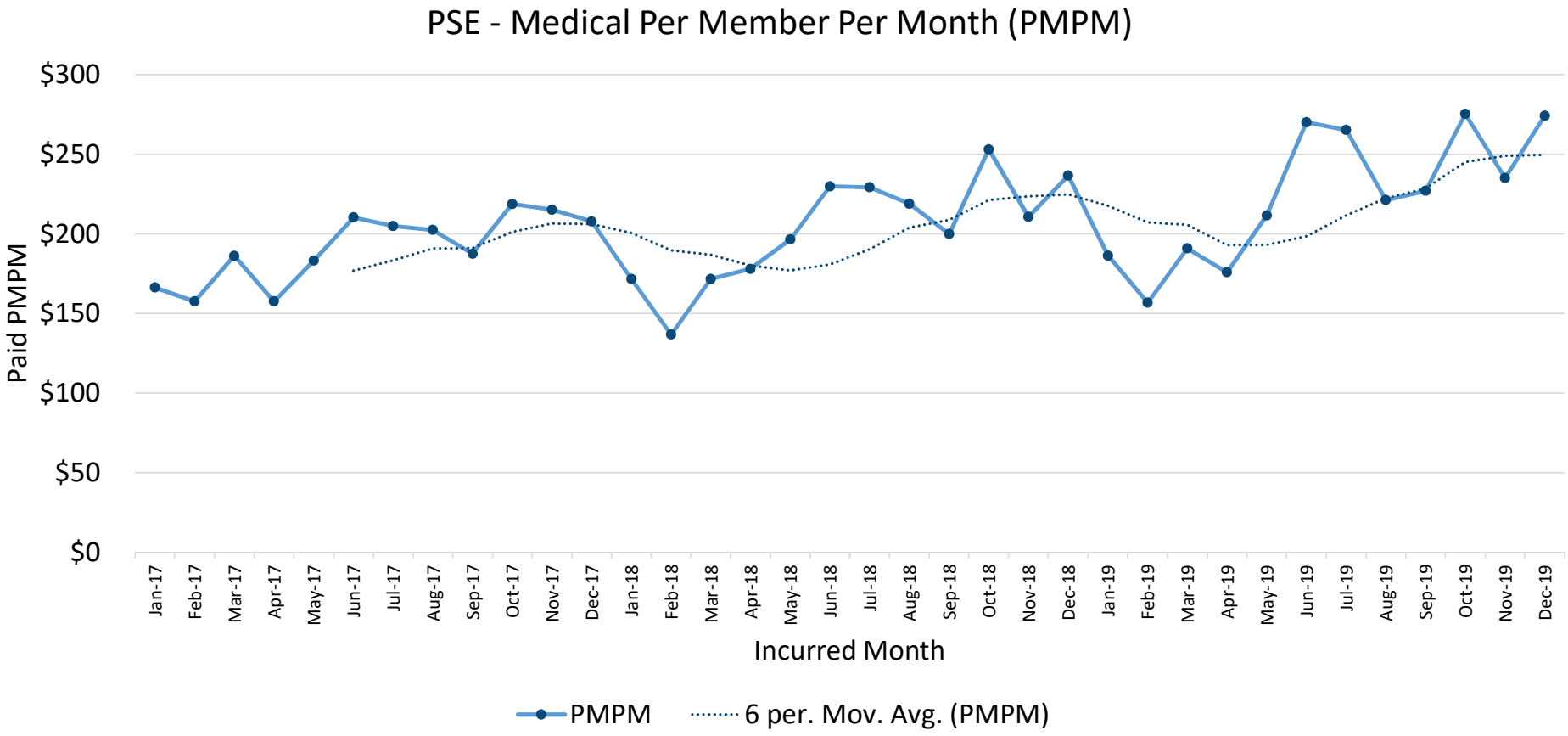
Projected Assets: 2019 – 2021

Development of 2021 End-of-Year Assets			
(a)	2019	End-of-Year Assets	$149.0
(b)	2020	Total Income	$332.4
(c)		Total Expenses	($375.8)
(d)		Allocated Assets	$25.3
(e) = (b) + (c) + (d)		Total Surplus / (Deficit)	($18.2)
(f) = (a) - (d) + (e)		End-of-Year Assets	$105.6
(g)	2021	Total Income	$340.5
(h)		Total Expenses	($413.1)
(i)		Allocated Assets	$15.5
(j) = (g) + (h) + (i)		Total Surplus / (Deficit)	($57.1)
(k) = (f) – (i) + (j)		End-of-Year Assets	$33.1

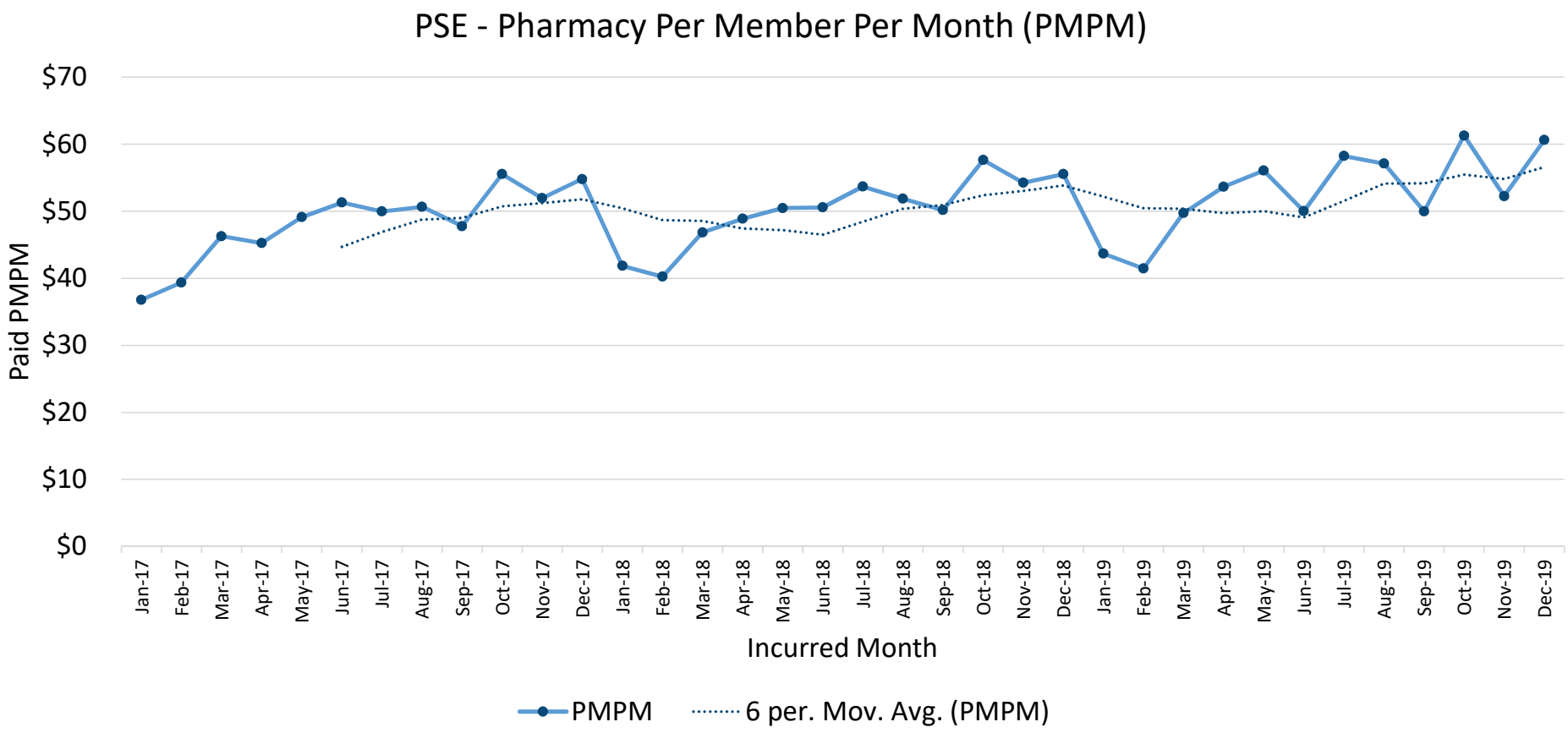
End of Year Assets



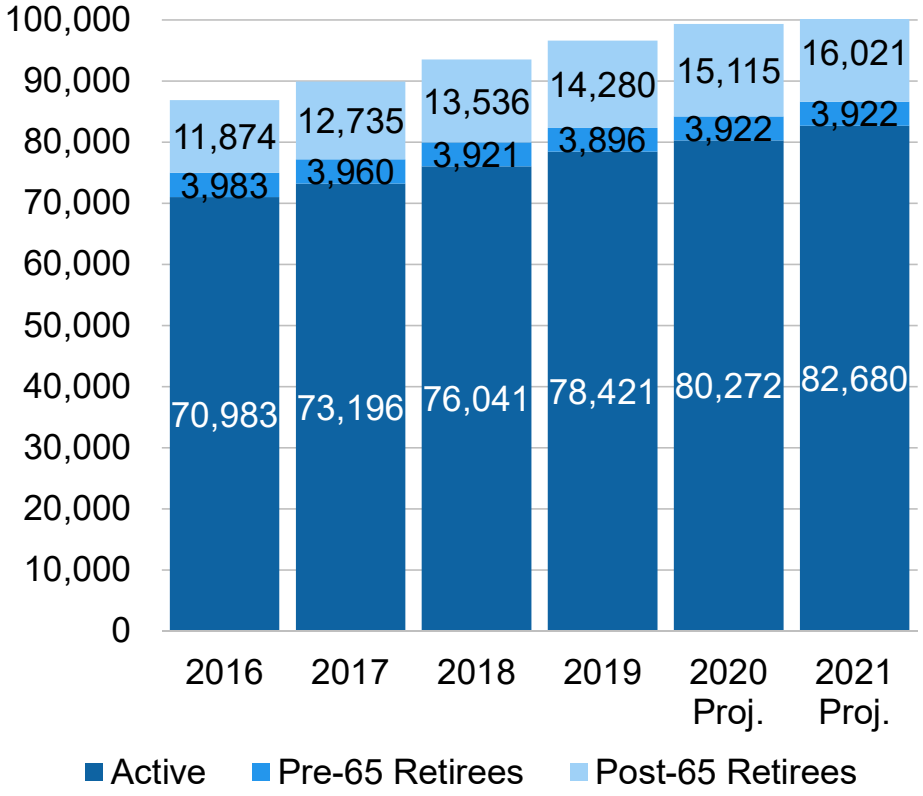
Monthly Trend - Medical

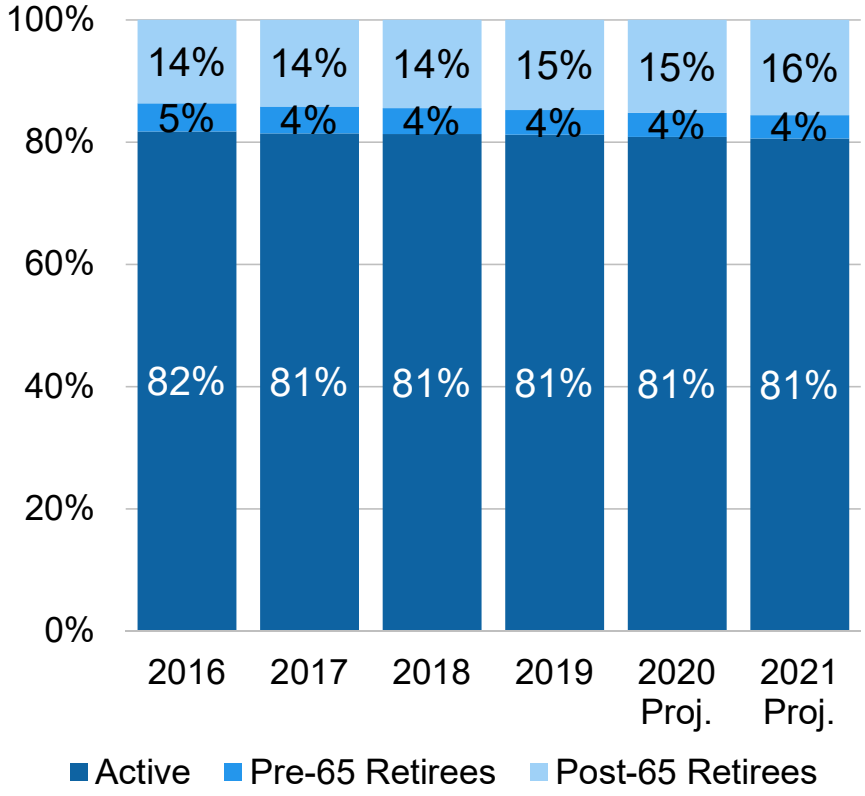


Monthly Trend - Pharmacy

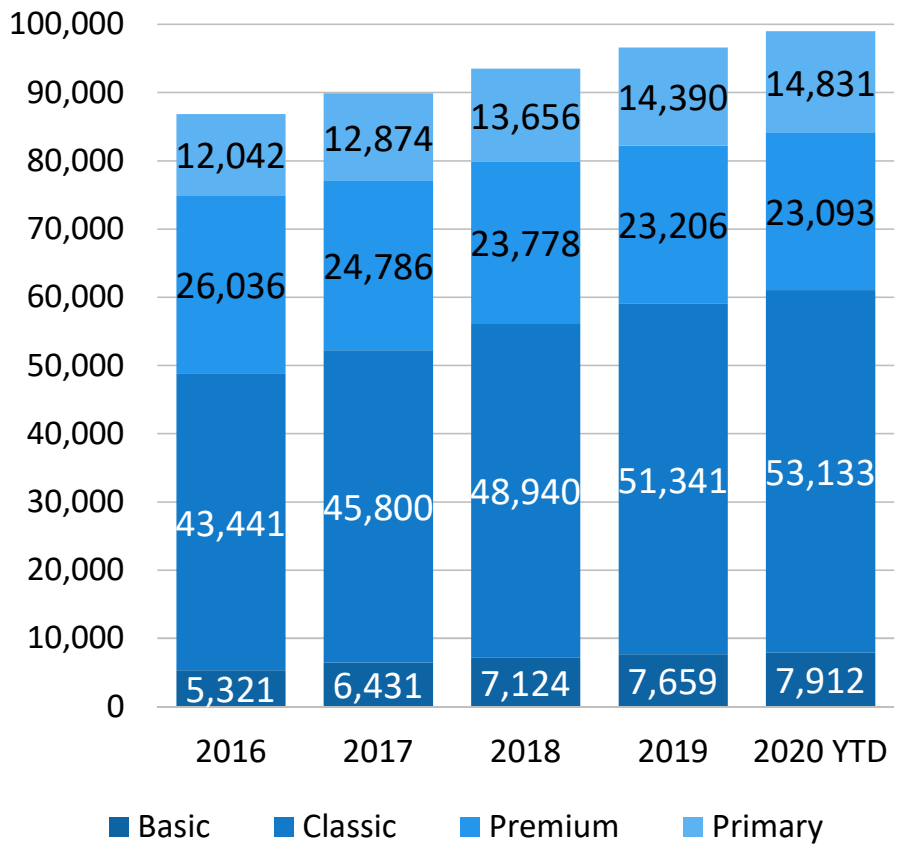


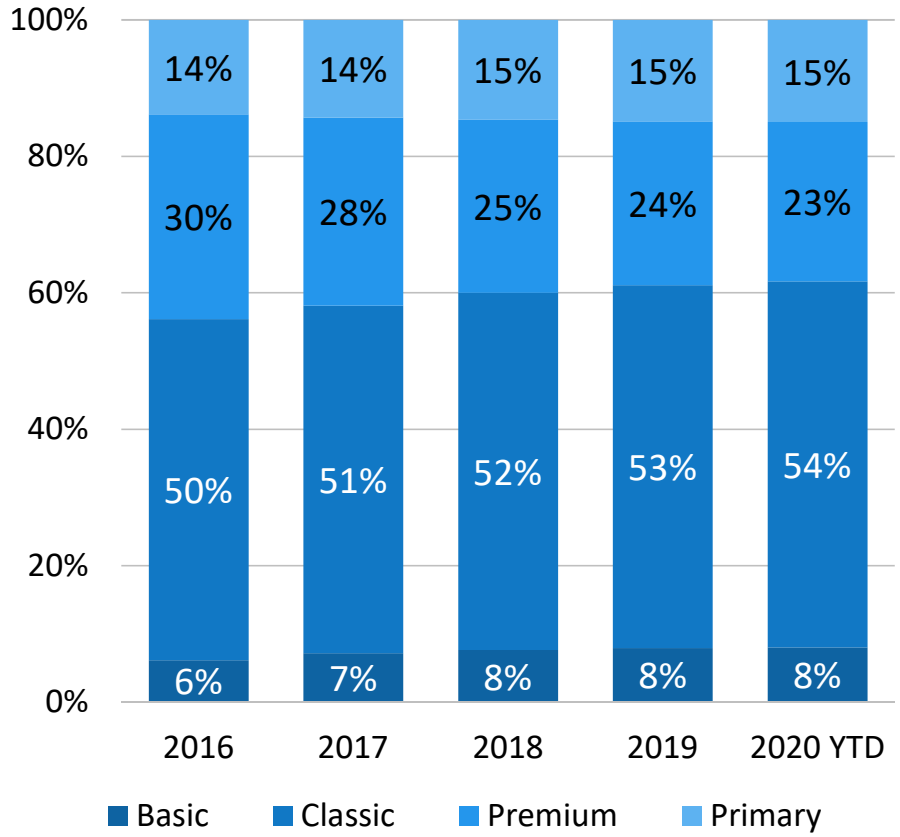
PSE - Average Membership by Status





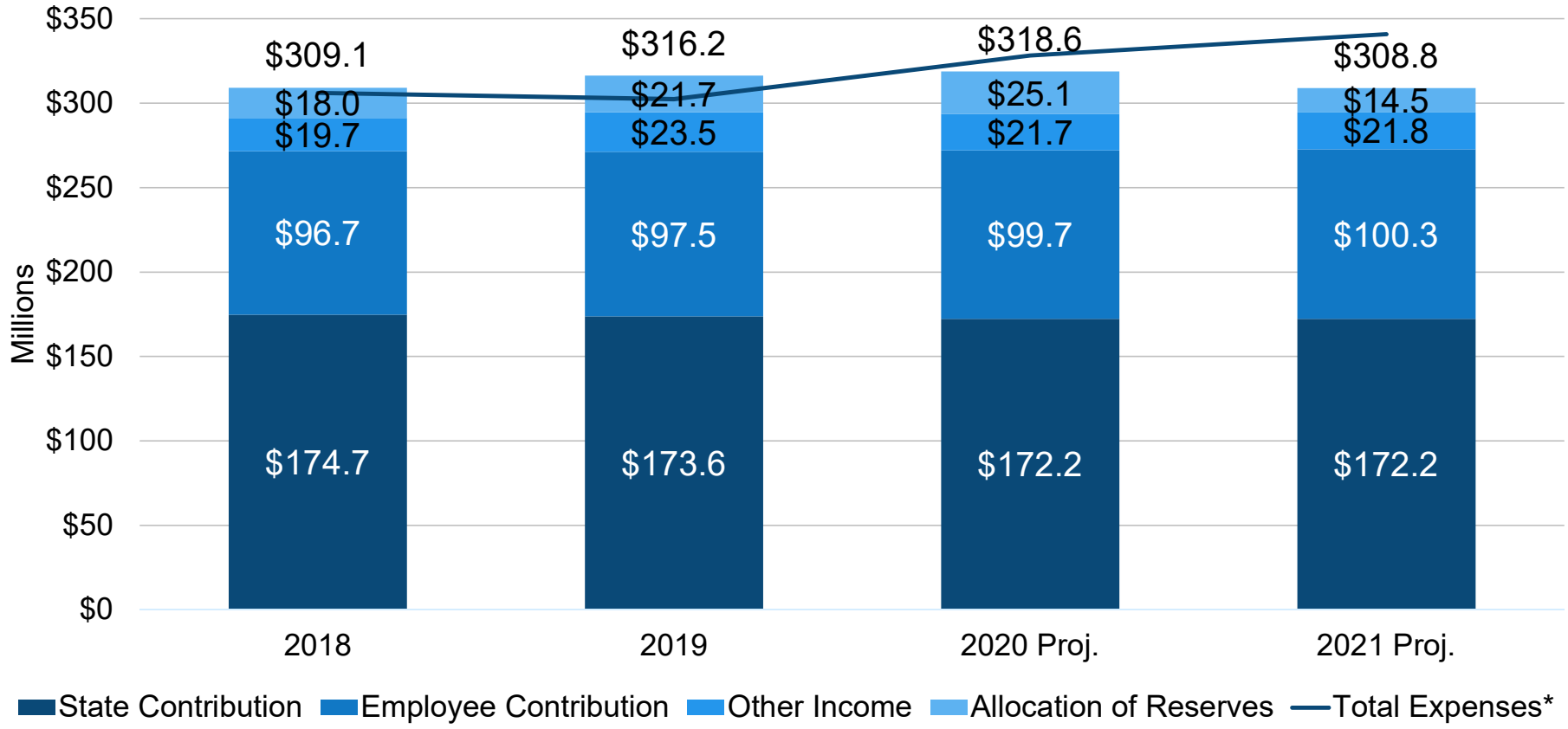
PSE - Average Membership by Plan





Appendix

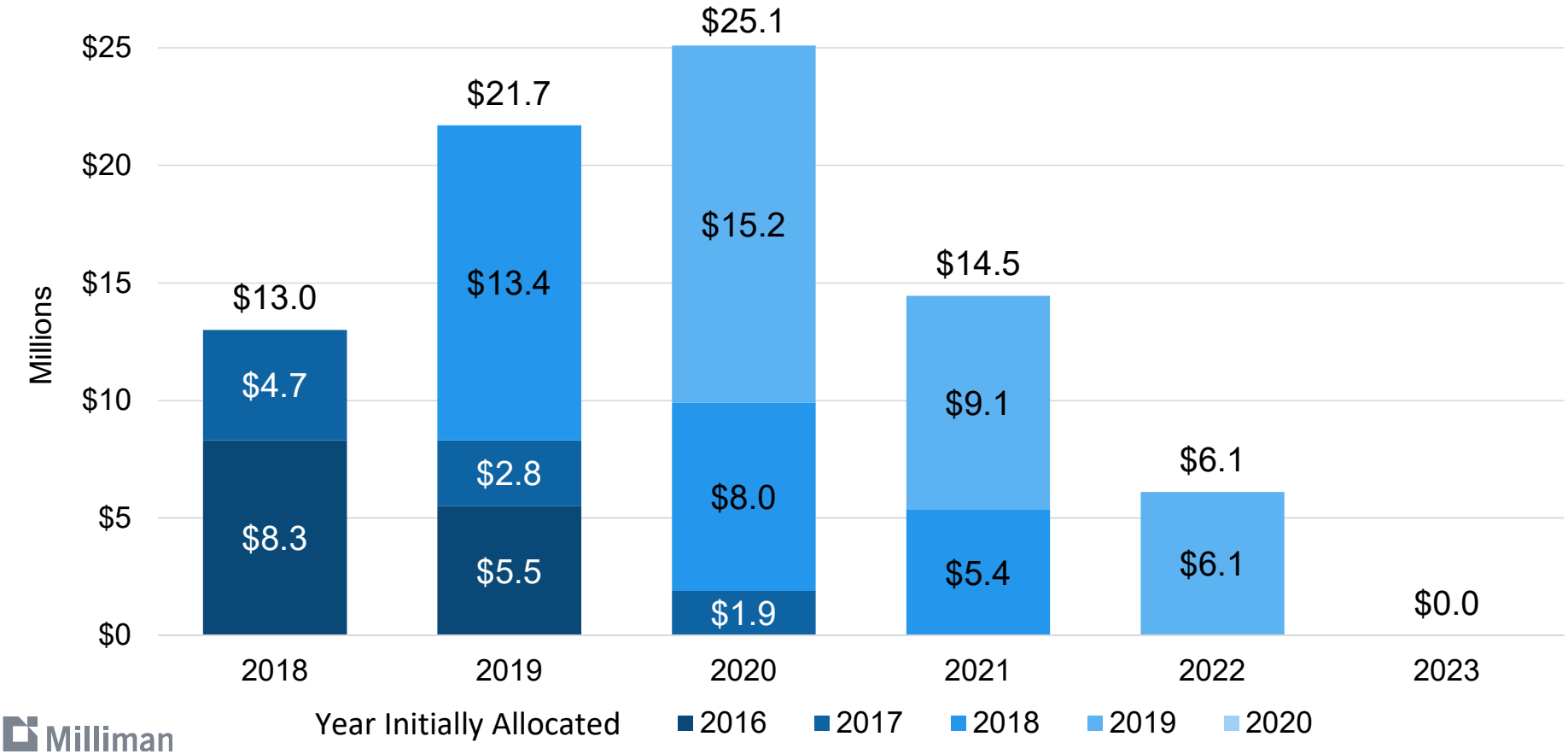
ASE - Income vs. Expenditure



* Total Expenses offset by Pharmacy Program

ASE - Reserves Allocation by Year

The chart represents the reserves amounts allocated each year (in millions), and how much reserves are available each year.



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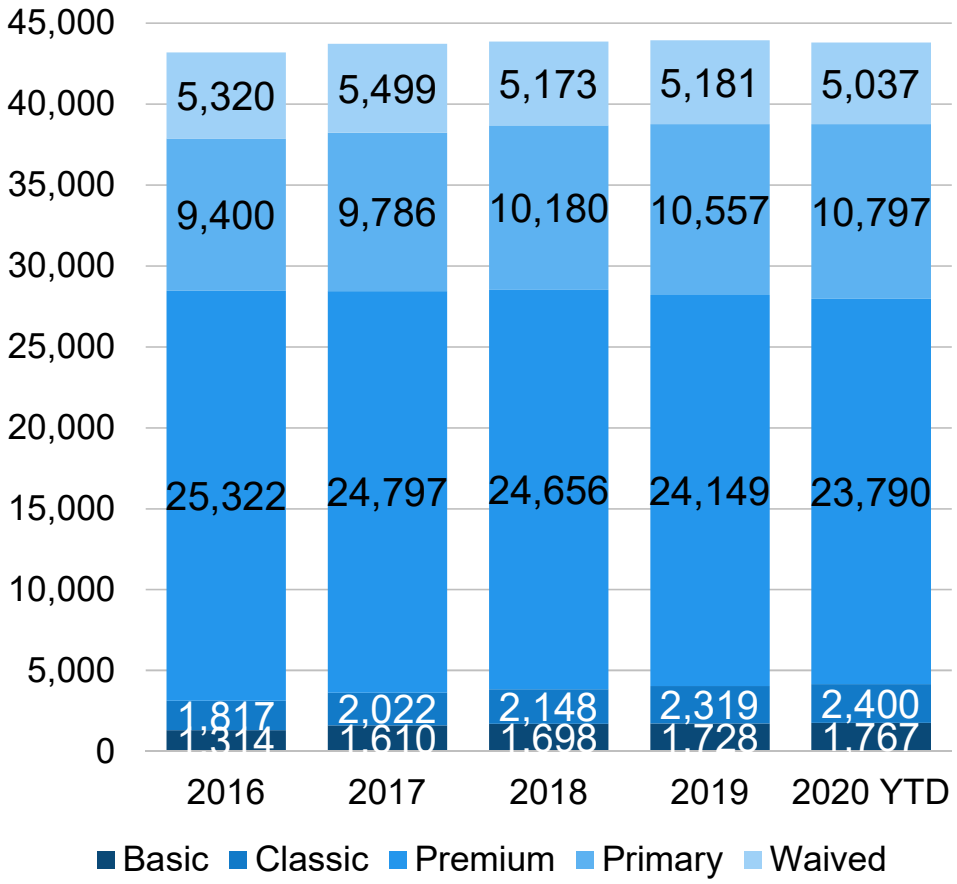
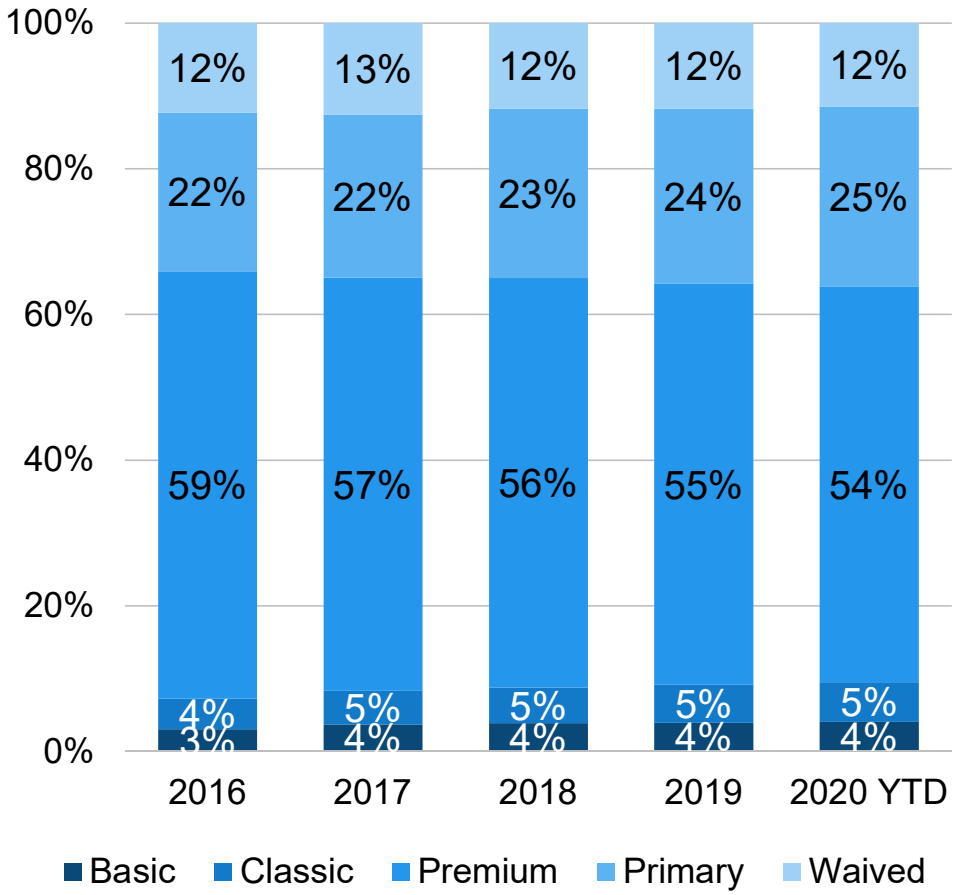
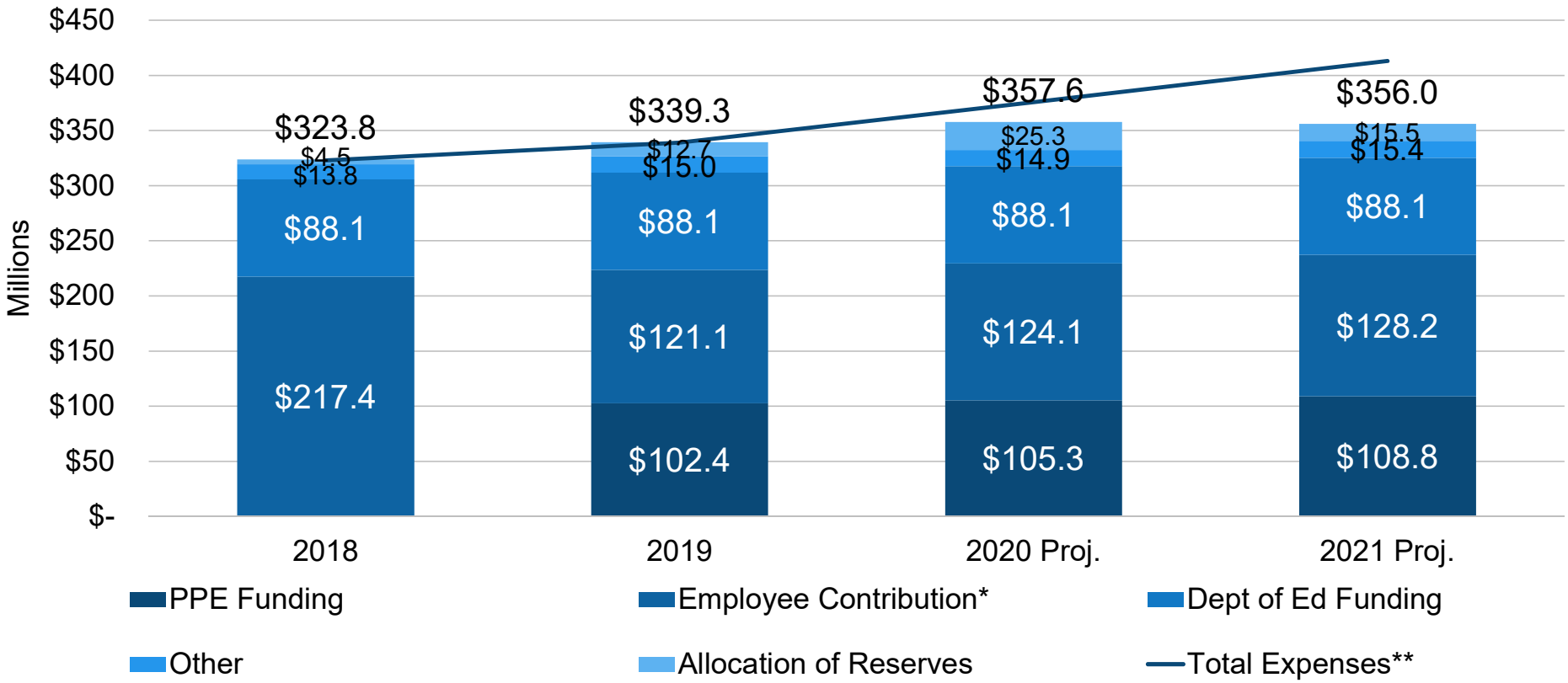
ASE - Average Enrollment (Subscribers) by Plan





Milliman

PSE - Income vs. Expenditure

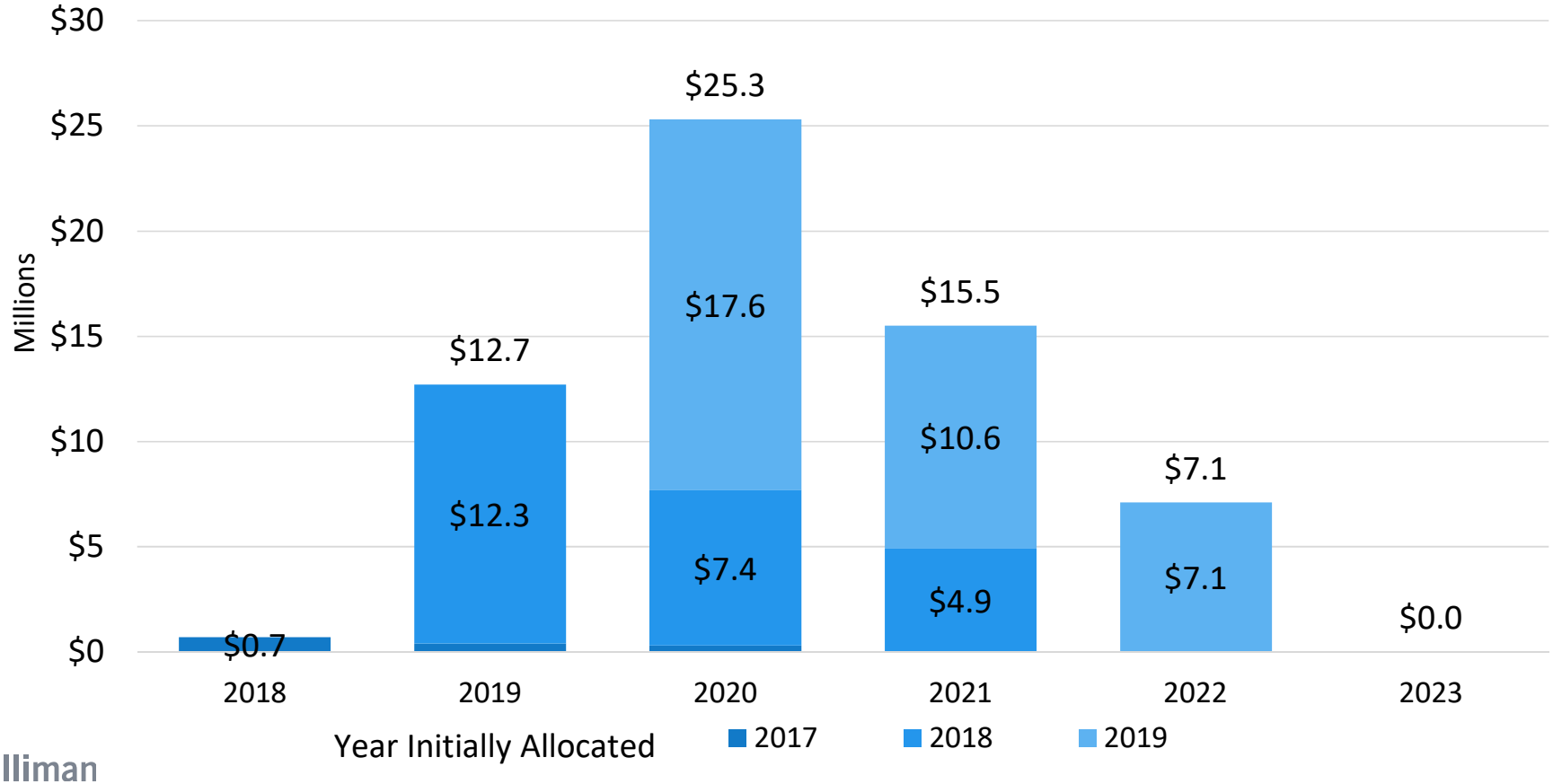


* 2018 Employee Contribution includes PPE Funding

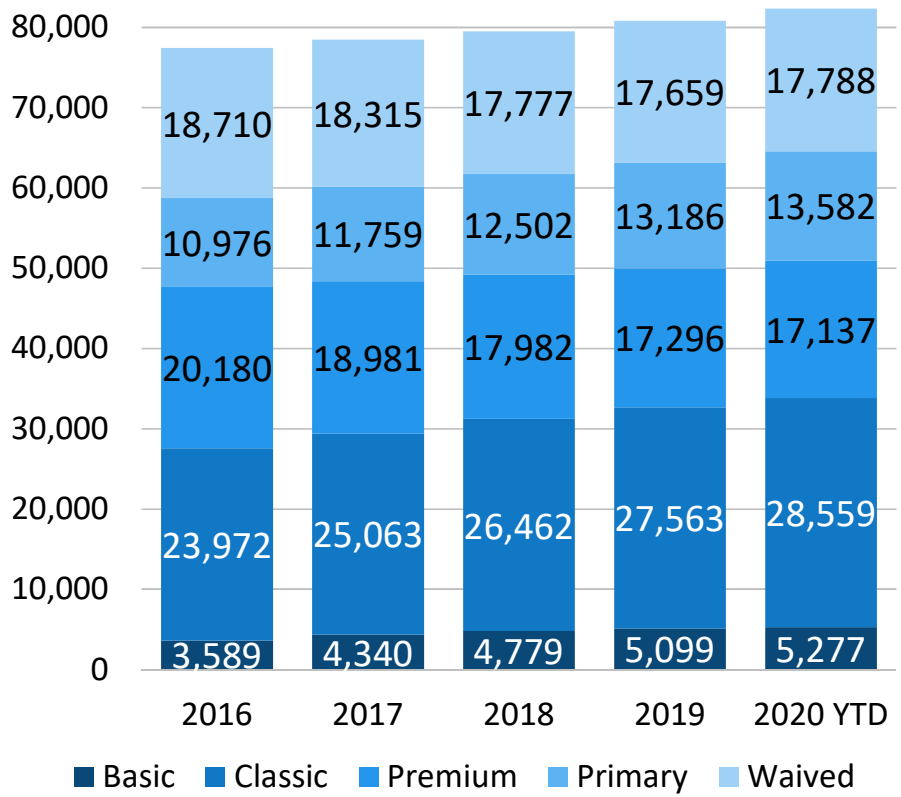
** Total Expenses offset by Pharmacy Program

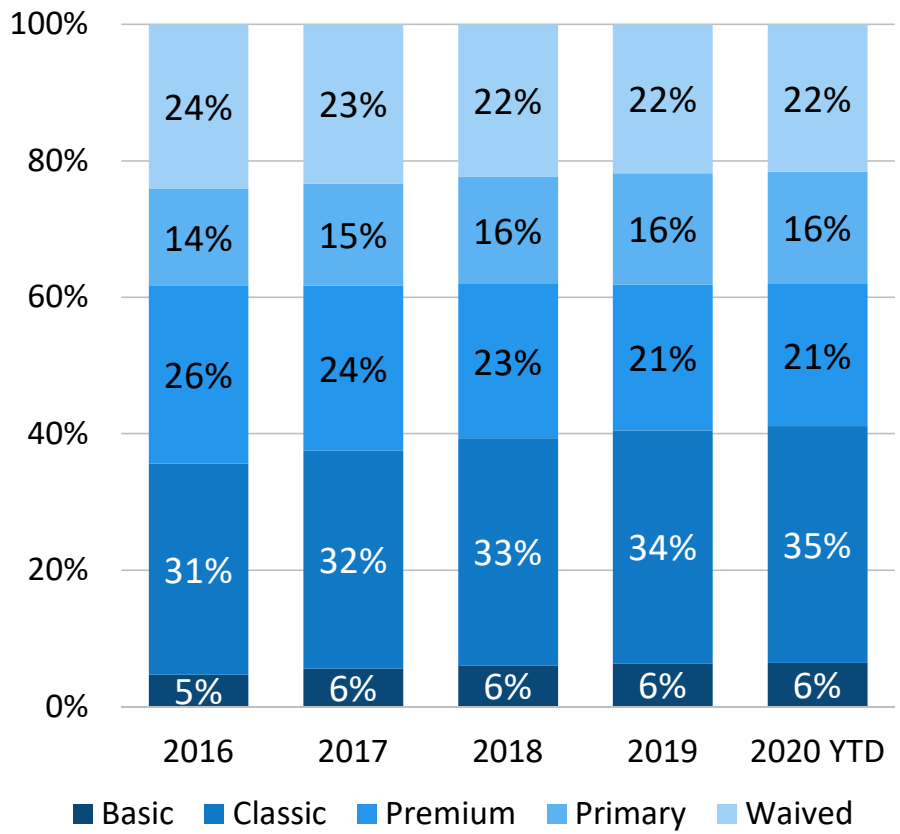
PSE - Reserves Allocation by Year

The chart represents the reserves amounts allocated each year (in millions), and how much reserves are available each year.



PSE - Average Enrollment (Subscribers) by Plan





Assumptions & Methodology

Assumptions - Trend

Division	Group	Medical Trend	Pharmacy Trend
ASE	Active/Pre-65 Retirees Post-65 Retirees	5.0% 5.0%	8.0% 8.0%
PSE	Active/Pre-65 Retirees Post-65 Retirees	7.0% 7.0%	8.0% 8.0%

Assumptions & Methodology

Assumptions – Benefit Plan Changes (2019 to 2021)

- ASE
  - No significant plan cost changes for Active, Pre-65, and Post-65 benefit plans
- PSE
  - No significant plan cost changes for Active, Pre-65, and Post-65 benefit plans

Assumptions & Methodology

Assumptions – Other

- Age/Gender
  - Age/Gender factor based on Milliman Health Cost Guidelines™
- Enrollment Projections
  - Actual enrollment utilized for January 2019 through January 2020
  - Projected February – December 2020 based on historical patterns from 2019
- Pharmacy Program
  - Projected program of $1.25 million per month for 2020, allocated between ASE / PSE based on pharmacy claims expense.
- Plan Administration Expense
  - ASE - $3.85 PMPM for CY2020 ($3.96 PMPM for CY2021)
  - PSE - $2.14 PMPM for CY2020 & CY2021

Assumptions & Methodology

Methodology

1. Summarized fee-for-service (FFS) medical and pharmacy claims incurred from January 1, 2019 to December 31, 2019 and paid from January 1, 2019 to February 29, 2020. Medical claims are gross of withholds. Reports reflects the timing of when EBD is expected to pay the withhold.
2. Converted the paid and incurred claims to incurred claims using completion factors. This incorporates the incurred but not reported (IBNR) claim reserve.
3. Summarized member months for January 1, 2019 to December 31, 2019.
4. Divided the summarized incurred claims by the appropriate member months to calculate PMPMs.
5. 2020 Projected the incurred claims PMPM from the midpoint of the experience period (July 1, 2019) to the midpoint of the contract period (July 1, 2020).
6. 2021 Projected the incurred claims PMPM from the midpoint of the experience period (July 1, 2019) to the midpoint of the contract period (July 1, 2021).
7. Made adjustments for seasonality, benefit changes, and age/gender mix.
8. Accounted for rating period fees and administrative expenses.
9. Where applicable, converted incurred budget to paid budget based on historical payment patterns.

Limitations

Courtney White and Paul Sakhrani are Members of the American Academy of Actuaries and a Fellow of the Society of Actuaries and meets the Qualification Standards of the American Academy of Actuaries to render opinion contained herein. To the best of our knowledge and belief, this analysis is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

The assumptions used in the development of the 2020 and 2021 budget are based on historical ASE and PSE claims, funding, and plan administration, historical ASE and PSE members by benefit plan, age/gender, and by month, 2019 and 2020 ASE and PSE benefit plan summaries, 2020 fees and administrative expenses, conversations with EBD regarding the program, and actuarial judgment.

While we reviewed the ABCBS and EBD information for reasonableness, we have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

Expected outcomes are sensitive to the underlying assumptions used. Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

Any reader of this report should possess a certain level of expertise in areas relevant to this analysis to appreciate the significance of the assumptions and the impact of these assumptions on the illustrated results. The reader should be advised by their own actuaries or other qualified professionals competent in the subject matter of this report, so as to properly interpret the material.

This presentation has been prepared for the sole use of the management of the State of Arkansas Employee Benefits Division for setting the ASE and PSE budget for CY2020 and CY2021. It may not be appropriate for other purposes. Milliman does not intend to benefit any third party from this analysis.

Milliman

Thank you

Courtney White, FSA, MAAA
Paul Sakhrani, FSA, MAAA