



## AGENDA

State and Public School Life and Health Insurance Board

April 21, 2015

1:00 p.m.

EBD Board Room – 501 Building, Suite 500

- I. *Call to Order ..... Dr. John Kirtley, Chairman*
- II. *Approval of March 17, 2015 Minutes..... Dr. John Kirtley, Chairman*
- III. *ASE-PSE Financials March, 2015 .....Marla Wallace, EBD Chief Fiscal Officer*
- IV. *RFP Update..... Dr. John Kirtley, Chairman*
- V. *Public School Health Insurance Transfer.. Jeff Altemus, Vice-Chair Benefits Com.*
- VI. *Benefits Sub-committee Report .... Shelby McCook, Benefits Committee Chairman*
- VII. *DUEC Report ..... Dr. Kat Neill, UAMS*
- VIII. *Catamaran Audit Update..... Sarah Bujak, Catamaran*
- IX. *Director’s Report..... Bob Alexander, EBD Executive Director*

### *Upcoming Meetings*

*May 19, 2015*

*June 23, 2015*

***NOTE: All material for this meeting will be available by electronic means only asepse-board@dfa.arkansas.gov***

***Notice: Silence your cell phones. Keep your personal conversations to a minimum. Observe restrictions designating areas as “Members and Staff only”***

# **State and Public School Life And Health Insurance Board Special Board Meeting Minutes April 21, 2015**

The 149<sup>th</sup> meeting of the State and Public School Life and Health Insurance Board (hereinafter called the Board), met on April 21, 2015 at 1:00 p.m. in the EBD Board Room, 501 Woodlane, Suite 500, Little Rock, AR 72201.

## **MEMBERS PRESENT**

Dr. Joseph Thompson  
Dr. Tony Thurman  
Renee Mallory  
Dan Honey  
Angela Avery  
Shelby McCook  
Dr. John Kirtley – Chairman  
Carla Haugen - Vice-Chairman  
Janis Harrison  
Dr. Andrew Kumpuris  
Lori Freno-Engman  
Katrina Burnett  
Robert Boyd

## **MEMBERS ABSENT**

Bob Alexander, Executive Director, Employee Benefits Division

## **OTHERS PRESENT:**

David Keisner, Dwight Davis , UAMS; Janna Keathley, Ethel Whittaker, Marla Wallace, Lori Eden, Stella Green, Sherry Bryant, Raina Porshay, Liz Tullos, EBD; Sylvia Landers, Eileen Wider, Minnesota Life; Kristi Jackson, Jennifer Vaughn, ComPsych; Pam Lawrence, AHH; Marc Watts, ASEA; Andy Davis, Arkansas Democrat Gazette; Jeff Altemus, Marion Schools; Wayne Whitley, Ronda Walthall, Larry Dickerson, AR Highway & Transportation Dept; Takisha Sanders, Kanita Collins, Martha Carlson, Health Advantage; Susan Walker, DataPath; Brenda Robinson, Susan O'Daniel, AEA; Kim Henderson, ADFA; Gini Ingram, Ro Summers, ACHI; Cecile Bledsoe, Senate; Steve Althoff, MTI; Susan Bujak, Susan McCerstor, Connie Bennett, Catamaran; Martha Hill, Robyn Keene, Mike Mertens, AAEA; Ella Walker-Rolfe, ARTA; Karen Langley, B.J. Himes, Qual Choice; Mike Pickens, Pickens Law Firm; Jim Templeton, AFA; Sam Smothers, Astra Zeneca; Steve Sewing, Acorda; Bill Clary, H &H; Lisa Boone, EBI; Derrick Smith; Mitchell Williams

## **CALL TO ORDER:**

Meeting was called to order by Dr. John Kirtley, Chairman

## **APPROVAL OF MINUTES:** *by John Kirtley, Chairman*

The request was made by Haugen to approve the March 17, 2015 minutes.

**Harrison made the motion to approve the minutes, Mallory seconded; all were in favor.**

## **Minutes approved**

## **FINANCIALS:** *by Marla Wallace, EBD Fiscal Officer*

Wallace reported financials for March, 2015. For PSE the month of March four (4) weeks of health claims was paid and three (3) weeks of pharmacy claims was paid. The Department of Education payment was received in the amount of \$16 million. There was a gain of \$24 million for the month and the year-to-date gain is \$35 million. Without the Department of Education payment the net gain for the month would have been \$8 million. The FICA savings for the month is \$473,000, and there is \$49 million in net assets.

For ASE the month of March also paid four (4) weeks of health claims, and three (3) weeks of pharmacy claims was paid. The gain for the month is \$7.3 million and the year-to-date gain is \$16.8 million. The net assets are more than \$42 million.

## **RFP UPDATE:** *by, Bob Alexander, EBD Executive Director*

Alexander reported a brief update on the various RFP's submitted. Meadors briefly reported on the HSA/FSA RFP.

**McCook motioned to authorize the Director to proceed with the HSA RFP as it was last presented and explained. Honey seconded. All were in favor.**

## **Motion Approved**

## **State Health Insurance Portability Rules:** *by, Jeff Altemus, Vice-Chair Benefits Subcommittee*

We, the people of AASBO, in order to perform a more perfect transfer of health insurance between school districts, establish consistency of procedure, ensure domestic portability of coverage, provide for the common fairness of cost to districts, promote the general right to transfer employment, secure

the blessings of EBD and healthcare law for ourselves and our posterity, do ordain and establish these State Health Insurance Portability Rules (SHIP Rules) for the PSEs of Arkansas.

Although Arkansas PSEs do not have common employers, they belong to the same “self-insured health insurance plan”, common in terms of pricing, structure, administration or oversight. In theory, PSEs should enjoy the same portability of insurance as ASEs who transfer freely about from agency to agency in the state government sector without health insurance concerns.

The AASBO constituency group of AAEA, with the office of EBD, has determined that the establishment of rules and procedures to ensure continued health insurance coverage for PSEs transferring from one Arkansas school district to another Arkansas school district is both prudent and necessary. To wit, the fundamental purposes of the following rules are to secure true portability of health insurance for PSEs with no break in coverage and no large out-of-pocket COBRA insurance payments.

This plan was developed to provide a balance of various factors:

- **Flexibility** – allowing each school district authority to do “what’s best for the district”.
- **Consistency** – knowing procedures exist and will be followed by other school districts so a transferring PSE can be set up for payroll at the beginning of the new school year.
- **Opportunity** – allowing a PSE to transfer between Arkansas school districts without breaking coverage of health insurance.
- **Openness** – providing a PSE transferring to another school district an incentive to disclose the transfer honestly without fear of extra COBRA costs or loss of coverage.

Alexander reported the rule is any school district that doesn’t comply with the portability rules that have been adopted by the PSE association; their employee leaving their employment and coming into employment will be treated as new hires.

**McCook motioned to adopt the insurance portability rules as presented, and the penalty should be set at two (2) times the monthly contribution required of school districts. Honey seconded.**

**Alexander recommended no penalty, but any school district that does not adopt and comply with the new portability rules; any new employment or re-employment will be processed as new employees.**

**After discussion:**

**McCook amended the motion to state; any school district that does not adopt and comply with the new portability rules; any new employment or re-employment will be processed as a new hire. Honey seconded. All were in favor.**

**Motion Approved**

**State and Public School Life and Health Insurance Board  
Benefits Sub-Committee Summary Report**

The following report resulted from a meeting of the Benefits Sub-Committee from April 10, 2015 with Shelby McCook presiding.

**Topics Discussed:**

- Alternate Provider Arrangement Consideration
- ArBenefits 2015 Renewal Analysis – Minnesota Life
- Review of Trends for Calendar year 2016 Rates - Cheiron

**Alternate Provider Arrangement Consideration – Dr. Andrew Kumpuris, Board Member**

Dr. Kumpuris reported Healthcare is a market place. The market place consists of Physicians, Hospitals, Insurance Companies, and the users. Arkansas is divided into six (6) healthcare districts. There are six (6) market places in the state of Arkansas. Dr. Kumpuris recommended considering taking advantage of the purchasing power in terms of attempting to lower rates for the members.

There are Accountable Care Organizations forming around the country. These organizations are outside the normal healthcare industry. Arkansas has organizations formed in the central and western part of the state. In order to offer members lower provider rates take the population in one of the defined healthcare areas; with individuals bidding on all the services offered from, physician, to hospital, and pharmacy. This would provide lower rates for members. If the member chooses to go outside that care they would pay an amount that would be more costly.

Dr. Kumpuris has concerns that some areas of the state may have lower rates than others. For those areas Dr. Kumpuris recommended to implement an equalizer taking the savings from one area and subsidize the funds to an area that has fewer savings.

The benefits are; this will create a more competitive market place for physicians and hospitals to compete for patients, and savings to the members.

McCook recommended form a committee with the following members to serve:

- Dr. Andrew Kumpuris
- Shelby McCook
- Dr. John Kirtley

- Bob Boyd
- Dr. Joseph Thompson

**Harrison motioned to recommend to the board to form a committee to investigate the benefits for review of the Alternate Provider Program. Haugen seconded. All were in favor.**

## **Motion Approved**

### **ArBenefits 2015 Renewal Analysis – Brian Anderson, Eileen Wider - Minnesota Life**

The state's active basic life rate was reduced significantly in conjunction with the merger with the Schools, based on expected lower mortality rates among school district employees. When two different groups are brought together at the same time premium rates under a plan, premium rates are established based on expected average mortality across the group as a whole. In general government employees, so the State rates were reduced when the population merged with the Larger School population.

However, a number of unexpected changes took place in following the 2012 RFP that have impacted the experience and resulted in Minnesota Life collecting significantly less premium than expected, and necessary to cover the cost of claim and expenses.

- School Districts were allowed to opt out of the Minnesota Life Group Plan.
- The supplemental life lapse rate among participating school districts has been very high.
- A high number of schools employees chose to cancel existing supplemental life coverage and elect expanded basic life coverage instead.
- The retiree supplemental life rate was capped at \$3.70 for existing school district retirees as of January 1, 2013.

Altemus requested information in terms of the affect it would have if the active PSE employees were required to have the basic life as a part of their health insurance.

Walker requested if Retiree rates change that Minnesota life would send letters to members thirty (30) days prior to the change.

### **Review of Trends for Calendar Year 2016 Rates**

Based on actual January 2015 enrollment, but using the same underlying claims cost assumptions as were used to set 2015 rates:

- January 2015 enrollment shows a slight increase in the number of active employees but decreases in the number of spouses and retirees enrolled.
- More employees elected premium and fewer elected basic than assumed.
- More employees qualified for wellness incentive than assumed.
- PSE is now receiving FICA savings estimated at \$5.6 million for 2015
- Net Impact is expected to be a gain of \$2.9 million

**McCook motioned for the board to accept the sub-committee report. Harrison seconded. All were in favor.**

## Motion Approved

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

The following report resulted from a meeting of the DUEC on April 6, 2015 with Dr. Kat Neill presiding.

#### 1. Recommended Changes to Current Coverage

##### A. Delivery Coordination Workgroup Report: *by Dr. David Keisner, UAMS*

Drugs used in the treatment of Cancers and non-cancer drugs were reviewed by the DCWG and a report made to the DUEC on April 6<sup>th</sup>. Recommendations from this report are outlined below.

|  | Current Coverage             | Proposed Coverage for 2015  |
|--|------------------------------|---|
| <u>Multiple Sclerosis (MS)</u><br>Lemtrada (alemtuzumab) | New Drug                     | Medical PA  |
| <u>IVIG</u><br>Multiple Products                         | T4 PA Pharmacy<br>Medical PA | PA Pharmacy products for self administration<br>Remove Medical PA |
| <u>Metastatic Melanoma</u><br>Opdivo (nivolumab)         | New Drug                     | Medical PA  |

##### B. TOPICAL NSAIDs REVIEW: *by, Dr. Jill Johnson, UAMS*

Topical NSAIDs have shown to be as efficacious as oral NSAIDs in the available clinical trials. Topical NSAIDs were reported to have a better safety profile when compared to systemic NSAIDs. Predominantly these results reflect gastrointestinal adverse events such as nausea, dyspepsia, and abdominal pain which are typically manageable. GI bleeds were not addressed in any of the reviewed trials. Use of topical diclofenac for actinic keratosis may not be as effective as topical 5-FU. It is reasonable to NOT cover topical NSAIDs based on the current evidence. In the past six (6) months there have been 773 users.

| Drug                               | Use | Current Coverage | Proposed Coverage |
|------------------------------------|-----|------------------|-------------------|
| Diclofenac Na transderm. soln 1.5% | OA  | Tier 1           | Exclude; 90 day   |

|  |            |               |   |
|--|------------|---------------|---|
| Flector (diclofenac TD Patch) 1.3%     | Acute pain | Tier 3        | communication to members (773 users in past 6 months) |
| Pennsaid (diclofenac TD soln) 1.5%, 2% | OA         | Tier 3        |   |
| Voltaren (diclofenac TD gel) 1%        | OA         | Tier 3        |   |
| Topical Diclofenac Gel 1%              | OA         | Tier 1        |   |
| Diclofenac Na transderm gel 3%         | AK         | Tier 1        |   |
| Solaraze (diclofenac TD gel) 3%        | AK         | Brand penalty |   |

**C. SECOND REVIEW OF ONFI: by Dr. Jill Johnson, UAMS**

| Drug            | Use   | Current Coverage | Proposed Coverage |
|-----------------|---|------------------|-------------------|
| Onfi (clobazam) | Lennox-Gastaut Syndrome<br>Uncontrolled drop seizures | Excluded         | Tier 3 PA         |

Dr. Thompson motioned to adopt the recommendation of A, B, & C. Harrison seconded. All were in favor.

**Motion Approved**

**D. Hepatitis C Review: by Dr. Jill Johnson, UAMS**

Dr. Johnson reported on information requested from board members. She met with Dr. Duarte, Liver Specialist at UAMS, regarding the current policy. The updated PA criteria are listed below. Updated coverage pathways are included as an addendum. The following modifications to current coverage and PA criteria are recommended.

1. Ensure the patient has CHRONIC hepatitis C. This requires either a HCV AB test, and then a viral load 6m later OR two viral loads 6m apart. We only treat CHRONIC hcv. Up to 20% of Hep C infections resolve on their own.
2. Remove esophageal varices and history of variceal bleeding from the list of decompensation manifestations that would lead to denial of therapy (unless listed on a liver transplant list).
3. Allow treatment when comorbidities exist (chronic HBV, autoimmune hepatitis, alcoholic hepatitis, hemochromatosis, Wilson’s disease, alpha1 antitrypsin deficiency) after referral to a gastroenterologist for treatment of concomitant diseases.
4. Include FibroScan and Fibrotest to APRI or FIB-4 as noninvasive tests to ascertain metavir F3 or F4 stage.
5. Allow access to Harvoni for GT1 treatment-naïve, interferon-eligible patients.
6. Following a completed therapy, if the patient experiences a relapse, he/she is eligible for retreatment. However, if treatment is abandoned, the patient would not be eligible to repeat the treatment.

**A. For any treatment to eradicate chronic hepatitis C virus (HCV)infection, the following criteria must be met regardless of which regimen is requested:**

|  |   |
|--|---|
| 1. The patient must test positive for chronic HCV infection. Two options: <ul style="list-style-type: none"> <li>• HCV antibody ≥6m before a positive HCV RNA (viral load) , OR</li> <li>• 2 HCV RNA levels 6 months apart</li> </ul> <input type="checkbox"/> The viral load must be documented. _____<br><input type="checkbox"/> The genotype and subtype must be documented. _____ | The diagnosis of CHRONIC HCV must be made. 15-25% seroconvert on their own and the patient clears the infection. We only treat chronic HCV infection. |
| 2. The patient must be free of using illicit drugs for the past 6 months.<br><input type="checkbox"/> A patient-signed statement attesting to this is acceptable.  | Any positive drug screen for injectable drug use during treatment stops access to the HCV drugs. Reinfection is a risk for IV drug users.             |

|   |   |
|---|---|
| 3. The patient must be free of abusing ethanol for the past 6 months. (defined as >3 glasses/d (1 glass is equivalent to beer 284 mL, wine 125 mL, or distilled spirits 25 mL for females and >4 glasses/d for males).<br><input type="checkbox"/> A patient-signed statement attesting to this is acceptable.  |   |
| 4. If the patient has cirrhosis, there must be NO signs of decompensation (ascites, episodes of spontaneous bacterial peritonitis, hepatic encephalopathy,), unless the patient is currently listed for liver transplant.<br><input type="checkbox"/> The drug profile for the past 1 year must be submitted.   | Unless currently LISTED on the liver transplant list. Patients with decompensation will not be treated unless currently listed on a verifiable list from a liver transplant center. |
| 5. The patient with liver disease due to any cause other than HCV infection (chronic hepatitis B infection, autoimmune hepatitis, alcoholic hepatitis, hemochromatosis, Wilson's disease, alpha1 antitrypsin deficiency) should be referred to a gastroenterologist.  |   |
| 6. The extent of fibrosis may be shown by liver biopsy, FIB-4, APRI, Fibroscan (transient elastography), or Fibrotest to demonstrate the patient has a Metavir score of F3 or F4.   |   |
| 7. Patients with extrahepatic manifestations of chronic HCV infection are candidates for therapy regardless of corresponding Metavir score as long as they meet the other requirements above.   |   |
| 8. If the patient was provided HCV eradication therapy and abandoned therapy, they are not eligible for a second course of treatment. If the patient completed but relapsed or had intolerance to the first course of therapy, then they would be eligible for subsequent treatment depending on what is requested and the clinical evidence.<br><input type="checkbox"/> A review of the drug profile for fills provided in the past for HCV eradication drug therapy. Further explanation by the patient/physician may be required. |   |

**B. Other questions which must be collected on EVERY patient seeking drug therapy for HCV infection:**

|   |   |
|---|---|
| 1. Is the patient currently on the liver transplant list? (Decompensated, metavir F4 patients are eligible for treatment, absent contraindications listed in #5 above.)   |   |
| 2. Has the patient previously received any treatment for HCV infection? If so, what regimen and duration?<br><input type="checkbox"/> This info must be captured even if drug was supplied by the manufacturer.   | This answer is needed to determine treatment eligibility. |
| 3. HIV positive patients must have absolute CD4 counts above 500 and not require HAART therapy or currently receive HAART therapy if the absolute CD4 count is below 200, to be eligible for HCV eradication treatment.<br><input type="checkbox"/> If HIV positive, the absolute CD4 count must be submitted from the past 6 months. |   |

**Dr. Thompson motioned to accepted Dr. Johnson's recommendations of 1 -6 above. Honey seconded. All were in favor.**

**Motion Approved**

**2. NEW DRUGS**

Johnson reported on new drugs. The review covered products released February – March 2015.

**Recommended Additions:**

| BRAND NAME | GENERIC NAME | PRICING (AWP) | INDICATION | SIMILAR THERAPIES ON FORMULARY/AWP | DUEC VOTE |
|------------|--------------|---------------|------------|------------------------------------|-----------|
|------------|--------------|---------------|------------|------------------------------------|-----------|

|                      |   |                               |   |  |  |
|----------------------|---|-------------------------------|---|--|--|
| Arnuity              | Fluticasone furoate aerosol powder breath act | \$156/100mcg;<br>\$209/200mcg | New fluticasone formulation. Once daily inhaled corticosteroid for maintenance tx of asthma as prophylactic therapy – not indicated for relief of acute bronchospasm  | T2 plan options: Flovent HFA: 110 mcg/\$2131, 220 mcg/\$359. Pulmicort Flexihaler 90 mcg/\$165, 180mcg/\$250. QVAR: 40 mcg/\$167, 80 mcg/\$224 | Tier 2   |
| INCRUSE ELPT INHALER | umeclidinium BR aero powder breath act        | \$270/30 doses                | Long-term, once daily maintenance treatment of air flow obstruction in patients with COPD, including chronic bronchitis and/or emphysema  | T2 plan options: Spiriva Respimat 60 doses/\$357; Spiriva Handihaler Powder/\$357. Tudorza Press air powder for inhalation: \$336/60 doses     | Tier 2   |
| SOOLANTRA CREAM      | ivermectin cream                              | \$330/30gm                    | Treatment of inflammatory lesions of rosacea  | T1 plan option: topical metronidazole gel,cream - \$42/45gm  | Tier 3, QL of 30 g tube/30d  |
| SAVAYSA TABS         | edoxaban tosylate                             | \$11.08/tab                   | Oral anticoagulant for reduction in the risk of stroke and systemic embolism in patients with atrial fibrillation that is unrelated to valvular heart disease and for treatment of DVT and PE in patients intially treated with an injectable anticoagulant |  | Tier 2, QL   |
| MOVANTIK             | naloxegol oxalate                             | \$9.98/tab (dose= 1 tab/day)  | Treatment of opioid-induced constipation in adults with chronic non-cancer pain   | Tier 3 plan options for opioid induced constipation: Amitiza/\$9.90 per day. Relistor by subcutaneous injection/\$86 every other day           | Cover, Tier3, QL of 1/1, revisit in 6 months (Sept 2015) for price reasons bring to DCWG in Sept 2015. |
| ZUBSOLV SUB 8.6-2.1  | buprenorphin e-naloxone SL tab 8.6-2.1mg      | \$12.67/tab                   | new dosage form   | Other ZUBSOLV strengths excluded by plan   | TIER 3 PA, QL #62/31. Revisit on 09/25/15.   |
| PAZEO DROPS          | olopatadine opgth solution 0.7%               | \$179/2.5ml                   | For ocular allergy itch relief  | Tier 1 plan options: azelastine/\$104 per 6 ml; olopatadine/\$78/5ml   | Tier 3   |

**Recommended Additions (continued):**

| BRAND NAME | GENERIC NAME | PRICING (AWP) | INDICATION | SIMILAR THERAPIES ON FORMULARY/AWP | DUEC VOTE |
|------------|--------------|---------------|------------|------------------------------------|-----------|
|------------|--------------|---------------|------------|------------------------------------|-----------|

|  |   |                |  |   |   |
|--|---|----------------|--|---|---|
| FLUZONE QUAD INJ                                 | influenza virus vac split quad intradermal pen      | \$24.70/pen    | flu vaccine  |   | Covered as per immun. policy  |
| BEXSERO INJ                                      | meningococcal Vac B inj in prefilled syringe        |                | Meningococcal vaccine  |   | Covered as per immun. policy  |
| <b>SPECIALTY DRUGS</b>                           |   |                |  |   |   |
| REYATAZ  | atazanavir oral powder packet 50mg                  | \$7.90 each    | New dosage formulation. For HIV infection  | Reyataz caps covered as specialty tier. 100mg cap = \$21.97   | Tier 3 PA, for infants >3m & children weighing 10-25kg, age edit of less than 7 years |
| VITEKTA  | elvitegravir tabs                                   | \$45.06/tab    | For use in combination with ritonavir, another protease inhibitor, and other antiretroviral drug (s) to treat HIV in adults who are antiretroviral experienced |   | Tier 3  |
| EVOTAZ TAB                                       | atazanavir 300mg-cobicistat 150 tab(Reyataz-Tybost) | \$56.14/tab    | Treatment of HIV infection   | Reyataz covered specialty tier (\$50.69/300mg tab) Tybost 150mg coded as excluded (\$7.20/150mg tab)  | Tier 3  |
| PREZCOBIX TAB                                    | darunavir 800mg-cobicistat 150mg(Prezista-Tybost)   | \$57.52/tab    | Treatment of HIV infection   | Prezista covered specialty tier (\$50.32/800mg tab) Tybost 150mg coded as excluded (\$7.20/150mg tab) | Tier 3  |
| COSENTYX INJ AUTO-INJECTOR AND PREFILLED SYRINGE | secukinumab SQ auto-injector ro prefilled syringe   | \$4,104/28 day | Human interleukin-17A antagonist indicated for treatment of moderate to severe plaque in adults who are candidates for systemic therapy or phototherapy        |   | Tier 4 PA   |

**Recommended Exclusions:**

| BRAND NAME | GENERIC NAME                      | PRICING (AWP)                    | INDICATION                              | SIMILAR THERAPIES ON FORMULARY/AWP   | Code |
|------------|-----------------------------------|----------------------------------|---|--|------|
| AFREZZA    | insulin regular(human) inhalation | \$271/box of 90-4unit cartridges | Inhaled insulin in 4 & 8 unit/cartridge | T2 plan options: Humulin R = \$71/10ml; Novolin R = \$60/10ml.<br>Note: Prices are listed at AWP | 13   |

|  |        |               |  |  |
|--|--------|---------------|--|--|
|  | powder | (\$0.75/unit) |  |  |
|--|--------|---------------|--|--|

**Recommended Exclusions (continued):**

| <b>BRAND NAME</b>       | <b>GENERIC NAME</b>                                 | <b>PRICING (AWP)</b>            | <b>INDICATION</b>   | <b>SIMILAR THERAPIES ON FORMULARY/AWP</b>   | <b>Code</b>                                  |
|-------------------------|---|---------------------------------|---|---|--|
| RAPIVAB                 | peramivir inj<br>200mg/20ml                         | \$380/20ml<br>vial              | Treatment of influenza infection in adults.<br>Dose=600mg IV as a single-dose infused over 15-30 minutes(given within 48 hours of onset of influenza symptoms)  |   | 13;<br>make sure excluded on J-codes as well |
| LIDOVEX CREAM 3.75%     | lidocream 3.75%                                     | \$1,297/60 gm tube              | Local anesthetics   | T1 plan options: lidocaine ointment 5%, lidocaine cream 3%  | 13   |
| QNASL CHILD SPRAY 40MCG | beclomethasone dipropionate nasal aerosol 40mcg/act | \$164/inhaler                   | Nasal steroid   | Plan options: generic products - azelastine, flunisolide, fluticasone - tier 1. Reference priced: Beconase, Beconase AQ, Flonase, Nasonex, mometasone, Rhinocort AQ, budesonide | 13   |
| OBREDON SOLUTION        | hydrocodone-guaifenesin soln 2.5-200mg/5ml          | \$5.75/5ml                      | Cold/cough/allergy combination  | Tier 1 products available guaifenesin/codeine   | 13   |
| RYTARY CAPS             | carbidopa & levodopa cap CR                         | \$2.76/cap                      | Treatment of Parkinson's disease  | Teir 1 plan options: carbidopa/levodopa extended release tabs = \$0.93/tab  | 13   |
| GLYXAMBI                | empagliflozin-linagliptin                           | \$19.20/tab                     | Treatment of Type 2 diabetes - combination of Jardiance[SGLT2] and Tradjenta[DPP-4 inhibitor]   | SGLT2 class excluded. Tradjenta is tier 3 with PA. Costs: Tradjenta - \$13.22/tab, Jardiance = \$13.71/tab  | 1  |
| DUOPA                   | carbidopa-levodopa entera suspension                | 1 box of 7 cartridges = \$1,694 | Enteral suspension of carbidopa-levodopa for the treatment of motor fluctuations for people with advanced Parkinson's disease. Duopa is administered using a small, portable infusion pump that delivers carbidopa & levodopa directly into the small |   | 13   |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
|  |  |  | intestine for 16 continuous hours via a procedurally placed tube |  |  |
|--|--|--|--|--|--|

**Recommended Exclusions (continued):**

| <b>BRAND NAME</b>      | <b>GENERIC NAME</b>                          | <b>PRICING (AWP)</b>   | <b>INDICATION</b>  | <b>SIMILAR THERAPIES ON FORMULARY/AWP</b> | <b>Code</b>         |
|------------------------|--|--|--|---|---------------------|
| SOTYLIZE SOLUTION      | sotalol oral solution 5mg/ml                 | \$1.50/ml  | Beta-adrenergic blocking agent. Oral solution of sotalol. Prior to approval of oral solution, the tablet form of the product was commonly compounded by pharmacists      | sotalol 80mg tab = \$0.45                 | 13                  |
| ROSULA                 | sulfacetamide w/sulfur wash 10-4.5%          | \$435/bottle   | For acne and seborrheic dermatitis   | Tier 1 generic options available          | 13                  |
| ONEXTON GEL            | clindamycin - benzoyl peroxide               | \$488/bottle   | Topical acne product   | Other like combinations excluded          | 13                  |
| <b>SPECIALTY DRUGS</b> |  |  |  |   |                     |
| BLINCYTO               | blinatumoma b for IV infusion                | \$3,814/35mcg  | For patients with Philadelphia chromosome-negative precursor B-cell acute lymphoblastic leukemia   |   | 1                   |
| MIRCERA                | methoxy polyethylene glycol-epoetin beta inj | 50mcg/\$108<br>75mcg/\$162<br>100mcg/\$216                               | Long-acting erythropoietin receptor activator indicated for treatment of anemia associated with chronic kidney disease. Dosed every 2 weeks.                             |   | 3                   |
| LYNPARAZA              | olaparib cap 50mg                            | \$30/cap.<br>Dose= 400mg by mouth twice a day.<br>\$13,440/448 caps      | Monotherapy with deleterious or suspected deleterious germline BRCA mutated advanced ovarian cancer who have been treated with three or more prior lines of chemotherapy |   | 1                   |
| IBRANCE CAP            | palbociclib                                  | \$11,802 for 21 day supply (125mg/day for 21 days, off 7 days and repeat | Treatment of advanced metastatic breast cancer   |   | 1; awaiting OS data |
| SIGNIFOR LAR INJ       | pasireotide for IM ER susp                   | Available in 20, 40, and 60mg. All strengths \$12,923/vial               | Treatment of patients with acromegaly. Initiate therapy with 4mg IM once every 28 days and may be increased to a max of 60mg   | Alternatives are octreotide.              | 13                  |

Not Reviewed/DCWG

| BRAND NAME                                    | INGREDIENTS  | PRICING (AWP)          | INDICATION   | SIMILAR THERAPIES ON FORMULARY/AWP | Code |
|---|--|------------------------|--|------------------------------------|------|
| <b>Compound Kits/Bulk Creams/Multivitamin</b> |  |                        |  |                                    |      |
| CLINOIN CREAM                                 | clindaymcin=tretinonoin-cholesty cream comp kit            |                        |  |                                    | 4    |
| FP NATURAL LOTION                             | lotion base  |                        |  |                                    | 4    |
| DIPENTOCAINE CREAM                            | diclofenac-gabapentin-lidocaine comp kit                   |                        |  |                                    | 4    |
| BIEST/PROGES CRE                              | estradiol-estriol-progesterone comp kit                    |                        |  |                                    | 4    |
| PCP 100 KIT                                   | mag cit-bisacodyl-petrolat-PEG-metoclopramide-electrol kit |                        |  |                                    | 4    |
| CENOVIA CREAM                                 | hydroquin-fluticas-tretinon cm kit                         |                        |  |                                    | 4    |
| CLARYS CREAM                                  | hydroquin-fluticas-tretinoin crem kit                      |                        |  |                                    | 4    |
| CLINDAP-T CREAM                               | adapalene-clindamycin cm kit                               |                        |  |                                    | 4    |
| EXTARDOL CREAM                                | amantadine-gabapen-diclofenac-baclofen-lido crm kit        |                        |  |                                    | 4    |
| GAPEAUM CRE BUDIBAC                           | bulk chemical compound kit                                 |                        |  |                                    | 4    |
| INNOPRAX-5 CREAM                              | amantadine-gabapent-diclofenac-baclofen-lido kit           |                        |  |                                    | 4    |
| SUPRACIL CRE                                  | fluorouracil-salicyclie cm kit                             |                        |  |                                    | 4    |
| TRISEON CREAM                                 | adapalene-clindaymycin - cm kit                            |                        |  |                                    | 4    |
| VALIDERM CRE                                  | calcitriol-fluticasone-tacrolimus cream kit                |                        |  |                                    | 4    |
| VERRUNEX                                      | fluorouracil-salicyclic cm kit                             |                        |  |                                    | 4    |
| NOVOCLAIR CRE                                 | tamoxifen-adapalene-diclofenac cm kit                      |                        |  |                                    | 4    |
| NUVYA   | tamoxifen-adapalene-diclofenac cm kit                      |                        |  |                                    | 4    |
| EMVOREN CRE                                   | diclofenac-amitripty-prilo-lido cm kit                     |                        |  |                                    | 4    |
| ZYVODOL                                       | diclofenac-amitripty-prilo-lido cm kit                     |                        |  |                                    | 4    |
| FLUORAC                                       | fluorouracil-diclofenac cm kit                             |                        |  |                                    | 4    |
| AMITRIPTYLIN CRE                              | bulk cm  |                        |  |                                    | 4    |
| BACLOFEN CRE                                  | bulk cm  |                        |  |                                    | 4    |
| OCUVEL  | multiple vitamins w/minerals & FA caps                     |                        | multivitamin   | multivitamin policy                | 7    |
| REVESTA CAP 1MG-5750                          | folic acid-cholecalciferol cap 1mg-5750 unit               | \$829/30 tabs          | folic acid/Vit D combo - not listed in Clinical Pharmacology | vitamin/no info                    | 7    |
| POLY-VI-FLOR MIS FS                           | pediatric multiple vitamins w/fluoride oral strip 1mg      | \$248/box of 30 strips | multivitamin strip   | vitamin policy                     | 7    |

**Not reviewed Misc:**

|                       |  |            |   |  |
|-----------------------|--|------------|---|--|
| EPIFIX                | amniotic membrane allograft (human)    |            | Surgical supply - not in scope of pharmacy benefits   |  |
| ZERBAXA INJECTION     | ceftolozane-tazobactam for inj 1-0.5GM | \$99/vial  | Combination IV anti-infective for complicated intra-abdominal and complicated urinary tract infections  | out of scope and/or DCW                                    |
| VYVANSE CAPS 10MG     | lisdexamfetamine dimesylate cap 10mg   |            | Vyvanse currently T3 with quantity limits and reference priced for members 26 and older. NOTE: new indication for Vyvanse - binge-eating disorder | new strength of covered product. Vyvanse reference priced. |
| PAIN RELIEF PAD PATCH | lidocaine-menthol patch 5-1%           | \$43/patch | Local anesthetics   | like products excluded                                     |
| SCAR PATCH PAD        | allantoin-lidocaine-petrolatum patch   | \$47/patch | Local anesthetics   | like products excluded                                     |
| PRECEDEX INJ          | dexmedetomidine IV solution            | n/a        | IV administered for sedation induction/maintenance - not in scope of pharmacy benefit   | out of scope and/or DCW                                    |

**Harrison motioned to adopt the recommendations. Mallory seconded. All were in favor.**

**Motion Approved****EBD REPORT:** *by Dr. David Keisner, UAMS*

Dr. Keisner reported at the previous board meeting the topic of vendor audits were discussed. The board requested input from the DUEC Committee in terms of what should be audited. The following are recommended:

- Brand/Generic fees are applied and priced correctly
- Singular Mac List is applied and priced correctly
- Rebates
- Eligibility
- Deductibles – to ensure they are calculated correctly on the high deductible plan
- “Lesser-than” Logic.
- AWP Discounts
- In-house: step therapy, quantity limits, prior authorizations, exclusions, etc.
- Contract Guarantees

## CATAMARAN AND VENDOR AUDITS: by Sarah Bujak, Catamaran

The following is an illustration of the previous audits performed:

| Current Deliverables                                     |   |                                     |  |                 |   |
|--|---|-------------------------------------|--|-----------------|---|
| Report   | Report Description  | Frequency                           | Recipient  | Delivery Method | Performance Guarantee                                     |
| MAC Appeal   | A report of all MAC appeals received during the month; includes product, appeal decision and response time; reported on a one-month lag   | Monthly                             | David Keisner  | ARBTask         | n/a   |
| Monthly MAC lists  | A report reflecting all changes to MACRC4250 made during the reporting month; reported on a one-month lag   | Monthly                             | Sherry Bryant  | ARBTask         | n/a   |
| Pass-Thru Reporting                                      | Report reflecting passthrough pricing structure; reported on a one-month lag  | Monthly                             | Lori Eden  | ARBTask         | n/a   |
| PMEC Newsletter  | A summary of Catamaran's PMEC (Pharmacy Membership Evaluation Committee) decisions; lists the pharmacy terminations, corrective actions, and follow-up actions from the previous meeting, along with attached documentation in support of the actions taken by Catamaran or provider communications as information only.  | Monthly                             | Bob Alexander, Lori Eden, Sherry Bryant, David Keisner | email           | n/a   |
| Performance Guarantee Report                             | Report reflecting how Catamaran performed against the Performance Guarantee's outlined in Appendix A of the contract/RFP  | Quarterly                           | Amy Tustison   | ARBTask         | Yes; \$1,000 per occurrence for failure to meet guarantee |
| Pharmacy Audit Recoveries                                | <p>Reporting on monies saved due to working with a pharmacy on a live claim rather than as part of an audit</p> <p><u>Live Audit</u><br/>A live audit is where, typically, the pharmacy is correcting at point of sale during an outreach and this creates a savings rather than a recovery. The additional benefit is the reduction in claim cost by managing the claims in a timely audit program. These savings are provided on the quarterly audit reports.</p> <p><u>Desk Audit</u><br/>Desk Audits are the more retrospective audit where the pharmacy has to submit documentation (hard copies, signature logs) for review by the audit team. Audits are closed typically without the pharmacy fixing the claim and therefore the audit takes time and finances are done in lump sums later. The financials related to these audits will have a natural lag while the pharmacies are placed on withholding and check by check Catamaran collects against the amount owed. We attempt to clear all the withholdings quarterly and produce checks.</p> | Quarterly                           | Marla Wallace  | email           | n/a   |
| Rebate Reporting   | Report of rebates received for the quarter; provided at Carrier/Account/Group level only as product level reporting is not available through the aggregator   | Quarterly                           | Amy Tustison   | ARBTask         | n/a   |
| IRS Form 1099  |   | Annual; by March 15 of each year    | Marla Wallace  | ARBTask         | Yes; \$100 per occurrence for failure to meet guarantee   |
| Confirmation letter regarding the Unclaimed Property Act |   | Annual; by November 15 of each year | Marla Wallace  | ARBTask         | Yes; \$100 per occurrence for failure to meet guarantee   |
| Available Deliverables                                   |   |                                     |  |                 |   |
| Report   | Report Description  | Frequency                           | Recipient  | Delivery Method | Performance Guarantee                                     |
| SSAE 16  | Report on controls placed in operation and test of operating effectiveness  | Annually as needed                  | TBD  | email           | n/a; section 2.0/S of the contract                        |

Bujak reported on the services provided by catamaran. They are as follows:

- Mac appeal report
- Monthly Mac List
- Pass through reporting
- Performance guarantee reports on a quarterly
- Pharmacy audit reports (live vs. desk audits)
- Quarterly payments for rebates
- Annual IRS form 1099
- Confirmation letter regarding unclaimed property

Dr. Kirtley requested information on several questions of concerns regarding the audits to be presented at the May 19<sup>th</sup> board meeting.

**DIRECTOR'S REPORT:** *by Bob Alexander, EBD Executive Director*

Alexander reported five (5) statutory bills passed that were presented to the legislative session, and discussed several statutory bills approved in the recent session.

McCook requested information from Qualchoice regarding incoming calls, dropped calls, and the timeline for processing claims. McCook is concerned with the performance standards as he represents retirees. McCook requested reports on a monthly and quarterly basis regarding the performance standards; with the first report to be presented at the benefits sub-committee meeting May 15<sup>th</sup>.

**Dr. Thompson motioned to acknowledge Dr. Kathryn Neill's, Associate Dean of the College of Pharmacy, service as the Chair of the DUEC Committee as the two year term ended. Dr. Kumpuris seconded. All were in favor.**

**Motion Approved**

**Meeting Adjourned at 2:46 p.m.**

**Arkansas State Employees (ASE) Financials - January 1, 2014 through March 31, 2014**

|              | GOLD          |                 | SILVER        |                 | BRONZE        |                 | GRAND TOTALS  |                 |
|--------------|---------------|-----------------|---------------|-----------------|---------------|-----------------|---------------|-----------------|
|              | Employee Only | Plus Dependents |
| Actives      | 24290         | 44598           | 1523          | 2819            | 2308          | 4510            | 28121         | 51927           |
| Retirees     | 2463          | 3425            | 25            | 37              | 55            | 103             | 2543          | 3565            |
| Medicare     | 8152          | 10812           |               |                 |               |                 | 8152          | 10812           |
| <b>TOTAL</b> | <b>34905</b>  | <b>58835</b>    | <b>1548</b>   | <b>2856</b>     | <b>2363</b>   | <b>4613</b>     | <b>38816</b>  | <b>66304</b>    |

**REVENUES & EXPENDITURES**

|   | Current Month        | Year to Date (3 months) |
|---|----------------------|-------------------------|
| <b>Funding</b>                          |                      |                         |
| State Contribution                      | \$ 14,317,578        | \$ 42,953,200           |
| Employee Contribution                   | \$ 7,636,636         | \$ 22,908,633           |
| Other                                   | \$ 1,247,102         | \$ 1,987,463            |
| Allocation for Actives - Plan Year 2014 | \$ 2,154,167         | \$ 6,462,500            |
| <b>Total Funding</b>                    | <b>\$ 25,355,483</b> | <b>\$ 74,311,796</b>    |
| <b>Expenses</b>                         |                      |                         |
| Medical Expenses                        |                      |                         |
| Claims Expense                          | \$ 13,154,499        | \$ 43,938,034           |
| Claims IBNR                             | \$ -                 | \$ -                    |
| Medical Administration Fees             | \$ 1,121,304         | \$ 3,310,903            |
| Refunds                                 | \$ 10,684            | \$ 42,371               |
| Employee Assistance Program (EAP)       | \$ 56,242            | \$ 168,711              |
| Life Insurance                          | \$ 54,747            | \$ 164,137              |
| Pharmacy Expenses                       |                      |                         |
| RX Claims                               | \$ 5,232,324         | \$ 16,584,154           |
| RX IBNR                                 | \$ -                 | \$ -                    |
| RX Administration                       | \$ 254,796           | \$ 763,156              |
| Plan Administration                     | \$ 372,618           | \$ 1,050,552            |
| <b>Total Expenses</b>                   | <b>\$ 20,257,215</b> | <b>\$ 66,022,019</b>    |
| <b>Net Income/(Loss)</b>                | <b>\$ 5,098,268</b>  | <b>\$ 8,289,777</b>     |

**BALANCE SHEET**

|  |   |                      |
|--|---|----------------------|
| <b>Assets</b>                            |   |                      |
| Bank Account                             |   | \$ 9,360,267         |
| State Treasury                           |   | \$ 71,491,322        |
| Due from Cafeteria Plan                  |   | \$ 668,305           |
| Due from PSE                             |   | \$ -                 |
| Receivable from Provider                 |   | \$ -                 |
| Accounts Receivable                      |   | \$ 439,134           |
| <b>Total Assets</b>                      |   | <b>\$ 81,959,028</b> |
| <b>Liabilities</b>                       |   |                      |
| Accounts Payable                         |   | \$ 2,520             |
| Deferred Revenues                        |   | \$ 4,920             |
| Due to Cafeteria                         |   | \$ 601               |
| Due to PSE                               |   | \$ 505,747           |
| Health IBNR                              |   | \$ 23,200,000        |
| RX IBNR                                  |   | \$ 2,400,000         |
| <b>Total Liabilities</b>                 |   | <b>\$ 26,113,788</b> |
| <b>Net Assets</b>                        |   | <b>\$ 55,845,240</b> |
| Less Reserves Allocated:                 |   |                      |
| Premiums for Plan Year 1/1/14 - 12/31/14 | (\$7,460,000 + \$9,390,000 + \$9,000,000) | \$ (19,387,500)      |
| Premiums for Plan Year 1/1/15 - 12/31/15 | (\$6,260,000 + \$5,400,000)               | \$ (11,660,000)      |
| Premiums for Plan Year 1/1/16 - 12/31/16 | (\$3,600,000)                             | \$ (3,600,000)       |
| Catastrophic Reserve                     |   | \$ (10,600,000)      |
| <b>Net Assets Available</b>              |   | <b>\$ 10,597,740</b> |

**Arkansas State Employees (ASE) Financials - January 1, 2015 through March 31, 2015**

|                | EMPLOYEE ONLY |             |             |              |  | EMPLOYEE + DEPENDENTS |             |              |              |
|----------------|---------------|-------------|-------------|--------------|--|-----------------------|-------------|--------------|--------------|
|                | ACTIVES       | RETIREES    | MEDICARE    | TOTAL        |  | ACTIVES               | RETIREES    | MEDICARE     | TOTAL        |
| <b>BASIC</b>   | 886           | 14          |             | 900          |  | 1568                  | 28          |              | 1596         |
| <b>CLASSIC</b> | 1822          | 55          |             | 1877         |  | 3134                  | 85          |              | 3219         |
| <b>PREMIUM</b> | 24704         | 2151        |             | 26855        |  | 43209                 | 2784        |              | 45993        |
| <b>PRIMARY</b> |               | 229         | 8667        | 8896         |  |                       | 469         | 11454        | 11923        |
| <b>TOTAL</b>   | <b>27412</b>  | <b>2449</b> | <b>8667</b> | <b>38528</b> |  | <b>47911</b>          | <b>3366</b> | <b>11454</b> | <b>62731</b> |

**REVENUES & EXPENDITURES**

|   | Current Month        | Year to Date (3 Months) |
|---|----------------------|-------------------------|
| <b>Funding</b>                          |                      |                         |
| State Contribution                      | \$ 14,362,878        | \$ 43,069,364           |
| Employee Contribution                   | \$ 8,047,498         | \$ 24,200,978           |
| Other                                   | \$ 711,116           | \$ 1,787,942            |
| Allocation for Actives - Plan Year 2015 | \$ 971,667           | \$ 2,915,000            |
| <b>Total Funding</b>                    | <b>\$ 24,093,159</b> | <b>\$ 71,973,285</b>    |
| <b>Expenses</b>                         |                      |                         |
| Medical Expenses                        |                      |                         |
| Claims Expense                          | \$ 10,873,595        | \$ 34,943,496           |
| Claims IBNR                             | \$ -                 | \$ -                    |
| Medical Administration Fees             | \$ 1,151,541         | \$ 3,195,108            |
| Refunds                                 | \$ (1,248)           | \$ (26,459)             |
| Employee Assistance Program (EAP)       | \$ 56,559            | \$ 169,561              |
| Life Insurance                          | \$ 55,141            | \$ 165,294              |
| Pharmacy Expenses                       |                      |                         |
| RX Claims                               | \$ 4,144,230         | \$ 15,049,230           |
| RX IBNR                                 | \$ -                 | \$ -                    |
| RX Administration                       | \$ 212,858           | \$ 637,604              |
| Plan Administration                     | \$ 288,301           | \$ 1,000,085            |
| <b>Total Expenses</b>                   | <b>\$ 16,780,977</b> | <b>\$ 55,133,920</b>    |
| <b>Net Income/(Loss)</b>                | <b>\$ 7,312,182</b>  | <b>\$ 16,839,365</b>    |

**BALANCE SHEET**

|  |                      |
|--|----------------------|
| <b>Assets</b>  |                      |
| Bank Account   | \$ 20,375,436        |
| State Treasury   | \$ 71,145,590        |
| Due from Cafeteria Plan  | \$ 709,521           |
| Due from PSE   | \$ -                 |
| Receivable from Provider   | \$ -                 |
| Accounts Receivable  | \$ 147,014           |
| <b>Total Assets</b>  | <b>\$ 92,377,560</b> |
| <b>Liabilities</b>   |                      |
| Accounts Payable   | \$ 4,014             |
| Deferred Revenues  | \$ -                 |
| Due to Cafeteria   | \$ 57                |
| Due to PSE   | \$ 344,690           |
| Due to Federal Government (\$44 fee)                                 | \$ -                 |
| Health IBNR  | \$ 24,700,000        |
| RX IBNR  | \$ 1,800,000         |
| <b>Total Liabilities</b>   | <b>\$ 26,848,761</b> |
| <b>Net Assets</b>  | <b>\$ 65,528,800</b> |
| Less Reserves Allocated  |                      |
| Premiums for Plan Year 1/1/15 - 12/31/15 (\$6,260,000 + \$5,400,000) | \$ (8,745,000)       |
| Premiums for Plan Year 1/1/16 - 12/31/16 (\$3,600,000)               | \$ (3,600,000)       |
| Catastrophic Reserve (2015 \$10,400,000)                             | \$ (10,400,000)      |
| <b>Net Assets Available</b>  | <b>\$ 42,783,800</b> |

Fifth Week of Claims \$

**Public School Employees (PSE) Financials - January 1, 2014 through March 31, 2014**

|              | GOLD          |                 | SILVER        |                 | BRONZE        |                 | GRAND TOTALS  |                 |
|--------------|---------------|-----------------|---------------|-----------------|---------------|-----------------|---------------|-----------------|
|              | Employee Only | Plus Dependents |
| Actives      | 18487         | 22438           | 5009          | 7838            | 23206         | 42008           | 46702         | 72284           |
| Retirees     | 1873          | 2179            | 102           | 105             | 1211          | 1517            | 3186          | 3801            |
| Medicare     | 8901          | 9753            |               |                 |               |                 | 8901          | 9753            |
| <b>TOTAL</b> | <b>29261</b>  | <b>34370</b>    | <b>5111</b>   | <b>7943</b>     | <b>24417</b>  | <b>43525</b>    | <b>58789</b>  | <b>85838</b>    |

**REVENUES & EXPENDITURES**

|   | Current Month        | Year to Date (3 months) |
|---|----------------------|-------------------------|
| <b>Funding</b>                                      |                      |                         |
| Per Participating Employee Funding (PPE Funding)    | \$ 8,485,280         | \$ 25,476,376           |
| Employee Contribution                               | \$ 10,134,339        | \$ 30,593,723           |
| Department of Education \$35,000,000 & \$15,000,000 | \$ 3,181,818         | \$ 13,295,455           |
| Other   | \$ 563,935           | \$ 575,226              |
| Allocation for Actives - Plan Year 2014             | \$ 3,583,333         | \$ 10,750,000           |
| <b>Total Funding</b>                                | <b>\$ 25,948,706</b> | <b>\$ 80,690,780</b>    |
| <b>Expenses</b>                                     |                      |                         |
| Medical Expenses                                    |                      |                         |
| Claims Expense                                      | \$ 14,237,825        | \$ 49,134,476           |
| Claims IBNR   | \$ -                 | \$ -                    |
| Medical Administration Fees                         | \$ 1,626,750         | \$ 4,803,909            |
| Refunds   | \$ 24,997            | \$ 51,304               |
| Employee Assistance Program (EAP)                   | \$ 80,827            | \$ 242,951              |
| Pharmacy Expenses                                   |                      |                         |
| RX Claims   | \$ 3,492,968         | \$ 11,691,478           |
| RX IBNR   | \$ -                 | \$ -                    |
| RX Administration                                   | \$ 332,999           | \$ 1,000,423            |
| Plan Administration                                 | \$ 443,903           | \$ 976,622              |
| <b>Total Expenses</b>                               | <b>\$ 20,240,269</b> | <b>\$ 67,901,163</b>    |
| <b>Net Income/(Loss)</b>                            | <b>\$ 5,708,436</b>  | <b>\$ 12,789,617</b>    |

**BALANCE SHEET**

|   |  |                      |
|---|--|----------------------|
| <b>Assets</b>   |  |                      |
| Bank Account  |  | \$ 21,100,540        |
| State Treasury  |  | \$ 49,123,666        |
| Receivable from Provider                                |  | \$ -                 |
| Accounts Receivable                                     |  | \$ 1,642,810         |
| Due from ASE  |  | \$ 505,747           |
| <b>Total Assets</b>                                     |  | <b>\$ 72,372,763</b> |
| <b>Liabilities</b>                                      |  |                      |
| Accounts Payable  |  | \$ 642               |
| Due to ASE  |  | \$ -                 |
| Deferred Revenues                                       |  | \$ -                 |
| Health IBNR   |  | \$ 28,000,000        |
| RX IBNR   |  | \$ 1,800,000         |
| <b>Total Liabilities</b>                                |  | <b>\$ 29,800,642</b> |
| <b>Net Assets</b>                                       |  | <b>\$ 42,572,121</b> |
| Less Reserves Allocated:                                |  |                      |
| Premiums for Plan Year 1/1/14 - 12/31/14 (\$43,000,000) |  | \$ (32,250,000)      |
| Catastrophic Reserve (2014 - \$11,100,000)              |  | \$ (10,322,121)      |
| <b>Net Assets Available</b>                             |  | <b>\$ (0)</b>        |

**Public School Employees (PSE) Financials - January 1, 2015 through March 31, 2015**

|                | EMPLOYEE ONLY |             |             |              | EMPLOYEE + DEPENDENTS |             |              |              |
|----------------|---------------|-------------|-------------|--------------|-----------------------|-------------|--------------|--------------|
|                | ACTIVES       | RETIREES    | MEDICARE    | TOTAL        | ACTIVES               | RETIREES    | MEDICARE     | TOTAL        |
| <b>BASIC</b>   | 2383          | 125         |             | 2508         | 3529                  | 150         |              | 3679         |
| <b>CLASSIC</b> | 21524         | 1578        |             | 23102        | 39456                 | 1921        |              | 41377        |
| <b>PREMIUM</b> | 20881         | 1298        |             | 22179        | 26785                 | 1398        |              | 28183        |
| <b>PRIMARY</b> |               | 111         | 9893        | 10004        |                       | 224         | 10822        | 11046        |
| <b>TOTAL</b>   | <b>44788</b>  | <b>3112</b> | <b>9893</b> | <b>57793</b> | <b>69770</b>          | <b>3693</b> | <b>10822</b> | <b>84285</b> |

**REVENUES & EXPENDITURES**

|   | Current<br>Month     | Year to Date<br>(3 Months) |
|---|----------------------|----------------------------|
| <b>Funding</b>                                      |                      |                            |
| Per Participating Employee Funding (PPE Funding)    | \$ 8,257,199         | \$ 24,754,572              |
| Employee Contribution                               | \$ 9,121,748         | \$ 27,561,833              |
| Department of Education \$35,000,000 & \$15,000,000 | \$ 19,475,771        | \$ 29,589,408              |
| Other   | \$ 829,072           | \$ 1,801,416               |
| Allocation for Actives                              | \$ 1,666,667         | \$ 5,000,000               |
| <b>Total Funding</b>                                | <b>\$ 39,350,457</b> | <b>\$ 88,707,229</b>       |
| <b>Expenses</b>                                     |                      |                            |
| Medical Expenses                                    |                      |                            |
| Claims Expense                                      | \$ 10,388,602        | \$ 36,703,663              |
| Claims IBNR   | \$ -                 | \$ -                       |
| Medical Administration Fees                         | \$ 1,569,656         | \$ 4,640,545               |
| Refunds   | \$ -                 | \$ (3,153)                 |
| Employee Assistance Program (EAP)                   | \$ 77,462            | \$ 232,531                 |
| Pharmacy Expenses                                   |                      |                            |
| RX Claims   | \$ 2,411,685         | \$ 9,199,339               |
| RX IBNR   | \$ -                 | \$ -                       |
| RX Administration                                   | \$ 293,859           | \$ 872,975                 |
| Plan Administration                                 | \$ 371,566           | \$ 1,167,459               |
| <b>Total Expenses</b>                               | <b>\$ 15,112,831</b> | <b>\$ 52,813,359</b>       |
| <b>Net Income/(Loss)</b>                            | <b>\$ 24,237,626</b> | <b>\$ 35,893,870</b>       |

**BALANCE SHEET**

|   |                       |
|---|-----------------------|
| <b>Assets</b>   |                       |
| Bank Account  | \$ 23,084,895         |
| State Treasury  | \$ 78,532,994         |
| Receivable from Provider  | \$ -                  |
| Accounts Receivable   | \$ 4,669,983          |
| Due to ASE  | \$ -                  |
| <b>Total Assets</b>   | <b>\$ 106,287,872</b> |
| <b>Liabilities</b>  |                       |
| Accounts Payable  | \$ 875                |
| Due to ASE  | \$ -                  |
| Deferred Revenues   | \$ -                  |
| Due to Federal Government (\$44 fee)  | \$ -                  |
| Health IBNR   | \$ 28,000,000         |
| RX IBNR   | \$ 1,400,000          |
| <b>Total Liabilities</b>  | <b>\$ 29,400,875</b>  |
| <b>Net Assets</b>   | <b>\$ 76,886,997</b>  |
| Less Reserves Allocated   |                       |
| Premiums for Plan Year 1/1/15 - 12/31/15 (\$20,000,000 rec'd from Dept. of Education) | \$ (15,000,000)       |
| Premium Assistance (FICA Savings)   | \$ (1,421,023)        |
| Catastrophic Reserve (2015 \$10,900,000)  | \$ (10,900,000)       |
| <b>Net Assets Available</b>   | <b>\$ 49,565,974</b>  |



## **State and Public School Life and Health Insurance Board Benefits Sub-Committee Summary Report**

The following report resulted from a meeting of the Benefits Sub-Committee from April 10, 2015 with Shelby McCook presiding.

### **Topics Discussed:**

- Alternate Provider Arrangement Consideration
- ARBenefits 2015 Renewal Analysis – Minnesota Life
- Review of Trends for Calendar year 2016 Rates - Cheiron

### **Alternate Provider Arrangement Consideration – Dr. Andrew Kumpuris, Board Member**

Dr. Kumpuris reported Healthcare is a market place. The market place consists of Physicians, Hospitals, Insurance Companies, and the users. Arkansas is divided into six (6) healthcare districts. There are six (6) market places in the state of Arkansas. Dr. Kumpuris recommended considering taking advantage of the purchasing power in terms of attempting to lower rates for the members.

There are Accountable Care Organizations forming around the country. These organizations are outside the normal healthcare industry. Arkansas has organizations formed in the central and western part of the state. In order to offer members lower provider rates take the population in one of the defined healthcare areas; with individuals bidding on all the services offered from, physician, to hospital, and pharmacy. This would provide lower rates for members. If the member chooses to go outside that care they would pay an amount that would be more costly.

Dr. Kumpuris has concerns that some areas of the state may have lower rates than others. For those areas Dr. Kumpuris recommended to implement an equalizer taking the savings from one area and subsidize the funds to an area that has less savings.

The benefits are; this will create a more competitive market place for physicians and hospitals to compete for patients, and savings to the members.

McCook recommended form a committee with the following members to serve:

- Dr. Andrew Kumpuris
- Shelby McCook
- Dr. John Kirtley
- Bob Boyd
- Dr. Joseph Thompson

Harrison motioned to recommend to the board to form a committee for research and review of the Alternate Provider Program. Haugen seconded. All were in favor.

## **Motion Approved**

### **ArBenefits 2015 Renewal Analysis – Brian Anderson, Eileen Wider - Minnesota Life**

The state's active basic life rate was reduced significantly in conjunction with the merger with the Schools, based on expected lower mortality rates among school district employees. When two different groups are brought together at the same time premium rates under a plan, premium rates are established based on expected average mortality across the group as a whole. In general government employees, so the State rates were reduced when the population merged with the Larger School population.

However, a number of unexpected changes took place in following the 2012 RFP that have impacted the experience and resulted in Minnesota Life collecting significantly less premium than expected, and necessary to cover the cost of claim and expenses.

- School Districts were allowed to opt out of the Minnesota Life Group Plan.

- The supplemental life lapse rate among participating school districts has been very high.
- A high number of schools employees chose to cancel existing supplemental life coverage and elect expanded basic life coverage instead.
- The retiree supplemental life rate was capped at \$3.70 for existing school district retirees as of January 1, 2013.

Altemus requested information in terms of the affect it would have if the active PSE employees were required to have the basic life as a part of their health insurance.

Walker requested if Retiree rates change that Minnesota life would send letters to members thirty (30) days prior to the change.

## **Review of Trends for Calendar Year 2016 Rates**

Based on actual January 2015 enrollment, but using the same underlying claims cost assumptions as were used to set 2015 rates:

- January 2015 enrollment shows a slight increase in the number of active employees but decreases in the number of spouses and retirees enrolled.
- More employees elected premium and fewer elected basic than assumed.
- More employees qualified for wellness incentive than assumed.
- PSE is now receiving FICA savings estimated at \$5.6 million for 2015
- Net Impact is expected to be a gain of \$2.9 million



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

The following report resulted from a meeting of the DUEC on April 6, 2015 with Dr. Kat Neill presiding.

**1. Recommended Changes to Current Coverage**

**A. Delivery Coordination Workgroup Report: by Dr. David Keisner, UAMS**

Drugs used in the treatment of Cancers and non-cancer drugs were reviewed by the DCWG and a report made to the DUEC on April 6<sup>th</sup>. Recommendations from this report are outlined below.

|  | <b>Current Coverage</b>      | <b>Proposed Coverage for 2015</b>                                 |
|--|------------------------------|---|
| <u>Multiple Sclerosis (MS)</u><br>Lemtrada (alemtuzumab) | New Drug                     | Medical PA  |
| <u>IVIG</u><br>Multiple Products                         | T4 PA Pharmacy<br>Medical PA | PA Pharmacy products for self administration<br>Remove Medical PA |
| <u>Metastatic Melanoma</u><br>Opdivo (nivolumab)         | New Drug                     | Medical PA  |

**B. TOPICAL NSAIDs REVIEW: by, Dr. Jill Johnson, UAMS**

Topical NSAIDs have shown to be as efficacious as oral NSAIDs in the available clinical trials. Topical NSAIDs were reported to have a better safety profile when compared to systemic NSAIDs. Predominantly these results reflect gastrointestinal adverse events such as nausea, dyspepsia, and abdominal pain which are typically manageable. GI bleeds were not addressed in any of the reviewed trials. Use of topical diclofenac for actinic keratosis may not be as effective as topical 5-FU. It is reasonable to NOT cover topical NSAIDs based on the current evidence. In the past six (6) months there have been 773 users.

| <b>Drug</b>                            | <b>Use</b> | <b>Current Coverage</b> | <b>Proposed Coverage</b>  |
|--|------------|-------------------------|---|
| Diclofenac Na transderm. soln 1.5%     | OA         | Tier 1                  | Exclude; 90 day communication to members (773 users in past 6 months) |
| Flector (diclofenac TD Patch) 1.3%     | Acute pain | Tier 3                  |   |
| Pennsaid (diclofenac TD soln) 1.5%, 2% | OA         | Tier 3                  |   |
| Voltaren (diclofenac TD gel) 1%        | OA         | Tier 3                  |   |
| Topical Diclofenac Gel 1%              | OA         | Tier 1                  |   |
| Diclofenac Na transderm gel 3%         | AK         | Tier 1                  |   |
| Solaraze (diclofenac TD gel) 3%        | AK         | Brand penalty           |   |

**C. SECOND REVIEW OF ONFI: by Dr. Jill Johnson, UAMS**

| <b>Drug</b>     | <b>Use</b>  | <b>Current Coverage</b> | <b>Proposed Coverage</b> |
|-----------------|---|-------------------------|--------------------------|
| Onfi (clobazam) | Lennox-Gastaut Syndrome<br>Uncontrolled drop seizures | Excluded                | Tier 3 PA                |

**D. Hepatitis C Review: by Dr. Jill Johnson, UAMS**

Dr. Johnson reported on information requested from board members. She met with Dr. Duarte, Liver Specialist at UAMS, regarding the current policy. The updated PA criteria are listed below. Updated coverage pathways are included as an addendum. The following modifications to current coverage and PA criteria are recommended.

1. Ensure the patient has CHRONIC hepatitis C. This requires either a HCV AB test and then a viral load 6m later OR two viral loads 6m apart. We only treat CHRONIC hcv. Up to 20% of Hep C infections resolve on their own.
2. Remove esophageal varices and history of variceal bleeding from the list of decompensation manifestations that would lead to denial of therapy (unless listed on a liver transplant list).
3. Allow treatment when comorbidities exist (chronic HBV, autoimmune hepatitis, alcoholic hepatitis, hemochromatosis, Wilson's disease, alpha1 antitrypsin deficiency) after referral to a gastroenterologist for treatment of concomitant diseases.
4. Include FibroScan and Fibrotest to APRI or FIB-4 as noninvasive tests to ascertain metavir F3 or F4 stage.
5. Allow access to Harvoni for GT1 treatment-naïve, interferon-eligible patients.
6. Following a completed therapy, if the patient experiences a relapse, he/she is eligible for retreatment. However, if treatment is abandoned, the patient would not be eligible to repeat the treatment.

**A. For any treatment to eradicate chronic hepatitis C virus (HCV)infection, the following criteria must be met regardless of which regimen is requested:**

|   |  |
|---|--|
| <p>1. The patient must test positive for chronic HCV infection. Two options:</p> <ul style="list-style-type: none"> <li>• HCV antibody ≥6m before a positive HCV RNA (viral load) , OR</li> <li>• 2 HCV RNA levels 6 months apart</li> </ul> <p><input type="checkbox"/>The viral load must be documented. _____</p> <p><input type="checkbox"/>The genotype and subtype must be documented. _____</p>  | <p>The diagnosis of CHRONIC HCV must be made. 15-25% seroconvert on their own and the patient clears the infection. We only treat chronic HCV infection.</p>                               |
| <p>2. The patient must be free of using illicit drugs for the past 6 months.</p> <p><input type="checkbox"/>A patient-signed statement attesting to this is acceptable.</p>   | <p>Any positive drug screen for injectable drug use during treatment stops access to the HCV drugs. Reinfection is a risk for IV drug users.</p>   |
| <p>3. The patient must be free of abusing ethanol for the past 6 months. (defined as &gt;3 glasses/d (1 glass is equivalent to beer 284 mL, wine 125 mL, or distilled spirits 25 mL for females and &gt;4 glasses/d for males).</p> <p><input type="checkbox"/>A patient-signed statement attesting to this is acceptable.</p>  |  |
| <p>4. If the patient has cirrhosis, there must be NO signs of decompensation (ascites, episodes of spontaneous bacterial peritonitis, hepatic encephalopathy,), unless the patient is currently listed for liver transplant.</p> <p><input type="checkbox"/>The drug profile for the past 1 year must be submitted.</p>   | <p>Unless currently LISTED on the liver transplant list. Patients with decompensation will not be treated unless currently listed on a verifiable list from a liver transplant center.</p> |
| <p>5. The patient with liver disease due to any cause other than HCV infection (chronic hepatitis B infection, autoimmune hepatitis, alcoholic hepatitis, hemochromatosis, Wilson's disease, alpha1 antitrypsin deficiency) should be referred to a gastroenterologist.</p>   |  |
| <p>6. The extent of fibrosis may be shown by liver biopsy, FIB-4, APRI, Fibroscan (transient elastography), or Fibrotest to demonstrate the patient has a Metavir score of F3 or F4.</p>  |  |
| <p>7. Patients with extrahepatic manifestations of chronic HCV infection are candidates for therapy regardless of corresponding Metavir score as long as they meet the other requirements above.</p>  |  |
| <p>8. If the patient was provided HCV eradication therapy and abandoned therapy, they are not eligible for a second course of treatment. If the patient completed but relapsed or had intolerance to the first course of therapy, then they would be eligible for subsequent treatment depending on what is requested and the clinical evidence.</p> <p><input type="checkbox"/>A review of the drug profile for fills provided in the past for HCV eradication drug therapy. Further explanation by the patient/physician may be required.</p> |  |

**B. Other questions which must be collected on EVERY patient seeking drug therapy for HCV infection:**

|   |  |
|---|--|
| <p>1. Is the patient currently on the liver transplant list? (Decompensated, metavir F4 patients are eligible for treatment, absent contraindications listed in #5 above.)</p>  |  |
| <p>2. Has the patient previously received any treatment for HCV infection? If so, what regimen and duration?</p> <p><input type="checkbox"/>This info must be captured even if drug was supplied by the manufacturer.</p>   | <p>This answer is needed to determine treatment eligibility.</p> |
| <p>3. HIV positive patients must have absolute CD4 counts above 500 and not require HAART therapy or currently receive HAART therapy if the absolute CD4 count is below 200, to be eligible for HCV eradication treatment.</p> <p><input type="checkbox"/>If HIV positive, the absolute CD4 count must be submitted from the past 6 months.</p> |  |

## 2. NEW DRUGS

Johnson reported on new drugs. The review covered products released February – March 2015.

### Recommended Additions:

| BRAND NAME           | GENERIC NAME                                  | PRICING (AWP)                 | INDICATION   | SIMILAR THERAPIES ON FORMULARY/AWP   | DUEC VOTE  |
|----------------------|---|-------------------------------|--|--|--|
| Arnuity              | Fluticasone furoate aerosol powder breath act | \$156/100mcg;<br>\$209/200mcg | New fluticasone formulation. Once daily inhaled corticosteroid for maintenance tx of asthma as prophylactic therapy – not indicated for relief of acute bronchospasm   | T2 plan options: Flovent HFA: 110 mcg/\$2131, 220 mcg/\$359. Pulmicort Flexihaler 90 mcg/\$165, 180mcg/\$250. QVAR: 40 mcg/\$167, 80 mcg/\$224 | Tier 2   |
| INCRUSE ELPT INHALER | umeclidinium BR aero powder breath act        | \$270/30 doses                | Long-term, once daily maintenance treatment of air flow obstruction in patients with COPD, including chronic bronchitis and/or emphysema   | T2 plan options: Spiriva Respimat 60 doses/\$357; Spiriva Handihaler Powder/\$357. Tudorza Press air powder for inhalation: \$336/60 doses     | Tier 2   |
| SOOLANTRA CREAM      | ivermectin cream                              | \$330/30gm                    | Treatment of inflammatory lesions of rosacea   | T1 plan option: topical metronidazole gel, cream - \$42/45gm   | Tier 3, QL of 30 g tube/30d  |
| SAVAYSA TABS         | edoxaban tosylate                             | \$11.08/tab                   | Oral anticoagulant for reduction in the risk of stroke and systemic embolism in patients with atrial fibrillation that is unrelated to valvular heart disease and for treatment of DVT and PE in patients initially treated with an injectable anticoagulant |  | Tier 2, QL   |
| MOVANTIK             | naloxegol oxalate                             | \$9.98/tab (dose= 1 tab/day)  | Treatment of opioid-induced constipation in adults with chronic non-cancer pain  | Tier 3 plan options for opioid induced constipation: Amitiza/\$9.90 per day. Relistor by subcutaneous injection/\$86 every other day           | Cover, Tier3, QL of 1/1, revisit in 6 months (Sept 2015) for price reasons bring to DCWG in Sept 2015. |
| ZUBSOLV SUB 8.6-2.1  | buprenorphin e-naloxone SL tab 8.6-2.1mg      | \$12.67/tab                   | new dosage form  | Other ZUBSOLV strengths excluded by plan   | TIER 3 PA, QL #62/31. Revisit on 09/25/15.   |
| PAZEO DROPS          | olopatadine opgth solution 0.7%               | \$179/2.5ml                   | For ocular allergy itch relief   | Tier 1 plan options: azelastine/\$104 per 6 ml; olopatadine/\$78/5ml   | Tier 3   |

**Recommended Additions (continued):**

| BRAND NAME                                       | GENERIC NAME  | PRICING (AWP)  | INDICATION   | SIMILAR THERAPIES ON FORMULARY/AWP  | DUEC VOTE   |
|--|---|----------------|--|---|---|
| FLUZONE QUAD INJ                                 | influenza virus vac split quad intradermal pen      | \$24.70/pen    | flu vaccine  |   | Covered as per immun. policy  |
| BEXSERO INJ                                      | meningococcal Vac B inj in prefiiled syringe        |                | Meningococcal vaccine  |   | Covered as per immun. policy  |
| <b>SPECIALTY DRUGS</b>                           |   |                |  |   |   |
| REYATAZ  | atazanavir oral powder packet 50mg                  | \$7.90 each    | New dosage formulation. For HIV infection  | Reyataz caps covered as specialty tier. 100mg cap = \$21.97   | Tier 3 PA, for infants >3m & children weighing 10-25kg, age edit of less than 7 years |
| VITEKTA  | elvitegravir tabs                                   | \$45.06/tab    | For use in combination with ritonavir, another protease inhibitor, and other antiretroviral drug (s) to treat HIV in adults who are antiretroviral experienced |   | Tier 3  |
| EVOTAZ TAB                                       | atazanavir 300mg-cobicistat 150 tab(Reyataz-Tybost) | \$56.14/tab    | Treatment of HIV infection   | Reyataz covered specialty tier (\$50.69/300mg tab) Tybost 150mg coded as excluded (\$7.20/150mg tab)  | Tier 3  |
| PREZCOBIX TAB                                    | darunavir 800mg-cobicistat 150mg(Prezista-Tybost)   | \$57.52/tab    | Treatment of HIV infection   | Prezista covered specialty tier (\$50.32/800mg tab) Tybost 150mg coded as excluded (\$7.20/150mg tab) | Tier 3  |
| COSENTYX INJ AUTO-INJECTOR AND PREFILLED SYRINGE | secukinumab SQ auto-injector ro prefiiled syringe   | \$4,104/28 day | Human interleukin-17A antagonist indicated for treatment of moderate to severe plaque in adults who are candidates for systemic therapy or phototherapy        |   | Tier 4 PA   |

**Recommended Exclusions:**

| BRAND NAME | GENERIC NAME                             | PRICING (AWP)                                  | INDICATION                              | SIMILAR THERAPIES ON FORMULARY/AWP  | Code |
|------------|--|--|---|---|------|
| AFREZZA    | insulin regular(human) inhalation powder | \$271/box of 90-4unit cartridges (\$0.75/unit) | Inhaled insulin in 4 & 8 unit/cartridge | T2 plan options: Humulin R = \$71/10ml; Novolin R = \$60/10ml. Note: Prices are listed at AWP | 13   |

**Recommended Exclusions (continued):**

| <b>BRAND NAME</b>       | <b>GENERIC NAME</b>                                 | <b>PRICING (AWP)</b>            | <b>INDICATION</b>  | <b>SIMILAR THERAPIES ON FORMULARY/AWP</b>   | <b>Code</b>                                  |
|-------------------------|---|---------------------------------|--|---|--|
| RAPIVAB                 | peramivir inj<br>200mg/20ml                         | \$380/20ml<br>vial              | Treatment of influenza infection in adults.<br>Dose=600mg IV as a single-dose infused over 15-30 minutes(given within 48 hours of onset of influenza symptoms)   |   | 13;<br>make sure excluded on J-codes as well |
| LIDOVEX CREAM 3.75%     | lidocream 3.75%                                     | \$1,297/60 gm tube              | Local anesthetics  | T1 plan options: lidocaine ointment 5%, lidocaine cream 3%  | 13   |
| QNASL CHILD SPRAY 40MCG | beclomethasone dipropionate nasal aerosol 40mcg/act | \$164/inhaler                   | Nasal steroid  | Plan options: generic products - azelastine, flunisolide, fluticasone - tier 1. Reference priced: Beconase, Beconase AQ, Flonase, Nasonex, mometasone, Rhinocort AQ, budesonide | 13   |
| OBREDON SOLUTION        | hydrocodone-guaifenesin soln 2.5-200mg/5ml          | \$5.75/5ml                      | Cold/cough/allergy combination   | Tier 1 products available guaifenesin/codeine   | 13   |
| RYTARY CAPS             | carbidopa & levodopa cap CR                         | \$2.76/cap                      | Treatment of Parkinson's disease   | Teir 1 plan options: carbidopa/levodopa extended release tabs = \$0.93/tab  | 13   |
| GLYXAMBI                | empagliflozin-linagliptin                           | \$19.20/tab                     | Treatment of Type 2 diabetes - combination of Jardiance[SGLT2] and Tradjenta[DPP-4 inhibitor]  | SGLT2 class excluded. Tradjenta is tier 3 with PA. Costs: Tradjenta - \$13.22/tab, Jardiance = \$13.71/tab  | 1  |
| DUOPA                   | carbidopa-levodopa entera suspension                | 1 box of 7 cartridges = \$1,694 | Enteral suspension of carbidopa-levodopa for the treatment of motor fluctuations for people with advanced Parkinson's disease. Duopa is administered using a small, portable infusion pump that delivers carbidopa & levodopa directly into the small intestine for 16 continuous hours via a procedurally placed tube |   | 13   |

**Recommended Exclusions (continued):**

| <b>BRAND NAME</b>      | <b>GENERIC NAME</b>                          | <b>PRICING (AWP)</b>   | <b>INDICATION</b>  | <b>SIMILAR THERAPIES ON FORMULARY/AWP</b> | <b>Code</b>         |
|------------------------|--|--|--|---|---------------------|
| SOTYLIZE SOLUTION      | sotalol oral solution 5mg/ml                 | \$1.50/ml  | Beta-adrenergic blocking agent. Oral solution of sotalol. Prior to approval of oral solution, the tablet form of the product was commonly compounded by pharmacists      | sotalol 80mg tab = \$0.45                 | 13                  |
| ROSULA                 | sulfacetamide w/sulfur wash 10-4.5%          | \$435/bottle   | For acne and seborrheic dermatitis   | Tier 1 generic options available          | 13                  |
| ONEXTON GEL            | clindamycin - benzoyl peroxide               | \$488/bottle   | Topical acne product   | Other like combinations excluded          | 13                  |
| <b>SPECIALTY DRUGS</b> |  |  |  |   |                     |
| BLINCYTO               | blinatumoma b for IV infusion                | \$3,814/35mcg  | For patients with Philadelphia chromosome-negative precursor B-cell acute lymphoblastic leukemia   |   | 1                   |
| MIRCERA                | methoxy polyethylene glycol-epoetin beta inj | 50mcg/\$108<br>75mcg/\$162<br>100mcg/\$216                               | Long-acting erythropoietin receptor activator indicated for treatment of anemia associated with chronic kidney disease. Dosed every 2 weeks.                             |   | 3                   |
| LYNPARAZA              | olaparib cap 50mg                            | \$30/cap.<br>Dose= 400mg by mouth twice a day.<br>\$13,440/448 caps      | Monotherapy with deleterious or suspected deleterious germline BRCA mutated advanced ovarian cancer who have been treated with three or more prior lines of chemotherapy |   | 1                   |
| IBRANCE CAP            | palbociclib                                  | \$11,802 for 21 day supply (125mg/day for 21 days, off 7 days and repeat | Treatment of advanced metastatic breast cancer   |   | 1; awaiting OS data |
| SIGNIFOR LAR INJ       | pasireotide for IM ER susp                   | Available in 20, 40, and 60mg. All strengths \$12,923/vial               | Treatment of patients with acromegaly. Initiate therapy with 4mg IM once every 28 days and may be increased to a max of 60mg   | Alternatives are octreotide.              | 13                  |

Not Reviewed/DCWG

| BRAND NAME                                    | INGREDIENTS  | PRICING (AWP)          | INDICATION   | SIMILAR THERAPIES ON FORMULARY/AWP | Code |
|---|--|------------------------|--|------------------------------------|------|
| <b>Compound Kits/Bulk Creams/Multivitamin</b> |  |                        |  |                                    |      |
| CLINOIN CREAM                                 | clindaymcin=tretinonoin-cholesty cream comp kit            |                        |  |                                    | 4    |
| FP NATURAL LOTION                             | lotion base  |                        |  |                                    | 4    |
| DIPENTOCAINE CREAM                            | diclofenac-gabapentin-lidocaine comp kit                   |                        |  |                                    | 4    |
| BIEST/PROGES CRE                              | estradiol-estriol-progesterone comp kit                    |                        |  |                                    | 4    |
| PCP 100 KIT                                   | mag cit-bisacodyl-petrolat-PEG-metoclopramide-electrol kit |                        |  |                                    | 4    |
| CENOVIA CREAM                                 | hydroquin-fluticas-tretinon cm kit                         |                        |  |                                    | 4    |
| CLARYS CREAM                                  | hydroquin-fluticas-tretinoin crem kit                      |                        |  |                                    | 4    |
| CLINDAP-T CREAM                               | adapalene-clindamycin cm kit                               |                        |  |                                    | 4    |
| EXTARDOL CREAM                                | amantadine-gabapen-diclofenac-baclofen-lido crm kit        |                        |  |                                    | 4    |
| GAPEAUM CRE BUDIBAC                           | bulk chemical compound kit                                 |                        |  |                                    | 4    |
| INNOPRAX-5 CREAM                              | amantadine-gabapent-diclofenac-baclofen-lido kit           |                        |  |                                    | 4    |
| SUPRACIL CRE                                  | fluorouracil-salicyclie cm kit                             |                        |  |                                    | 4    |
| TRISEON CREAM                                 | adapalene-clindaymycin - cm kit                            |                        |  |                                    | 4    |
| VALIDERM CRE                                  | calcitriol-fluticasone-tacrolimus cream kit                |                        |  |                                    | 4    |
| VERRUNEX                                      | fluorouracil-salicyclic cm kit                             |                        |  |                                    | 4    |
| NOVOCLAIR CRE                                 | tamoxifen-adapalene-diclofenac cm kit                      |                        |  |                                    | 4    |
| NUVYA   | tamoxifen-adapalene-diclofenac cm kit                      |                        |  |                                    | 4    |
| EMVOREN CRE                                   | diclofenac-amitripty-prilo-lido cm kit                     |                        |  |                                    | 4    |
| ZYVODOL                                       | diclofenac-amitripty-prilo-lido cm kit                     |                        |  |                                    | 4    |
| FLUORAC                                       | fluorouracil-diclofenac cm kit                             |                        |  |                                    | 4    |
| AMITRIPTYLIN CRE                              | bulk cm  |                        |  |                                    | 4    |
| BACLOFEN CRE                                  | bulk cm  |                        |  |                                    | 4    |
| OCUVEL  | multiple vitamins w/minerals & FA caps                     |                        | multivitamin   | multivitamin policy                | 7    |
| REVESTA CAP 1MG-5750                          | folic acid-cholecalciferol cap 1mg-5750 unit               | \$829/30 tabs          | folic acid/Vit D combo - not listed in Clinical Pharmacology | vitamin/no info                    | 7    |
| POLY-VI-FLOR MIS FS                           | pediatric multiple vitamins w/fluoride oral strip 1mg      | \$248/box of 30 strips | multivitamin strip   | vitamin policy                     | 7    |

**Not reviewed Misc:**

|                       |  |            |   |  |
|-----------------------|--|------------|---|--|
| EPIFIX                | amniotic membrane allograft (human)    |            | Surgical supply - not in scope of pharmacy benefits   |  |
| ZERBAXA INJECTION     | ceftolozane-tazobactam for inj 1-0.5GM | \$99/vial  | Combination IV anti-infective for complicated intra-abdominal and complicated urinary tract infections  | out of scope and/or DCW                                    |
| VYVANSE CAPS 10MG     | lisdexamfetamine dimesylate cap 10mg   |            | Vyvanse currently T3 with quantity limits and reference priced for members 26 and older. NOTE: new indication for Vyvanse - binge-eating disorder | new strength of covered product. Vyvanse reference priced. |
| PAIN RELIEF PAD PATCH | lidocaine-menthol patch 5-1%           | \$43/patch | Local anesthetics   | like products excluded                                     |
| SCAR PATCH PAD        | allantoin-lidocaine-petrolatum patch   | \$47/patch | Local anesthetics   | like products excluded                                     |
| PRECEDEX INJ          | dexmedetomidine IV solution            | n/a        | IV administered for sedation induction/maintenance - not in scope of pharmacy benefit   | out of scope and/or DCW                                    |

**3. EBD REPORT: by Dr. David Keisner, UAMS**

Dr. Keisner reported at the previous board meeting the topic of vendor audits were discussed. The board requested input from the DUEC Committee in terms of what should be audited. The following are recommended:

- Brand/Generic fees are applied and priced correctly
- Singular Mac List is applied and priced correctly
- Rebates
- Eligibility
- Deductibles – to ensure they are calculated correctly on the high deductible plan
- “Lesser-than” Logic.
- AWP Discounts
- In-house: step therapy, quantity limits, Prior Authorizations, exclusions, etc.
- Contract Guarantees

***Respectfully submitted,***

**Kathryn Neill, PharmD  
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  | <b>Convenience Kit Policy</b> - 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  | <b>Medical Food Policy</b> - 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.<br>A medical food is defined below:<br>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."<br>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  | <b>Cough &amp; Cold Policy</b> - 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  | <b>Multivitamin Policy</b> - 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 | <b>Oral Contraceptives Policy</b> - 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   |

Addendum: HCV Cliff Notes with all options 4/9/15  
 Jill Johnson, Pharm.D., BCPS

Note: All noncirrhosis must be Metavir F3 to treat. Underlined/bolded are the preferred treatment regimens for EBD patients.

| GT1 |   | AWP   |
|-----|---|---|
| 1   | GT1 treatment naïve, noncirrhosis, interferon eligible                                  | Sofosbuvir PR X12w 89% \$115,642<br>Sofosbuvir/simeprevir 12w \$180,432<br>Simeprevir PR \$138,992<br><u><b>Harvoni 8w</b></u> \$75,600<br>GT1a Viekira + R 12w \$102,347<br>GT1b Viekira 12w \$99,983  |
| 2   | GT1 treatment naïve, noncirrhosis, interferon-INeligible                                | <u><b>Harvoni 8w</b></u> \$75,600<br>Sofosbuvir/simeprevir 12w \$180,432<br>GT1a Viekira + R 12w \$102,347<br>GT1b Viekira 12w \$99,983   |
| 3   | GT1 treatment naïve, decompensated F4 cirrhosis <u>AND listed for liver transplant,</u> | Harvoni 12w \$113,400<br><u><b>ViekiraR 12w</b></u> \$99,983  |
| 4   | GT1 treatment naïve, compensated cirrhosis (F4),interferon-eligible                     | Sofosbuvir PR X 12w \$115,642<br>Harvoni 12w \$113,400<br><u><b>ViekiraR 12w</b></u> \$99,983   |
| 5   | GT1 treatment naïve, compensated cirrhosis, interferon-INeligible                       | Sofos/Sime 12w, 93%SVR12 (All F3/F4) \$180,432<br>Harvoni 12w, 99%SVR12 (only 16% had comp cirrhosis) \$113,400<br><u><b>ViekiraR 12w 94%SVR12 (100% w/ cirrhosis)</b></u> \$102,347<br>Viekira 12w 99%SVR12 (13% were F3) \$99,983   |
| 6   | GT1 Prior nonresponders to PR, noncirrhosis   | Simeprevir12PR48, 53%SVR \$138,992<br>Harvoni 12w 94%, 24w=99% (39% had received prev tx with PR;61% had received prev tx w/ PI)(45% were prev nonresponders; 55% were prev relapsers). \$113,400-\$226,800<br><u><b>ViekiraR12: GT1 SVR 93% (Kowdley)</b></u> \$102,347<br>ViekiraR12: GT1 SVR=95.2% (SAPPHIRE-II) \$102,347<br><u><b>Viekira12: GT1b 100% (PEARL-II)</b></u> \$99,983 |
| 7   | GT1 Prior nonresponders to PR, compensated cirrhosis                                    | Simep12/PR48 53%SVR; (not stated number of cirrhosis) Not a good response<br>Harvoni 12w 93.6% (but included only 20% w/ cirrhosis). \$113,400<br><u><b>ViekiraR 12w: GT1a SVR 80% (TURQUOISE-II)</b></u> \$102,347<br>ViekiraR 24w: GT1a SVR 92.9% (TURQUOISE-II) \$199,966<br><u><b>ViekiraR 12w: GT1b 100% (TURQUOISE-II)</b></u> \$102,347  |

|            |   |   |  |
|------------|---|---|--|
| 8          | GT1 Prior nonresponder to BPR or TPR, noncirrhosis                                    | F3s are covered:<br><b>Harvoni 12w 94%</b>  | \$113,400  |
| 9          | GT1 Prior relapsers after PR, noncirrhosis  | Sime12PR48 SVR79-83% (PROMISE,ASPIRE)<br>Harvoni 12w SVR=93.6% (ION-2)<br><b>ViekiraR12: GT1a SVR=95.3% (SAPPHIRE-II)</b><br><b>ViekiraR12: GT1b SVR=100% (PEARL-II)</b>  | \$138,992 poor response<br>\$113,400<br>\$102,347<br>\$102,347 |
| 10         | GT1 Prior relapsers after PR, compensated cirrhosis                                   | Sime/sofos 24w (SVR100%, n=16)<br>Sime12PR48 (SVR 77%), but not reported #w/prevcirrhosis<br>Harvoni 12w (SVR 93% w/ 55%represent by relapsers; only 20%w/cirrhosis)<br><b>ViekiraR 12w (GT1a) (SVR 93.3%)(Turquoise-II)</b><br>ViekiraR 24w (GT1b) (SVR 100%) (Turquoise-II) | \$360,864<br>\$138,992<br>\$113,400<br>\$102,347<br>\$199,966  |
| 11         | GT1, treatment experienced, coinfectd w/ HIV  | <b>Cover same as without HIV.</b>   |  |
| <b>GT2</b> |   |   |  |
| 12         | GT2 trtmt naïve, w/or w/o compensated cirrhosis                                       | <b>PR24w</b>  | \$29,680   |
| 13         | GT2 treatment(PR)-experienced   | F3s:<br><b>Sofosbuvir+R 12w (SVR88%)</b>  | \$103,163  |
| 14         | GT2 treatment naïve, unable to take interferon, noncirrhotic                          | F3s:<br><b>Sofosbuvir+R 12w (SVR88%)</b>  | \$103,163  |
| 15         | GT2 treatment naïve, unable to take interferon, compensated cirrhotic                 | <b>Sofosbuvir+R 12w</b>   | \$103,163  |
| <b>GT3</b> |   |   |  |
| 16         | GT3 treatment naïve, with or without compensated cirrhosis if able to take interferon | <b>PR24w</b>  | \$29,680   |
| 17         | GT3 treatment naïve, NONcirrhotic, unable to take interferon                          | <b>SR 24</b>  | \$206,326  |
| 18         | GT3 treatment-experienced, compensated cirrhosis, interferon INeligible               | <b>SR 24</b>  | \$206,326  |
| <b>GT4</b> |   |   |  |
| 19         | GT4, interferon eligible, treatment naïve, NONcirrhotics                              | F3s: <b>SPR12w</b>  | \$115,642  |
| 20         | GT4, interferon eligible, treatment naïve, compensated cirrhosis                      | <b>SPR12w</b>   | \$115,642  |

|    |                            |              |  |
|----|----------------------------|--------------|--|
|    |                            |              |  |
| 21 | GT4, interferon ineligible | Not covered. |  |
|    |                            |              |  |
|    | GT5                        |              |  |
| 22 | GT5                        | Not covered. |  |
|    | GT6                        |              |  |
| 23 | GT6                        | Not covered. |  |

**Addendum: Hepatitis C**  
**EBRx Prior Authorization Criteria**  
**04/09/2015**  
**Jill Johnson, Pharm.D., BCPS**

**A.** For any treatment to eradicate chronic hepatitis C virus (HCV)infection, the following criteria must be met regardless of which regimen is requested:

|  |  |
|--|--|
| <p>1. The patient must test positive for chronic HCV infection. Two options:</p> <ul style="list-style-type: none"> <li>• HCV antibody <math>\geq</math>6m before a positive HCV RNA (viral load) , OR</li> <li>• 2 HCV RNA levels 6 months apart</li> </ul> <p><input type="checkbox"/> The viral load must be documented. _____</p> <p><input type="checkbox"/> The genotype and subtype must be documented. _____</p>   | <p>The diagnosis of CHRONIC HCV must be made. 15-25% seroconvert on their own and the patient clears the infection. We only treat chronic HCV infection.</p>                               |
| <p>2. The patient must be free of using illicit drugs for the past 6 months.</p> <p><input type="checkbox"/> A patient-signed statement attesting to this is acceptable.</p>   | <p>Any positive drug screen for injectable drug use during treatment stops access to the HCV drugs. Reinfection is a risk for IV drug users.</p>   |
| <p>3. The patient must be free of abusing ethanol for the past 6 months. (defined as &gt;3 glasses/d (1 glass is equivalent to beer 284 mL, wine 125 mL, or distilled spirits 25 mL for females and &gt;4 glasses/d for males).</p> <p><input type="checkbox"/> A patient-signed statement attesting to this is acceptable.</p>  |  |
| <p>4. If the patient has cirrhosis, there must be NO signs of decompensation (ascites, episodes of spontaneous bacterial peritonitis, hepatic encephalopathy,), unless the patient is currently listed for liver transplant.</p> <p><input type="checkbox"/> The drug profile for the past 1 year must be submitted.</p>   | <p>Unless currently LISTED on the liver transplant list. Patients with decompensation will not be treated unless currently listed on a verifiable list from a liver transplant center.</p> |
| <p>5. The patient with liver disease due to any cause other than HCV infection (chronic hepatitis B infection, autoimmune hepatitis, alcoholic hepatitis, hemochromatosis, Wilson’s disease, alpha1 antitrypsin deficiency) should be referred to a gastroenterologist.</p>  |  |
| <p>6. The extent of fibrosis may be shown by liver biopsy, FIB-4, APRI, Fibroscan (transient elastography), or Fibrotest to demonstrate the patient has a Metavir score of F3 or F4.</p>   |  |
| <p>7. Patients with extrahepatic manifestations of chronic HCV infection are candidates for therapy regardless of corresponding Metavir score as long as they meet the other requirements above.</p>   |  |
| <p>8. If the patient was provided HCV eradication therapy and abandoned therapy, they are not eligible for a second course of treatment. If the patient completed but relapsed or had intolerance to the first course of therapy, then they would be eligible for subsequent treatment depending on what is requested and the clinical evidence.</p> <p><input type="checkbox"/> A review of the drug profile for fills provided in the past for HCV eradication drug therapy. Further explanation by the patient/physician may be required.</p> |  |

**B.** Other questions which must be collected on EVERY patient seeking drug therapy for HCV infection:

|  |  |
|--|--|
| <p>1. Is the patient currently on the liver transplant list? (Decompensated, metavir F4 patients are eligible for treatment, absent contraindications listed in #5 above.)</p>   |  |
| <p>2. Has the patient previously received any treatment for HCV infection? If so, what regimen and duration?</p> <p><input type="checkbox"/> This info must be captured even if drug was supplied by the manufacturer.</p>   | <p>This answer is needed to determine treatment eligibility.</p> |
| <p>3. HIV positive patients must have absolute CD4 counts above 500 and not require HAART therapy or currently receive HAART therapy if the absolute CD4 count is below 200, to be eligible for HCV eradication treatment.</p> <p><input type="checkbox"/> If HIV positive, the absolute CD4 count must be submitted from the past 6 months.</p> |  |

**C. Coverage Policies**

The premise for the policies below is multifactorial.

First, chronic HCV is a progressive disease that takes decades to develop cirrhosis or hepatocellular carcinoma and only 20% develop cirrhosis over 20-30 years and 5% die from cirrhosis or liver cancer. Second, achieving a sustained viral response 12 or 24 weeks after the end of drug therapy (SVR12 or SVR24) is not a cure. SVR is a surrogate marker for the actual outcome of liver morbidity or mortality (including decompensated liver cirrhosis, hepatocellular carcinoma, liver transplantation, or death from liver related causes). Thus the objective is not how many patients develop SVRs but how many are spared from ESLD. None of the drug trials evaluated these outcomes. All the studies linking SVR to clinical outcomes are observational studies and are subject to confounding. Additionally, patients who achieve SVR remain at risk for developing HCC, although the risk is lower than if SVR had not been achieved. To date (2/10/15), all data showing a decrease in liver morbidity or mortality included interferon + ribavirin in the HCV eradication therapy. There are no data to show a non-interferon containing regimen for HCV eradication reduces liver-related morbidity or mortality. However, the available observational studies with interferon show achieving an SVR24 correlates to improved quality of life and reduction in fatigue, and approximately an 80% decrease in decompensated liver disease, HCC, liver transplant, and all-cause mortality. It appears that some risk for HCC remains, even in those achieving SVR.

| Condition                          | Number of individuals |
|------------------------------------|-----------------------|
| Infection with hepatitis C         | 100                   |
| Develop symptoms                   | 20-30                 |
| Remain asymptomatic                | 70-80                 |
| Develop chronic infection          | 75-85                 |
| Develop chronic liver disease      | 60-70                 |
| Develop cirrhosis over 20-30 years | 5-20                  |
| Die from cirrhosis or liver cancer | 1-5                   |

**Current Data (3/22/15):**

| GT1 |  | Sofosbuvir PR  | Sofosbuvir/Simep  | Simeprevir PR  | Harvoni   | Viekira Pak |
|-----|--|--|---|--|-----------|-------------|
| 1   | GT1 treatment naïve, noncirrhosis, interferon eligible | SPR12 covered if Metavir score F3.   | Not covered. Relapse reported to be 13%.  | Effective.   | Effective | Effective.  |
|     |  | Boceprevir: Poordad, et al, showed BPR was effective.<br>Boceprevir: Kwo, et al, showed BPR was effective.<br>Boceprevir: Sulkowski, et al, in HIV+ population, showed B triple tx works.<br>Telaprevir: Sulkowski, et al, in HIV+ population, showed T triple tx works.<br>Sofosbuvir: NEUTRINO showed sofos to be effective. Had 17% cirrhotics. | Cosmos, part of cohort-2. 76% were GT1a. They were F3 or F4. Some in cohort 2 had previous failure of PR. | NEUTRINO<br>Boceprevir & telaprevir triple therapy is effective.<br>Unknown which of the 3 is more effective. Must have Q80K negativity for simeprevir.<br>QUEST-1 & -2. |           |             |

|   |  |  |                                |                                   |   |  |
|---|--|--|--------------------------------|-----------------------------------|---|--|
|   |  | Sofosbuvir: Study 1910. In HIV+ population showed sofosPR is effective. Lawitz, Lalezari, et al. Comparative sofosbuvirPR vs PR trial. 0% cirrhotics. High PR response rate. Ledipasvir+sofos. Afdhal, et al. Ledipasvir+sofos has efficacy. No SOC control arm. |                                |                                   |   |  |
| 2 | GT1 treatment naïve, noncirrhosis, interferon-INeligible                             | Contains interferon.   | Not covered. Relapse rate 13%. | Not covered. Contains interferon. | Harvoni 8w (LONESTAR, ION-3)  | GT1a with ribavirin. GT1b without ribavirin for 12 w. (PEARLIII/IV).   |
|   |  | Sofosbuvir: PHOTON-1 (via PI) showed sofos +R to be effective. No control arms. Ledipasvir+sofos. Afdhal, et al. Ledipasvir+sofos has efficacy. No SOC control arm.  | Cosmos, Part of cohort-2.      |                                   |   |  |
| 3 | GT1 treatment naïve, decompensated cirrhosis <u>AND</u> listed for liver transplant, | Not covered.   | Not covered.                   | Not covered.                      | Harvoni 12w (ION-1, but only 16% had cirrhosis; results not broken down by cirrhosis)   | GT1a or 1b: ViekiraR 12w (TURQUOISEII)   |
|   |  |  |                                |                                   | Package insert states, “No dosage adjustment of HARVONI is required for patients with mild, moderate, or severe hepatic impairment (Child-Pugh Class A, B, or C). Safety and efficacy of HARVONI have not been established in patients with decompensated cirrhosis”. | TURQUOISEII showed GT1a SVR=92% regardless of 12 or 24w. All were cirrhotic. All received R. GT1b,SVR=100%,12w or 24w. Package insert says, “VIEKIRA PAK is not recommended in HCV-infected patients with moderate hepatic impairment (Child-Pugh B). VIEKIRA PAK is contraindicated in patients with severe (Child-Pugh C) hepatic impairment.” |
| 4 | GT1 treatment naïve, compensated cirrhosis, interferon-eligible                      | Covered for 12 w combined w/ PR.   |                                |                                   | Harvoni 12w   | ViekiraR 12w (regardless of GT1a/b—add R due to cirrhosis and Turquoise-II data)   |

| GT1 |   | Sofosbuvir PR  | Sofosbuvir/Simep                        | Simeprevir PR   | Harvoni   | Viekira Pak  |
|-----|---|--|---|---|---|--|
|     |   | <p>Boceprevir: Poordad, et al, showed BPR was effective. Had 7-11% cirrhotics.</p> <p>Telaprevir: Jacobson, et al. showed telaprevir is effective. Had 6-7% cirrhotics.</p> <p>NEUTRINO</p> <p>Lepidasvir+sofos. Afdhal, et al. Ledipasvir+sofos has efficacy. No SOC control arm. Had 16% cirrhotics.</p>   |   | <p>QUEST-1 &amp; -2. Had up to 10% cirrhotics. Unknown which of the 3 DAAs is more effective. Must have Q80K negativity for simeprevir.</p> <p>Boceprevir: Poordad, et al, showed BPR was effective. Had 7-11% cirrhotics.</p> <p>Telaprevir: Jacobson, et al. showed telaprevir is effective. Had 6-7% cirrhotics.</p>   | <p>SVR was 99% (but only 16% in this population represents compensated cirrhosis.)</p>                                      | <p>Turquoise II-showed a 92%-96% SVR12.</p>  |
| 5   | GT1 treatment naïve, compensated cirrhosis, interferon-INeligible | Not covered. These patients cannot take interferon.  | 93% SVR12 (all F3 or F4), Sofos/Sime12w | Not covered.  | 99% w Harvoni 12w (only 16% had comp cirrhosis)   | 92.2% w/ ViekiraR 12w  |
|     |   | <p>No peer-reviewed data to support use of non-interferon regimens in this population.</p> <p>COSMOS, Cohort 2, treatment naïve with cirrhosis. Noncomparative trial. Exclusion of “nonvirologic failures”, (not ITT). Phase 2. Small N. (We reject COSMOS until it undergoes peer review and is published and available through PubMed.)</p> <p>Osinusi, Meissner, et al. S+R showed 68% SVR24 with weightbased R. Compared only to non-wt-based R.</p> | Relapse high and costliest regimen.     | <p>No peer-reviewed data to support use of non-interferon regimens in this population.</p> <p>COSMOS, Cohort 2, treatment naïve with cirrhosis. Noncomparative trial. Exclusion of “nonvirologic failures”, (not ITT). Phase 2. Not yet published. Small N. (We reject COSMOS until it undergoes peer review and is published and available through PubMed.)</p> <p>Osinusi, Meissner, et al. S+R showed 68% SVR24 with weightbased R. Compared only to non-wt-based R.</p> |   | <p>Turquoise-II-100% of this population had cirrhosis, Child-Pugh Class A.</p>                         |
| GT1 |   | Sofosbuvir PR  | Sofosbuvir/Simep                        | Simeprevir PR   | Harvoni   | Viekira Pak  |
| 6   | GT1 Prior nonresponders to PR, noncirrhosis                       | Not covered. Await more advanced disease. SR (without PEG) SVR 10%.  |   | 53%SVR w simep12/PR48 (ASPIRE) (not stated number w/ cirrhosis); not covered.   | SVR overall for Harvoni12w was 94% (45% were prior non responders; 55% were prior relapsers) but included 20% w/ cirrhosis. | <p>GT1 SVR 93% (Kowdley, et al.)</p> <p>GT1a SVR=95.2% w/ ViekPak 12w</p> <p>GT1b SVR=100% w/ Viek</p> |

|   |  |   |  |   |  |  |
|---|--|---|--|---|--|--|
|   |  |   |  |   | Noncirrhosis must be F3.   | Pak 12w (PEARL-II)   |
|   |  | Boceprevir: Bacon, et al, showed boceprevir is effective.<br>Telaprevir: McHutchison et al, showed telaprevir is effective.<br>Telaprevir: Zeuzem, et al, showed telaprevir is effective.<br>Sofosbuvir: COSMOS. Cohort 2 (prior nonresponders, metavir 4) shows sofos is effective but had inadequate power and no comparative arms. Optimist-1 and Optimist-2 (sofos+simep), phase 3 began recruiting 4/2014. |  | From PI: PROMISE showed simeprevir works better than PR. No comparisons to triple tx.<br>COSMOS was noncomparative and no power to determine conclusion. Awaiting Optimist-1 and -2.                              | ION-2. Harvoni24w SVR=99%.   | GT1a overall=SVR96%;<br>GT1b overall=SVR96.7% in SAPPHIRE-II.<br>GT1b SVR93% with Riba, 100% w/o Riba in PEARL-II  |
| 7 | GT1 Prior nonresponders to PR, compensated cirrhosis | No data. Not covered.   | (COSMOS was all F0-2).<br>Not covered. | 53%SVR w simep12/PR48 (ASPIRE) (not stated number w/ cirrhosis); not covered.   | SVR overall for Harvoni12w was 93.6% (prior non responders) but included only 20% w/ cirrhosis.  | GT1a SVR80% w/ViekiraR 12w<br>GT1a SVR 92.9% w/ViekiraR 24w<br>GT1b100% w/ViekiraR12w (TURQUOISE-II)   |
|   |  | COSMOS was not comparative to other triple therapy or other double therapy.   |  | Other triple therapy is covered and response rates are similar or better with boceprevir regimens.<br>Bacon, et al.<br>McHutchison, et al.<br>Zeuzem, et al.<br>PROMISE (simeprevir PI)<br>ASPIRE (simeprevir PI) |  | Turquoise-II—All these pts had cirrhosis (Metavir score >3 by liver biopsy or FibroScan, A Child-Pugh class A of <7; prev telaprevir or bocep users were excluded.)<br>The 80% and 92.9% rates for GT1a confidence intervals overlapped. |
| 8 | GT1 Prior nonresponder to BPR or TPR, noncirrhosis   | No data.  | No data.                               | No data.  | F3s are covered Harvoni12w. (ION-2)  | No data. SAPPHIRE-II excluded prev PI pts.   |
|   |  |   |  | No data.  | ION-2 data: 89% had previous bocep or telap exposure. (39% had received prev tx with PR;61% had received prev tx w/ PI)(45% were prev nonresponders; 55% were prev relapsers). |  |
| 9 | GT1 Prior relapsers after PR, noncirrhosis           | Not covered.  | No Data.                               | SVR was 79%(PROMISE), 83%(ASPIRE). Must be Q80K negative. Sample included 20% cirrhotics. Sime12PR48.   | Harvoni 12. SVR was 93.6% overall. (55% were relapsers. ION-2).  | GT1 a or b: ViekiraR 12w, SVR 96% (SAPPHIRE-II- excluded F3 & F4)<br><b>NO DATA in F3s</b>   |

|    |   |   |   |  |   |  |
|----|---|---|---|--|---|--|
|    |   |   |   |  |   | GT1b: ViekiraR 12w, SVR 100% (PEARL-II)<br><b>NO DATA in F3s</b>   |
|    |   |   | COSMOS was prior null responders, not prior relapsers                               | PROMISE. ASPIRE.   | ION-2   | SAPPHIRE-II.   |
| 10 | GT1 Prior relapsers after PR, compensated cirrhosis | No data. Not Covered.   | (COSMOS)57% were previous nonresponders. Sime/sofos 24w overall SVR was 100% (n=16) | (ASPIRE)77%SVR w/ Sime12PR48 but not reported how many had cirrhosis. NOT Covered.   | SVR overall for Harvoni12w was 93.6% (but only 55% were previous relapsers and included only 20% w/ cirrhosis). | GT1a: ViekiraR 24w, SVR 100%<br>GT1b: ViekiraR 12w, SVR 100% (TURQUOISE-II)  |
|    | <b>GT1</b>  | <b>Sofosbuvir PR</b>  | <b>Sofosbuvir/Simep</b>   | <b>Simeprevir PR</b>   | <b>Harvoni</b>  | <b>Viekira Pak</b>   |
|    |   | No peer-reviewed data to support use of non-interferon regimens in this population.<br>COSMOS, Cohort 2, treatment naïve with cirrhosis. Noncomparative trial. Exclusion of “nonvirologic failures”, (not ITT). Phase 2.<br>Osinusi, Meissner, et al. S+R showed 68% SVR24 with weightbased R. Compared only to non-wt-based R.<br>Boceprevir: Bacon, et al, showed boceprevir is effective. Had 10-14% cirrhotics<br>Telaprevir: McHutchison et al, showed telaprevir is effective. Had 11-20% cirrhotics.<br>Telaprevir: Zeuzem, et al, showed telaprevir is effective. Had 23-27% cirrhotics.<br>Sofosbuvir: COSMOS. Cohort 2 (prior nonresponders, metavir 4) shows sofos is effective. |   | Bacon BR, et al. Boceprevir evidence.<br>PROMISE provides evidence that simeprevir12PR12, PR12 is effective.<br>McHutchison provides evidence that T12PR24 is effective. |   | Turquoise II: in GT1a relapsers, treatment for 24w instead of 12w increased SVR from 93.3 to 100%. GT1b relapsers achieved 100%SVR w/ 12w. |
| 11 | GT1, treatment experienced, coinfectd w/ HIV        | Cover same as without HIV.  | Cover same as without HIV.  | Cover same as without HIV.   | Cover same as without HIV.  | Cover same as without HIV.   |
| 12 | GT2 trtmt naïve, w/or w/o compensated cirrhosis     | Not covered. Peginterferon + ribavirin is covered and should be dosed according to patient weight.  | Not covered   | Not covered.   | Not covered   | Not covered.   |
|    |   | FISSION (GT2, tx-naïve) compared SR12 to PR24 but used higher R   |   |  |   |  |

|            |   |   |                         |                      |                |                    |
|------------|---|---|-------------------------|----------------------|----------------|--------------------|
|            |   | dose in the SR12 group, creating a confounder where we can't tell if it was a function of the R dose. Previous data (Osinusi a, et al. Jama 2013;310(8):804-11, showed R dose matters. PHOTON (HIV+ population) provides evidence of efficacy; n=26), however, it did not have a control arm to compare to. Unknown whether PR if more effective. |                         |                      |                |                    |
| <b>GT</b>  |   | <b>Sofosbuvir PR</b>  | <b>Sofosbuvir/Simep</b> | <b>Simeprevir PR</b> | <b>Harvoni</b> | <b>Viekira Pak</b> |
| 13         | GT2 treatment(PR)-experienced   | Sofosbuvir + R 12w without Peg. SVR 88% (VALENCE)   | No data                 | No data              | No data        | No data            |
|            |   | FUSION (19% of included pts) showed efficacy in 82% w/ SVR12. No comparative arm. VALENCE (although Valence became a descriptive trial only after a mid-trial protocol amendment.)  |                         |                      |                |                    |
| 14         | GT2 treatment naïve, unable to take interferon, noncirrhotic          | Sofosbuvir + R 12w without Peg. SVR 88% (VALENCE)   | Not covered.            | Not covered.         | Not covered.   | Not covered.       |
|            |   | FUSION (19% of included pts) showed efficacy. POSITRON (all w/ inability to take interferon) showed SR12 effective. Nothing to compare to.  |                         |                      |                |                    |
| 15         | GT2 treatment naïve, unable to take interferon, compensated cirrhotic | Sofosbuvir + R 12w without Peg. SVR 88% (VALENCE)   | Not covered.            | Not covered.         | Not covered.   | Not covered.       |
|            |   | Due to this being the best current alternative in a cirrhotic patient, it is justifiable to treat. FUSION (19% of included pts) showed efficacy. POSITRON (all w/ inability to take interferon) showed SR12 effective.  |                         |                      |                |                    |
| <b>GT3</b> |   | <b>Sofosbuvir PR or Sofosbuvir-Riba</b>   | <b>Sofosbuvir/Simep</b> | <b>Simeprevir PR</b> | <b>Harvoni</b> | <b>Viekira Pak</b> |
| 16         | GT3 treatment naïve, with or  | Not covered. Sofosbuvir with ribavirin and without peginterferon  | No data.                | No data.             | No data.       | No data.           |

|            |   |  |          |  |          |          |
|------------|---|--|----------|--|----------|----------|
|            | without compensated cirrhosis if able to take interferon                | also not covered. No comparative data to know if it is any better than PR alone. (PR 24 would be preferred.)   |          |  |          |          |
|            |   | FISSION showed a worse SVR12 compared to PR24 despite the larger R dose in the SR12 arm. Therefore, may not be as effective as PR24.<br>VALENCE showed efficacy in GT3 w/ SR24, however, no control arm.<br>PHOTON showed efficacy in GT3 with SR24. |          |  |          |          |
| 17         | GT3 treatment naïve, NONcirrhotic, unable to take interferon            | F3s:<br>Sofosbuvir + Ribavirin 24w (SVR was 92%) (VALENCE)   | No data. | No data.                                     | No data. | No data. |
|            |   | VALENCE  |          |  |          |          |
| 18         | GT3 treatment-experienced, compensated cirrhosis, interferon INeligible | Covered with ribavirin X24 weeks (SVR 60%)VALENCE  | No data. | No data.                                     | No data. | No data. |
|            |   | FUSION & POSITRON; the alternative is PR and these patients are either interferon-experienced or ineligible for it.  |          |  |          |          |
| <b>GT4</b> |   |  |          |  |          |          |
| 19         | GT4, interferon eligible, treatment naïve, NONcirrhotics                | SPR 12w (SVR96%)NEUTRINO   | No data. | No data.                                     | No data. | No data. |
|            |   | NEUTRINO showed 96% for GT4, however, the number of patients representing this population is small.<br>N=28  |          |  |          |          |
| 20         | GT4, interferon eligible, treatment naïve, compensated cirrhosis        | SPR X12w   | No data. | No data.                                     | No data. | No data. |
|            |   | NEUTRINO. Not as much time to wait.  |          |  |          |          |
| 21         | GT4, interferon ineligible  | Not covered (or desired).  | No data. | No data.                                     | No data. | No data. |
|            |   | Evidence is in abstract form only from April 2014 EASL meeting. Ruane PJ, et al.   |          | Awaiting trial results per AASLD guidelines. |          |          |

| GT5 |     |  |          |          |          |          |
|-----|-----|--|----------|----------|----------|----------|
| 22  | GT5 | Not covered.                           | No data. | No data. | No data. | No data. |
|     |     | NEUTRINO included an N=1 GT5 patient.  |          |          |          |          |
| GT6 |     |  |          |          |          |          |
| 23  | GT6 | Not covered.                           | No data. | No data. | No data. | No data. |
|     |     | NEUTRINO included an N=6 GT6 patients. |          |          |          |          |

\*In all cases in which ribavirin is covered, the dose must be weight-based.

\*\*Acceptable reasons for interferon ineligibility are listed below and must be documented PREVIOUSLY in the medical record:

- dermatomyositis, immune (idiopathic) thrombocytopenic purpura, inflammatory bowel disease, interstitial lung disease, interstitial nephritis, polymyositis, psoriasis, rheumatoid arthritis, sarcoidosis, systemic lupus erythematosus,
- Significant psychiatric disease necessitating hospitalization or period of disability or a history of psychosis, schizophrenia, bipolar disorder, moderate depression, schizoaffective disorder, suicidal ideation, or suicide attempt documented in the medical record.
- Significant local or systemic adverse reaction to IFN (e.g., hypersensitivity, injection site reactions),
- Significant cognitive impairment,
- Neuropathy,
- Thrombocytopenia (platelets < 25,000/ $\mu$ L),
- Neutropenia (ANC < 500/ $\mu$ L),
- Development of colitis, non-alcoholic pancreatitis or ophthalmologic disorders,
- Seizure disorder,
- Poorly controlled thyroid dysfunction;
- hyperthyroidism (TSH  $\geq$  2 x the upper limit of normal (ULN) and  $\leq$  10 x ULN) or hypothyroidism (TSH < the lower limit of normal (LLN) and > 0.1  $\mu$ IU/mL)
- Retinal disease

\*\*\*Fibrosis refers to Metavir F3 and cirrhosis refers to F4. A liver biopsy is required to differentiate between the two.

## Executive Summary

- Attached is a summary of estimated split experience for the ASE and PSE populations. While loss ratios for the ASE group are generally higher than loss ratios for the PSE group, this is expected due to different expected mortality rates for the two groups.
- The State's active basic life rate was reduced significantly in conjunction with the merger with the Schools, based on expected lower mortality rates among school district employees. When two different groups are brought together at the same premium rates under a plan, premium rates are established based on expected average mortality across the group as a whole. In general, actuarial analyses find that school employees have lower mortality rates than general government employees, so the State rates were reduced when the population merged with the larger Schools population.
- However, a number of unexpected changes took place following the 2012 RFP that have impacted the experience and resulted in Minnesota Life collecting significantly less premium than expected and than necessary to cover the cost of claims and expenses:
  - School districts were allowed to opt out of the Minnesota Life group plan.
  - The supplemental life lapse rate among participating school districts has been very high.
  - A high number of schools employees chose to cancel existing supplemental life coverage and elect expanded basic life coverage instead.
  - The retiree supplemental life rate was capped at \$3.70 for existing school district retirees as of January 1, 2013.
- Following the experience summary is a summary of expected experience had all PSE supplemental life volume transferred to Minnesota Life and had PSE supplemental retiree coverage for retirees age 75+ been paid for at the proposed \$7.12 rate. The analysis shows that the current premium rates would be appropriate for the upcoming rate guarantee period.
- Based on actual enrollment though, there are several lines of coverage performing poorly for both ASE and PSE. Our renewal recommendation is to confine the renewal rate increases to these coverages and to increase the PSE retiree supplemental life age 75+ rate to the original proposed rate and the rate charged for active employees and ASE retirees:
  - Retiree Basic Life: 200% increase
  - Retiree Expanded Basic Life: 200% increase
  - Retiree Supplemental Life: 10.5% increase (result of increasing PSE 75+ rate to \$7.12)
  - Active and Retiree Spouse Life: 50% increase

## Estimated ASE versus PSE Experience

### Active Basic

|              | <u>% Total</u> | <u>Estimated Premium<sup>1</sup></u> | <u>Incurred Claims<sup>2</sup></u> | <u>Loss Ratio</u> | <u>Change to Current<sup>3</sup></u> |
|--------------|----------------|--------------------------------------|------------------------------------|-------------------|--------------------------------------|
| State        | 35.4%          | 1,098,884                            | 1,392,051                          | 126.7%            | 42.9%                                |
| Schools      | 64.6%          | 2,001,641                            | 2,020,224                          | 100.9%            | 13.9%                                |
| <b>Total</b> | <b>100.0%</b>  | <b>3,100,525</b>                     | <b>3,412,275</b>                   | <b>110.1%</b>     | <b>24.1%</b>                         |

### Retiree Basic

|              | <u>% Total</u> | <u>Estimated Premium<sup>1</sup></u> | <u>Incurred Claims<sup>2</sup></u> | <u>Loss Ratio</u> | <u>Change to Current<sup>3</sup></u> |
|--------------|----------------|--------------------------------------|------------------------------------|-------------------|--------------------------------------|
| State        | 95.0%          | 280,580                              | 2,385,369                          | 850.2%            | 859.0%                               |
| Schools      | 5.0%           | 14,767                               | 116,558                            | 789.3%            | 790.4%                               |
| <b>Total</b> | <b>100.0%</b>  | <b>295,347</b>                       | <b>2,501,927</b>                   | <b>847.1%</b>     | <b>855.6%</b>                        |

### Active Exp Basic

|              | <u>% Total</u> | <u>Estimated Premium<sup>1</sup></u> | <u>Incurred Claims<sup>2</sup></u> | <u>Loss Ratio</u> | <u>Change to Current<sup>3</sup></u> |
|--------------|----------------|--------------------------------------|------------------------------------|-------------------|--------------------------------------|
| State        | 33.6%          | 693,167                              | 374,111                            | 54.0%             | -39.1%                               |
| Schools      | 66.4%          | 1,368,774                            | 259,194                            | 18.9%             | -78.6%                               |
| <b>Total</b> | <b>100.0%</b>  | <b>2,061,941</b>                     | <b>633,305</b>                     | <b>30.7%</b>      | <b>-65.4%</b>                        |

### Retiree Exp Basic

|              | <u>% Total</u> | <u>Estimated Premium<sup>1</sup></u> | <u>Incurred Claims<sup>2</sup></u> | <u>Loss Ratio</u> | <u>Change to Current<sup>3</sup></u> |
|--------------|----------------|--------------------------------------|------------------------------------|-------------------|--------------------------------------|
| State        | 50.0%          | 11,899                               | 53,924                             | 453.2%            | 411.2%                               |
| Schools      | 50.0%          | 11,899                               | 26,771                             | 225.0%            | 153.8%                               |
| <b>Total</b> | <b>100.0%</b>  | <b>23,799</b>                        | <b>80,695</b>                      | <b>339.1%</b>     | <b>282.5%</b>                        |

### Active Supplemental

|              | <u>% Total</u> | <u>Estimated Premium<sup>1</sup></u> | <u>Incurred Claims<sup>2</sup></u> | <u>Loss Ratio</u> | <u>Change to Current<sup>3</sup></u> |
|--------------|----------------|--------------------------------------|------------------------------------|-------------------|--------------------------------------|
| State        | 50.0%          | 3,102,984                            | 1,556,100                          | 50.1%             | -43.4%                               |
| Schools      | 50.0%          | 3,102,908                            | 2,032,283                          | 65.5%             | -26.1%                               |
| <b>Total</b> | <b>100.0%</b>  | <b>6,205,892</b>                     | <b>3,588,383</b>                   | <b>57.8%</b>      | <b>-34.8%</b>                        |

### Retiree Supplemental

|              | <u>% Total</u> | <u>Estimated Premium<sup>1</sup></u> | <u>Incurred Claims<sup>2</sup></u> | <u>Loss Ratio</u> | <u>Change to Current<sup>3</sup></u> |
|--------------|----------------|--------------------------------------|------------------------------------|-------------------|--------------------------------------|
| State        | 35.8%          | 1,621,659                            | 1,390,459                          | 85.7%             | -3.3%                                |
| Schools      | 64.2%          | 2,908,082                            | 3,668,183                          | 126.1%            | 42.3%                                |
| <b>Total</b> | <b>100.0%</b>  | <b>4,529,741</b>                     | <b>5,058,642</b>                   | <b>111.7%</b>     | <b>26.0%</b>                         |

### Active Spouse

|              | <u>% Total</u> | <u>Estimated Premium<sup>1</sup></u> | <u>Incurred Claims<sup>2</sup></u> | <u>Loss Ratio</u> | <u>Change to Current<sup>3</sup></u> |
|--------------|----------------|--------------------------------------|------------------------------------|-------------------|--------------------------------------|
| State        | 55.9%          | 629,594                              | 629,749                            | 100.0%            | 12.8%                                |
| Schools      | 44.1%          | 497,627                              | 808,741                            | 162.5%            | 83.3%                                |
| <b>Total</b> | <b>100.0%</b>  | <b>1,127,221</b>                     | <b>1,438,490</b>                   | <b>127.6%</b>     | <b>44.0%</b>                         |

### Retiree Spouse

|              | <u>% Total</u> | <u>Estimated Premium<sup>1</sup></u> | <u>Incurred Claims<sup>2</sup></u> | <u>Loss Ratio</u> | <u>Change to Current<sup>3</sup></u> |
|--------------|----------------|--------------------------------------|------------------------------------|-------------------|--------------------------------------|
| State        | 96.2%          | 100,617                              | 495,657                            | 492.6%            | 455.7%                               |
| Schools      | 3.8%           | 4,027                                | 13,576                             | 337.1%            | 280.3%                               |
| <b>Total</b> | <b>100.0%</b>  | <b>104,644</b>                       | <b>509,233</b>                     | <b>486.6%</b>     | <b>448.9%</b>                        |

### TOTAL

|              | <u>% Total</u> | <u>Estimated Premium<sup>1</sup></u> | <u>Incurred Claims<sup>2</sup></u> | <u>Loss Ratio</u> | <u>Change to Current<sup>3</sup></u> |
|--------------|----------------|--------------------------------------|------------------------------------|-------------------|--------------------------------------|
| State        | 43.2%          | 7,539,384                            | 8,277,420                          | 109.8%            | 23.8%                                |
| Schools      | 56.8%          | 9,909,725                            | 8,945,530                          | 90.3%             | 1.8%                                 |
| <b>Total</b> | <b>100.0%</b>  | <b>17,449,110</b>                    | <b>17,222,950</b>                  | <b>98.7%</b>      | <b>11.3%</b>                         |

<sup>1</sup>Active paid premium split based on current ASE to PSE enrollment; retiree paid premium split based on internal premium allocations

<sup>2</sup>Incurred claims split based on information provided by ARBenefits

<sup>3</sup>Change to Current equals Loss Ratio divided by target loss ratio

## Adjusted ASE versus PSE Experience

### Adjustments

Increase PSE active supplemental premium to expected premium based on 2012 RFP volumes (169% higher).

Adjusted PSE active claims to same 65% incurred loss ratio over the experience period.

Increased PSE supplemental retiree premium by 16.4% (estimated impact of uncapping the 75+ rate).

|              | <u>% Total</u> | <u>Estimated Premium<sup>1</sup></u> | <u>Incurred Claims<sup>2</sup></u> | <u>Loss Ratio</u> | <u>Change to Current<sup>3</sup></u> |
|--------------|----------------|--------------------------------------|------------------------------------|-------------------|--------------------------------------|
| State        | 35.4%          | 1,098,884                            | 1,392,051                          | 126.7%            | 42.9%                                |
| Schools      | 64.6%          | 2,001,641                            | 2,020,224                          | 100.9%            | 13.9%                                |
| <b>Total</b> | <b>100.0%</b>  | <b>3,100,525</b>                     | <b>3,412,275</b>                   | <b>110.1%</b>     | <b>24.1%</b>                         |

### Retiree Basic

|              | <u>% Total</u> | <u>Estimated Premium<sup>1</sup></u> | <u>Incurred Claims<sup>2</sup></u> | <u>Loss Ratio</u> | <u>Change to Current<sup>3</sup></u> |
|--------------|----------------|--------------------------------------|------------------------------------|-------------------|--------------------------------------|
| State        | 95.0%          | 280,580                              | 2,385,369                          | 850.2%            | 859.0%                               |
| Schools      | 5.0%           | 14,767                               | 116,558                            | 789.3%            | 790.4%                               |
| <b>Total</b> | <b>100.0%</b>  | <b>295,347</b>                       | <b>2,501,927</b>                   | <b>847.1%</b>     | <b>855.6%</b>                        |

### Active Exp Basic

|              | <u>% Total</u> | <u>Estimated Premium<sup>1</sup></u> | <u>Incurred Claims<sup>2</sup></u> | <u>Loss Ratio</u> | <u>Change to Current<sup>3</sup></u> |
|--------------|----------------|--------------------------------------|------------------------------------|-------------------|--------------------------------------|
| State        | 33.6%          | 693,167                              | 374,111                            | 54.0%             | -39.1%                               |
| Schools      | 66.4%          | 1,368,774                            | 259,194                            | 18.9%             | -78.6%                               |
| <b>Total</b> | <b>100.0%</b>  | <b>2,061,941</b>                     | <b>633,305</b>                     | <b>30.7%</b>      | <b>-65.4%</b>                        |

### Retiree Exp Basic

|              | <u>% Total</u> | <u>Estimated Premium<sup>1</sup></u> | <u>Incurred Claims<sup>2</sup></u> | <u>Loss Ratio</u> | <u>Change to Current<sup>3</sup></u> |
|--------------|----------------|--------------------------------------|------------------------------------|-------------------|--------------------------------------|
| State        | 50.0%          | 11,899                               | 53,924                             | 453.2%            | 411.2%                               |
| Schools      | 50.0%          | 11,899                               | 26,771                             | 225.0%            | 153.8%                               |
| <b>Total</b> | <b>100.0%</b>  | <b>23,799</b>                        | <b>80,695</b>                      | <b>339.1%</b>     | <b>282.5%</b>                        |

### Active Supplemental

|              | <u>% Total</u> | <u>Estimated Premium<sup>1</sup></u> | <u>Incurred Claims<sup>2</sup></u> | <u>Loss Ratio</u> | <u>Change to Current<sup>3</sup></u> |
|--------------|----------------|--------------------------------------|------------------------------------|-------------------|--------------------------------------|
| State        | 27.1%          | 3,102,984                            | 1,556,100                          | 50.1%             | -43.4%                               |
| Schools      | 72.9%          | 8,349,927                            | 5,468,874                          | 65.5%             | -26.1%                               |
| <b>Total</b> | <b>100.0%</b>  | <b>11,452,910</b>                    | <b>7,024,974</b>                   | <b>61.3%</b>      | <b>-30.8%</b>                        |

### Retiree Supplemental

|              | <u>% Total</u> | <u>Estimated Premium<sup>1</sup></u> | <u>Incurred Claims<sup>2</sup></u> | <u>Loss Ratio</u> | <u>Change to Current<sup>3</sup></u> |
|--------------|----------------|--------------------------------------|------------------------------------|-------------------|--------------------------------------|
| State        | 32.4%          | 1,621,659                            | 1,390,459                          | 85.7%             | -3.3%                                |
| Schools      | 67.6%          | 3,384,940                            | 3,668,183                          | 108.4%            | 22.2%                                |
| <b>Total</b> | <b>100.0%</b>  | <b>5,006,599</b>                     | <b>5,058,642</b>                   | <b>101.0%</b>     | <b>14.0%</b>                         |

### Active Spouse

|              | <u>% Total</u> | <u>Estimated Premium<sup>1</sup></u> | <u>Incurred Claims<sup>2</sup></u> | <u>Loss Ratio</u> | <u>Change to Current<sup>3</sup></u> |
|--------------|----------------|--------------------------------------|------------------------------------|-------------------|--------------------------------------|
| State        | 55.9%          | 629,594                              | 629,749                            | 100.0%            | 12.8%                                |
| Schools      | 44.1%          | 497,627                              | 808,741                            | 162.5%            | 83.3%                                |
| <b>Total</b> | <b>100.0%</b>  | <b>1,127,221</b>                     | <b>1,438,490</b>                   | <b>127.6%</b>     | <b>44.0%</b>                         |

### Retiree Spouse

|              | <u>% Total</u> | <u>Estimated Premium<sup>1</sup></u> | <u>Incurred Claims<sup>2</sup></u> | <u>Loss Ratio</u> | <u>Change to Current<sup>3</sup></u> |
|--------------|----------------|--------------------------------------|------------------------------------|-------------------|--------------------------------------|
| State        | 96.2%          | 100,617                              | 495,657                            | 492.6%            | 455.7%                               |
| Schools      | 3.8%           | 4,027                                | 13,576                             | 337.1%            | 280.3%                               |
| <b>Total</b> | <b>100.0%</b>  | <b>104,644</b>                       | <b>509,233</b>                     | <b>486.6%</b>     | <b>448.9%</b>                        |

### TOTAL

|                | <u>% Total</u> | <u>Estimated Premium<sup>1</sup></u> | <u>Incurred Claims<sup>2</sup></u> | <u>Loss Ratio</u> | <u>Change to Current<sup>3</sup></u> |
|----------------|----------------|--------------------------------------|------------------------------------|-------------------|--------------------------------------|
| <b>State</b>   | <b>32.5%</b>   | <b>7,539,384</b>                     | <b>8,277,420</b>                   | <b>109.8%</b>     | <b>23.8%</b>                         |
| <b>Schools</b> | <b>67.5%</b>   | <b>15,633,601</b>                    | <b>12,382,121</b>                  | <b>79.2%</b>      | <b>-10.7%</b>                        |
| <b>Total</b>   | <b>100.0%</b>  | <b>23,172,986</b>                    | <b>20,659,541</b>                  | <b>89.2%</b>      | <b>0.6%</b>                          |

<sup>1</sup>Active paid premium split based on current ASE to PSE enrollment; retiree paid premium split based on internal premium allocations

<sup>2</sup>Incurred claims split based on information provided by ARBenefits

<sup>3</sup>Change to Current equals Loss Ratio divided by target loss ratio

## ARBenefits Life Proposed Renewal Rate Options

| <u>Coverage</u>             | <u>Current Annual Premium</u> | <u>Recommended Renewal</u> |                       |
|-----------------------------|-------------------------------|----------------------------|-----------------------|
|                             |                               | <u>Rate Change</u>         | <u>Annual Premium</u> |
| Active Basic Life           | \$ 891,464                    | 0.0%                       | \$ 891,464            |
| Retiree Basic Life          | \$ 150,288                    | 200.0%                     | \$ 450,864            |
| Active Expanded Basic Life  | \$ 592,850                    | 0.0%                       | \$ 592,850            |
| Retiree Expanded Basic Life | \$ 12,110                     | 200.0%                     | \$ 36,330             |
| Active Supplemental Life    | \$ 4,337,895                  | 0.0%                       | \$ 4,337,895          |
| Retiree Supplemental Life   | \$ 2,280,793                  | 10.5%                      | \$ 2,520,898          |
| Active Spouse Life          | \$ 548,035                    | 50.0%                      | \$ 822,053            |
| Retiree Spouse Life         | \$ 57,139                     | 50.0%                      | \$ 85,709             |
| Active & Retiree Child Life | \$ 196,688                    | 0.0%                       | \$ 196,688            |
| Basic AD&D                  | \$ 204,164                    | 0.0%                       | \$ 204,164            |
| Supplemental AD&D           | \$ 256,242                    | 0.0%                       | \$ 256,242            |
| <b>Total Life</b>           | <b>\$ 9,527,668</b>           | <b>9.1%</b>                | <b>\$ 10,395,156</b>  |

## ARBenefits Life Sample Premium Comparisons

| <u>Retiree Basic Life</u> | <u>Face Amount</u> | <u>Current Monthly Premium</u> | <u>Renewal Monthly Premium</u> | <u>Monthly Premium Change</u> |
|---------------------------|--------------------|--------------------------------|--------------------------------|-------------------------------|
| Standard Benefit          | \$5,000            | \$1.45                         | \$4.35                         | \$2.90                        |

  

| <u>Retiree Expanded Basic Life</u> | <u>Face Amount</u> | <u>Current Monthly Premium</u> | <u>Renewal Monthly Premium</u> | <u>Monthly Premium Change</u> |
|------------------------------------|--------------------|--------------------------------|--------------------------------|-------------------------------|
| Lowest Benefit                     | \$2,500            | \$0.73                         | \$2.18                         | \$1.45                        |
| Average Benefit                    | \$6,000            | \$1.74                         | \$5.22                         | \$3.48                        |
| Highest Benefit                    | \$20,000           | \$5.80                         | \$17.40                        | \$11.60                       |

  

| <u>PSE Supplemental Retiree Life (75+)</u> | <u>Face Amount</u> | <u>Current Monthly Premium</u> | <u>Renewal Monthly Premium</u> | <u>Monthly Premium Change</u> |
|--|--------------------|--------------------------------|--------------------------------|-------------------------------|
| Lowest Benefit                             | \$1,000            | \$3.70                         | \$7.12                         | \$3.42                        |
| Average Benefit                            | \$12,000           | \$44.40                        | \$85.44                        | \$41.04                       |
| Highest Benefit                            | \$39,000           | \$144.30                       | \$277.68                       | \$133.38                      |

  

| <u>Active/Retiree Spouse Life</u> | <u>Face Amount</u> | <u>Current Monthly Premium</u> | <u>Renewal Monthly Premium</u> | <u>Monthly Premium Change</u> |
|-----------------------------------|--------------------|--------------------------------|--------------------------------|-------------------------------|
| Lowest Benefit                    | \$1,000            | \$0.44                         | \$0.66                         | \$0.22                        |
| Average Benefit                   | \$12,000           | \$5.28                         | \$7.92                         | \$2.64                        |
| Highest Benefit                   | \$50,000           | \$22.00                        | \$33.00                        | \$11.00                       |

# Catamaran Reporting and Auditing

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In response to data requested by Bob Alexander and Dr. Kumpuris

**Sarah Bujak**

4/14/2015

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## Current reporting provided

See attachment “Reporting deliverables\_Final.xlsx” for more details

### Monthly

**MAC Appeal** → A report, reported on a one-month lag, of all MAC appeals received during the month; includes product, appeal decision and response time

**MAC lists** → A report, reported on a one-month lag, reflecting all changes to MACRC4250 made during the reporting month

**Pass-Thru Reporting** → A report, reported on a one-month lag, reflecting pass-thru pricing structure

**PMEC Newsletter** → A summary of Catamaran's PMEC (Pharmacy Membership Evaluation Committee) decisions; lists the pharmacy terminations, corrective actions, and follow-up actions from the previous meeting, along with documentation in support of the actions taken by Catamaran or provider communications as information only

### Quarterly

**Performance Guarantee** → A report reflecting how Catamaran performed against the Performance Guarantee's outlined in Appendix A of the contract/RFP

**Pharmacy Audit Recoveries** → Reporting on monies saved due to working with a pharmacy on a live claim rather than as part of an audit

#### Live Audit

A live audit is where, typically, the pharmacy is correcting at point of sale during an outreach thus creating a savings rather than a recovery. The additional benefit is the reduction in claim cost by managing the claims in a timely audit program. These savings are provided in the quarterly audit reports.

#### Desk Audit

Desk Audits are a more retrospective audit where the pharmacy has to submit documentation (hard copies, signature logs) for review by the audit team. Audits are closed typically without the pharmacy fixing the claim and therefore the audit takes time and finances are done in lump sums later.

The financials related to these audits will have a natural lag while the pharmacies are placed on withholding and check by check Catamaran collects against the amount owed. We attempt to clear all the withholdings quarterly and produce checks.

**Rebate** → A report of rebates received for the quarter; provided at Carrier/Account/Group level only as product level reporting is not available through the aggregator

### Annual

**IRS Form 1099**

**Confirmation letter regarding the Unclaimed Property Act**

## Available report/audit

**SSAE 16** → An annual report on Catamaran controls placed in operation and test of operating effectiveness

## Information on other audits performed by Catamaran

### Standard Audit

Activities that have a direct impact on the financial performance and/or guarantees, as specified in the agreement between the State of Arkansas and Catamaran, are fully auditable by a third party.

Annually, Catamaran will allow a client to audit claims, rebates, and other relevant records which shall be made accessible upon thirty (30) days prior written notice, subject to a non-disclosure. The audit shall be limited to review of rebates and claims transactions for adherence to and accuracy against the approved plan design and pricing under this agreement. The client acknowledges that it shall not be entitled to audit: (i) documents that Catamaran deems proprietary, confidential or trade secret; and (ii) documents Catamaran is barred from disclosing by law or pursuant to an obligation of confidentiality to a third party. All information and records reviewed pursuant to this section shall be considered Confidential Information for purposes of this Agreement. An onsite audit as well as the scope and timeframe of audit and must be pre-approved by Catamaran.

Due to the high demand placed on Catamaran's staff's time during the annual renewal period of December and January, no audits may be initiated or conducted during these months. Subject to the confidentiality provisions in rebate contracts, once annually, between the months of January and September, a top ten accounting firm mutually agreeable by both parties can inspect and audit Catamaran's books and records relating to rebates as dictated by the client agreement.

The audit scope may not exceed 12 months, unless the audit relates to a financial guarantee exceeding 12 months. In such cases, the audit is limited to the term of the financial agreement.

A final, written audit report will be provided by the client or its auditor within 60 days of the end of the audit. Catamaran will have 90 days to respond to the report. The client or its auditor will have 30 days to respond to our response. However, if the client fails to provide a final audit report within 60 days or fails to respond within 30 days of Catamaran's response, the audit will be closed.

Other Catamaran company operations, such as employee records, are not auditable.

### Willingness to provide copies of audit schedules

Catamaran has a comprehensive audit approach focused on the review of controls and related policies and procedures to ensure timely and accurate processing of transactions. Documentation related to the audits performed is confidential and proprietary information of Catamaran and is exempt from disclosure. Catamaran has responded expeditiously to client requests; however, we have not disclosed audit documentation.

Catamaran does not share audit results with clients as those are confidential and proprietary. However, to the extent that any audit findings impact any specific client, Catamaran provides notification to each client along with a member impact analysis and any corresponding corrective action plans, as applicable.

### **Catamaran's annual monitoring/internal audit plan**

Catamaran has a comprehensive audit approach focused on the review of controls and related policies and procedures to ensure timely and accurate processing of transactions. We perform audits of various operational functions within the organization. These audits are focused on the review of transactions and related controls to ensure compliance with company and regulatory guidelines.

The frequency of compliance auditing of operational areas is determined by the results of the Annual Compliance Risk Assessment; implementation of new rule/regulations, or risks identified during an external audit. However, documentation related to audits performed is confidential and proprietary information of Catamaran and is exempt from disclosure.

### **CMS audit**

Some of Catamaran's clients have had CMS audits of the prior authorization area. We have a dedicated audit team that manages and coordinates regulatory audits such as CMS and State regulatory audits for any delegated functions. The audit team utilizes a collaborative approach to working with clients to ensure end-to-end support from the onset of the audit notice through any post-audit activity. Examples of audit support would include preparation for the audit, conference calls to review requirements, accurate and timely delivery of client audit requests (e.g., data, policies and procedures, etc.), participation during the audit as necessary, and managing all post audit activities until the audit is completed.

We are unable to disclose client information such as the names and results of client regulatory audits. The results of any client audit are confidential and proprietary and not subject to disclosure.