



AGENDA

State and Public School Life and Health Insurance Board

August 16, 2016

1:00 p.m.

EBD Board Room – 501 Building, Suite 500

- I. Call to Order Dan Honey, Vice-Chairman*
- II. Approval of July 19, 2016 Minutes Dan Honey, Vice-Chairman*
- III. ASE-PSE Financials July, 2016 Marla Wallace, EBD Fiscal Officer*
- IV. DUEC Committee Report Dr. Hank Simmons, UAMS*
- V. Fiscal Year Update John Colberg, Cheiron*
- VI. Director’s Report Chris Howlett, EBD Executive Director*

Upcoming Meetings

October 18, 2016; November 15, 2016

NOTE: All material for this meeting will be available by electronic means only ethel.whittaker@dfa.arkansas.gov. Notice: Silence your cell phones. Keep your personal conversations to a minimum. Observe restrictions designating areas as “Members and Staff only”

State and Public School Life And Health Insurance Board Meeting Board Meeting Minutes August 16, 2016

The 162nd meeting of the State and Public School Life and Health Insurance Board (hereinafter called the Board), met on August 16, 2016, at 1:00 p.m. in the EBD Board Room, 501 Woodlane, Suite 500, Little Rock, AR 72201.

MEMBERS PRESENT

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

MEMBERS ABSENT

Dr. Tony Thurman
Carla Haugen -Chairman

Chris Howlett, EBD Executive Director, Employee Benefits Division

OTHERS PRESENT:

Geri Bemberg, UAMS; Ethel Whittaker, Matt Turner, Marla Wallace, Stella Green, Cecilia Walker, Lori Eden, Janna Keathley, Eric Gallo, Terri Freeman, Gretchen Baggett, EBD; Kristi Jackson, Jennifer Vaughn, ComPsych; Pam Lawrence, AHH; Sylvia Landers, Eileen Wider, Minnesota Life; Drew Crawford, Sebco; Marc Watts, ASEA; Ronda Walthall, Wayne Whitley, AR Highway & Transportation Dept; Jessica Akins, Takisha Sanders, Health Advantage; John Vinson, Scott Pace, APA; Martha Hill, Mitchell Williams; Bill Clary, H&H; Jackie Baker, ASP; Karyn Langley, Qual Choice; Stephen Carroll, Allcare; Andy Davis, Arkansas Democrat-Gazette; Allison Drennon; Insurance Advantage; Liz Tullos, WageWorks; Steve Althoff, MTI; Sam Smothers, Astra Zeneca; Scott McRae, APSRC; Karen Henson, AGFC; David Kissia, AEA; Sean Seago, Merck; Martha Carlson, ABCBS; Elizabeth Whittington, Mike Motley, ACHI; Erica Gee, Attorney; Richard Ponder, J & J; Susan Woodall, Ramon Vickman, MedImpact; Amanda Quick, ASBP; Robyn Keene, AAEA; Frances Bauman

CALL TO ORDER:

Meeting was called to order by Dan Honey, Vice-Chairman

I. **APPROVAL OF MINUTES:** *by Dan Honey, Vice-Chairman*

The request was made by Honey to approve July 19, 2016, minutes.

Mallory made the motion to adopt the minutes with the recommended changes. Freno-Engman seconded; all were in favor.

Minutes approved.

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

Wallace reported financials for July 2016. For July PSE, three (3) weeks of medical and pharmacy claims were paid. The FICA savings for the month is \$472,000 and the Patient Center Outcomes Research Institute fee, which is mandated by the Affordable Care Act, was paid amounting to \$182,000. The call center employees funding amount was \$300,000.00. There was a net gain of \$11.9 million for the month, and \$23.0 million year-to-date. The net assets available are \$54.6 million.

For ASE the month of July, three (3) weeks of medical and pharmacy claims were paid. The Patient Center Outcomes Research Institute Fee is \$134,696. The call center funding amount was \$325,000. The net gain was \$8.89 million. The year-to-date is \$14.97 million. The net assets available are \$42.87 million.

III. The following report pertains to a meeting of the DUEC on August 1, 2016, with Dr. Hank Simmons presiding.

Cost effectiveness of Healthcare Interventions: *Dr. Bradley C. Martin, Pharm D.*

DOES COST EFFECTIVENESS REALLY MATTER?

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

USING COST EFFECTIVENESS DATA

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

Option 2. Allow reported and evaluated cost-effectiveness data to be presented, alongside clinical data, for coverage determination.

-Weigh ICER information more for high budgetary impact medications

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

I. Recommended Changes to Current Coverage

A. Delivery Coordination Workgroup Report: *by Dr. Geri Bemberg, UAMS*

Drugs used in the treatment of cancers and non-cancer drugs were reviewed by the DCWG in May, and a report made to the DUEC on August 1st. Recommendations from this report are outlined below.

	Current Coverage	Proposed Coverage
<u>Hemophilia</u>		
Class review	Covered, Tier 4PA	Continue coverage with PA, allow for rebates
<u>Chronic Lymphocytic Leukemia</u>		
Obinutuzumab (Gazyva) + Chlorambucil	Excluded	Cover, PA
<u>Renal Cell Carcinoma</u>		
Cabozantinib (Cabometyx)	Excluded	Exclude
Lenvatinib (Lenvima) w/ Everolimus	Excluded	Cover, T4 PA

Dr. Thompson questioned if 1. A is based on evidence or cost?

Dr. Bemberg stated the recommendations are based on clinical evidence and when cost data become available that information will be reviewed and considered.

B. 2nd Review of Drugs: *by Dr. Jill Johnson and Dr. Geoff Fenich, UAMS*

1) Kuvan (sapropterin): Kuvan (sapropterin) is a phenylalanine hydroxylase activator used for reduction of phenylalanine (Phe) levels in patients with hyperphenylalaninemia (HPA) secondary to BH4-responsive Phenylketonuria (PKU). Kuvan is used in conjunction with a Phe-restricted diet.

Recommendation: Cover Tier 4 with PA

2) Belimumab (Benlysta): The current position of EBRx is to exclude from coverage belimumab, indicated for the treatment of SLE. The exclusion was based on interpretation of the results from 2 phase III clinical trials that used the systemic lupus erythematosus responder index (SRI) as the primary endpoint.

New considerations were made, and Dr. Johnson offered several options on coverage or continued exclusion.

After discussion, the committee decided to continue to exclude the medication and review in 6 months.

3) Cabozantinib (Cabometyx): For treatment of advanced renal cell carcinoma in patients who receive prior anti-angiogenic therapy.

New evidence for overall survival has emerged since the DCWG meeting in May and was presented to the committee.

Recommendation: Cover Tier 4 with PA

4) Cabozantinib (Cometriq): For treatment of medullary thyroid cancer.

Cabozantinib is currently excluded due to lack of OS benefit in the setting of medullary thyroid cancer with approval based on PFS. FDA has recently updated the PI with final PFS results. Since then, final OS data has been presented in abstract form.

Recommendation: Cover Tier 4 with PA

C. New Formulary Consideration: *by Dr. Geri Bemberg, UAMS*

- 1) Triptans Reference Pricing Proposal** – Triptans are a class of medications used for the treatment of migraines. There are currently multiple options available in different dosage forms, brand names, and generics. A review was done to see if it would be appropriate to reference price this class. It was concluded that there is no consistent evidence that one triptan has any particular advantage or disadvantage over another in any subgroup based on any factor. There appears to be no difference between oral products, although injectables were having a slightly quicker onset of action.

Recommendation: Reference price orals to sumatriptan tablet price. Place sumatriptan and rizatriptan tablets at Tier 1. Place injectables at Tier 3.

- 2) Proton Pump Inhibitors** – Medications used to treat heartburn and stomach ulcers. PPI's include drugs such as Nexium, Dexilant, Prilosec, Prevacid, Aciphex, Protonix and their generic versions esomeprazole, omeprazole, lansoprazole, dexlansoprazole, rabeprazole, and pantoprazole. With so much evidence out concerning the adverse effects of these medications and many over the counter options available, it was recommended to exclude these medications from coverage.

Recommendation: Exclude all PPI's, with the exception of First-Lansoprazole, which would be covered Tier 2 with swallow criteria (7 years old).

- 3) Nasal Steroids** – Given that there are three nasal steroids now available over the counter and that there are no known clinical differences between the efficacy of the available nasal steroids on the market (legend or OTC), exclude nasal steroids from the formulary. This would shift utilization to the OTC products. Savings to the plan would be approximate \$80,000/quarter or \$320,000/year. There was a discussion about why Azelastine, a nasal antihistamine was included in the original reference pricing model. Pricing with the new MAC list with MedImpact was also discussed, as well as its impact on the current plan spend in this category.

Recommendation: Continue coverage in this class for now, and re-review at a later date.

II. NEW DRUGS

Please see the attachment.

III. INHALER REBATE DISCUSSION: *by Dr. Rachael McCaleb, UAMS*

Drugs for the treatment of Asthma and Chronic Obstructive Pulmonary Disease (COPD).

Recommendations: EBD Formulary may include up to two covered products in each subcategory; all other products will be excluded.

- **Generic products not included. Brand only products included in the contracting process.**
- **Require price protection for the life of the contract**
- **Prior authorization criteria currently in place for selected agents will continue and is not negotiable in the contracting process.**

IV. EBD REPORT: *by Dr. Geri Bemberg, UAMS*

Dr. Bemberg gave an update on the PBM switch to MedImpact. She also gave an overview of the first two quarters of pharmacy spend for the plan. Currently, program spend is up about 10% over this time last year. Major influences for the increase in cost include hepatitis C treatment, specialty utilization, and inflation. Currently, specialty medications makeup about 0.6% of the total number of prescriptions filled on the plan but account for 38.9% of the total plan paid. This percentage is up a little over 4% from last year. Comparing 2015 to 2014, 2015 saw an increase of about 4% as well in the percentage of total plan paid accounted for by specialty drugs. Member cost share is down a little over 2%, and generic utilization is at 91.2%.

Dr. Bemberg then asked for recommendations on the next category for Dr. McCaleb to review for rebate contracting. She suggested anticoagulants, contraceptives, and other diabetes agents. The committee recommended for Dr. McCaleb to look at oral anticoagulants next.

Respectfully submitted,

**Dr. Hank Simmons,
Chair, DUEC**

McCook recommended that Dr. Martin from UAMS present a cost analysis report, to increase the Board's knowledge and address any questions or concerns regarding the cost effectiveness of PPI's.

McCook motioned to invite Dr. Martin to the next meeting to address the concerns of the Board. Dr. Thompson seconded.

McCook amended the previous motion to recommend approval of the report and invite Dr.

Martin to the next meeting. There was no second to the motion.

Discussion:

Harrison inquired in regards to Proton Pump Inhibitors how many letters will be sent to the members.

Dr. Bemberg reported there would be 11,000 members affected by the change.

To reduce the over-flow of potential calls from members affected by the change, Harrison recommended to include in the letter that OTC drugs may be a cost savings to the member.

Boyd inquired is the savings in dollars or of those 11,000 members should 10,000 not use the product due to adverse reactions?

Dr. Bemberg reported currently there is not a tracking method in place in regards to how many members are taking the drug or the affects.

McCook inquired if OTC Proton Pump Inhibitors are less than tier 1? Dr. Bemberg reported no.

McCook recommended that the plan provides the OTC PPI's at tier 1.

Dr. Thompson inquired is the total price more as OTC or prescribed?

Dr. Bemberg reported the total price whether prescribed or OTC depends on the medication.

After discussion, McCook withdrew his previous motion.

Dr. Kumpuris motioned that the Board would invite Dr. Martin to the next meeting for a detailed presentation. Freno-Engman seconded; all were in favor.

Motion approved.

McCook motioned to approve the report. Boyd seconded.

Discussion:

Harrison reported since there is so much literature regarding the adverse effects of Proton Pump Inhibitors, currently for a member to obtain a prescription they must have approval from a medical physician. If the physician is checking each patient for adverse effects and PPI's are excluded the member will be able to purchase the PPI's without a prescription. At that point, the physician would not have knowledge that the member may be taking a medicine that has an adverse effect. Harrison does not agree with approving this class of medication.

McCook withdrew the previous motion to approve the report.

Dr. Thompson motioned to approve C.1., Triptans. Dr. Kirtley seconded; all were in favor.

Motion approved.

Dr. Thompson motioned to approve C.2., Proton Pump Inhibitors. Boyd seconded; a greater number of members opposed.

Motion not approved.

Dr. Thompson motioned to reject C.3., Nasal Steroids.

Dr. Thompson modified the previous motion to state the committee will provide a singular recommendation for Azelastine and a collective recommendation for Nasal Steroids at the next meeting. Harrison seconded; all were in favor.

Motion approved.

Dr. Kirtley motioned to adopt A & B of Section I. Harrison seconded; all were in favor.

Motion approved.

Dr. Thompson recommended approval of A1, A2, B1, and B2 of section II except Cinquair, whereas there will be a presentation regarding the clinical management assessment to ensure the decision made is the most cost effective for the plan. Dr. Kirtley seconded; all were in favor.

Motion approved.

Dr. Kumpuris requested the working definition of cost effectiveness and basic information that is standardized regarding the cost to be presented at the next Board meeting.

IV. FINANCIAL AND REGULATORY UPDATE: *by John Colberg, Cheiron Inc.*

Colberg reported on Updated Asset Projections and Nondiscrimination Regulation. PSE updated asset projection for 2016 is \$38 million in state contributions, \$10 million for future contribution allocations, and \$44 million unallocated assets. ASE asset projection is \$13 million allocated for future contributions and \$33 million unallocated assets.

Nondiscrimination Regulation under Section 1557 of the Affordable Care Act became in effect on July 18, 2016. The regulation applies to entities receiving Federal funds from the Health & Human Services (HHS). ASE receives Medicare Retiree Drug Subsidies, and PSE may not be subject to the regulation (need to confirm no HHS funds received).

There are specific administrative requirements as well as plan design requirements effective for 2017 plan year. Also, a notice requirement must be posted on October 16, 2016.

Please see the attached report for a detailed list of requirements.

V. DIRECTOR'S REPORT: *by Chris Howlett, EBD Executive Director*

Howlett reported the division is currently reviewing the Affordable Care Act Mandate (Section 1557), and sought advice from the Attorney's General's office to ensure the agency is in compliance with the requirements.

One of the components reviewed is the processes that would bind the plan to the mandate and the cost analysis. If the current mandate requirements are not cost effective, it may be better for the plan to eliminate the binding process.

Howlett reported the staff is preparing for open enrollment to kick-off in September for the plan year 2017. The Health Insurance Representative meetings have been in process for two weeks with positive results.

The actuarial services contract is currently in the procurement process and should be finalized by the end of August. The division is currently reviewing the plan design and the wellness program for the best design for 2018.

Howlett reported the division is also reviewing similar plans from Oklahoma, Georgia, Arizona, Texas, and New Mexico.

Dr. Kirtley reported receiving calls upon returning from vacation regarding pharmacy reimbursement payments.

Dr. Kirtley requested an update regarding the pharmacies that experienced a delay in reimbursement payments.

Howlett reported receiving a message on August 10, 2016, from Dr. Pace regarding payments that had not been received by several pharmacies. The incident was mediated and resolved in twelve hours.

Dr. Kirtley inquired how many pharmacies were affected by the delay. Howlett will provide additional information at the next meeting.

Dr. Kirtley reported the payments and the resolution were approximately two or three weeks delayed. Dr. Kirtley inquired is there a contract penalty for MedImpact? Howlett reported yes if deemed appropriate for the situation.

There was no further discussion.

Harrison motioned to adjourn. Honey seconded; all were in favor.

Meeting adjourned.

Regarding the Pharmacy Reimbursement Funds:

The following information was sent to the Board August 22, 2016.

The Initial concern was presented by Dr. Pace with APA on August 10th. Below is a recap of the initial issue/resolution.

Pharmacy reimbursements were not being paid out, and it appeared to be only from MedImpact. All claims from an eligibility kick-out file were not included in the payments to MedImpact. This is a normal business process between EBD and the PBM for these claims not to be paid until eligibility is confirmed by the PBM. This is to prevent payment for invalid claims. Unbeknownst to EBD, MedImpact **held all payments** to pharmacies instead of just the kick out claims. MedImpact has acknowledged this should not have happened and will not occur in the future. EBD was not aware of any problem with the payments to pharmacies until Dr. Pace brought it to the attention of EBD. At that point, MedImpact was contacted by email and a phone call and the issue was corrected, with payment released within 12 hours.

Below is additional information as of Friday, 8-19-16:

MedImpact has confirmed with Accounts Payable that all pharmacies have been paid for EBD claims processed 7/1/2016 through 8/4/2016. To note, for the claim period 7/29/16 through 8/4/2016, the pharmacy payments were released today 8/19/2016 so pharmacies may not have received their checks or EFT payments yet.

For the 7/1/2016 through 7/11/2016 claim period, they confirmed that all pharmacy payments were withheld due to the short pays (kick out claims). They pulled the detail and discovered the following. There were 737 Arkansas pharmacies impacted representing 22,767 claims and \$2,426,078.56 which averages \$3,291.82 per pharmacy.

EBD is currently looking at any damages associated with performance standards as was mentioned before.

Attachment:

Dr. Jill Johnson reported on new drugs. The review covered products released February 1, 2016 – May 23, 2016.

A. Recommended Additions**1. Nonspecialty Medications**

BRAND NAME	GENERIC NAME	PRICING (AWP)	INDICATION	SIMILAR THERAPIES ON FORMULARY	DUEC VOTE
Otiprio Suspension	Ciprofloxacin Intratympanic Suspension 6%	\$339.84	Tx of Pediatric patients w/ bilateral otitis media w/ effusion undergoing tympanostomy tube placement	Cipro ophthalmic 0.3% covered T1, Cipro otic 0.2% excluded	Cover
Zembrace SymTouch Inj	Sumatriptan Succinate soln auto-inj 3mg/0.5mL	\$359.40/inj	Migraine	Generics available T1, T2. Brands available T2 and T3.	Reference price with other triptans

BRAND NAME	GENERIC NAME	PRICING (AWP)	INDICATION	SIMILAR THERAPIES ON FORMULARY	DUEC VOTE
Methergine	Methylergonovine maleate tablet 0.2mg	\$56.40/tablet	Prevention of hemorrhage		Cover Tier 1, QL of 28
Aczone gel	Dapsone Gel 7.5%	\$594/tube	Acne vulgaris	Multiple topical and oral acne products covered	Cover Tier 3
Onzetra	Sumatriptan Succinate Exhaler Powder 11mg/nosepiece	\$36.60/nosepiece	Migraine	Generics available T1, T2. Brands available T2 and T3.	Reference price with other triptans
Potassium gluconate	Potassium gluconate tablet 550mg (90mg equiv K)	\$0.03/tablet			Cover Tier 1
Nuplazid	Pimavanserin Tartrate tablet 17mg (Base equiv)	\$39/tablet	Parkinson disease psychosis	Quetiapine available T1	Cover Tier 4, PA

2. Specialty Medications

BRAND NAME	GENERIC NAME	PRICING (AWP)	INDICATION	SIMILAR THERAPIES ON FORMULARY	DUEC VOTE
Xeomin	Incobotulinumtoxin A for IM Inj 200 unit	\$1,118.40/vial	Multiple indications	Other strengths of Xeomin are PA'ed w/ other botulinum products	Cover , PA Medical

Xuriden Powder	Uridine Triacetate Oral Granules Packet 2G	\$900/packet	Treatment of hereditary orotic aciduria; Emergency tx of fluorouracil or capecitabine overdose	Also available as Vistogard in 10g packets for \$4,500/packet	Cover Tier 4 PA
Vistogard Packet	Uridine Triacetate Oral Granules Packet 10G	\$4,500/packet	Treatment of hereditary orotic aciduria; Emergency tx of fluorouracil or capecitabine overdose	Also available as Xuriden in 2g packets for \$900/packet	Cover Tier 4 PA
Odefsey	Emtricitabine-Rilpivirine-Tenofovir AF Tablets 200-25-25mg	\$93.83/tablet	HIV	Other HIV products T4	Cover Tier 4
Xeljanz XR	Tofacitinib Citrate Tablet SR 24hr 11mg	\$126.77/tablet	Rheumatoid Arthritis	Xeljanz IR covered T4PA, \$69.37/tablet	Cover Tier 4 PA, follow up on cost 10/16

BRAND NAME	GENERIC NAME	PRICING (AWP)	INDICATION	SIMILAR THERAPIES ON FORMULARY	DUEC VOTE
Alprolix Injection	Coagulation Factor IX (Recomb) for Inj 250unit	\$3.42/vial	Control or prevention of bleeding in patients with factor IX deficiency	Other hemophilia products Tier 4PA	Cover Tier 4 PA
Descovy	Emtricitabine-Tenofovir Alafenamide Fumarate Tablet 200-25mg	\$58.66/tablet	HIV	Other HIV products at Tier 4	Cover Tier 4
Wilate Inj	Antihemophilic Factor/VWF (Human) for Inj 500-500 unit kit	\$1.56	Hemophilia A	Other hemophilia products Tier 4PA	Cover Tier 4 PA
Cabometyx	Cabozantinib S-Malate Tablets 20mg, 40mg, 60mg	\$550/tablet	Renal Cell Carcinoma	Options covered T4PA	Cover Tier 4 PA
Xofigo Inj	Radium 223 Dichloride Inj 30 microcurie/mL	\$25,841.33	Castration-resistant prostate cancer w/ symptomatic bone mets	Covered prostate meds are at T4PA	Cover Tier 4 PA
Daklinza	Daclatasvir Dihydrochloride Tablet 90mg	\$900/tablet	Chronic Hep C – this dose for use with patients taking w/ a moderate CYP3A4 inducer or nevirapine	Covered Hep C meds are under T4PA	Cover Tier 4 PA
Lenvima	Lenvatinib Capsule Therapy Pack 18mg	\$192.53 - \$258.80/dose	Renal Cell Carcinoma	Options covered T4PA	Cover Tier 4 PA

	daily dose, 8mg daily dose				
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B. Recommended Exclusions

1. Nonspecialty Medications

BRAND NAME	GENERIC NAME	PRICING (AWP)	INDICATION	SIMILAR THERAPIES ON FORMULARY	DUEC VOTE
Vraylar	Cariprazine HCl Capsules 1.5mg, 3mg, 4.5mg, 6mg (Base equiv) & Therapy packs	\$40.24/cap	Bipolar disorder, Schizophrenia	Several generics covered T1; Brands covered T2	Exclude, Code 1
Lido-Rx Cream	Lidocaine-Capsaicin Cream 4-0.1%	\$247.25/30g tube	Temporary pain relief	Multiple lidocaine products covered	Exclude, Code 13
Allzital	Butalbital-acetaminophen tablets 25-325mg	\$7.81/tab	Tension or muscle contraction headache	Bupap 50-300mg covered T2 (\$16.18/tab). Butalbital-apap 50-325 covered T1 (MAC)	Exclude, Code 13

BRAND NAME	GENERIC NAME	PRICING (AWP)	INDICATION	SIMILAR THERAPIES ON FORMULARY	DUEC VOTE
Previdolrx Pak	Diclofenac tablet 75mg-omeprazole cap 20mg-Capsicum CR 0.025% THPK	\$1,999/pack	Pain relief	Diclofenac tabs available T1, omeprazole available T1	Exclude, Code 13
Metoprolol	Metoprolol tartrate tablets 37.5mg, 75mg	\$1.46- \$2.44/tablet	Cardiovascular	Metoprolol tartrate, metoprolol succinate other strengths available T1 (MAC)	Exclude, Code 13
Adzenys XR	Amphetamine ER Dispersible Tablets 3.1mg, 6.3mg, 9.4mg, 12.5mg, 15.7mg, 18.8mg	\$10.80/tablet	ADHD	Generic amphetamine IR products available T1 (MAC), generic XR amphetamine products available T1 <26yrs, RBP for >26yrs (MAC) Multiple other	Exclude, Code 13

				ADHD meds covered	
Zingo Injection	Lidocaine HCl Powder for Intradermal Jet-Inj 0.5mg	\$26.40	Topical anesthesia	Multiple lidocaine products covered	NA Medical; to be used in a physical office or hospital
Ultravate Lotion	Halobetasol Propionate Lotion 0.05%	\$1,083/60mL	Steroid-responsive dermatoses	Multiple dermatological products covered	Exclude, Code 13
Otrexup Inj	Methotrexate Soln PF Auto-Inj 17.5mg/0.4mL, 22.5mg/0.4mL	\$431.25/inj	Multiple cancers	Other Otrexup products excluded. Mtx tabs covered T1, inj covered T1	Exclude, Code 13
Renacidin Topical	Citric Acid & D-Gluconic Acid Solution	\$6.38/unit	Prevention of calcifications of indwelling urethral catheters & cystostomy tubes		Exclude, Code 3
Xtampza ER	Oxycodone ER Capsule 12hr abuse-deterrent 9mg, 13.5mg, 18mg, 27mg, 36mg	\$4.04 - \$12.94/capsule	Pain management	Oxycodone IR available T1. ER available T1	Exclude, Code 13
Briviact	Brivaracetam Tablets 10mg, 25mg, 50mg, 75mg, 100mg	\$18.20/tablet	Partial onset seizures	Multiple anticonvulsants covered at different tiers	Exclude, Code 13

BRAND NAME	GENERIC NAME	PRICING (AWP)	INDICATION	SIMILAR THERAPIES ON FORMULARY	DUEC VOTE
Briviact Oral Solution	Brivaracetam Oral Solution 10mg/mL	\$3.64/mL	Partial onset seizures	Multiple anticonvulsants covered at different tiers	Exclude, Code 13

2. Specialty Medications

BRAND NAME	GENERIC NAME	PRICING (AWP)	INDICATION	SIMILAR THERAPIES ON FORMULARY	DUEC VOTE
Bridion Solution	Sugammadex Sodium IV 200 mg/2mL, 500mg/5mL	\$114-208.80/vial	Reversal of neuromuscular blockage induced by rocuronium or vecuronium in adults undergoing surgery	Out of scope of pharmacy benefits	N/A Medical

Docetaxel Inj	Docetaxel (Non-alcohol Formulary) IV Solution 20mg/mL, 80mg/4mL, 160mg/8mL	\$258/mL	Various Cancers	Docetaxel is also available in other IV formulations	N/A Medical
Spritam	Levetiracetam Tablets Disintegrating Soluble 250mg, 500mg, 750mg, 1000mg	\$8.67/tab	Seizure disorders	Levetiracetam IR & ER tablets, and oral solution available T1 (MAC)	Exclude, Code 13
Taltz Inj	Ixekizumab Subcutaneous Solution Auto-inj & Prefilled Syringe 80mg/mL	\$4,924.38/inj	Plaque psoriasis	TIMS available T4PA. Going for rebate	Exclude, Code 13.
Cinquair Inj	Reslizumab IV Infusion Solution 100mg/10mL (10mg/mL)	\$1,002/vial	Asthma	Multiple oral asthma products and inhalers available at all Tier levels. Xolair available T4PA (\$1,134.42)	Exclude, code 13. Also exclude Nucala from coverage.
Evomela Inj	Melphalan HCl for Inj 50mg (Propylene Glycol (PG) Free)	\$3,007.64/inj	Multiple myeloma	Some myeloma products covered T4PA	N/A Medical

BRAND NAME	GENERIC NAME	PRICING (AWP)	INDICATION	SIMILAR THERAPIES ON FORMULARY	DUEC VOTE
Venclexta	Venetoclax Tablets 10mg, 50mg, 100mg, & Therapy Starter Pack	\$9.56 - \$95.60/tablet	CLL	Some CLL products covered T4PA	Exclude, Code 2
Impavido	Miltefosine Capsule 50mg	\$685.71/capsule	Leishmaniasis		Exclude, Code 13
Hymovis Inj	Hyaluronan Intra-Articular Solution Prefilled Syringe 24mg/3mL	\$160/injection	Osteoarthritis of the knee	Single injections (Synvisc-One, Monovisc, Gel-One) covered with PA	Exclude, Code 13
Tecentriq Inj	Atezolizumab IV Solution 1200mg/20mL	\$10,344/vial	Urothelial carcinoma		Exclude, Code 2

The committee recommended the proposed coverage for non-specialty additions, specialty additions, non-specialty exclusions, and specialty exclusions.

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

	EMPLOYEE ONLY				EMPLOYEE + DEPENDENTS			
	ACTIVES	RETIREES	MEDICARE	TOTAL	ACTIVES	RETIREES	MEDICARE	TOTAL
BASIC	971	20		991	1673	36		1709
CLASSIC	1820	65		1885	3112	95		3207
PREMIUM	23995	2217		26212	41870	2881		44751
PRIMARY		217	8847	9064		445	11642	12087
TOTAL	26786	2519	8847	38152	46655	3457	11642	61754

REVENUES & EXPENDITURES

	Current Month	Year to Date (7 Months)
Funding		
State Contribution	\$ 14,693,140	\$ 100,849,364
Employee Contribution	\$ 7,935,582	\$ 55,937,835
Other	\$ 115,062	\$ 9,140,274
Allocation for Actives - Plan Year 2015	\$ 971,667	\$ 6,801,667
Total Funding	\$ 23,715,451	\$ 172,729,140
Expenses		
Medical Expenses		
Claims Expense	\$ 11,590,765	\$ 90,498,730
Claims IBNR	\$ -	\$ -
Medical Administration Fees	\$ 1,028,303	\$ 7,533,441
Refunds	\$ -	\$ (89,076)
Employee Assistance Program (EAP)	\$ 55,837	\$ 394,174
Life Insurance	\$ 54,495	\$ 384,413
Pharmacy Expenses		
RX Claims	\$ 5,612,108	\$ 41,522,784
RX IBNR	\$ -	\$ -
RX Administration	\$ 209,371	\$ 1,482,998
Plan Administration	\$ 322,887	\$ 3,794,176
Total Expenses	\$ 18,873,767	\$ 145,521,638
Net Income/(Loss)	\$ 4,841,684	\$ 27,207,502

BALANCE SHEET

Assets	
Bank Account	\$ 13,887,095
State Treasury	\$ 81,281,496
Due from Cafeteria Plan	\$ 5,195,886
Due from PSE	\$ 355,397
Receivable from Provider	\$ -
Accounts Receivable	\$ (1,077,897)
Total Assets	\$ 99,641,977
Liabilities	
Accounts Payable	\$ 7,040
Deferred Revenues	\$ 684
Due to Cafeteria	\$ 1
Due to PSE	\$ 4,270
Due to Federal Government (\$44 fee)	\$ 1,119,712
Health IBNR	\$ 24,700,000
RX IBNR	\$ 1,800,000
Total Liabilities	\$ 27,631,707
Net Assets	\$ 72,010,270
Less Reserves Allocated	
Premiums for Plan Year 1/1/15 - 12/31/15 (\$6,260,000 + \$5,400,000)	\$ (4,858,333)
Premiums for Plan Year 1/1/16 - 12/31/16 (\$3,600,000 + \$12,600,000)	\$ (16,200,000)
Premiums for Plan Year 1/1/17 - 12/31/17 (\$7,560,000))	\$ (7,560,000)
Premiums for Plan Year 1/1/18 - 12/31/18 (\$5,040,000)	\$ (5,040,000)
Catastrophic Reserve (2015 \$10,400,000)	\$ (10,400,000)
Net Assets Available	\$ 27,951,936

Fifth Week of Claims \$0

Arkansas State Employees (ASE) Financials - January 1, 2016 through July 31, 2016

	EMPLOYEE ONLY				EMPLOYEE + DEPENDENTS			
	ACTIVES	RETIREES	MEDICARE	TOTAL	ACTIVES	RETIREES	MEDICARE	TOTAL
BASIC	1267	38		1305	2099	53		2152
CLASSIC	1764	68		1832	2952	93		3045
PREMIUM	22802	2186		24988	39809	2828		42637
PRIMARY		213	9286	9499		435	12130	12565
TOTAL	25833	2505	9286	37624	44860	3409	12130	60399

REVENUES & EXPENDITURES

	Current Month	Year to Date (7 Months)
Funding		
1 State Contribution	\$ 14,702,184	\$ 102,859,120
2 Employee Contribution	\$ 7,931,881	\$ 55,759,057
3 Other	\$ 96,426	\$ 9,051,905
4 Allocation of Reserves	\$ 1,350,000	\$ 9,450,000
Total Funding	\$ 24,080,490	\$ 177,120,082
Expenses		
Medical Expenses		
5 Claims Expense	\$ 9,357,992	\$ 100,738,452
6 Claims IBNR	\$ -	\$ 3,300,000
7 Medical Administration Fees	\$ 1,074,348	\$ 7,673,114
8 Refunds	\$ -	\$ 265
9 Employee Assistance Program (EAP)	\$ 54,881	\$ 386,844
Life Insurance	\$ 78,983	\$ 555,998
Pharmacy Expenses		
11 RX Claims	\$ 3,919,090	\$ 44,627,440
12 RX IBNR	\$ -	\$ (100,000)
13 RX Administration	\$ 43,950	\$ 1,326,286
14 Plan Administration	\$ 655,629	\$ 3,639,298
Total Expenses	\$ 15,184,873	\$ 162,147,697
15 Net Income/(Loss)	\$ 8,895,618	\$ 14,972,385

BALANCE SHEET

Assets	
16 Bank Account	\$ 7,096,482
17 State Treasury	\$ 90,985,205
18 Due from Cafeteria Plan	\$ 5,018,599
19 Due from PSE	\$ 177,363
20 Receivable from Provider	\$ -
21 Accounts Receivable	\$ 9,757
Total Assets	\$ 103,287,406
Liabilities	
22 Accounts Payable	\$ 1,253
23 Deferred Revenues	\$ -
24 Due to Cafeteria	\$ -
25 Due to PSE	\$ -
26 Due to Federal Government (\$27 fee)	\$ 664,295
27 Health IBNR	\$ 28,000,000
28 RX IBNR	\$ 1,700,000
Total Liabilities	\$ 30,365,548
Net Assets	\$ 72,921,858
Less Reserves Allocated	
29 Premiums for Plan Year 1/1/16 - 12/31/16 (\$3,600,000 + \$12,600,000)	\$ (6,750,000)
30 Premiums for Plan Year 1/1/17 - 12/31/17 (\$7,560,000)	\$ (7,560,000)
31 Premiums for Plan Year 1/1/18 - 12/31/18 (\$5,040,000)	\$ (5,040,000)
32 Catastrophic Reserve (2016 \$10,700,000)	\$ (10,700,000)
33 Net Assets Available	\$ 42,871,858
34 Fifth Week of Claims \$0	

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

	EMPLOYEE ONLY				EMPLOYEE + DEPENDENTS			
	ACTIVES	RETIREES	MEDICARE	TOTAL	ACTIVES	RETIREES	MEDICARE	TOTAL
BASIC	2325	220		2545	3478	274		3752
CLASSIC	20559	1925		22484	38013	2354		40367
PREMIUM	19537	1269		20806	25212	1365		26577
PRIMARY		105	10279	10384		212	11225	11437
TOTAL	42421	3519	10279	56219	66703	4205	11225	82133

REVENUES & EXPENDITURES

	Current Month	Year to Date (7 Months)
Funding		
Per Participating Employee Funding (PPE Funding)	\$ 7,948,341	\$ 57,390,778
Employee Contribution	\$ 9,020,395	\$ 63,899,210
Department of Education \$35,000,000 & \$15,000,000	\$ 6,931,818	\$ 46,634,862
Other	\$ 513,671	\$ 4,325,622
Allocation for Actives	\$ 1,666,667	\$ 11,666,667
Total Funding	<u>\$ 26,080,891</u>	<u>\$ 183,917,140</u>
Expenses		
Medical Expenses		
Claims Expense	\$ 14,013,580	\$ 95,806,245
Claims IBNR	\$ -	\$ -
Medical Administration Fees	\$ 1,485,491	\$ 10,957,154
Refunds	\$ -	\$ (66,503)
Employee Assistance Program (EAP)	\$ 74,952	\$ 539,447
Pharmacy Expenses		
RX Claims	\$ 3,786,434	\$ 26,500,167
RX IBNR	\$ -	\$ -
RX Administration	\$ 289,849	\$ 2,043,406
Plan Administration	\$ 443,114	\$ 5,170,855
Total Expenses	<u>\$ 20,093,420</u>	<u>\$ 140,950,771</u>
Net Income/(Loss)	\$ 5,987,472	\$ 42,966,369

BALANCE SHEET

Assets	
Bank Account	\$ 14,050,148
State Treasury	\$ 88,678,982
Receivable from Provider	\$ -
Accounts Receivable	\$ 5,948,107
Due from ASE	\$ 4,270
Total Assets	<u>\$ 108,681,507</u>
Liabilities	
Accounts Payable	\$ 983
Due to ASE	\$ 355,397
Deferred Revenues	\$ 19,082
Due to Federal Government (\$44 fee)	\$ 1,613,216
Health IBNR	\$ 28,000,000
RX IBNR	\$ 1,400,000
Total Liabilities	<u>\$ 31,388,678</u>
Net Assets	\$ 77,292,829
Less Reserves Allocated	
Premiums for Plan Year 1/1/15 - 12/31/15 (\$20,000,000 rec'd from Dept. of Education)	\$ (8,333,333)
Premiums for Plan Year 1/1/16 - 12/31/16 (\$9,600,000)	\$ (9,600,000)
Premiums for Plan Year 1/1/17 - 12/31/17 (\$5,760,000)	\$ (5,760,000)
Premiums for Plan Year 1/1/18 - 12/31/18 (\$3,840,000)	\$ (3,840,000)
Premium Assistance (FICA Savings)	\$ (3,296,735)
Catastrophic Reserve (2015 \$10,900,000)	\$ (10,900,000)
Net Assets Available	<u>\$ 35,562,760</u>

Fifth Week of Claims \$0

Public School Employees (PSE) Financials - January 1, 2016 through July 31, 2016

	EMPLOYEE ONLY					EMPLOYEE + DEPENDENTS			
	ACTIVES	RETIREES	MEDICARE	TOTAL		ACTIVES	RETIREES	MEDICARE	TOTAL
BASIC	3123	317		3440		4695	393		5088
CLASSIC	21131	2120		23251		39626	2584		42210
PREMIUM	18421	1016		19437		24021	1087		25108
PRIMARY		84	11089	11173			168	12086	12254
TOTAL	42675	3537	11089	57301		68342	4232	12086	84660

REVENUES & EXPENDITURES

	Current Month	Year to Date (7 Months)
Funding		
1 Per Participating Employee Funding (PPE Funding)	\$ 7,863,394	\$ 56,967,857
2 Employee Contribution	\$ 9,224,164	\$ 65,040,250
3 Department of Education \$35,000,000 & \$15,000,000 & Other Funding	\$ 6,931,818	\$ 30,340,909
4 Other	\$ 531,514	\$ 4,499,176
5 Allocation of Reserves	\$ 3,975,000	\$ 27,825,000
Total Funding	<u>\$ 28,525,891</u>	<u>\$ 184,673,192</u>
Expenses		
Medical Expenses		
6 Claims Expense	\$ 11,381,443	\$ 112,184,425
7 Claims IBNR	\$ -	\$ 2,000,000
8 Medical Administration Fees	\$ 1,593,950	\$ 11,525,717
9 Refunds	\$ -	\$ -
10 Employee Assistance Program (EAP)	\$ 74,729	\$ 540,142
Pharmacy Expenses		
11 RX Claims	\$ 2,734,648	\$ 28,824,814
12 RX IBNR	\$ -	\$ (300,000)
13 RX Administration	\$ 66,807	\$ 1,921,326
14 Plan Administration	\$ 752,353	\$ 4,838,131
Total Expenses	<u>\$ 16,603,930</u>	<u>\$ 161,534,555</u>
16 Net Income/(Loss)	\$ 11,921,961	\$ 23,138,637

BALANCE SHEET

Assets	
17 Bank Account	\$ 16,165,296
18 State Treasury	\$ 109,027,362
19 Receivable from Provider	\$ -
20 Accounts Receivable	\$ 5,118,710
21 Due from ASE	\$ -
Total Assets	<u>\$ 130,311,368</u>
Liabilities	
22 Accounts Payable	\$ 2,917
23 Due to ASE	\$ 177,363
24 Deferred Revenues	\$ -
25 Due to Federal Government (\$27 fee)	\$ 1,010,826
26 Health IBNR	\$ 30,000,000
27 RX IBNR	\$ 1,100,000
Total Liabilities	<u>\$ 32,291,106</u>
28 Net Assets	\$ 98,020,263
Less Reserves Allocated	
29 Premiums for Plan Year 1/1/16 - 12/31/16 (\$9,600,000 + \$20,000,000 DOE + 18,100,000 DOE)	\$ (19,875,000)
30 Premiums for Plan Year 1/1/17 - 12/31/17 (\$5,760,000)	\$ (5,760,000)
31 Premiums for Plan Year 1/1/18 - 12/31/18 (\$3,840,000)	\$ (3,840,000)
33 Premium Assistance (FICA Savings)	\$ (3,412,815)
32 Catastrophic Reserve (2016 \$10,500,000)	\$ (10,500,000)
34 Net Assets Available	<u>\$ 54,632,448</u>
35 Fifth Week of Claims	\$ 0



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

The following report pertains to a meeting of the DUEC on August 1, 2016 with Dr. Hank Simmons presiding.

Cost effectiveness of Healthcare Interventions: *Dr. Bradley C. Martin, Pharm D.*

DOES COST EFFECTIVENESS REALLY MATTER?

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

USING COST EFFECTIVENESS DATA

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

Option 2. Allow reported and evaluated cost effectiveness data to be presented, alongside clinical data, for coverage determination.

-Weigh ICER information more for high budgetary impact medications

Option 3. Ignore cost effectiveness considerations in decision making

I. Recommended Changes to Current Coverage

A. Delivery Coordination Workgroup Report: *by Dr. Geri Bemberg, UAMS*

Drugs used in the treatment of cancers and non-cancer drugs were reviewed by the DCWG in May and a report made to the DUEC on August 1st. Recommendations from this report are outlined below.

	Current Coverage	Proposed Coverage
<u>Hemophilia</u>		
Class review	Covered, Tier 4PA	Continue coverage with PA, allow for rebates
<u>Chronic Lymphocytic Leukemia</u>		
Obinutuzumab (Gazyva) + Chlorambucil	Excluded	Cover, PA
<u>Renal Cell Carcinoma</u>		
Cabozantinib (Cabometyx)	Excluded	Exclude
Lenvatinib (Lenvima) w/ Everolimus	Excluded	Cover, T4 PA

B. 2nd Review of Drugs: *by Dr. Jill Johnson and Dr. Geoff Fenich, UAMS*

1) Kuvan (sapropterin): Kuvan (sapropterin) is a phenylalanine hydroxylase activator used for reduction of phenylalanine (Phe) levels in patients with hyperphenylalaninemia (HPA) secondary to BH4-responsive Phenylketonuria (PKU). Kuvan is used in conjunction with a Phe-restricted diet.

Recommendation: Cover Tier 4 with PA

2) Belimumab (Benlysta): The current position of EBRx is to exclude from coverage belimumab, indicated for the treatment of SLE. Exclusion was based on interpretation of the results from 2 phase III clinical trials that used the systemic lupus erythematosus responder index (SRI) as the primary endpoint.

New considerations were made and Dr. Johnson offered several options on coverage or continued exclusion.

After discussion the committee decided to continue to exclude the medication, and rereview in 6 months.

3) Cabozantinib (Cabometyx): For treatment of advanced renal cell carcinoma in patients who receive prior anti-angiogenic therapy.

New evidence for overall survival has emerged since the DCWG meeting in May, and was presented to the committee.

Recommendation: Cover Tier 4 with PA

4) Cabozantinib (Cometriq): For treatment of medullary thyroid cancer.

Cabozantinib is currently excluded due to lack of OS benefit in the setting of medullary thyroid cancer with approval based on PFS. FDA has recently updated the PI with final PFS results. Since then, final OS data has been presented in abstract form.

Recommendation: Cover Tier 4 with PA

C. New Formulary Consideration: by Dr. Geri Bemberg, UAMS

- 1) **Triptans Reference Pricing Proposal** – Triptans are a class of medications used for the treatment of migraines. There are currently multiple options available in different dosage forms, brand names, and generics. A review was done to see if it would be appropriate to reference price this class. It was concluded that there is no consistent evidence that one triptan has any particular advantage or disadvantage over another in any subgroup based on any factor. There appears to be no difference between oral products, although injectables having a slightly quicker onset of action.

Recommendation: Reference price orals to sumatriptan tablet price. Place sumatriptan and rizatriptan tablets at Tier 1. Place injectables at Tier 3.

- 2) **Proton Pump Inhibitors** – Medications used to treat heartburn and stomach ulcers. PPI’s include drugs such as Nexium, Dexilant, Prilosec, Prevacid, Aciphex, Protonix and their generic versions esomeprazole, omeprazole, lansoprazole, dexlansoprazole, rabeprazole, and pantoprazole. With so much evidence out concerning the adverse effects of these medications and many over the counter options available, it was recommended to exclude these medications from coverage.

Recommendation: Exclude all PPI’s, with the exception of First-Lansoprazole, which would be covered Tier 2 with swallow criteria (7 years old).

- 3) **Nasal Steroids** –Given that there are 3 nasal steroids now available over the counter and that there are no known clinical differences between the efficacy of the available nasal steroids on the market (legend or OTC), exclude nasal steroids from the formulary. This would shift utilization to the OTC products. Savings to the plan would be approximately \$80,000/quarter or \$320,000/year. There was discussion about why Azelastine, a nasal antihistamine was included in the original reference pricing model. Pricing with the new MAC list with MedImpact was also discussed, as well as its impact on the current plan spend in this category.

Recommendation: Continue coverage in this class for now, and rereview at a later date.

II. NEW DRUGS

Dr. Jill Johnson reported on new drugs. The review covered products released February 1, 2016 – May 23, 2016.

A. Recommended Additions

1. Nonspecialty Medications

BRAND NAME	GENERIC NAME	PRICING (AWP)	INDICATION	SIMILAR THERAPIES ON FORMULARY	DUEC VOTE
Otiprio Suspension	Ciprofloxacin Intratympanic Suspension 6%	\$339.84	Tx of Pediatric patients w/ bilateral otitis media w/ effusion undergoing tympanostomy tube placement	Cipro ophthalmic 0.3% covered T1, Cipro otic 0.2% excluded	Cover
Zembrace SymTouch Inj	Sumatriptan Succinate soln auto-inj 3mg/0.5mL	\$359.40/inj	Migraine	Generics available T1, T2. Brands available T2 and T3.	Reference price with other triptans

BRAND NAME	GENERIC NAME	PRICING (AWP)	INDICATION	SIMILAR THERAPIES ON FORMULARY	DUEC VOTE
Methergine	Methylergonovine maleate tablet 0.2mg	\$56.40/tablet	Prevention of hemorrhage		Cover Tier 1, QL of 28
Aczone gel	Dapsone Gel 7.5%	\$594/tube	Acne vulgaris	Multiple topical and oral acne products covered	Cover Tier 3
Onzetra	Sumatriptan Succinate Exhaler Powder 11mg/nosepiece	\$36.60/nosepiece	Migraine	Generics available T1, T2. Brands available T2 and T3.	Reference price with other triptans
Potassium gluconate	Potassium gluconate tablet 550mg (90mg equiv K)	\$0.03/tablet			Cover Tier 1
Nuplazid	Pimavanserin Tartrate tablet 17mg (Base equiv)	\$39/tablet	Parkinson disease psychosis	Quetiapine available T1	Cover Tier 4, PA

2. Specialty Medications

BRAND NAME	GENERIC NAME	PRICING (AWP)	INDICATION	SIMILAR THERAPIES ON FORMULARY	DUEC VOTE
Xeomin	Incobotulinumtoxin A for IM Inj 200 unit	\$1,118.40/vial	Multiple indications	Other strengths of Xeomin are PA'ed w/ other botulinum products	Cover , PA Medical
Xuriden Powder	Uridine Triacetate Oral Granules Packet 2G	\$900/packet	Treatment of hereditary orotic aciduria; Emergency tx of fluorouracil or capecitabine overdose	Also available as Vistogard in 10g packets for \$4,500/packet	Cover Tier 4 PA
Vistogard Packet	Uridine Triacetate Oral Granules Packet 10G	\$4,500/packet	Treatment of hereditary orotic aciduria; Emergency tx of fluorouracil or capecitabine overdose	Also available as Xuriden in 2g packets for \$900/packet	Cover Tier 4 PA
Odefsey	Emtricitabine-Rilpivirine-Tenofovir AF Tablets 200-25-25mg	\$93.83/tablet	HIV	Other HIV products T4	Cover Tier 4
Xeljanz XR	Tofacitinib Citrate Tablet SR 24hr 11mg	\$126.77/tablet	Rheumatoid Arthritis	Xeljanz IR covered T4PA, \$69.37/tablet	Cover Tier 4 PA, follow up on cost 10/16

BRAND NAME	GENERIC NAME	PRICING (AWP)	INDICATION	SIMILAR THERAPIES ON FORMULARY	DUEC VOTE
Alprolix Injection	Coagulation Factor IX (Recomb) for Inj 250unit	\$3.42/vial	Control or prevention of bleeding in patients with factor IX deficiency	Other hemophilia products Tier 4PA	Cover Tier 4 PA
Descovy	Emtricitabine-Tenofovir Alafenamide Fumarate Tablet 200-25mg	\$58.66/tablet	HIV	Other HIV products at Tier 4	Cover Tier 4
Wilate Inj	Antihemophilic Factor/VWF (Human) for Inj 500-500 unit kit	\$1.56	Hemophilia A	Other hemophilia products Tier 4PA	Cover Tier 4 PA
Cabometyx	Cabozantinib S-Malate Tablets 20mg, 40mg, 60mg	\$550/tablet	Renal Cell Carcinoma	Options covered T4PA	Cover Tier 4 PA
Xofigo Inj	Radium 223 Dichloride Inj 30 microcurie/mL	\$25,841.33	Castration-resistant prostate cancer w/ symptomatic bone mets	Covered prostate meds are at T4PA	Cover Tier 4 PA
Daklinza	Daclatasvir Dihydrochloride Tablet 90mg	\$900/tablet	Chronic Hep C – this dose for use with patients taking w/ a moderate CYP3A4 inducer or nevirapine	Covered Hep C meds are under T4PA	Cover Tier 4 PA
Lenvima	Lenvatinib Capsule Therapy Pack 18mg daily dose, 8mg daily dose	\$192.53 - \$258.80/dose	Renal Cell Carcinoma	Options covered T4PA	Cover Tier 4 PA

B. Recommended Exclusions
1. Nonspecialty Medications

BRAND NAME	GENERIC NAME	PRICING (AWP)	INDICATION	SIMILAR THERAPIES ON FORMULARY	DUEC VOTE
Vraylar	Cariprazine HCl Capsules 1.5mg, 3mg, 4.5mg, 6mg (Base equiv) & Therapy packs	\$40.24/cap	Bipolar disorder, Schizophrenia	Several generics covered T1, Brands covered T2	Exclude, Code 1
Lido-Rx Cream	Lidocaine-Capsaicin Cream 4-0.1%	\$247.25/30g tube	Temporary pain relief	Multiple lidocaine products covered	Exclude, Code 13
Allzital	Butalbital-acetaminophen tablets 25-325mg	\$7.81/tab	Tension or muscle contraction headache	Bupap 50-300mg covered T2 (\$16.18/tab). Butalbital-apap 50-325 covered T1 (MAC)	Exclude, Code 13

BRAND NAME	GENERIC NAME	PRICING (AWP)	INDICATION	SIMILAR THERAPIES ON FORMULARY	DUEC VOTE
Previdolrx Pak	Diclofenac tablet 75mg-omeprazole cap 20mg-Capsicum CR 0.025% THPK	\$1,999/pack	Pain relief	Diclofenac tabs available T1, omeprazole available T1	Exclude, Code 13
Metoprolol	Metoprolol tartrate tablets 37.5mg, 75mg	\$1.46-\$2.44/tablet	Cardiovascular	Metoprolol tartrate, metoprolol succinate other strengths available T1 (MAC)	Exclude, Code 13
Adzenys XR	Amphetamine ER Dispersible Tablets 3.1mg, 6.3mg, 9.4mg, 12.5mg, 15.7mg, 18.8mg	\$10.80/tablet	ADHD	Generic amphetamine IR products available T1 (MAC), generic XR amphetamine products available T1 <26yrs, RBP for >26yrs (MAC) Multiple other ADHD meds covered	Exclude, Code 13
Zingo Injection	Lidocaine HCl Powder for Intradermal Jet-Inj 0.5mg	\$26.40	Topical anesthesia	Multiple lidocaine products covered	NA Medical; to be used in a physical office or hospital
Ultravate Lotion	Halobetasol Propionate Lotion 0.05%	\$1,083/60mL	Steroid-responsive dermatoses	Multiple dermatological products covered	Exclude, Code 13
Otrexup Inj	Methotrexate Soln PF Auto-Inj 17.5mg/0.4mL, 22.5mg/0.4mL	\$431.25/inj	Multiple cancers	Other Otrexup products excluded. Mtx tabs covered T1, inj covered T1	Exclude, Code 13
Renacidin Topical	Citric Acid & D-Gluconic Acid Solution	\$6.38/unit	Prevention of calcifications of indwelling urethral catheters & cystostomy tubes		Exclude, Code 3
Xtampza ER	Oxycodone ER Capsule 12hr abuse-deterrent 9mg, 13.5mg, 18mg, 27mg, 36mg	\$4.04 - \$12.94/capsule	Pain management	Oxycodone IR available T1. ER available T1	Exclude, Code 13
Briviact	Brivaracetam Tablets 10mg, 25mg, 50mg, 75mg, 100mg	\$18.20/tablet	Partial onset seizures	Multiple anticonvulsants covered at different tiers	Exclude, Code 13

BRAND NAME	GENERIC NAME	PRICING (AWP)	INDICATION	SIMILAR THERAPIES ON FORMULARY	DUEC VOTE
Briivact Oral Solution	Brivaracetam Oral Solution 10mg/mL	\$3.64/mL	Partial onset seizures	Multiple anticonvulsants covered at different tiers	Exclude, Code 13

2. Specialty Medications

BRAND NAME	GENERIC NAME	PRICING (AWP)	INDICATION	SIMILAR THERAPIES ON FORMULARY	DUEC VOTE
Bridion Solution	Sugammadex Sodium IV 200 mg/2mL, 500mg/5mL	\$114-208.80/vial	Reversal of neuromuscular blockage induced by rocuronium or vecuronium in adults undergoing surgery	Out of scope of pharmacy benefits	N/A Medical
Docetaxel Inj	Docetaxel (Non-alcohol Formulary) IV Solution 20mg/mL, 80mg/4mL, 160mg/8mL	\$258/mL	Various Cancers	Docetaxel is also available in other IV formulations	N/A Medical
Spritam	Levetiracetam Tablets Disintegrating Soluble 250mg, 500mg, 750mg, 1000mg	\$8.67/tab	Seizure disorders	Levetiracetam IR & ER tablets, and oral solution available T1 (MAC)	Exclude, Code 13
Taltz Inj	Ixekizumab Subcutaneous Solution Auto-inj & Prefilled Syringe 80mg/mL	\$4,924.38/inj	Plaque psoriasis	TIMS available T4PA. Going for rebate	Exclude, Code 13.
Cinquair Inj	Reslizumab IV Infusion Solution 100mg/10mL (10mg/mL)	\$1,002/vial	Asthma	Multiple oral asthma products and inhalers available at all Tier levels. Xolair available T4PA (\$1,134.42)	Exclude, code 13. Also exclude Nucala from coverage.
Evomela Inj	Melphalan HCl for Inj 50mg (Propylene Glycol (PG) Free)	\$3,007.64/inj	Multiple myeloma	Some myeloma products covered T4PA	N/A Medical

BRAND NAME	GENERIC NAME	PRICING (AWP)	INDICATION	SIMILAR THERAPIES ON FORMULARY	DUEC VOTE
Venclexta	Venetoclax Tablets 10mg, 50mg, 100mg, & Therapy Starter Pack	\$9.56 - \$95.60/tablet	CLL	Some CLL products covered T4PA	Exclude, Code 2
Impavido	Miltefosine Capsule 50mg	\$685.71/capsule	Leishmaniasis		Exclude, Code 13
Hymovis Inj	Hyaluronan Intra- Articular Solution Prefilled Syringe 24mg/3mL	\$160/injection	Osteoarthritis of the knee	Single injections (Synvisc-One, Monovisc, Gel- One) covered with PA	Exclude, Code 13
Tecentriq Inj	Atezolizumab IV Solution 1200mg/20mL	\$10,344/vial	Urothelial carcinoma		Exclude, Code 2

The committee recommended the proposed coverage for non-specialty additions, specialty additions, non-specialty exclusions, and specialty exclusions.

III. INHALER REBATE DISCUSSION: by Dr. Rachael McCaleb, UAMS

Drugs for the treatment of Asthma and Chronic Obstructive Pulmonary Disease (COPD).

Recommendations: EBD Formulary may include up to two covered products in each subcategory; all other products will be excluded.

- **Generic products not included. Brand only products included in the contracting process.**
- **Require price protection for the life of the contract**
- **Prior authorization criteria currently in place for selected agents will continue and is not negotiable in the contracting process.**

IV. EBD REPORT: by Dr. Geri Bemberg, UAMS

Dr. Bemberg gave an update on the PBM switch to MedImpact. She also gave an overview of the first 2 quarters of pharmacy spend for the plan. Currently, plan spend is up about 10% over this time last year. Major influences for the increase in cost include hepatitis C treatment, specialty utilization, and inflation. Currently specialty medications make up about 0.6% of the total number of prescriptions filled on the plan, but account for 38.9% of the total plan paid. This percentage is up a little over 4% from last year. Comparing 2015 to 2014, 2015 saw an increase of about 4% as well in the percentage of total plan paid accounted for by specialty drugs. Member cost share is down a little over 2%, and generic utilization is at 91.2%.

Dr. Bemberg then asked for recommendations on the next category for Dr. McCaleb to review for rebate contracting. She suggested anticoagulants, contraceptives, and other diabetes agents. The committee recommended for Dr. McCaleb to look at oral anticoagulants next.

Respectfully submitted,

Dr. Hank Simmons,
Chair, DUEC

*New Drug Code Key:

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

11	Oral Contraceptives Policy - OCs which are new to the market may be covered by the plan with a zero dollar, tier 1, 2, or 3 copay, or may be excluded. If a new-to-market OC provides an alternative product not similarly achieved by other OCs currently covered by the plan, the DUEC will consider it as a new drug. IF the drug does not offer a novel alternative or offers only the advantage of convenience, it may not be considered for inclusion in the plan.
12	Other
13	Insufficient clinical benefit OR alternative agent(s) available

Arkansas State Employees & Public School Employees Health Benefits Program



Financial & Regulatory Update

August 16, 2016
Board Meeting

John Colberg, FSA, MAAA

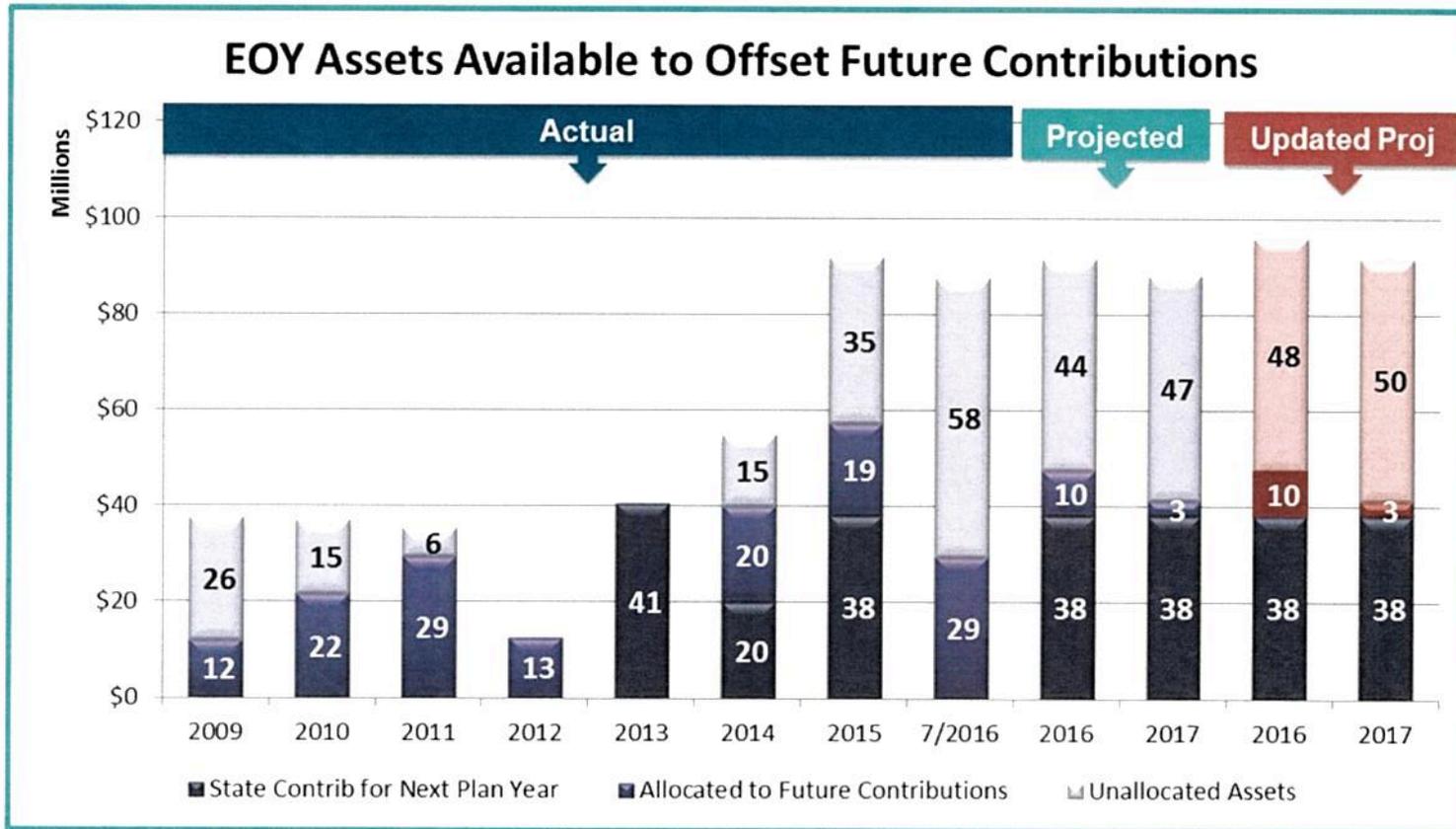


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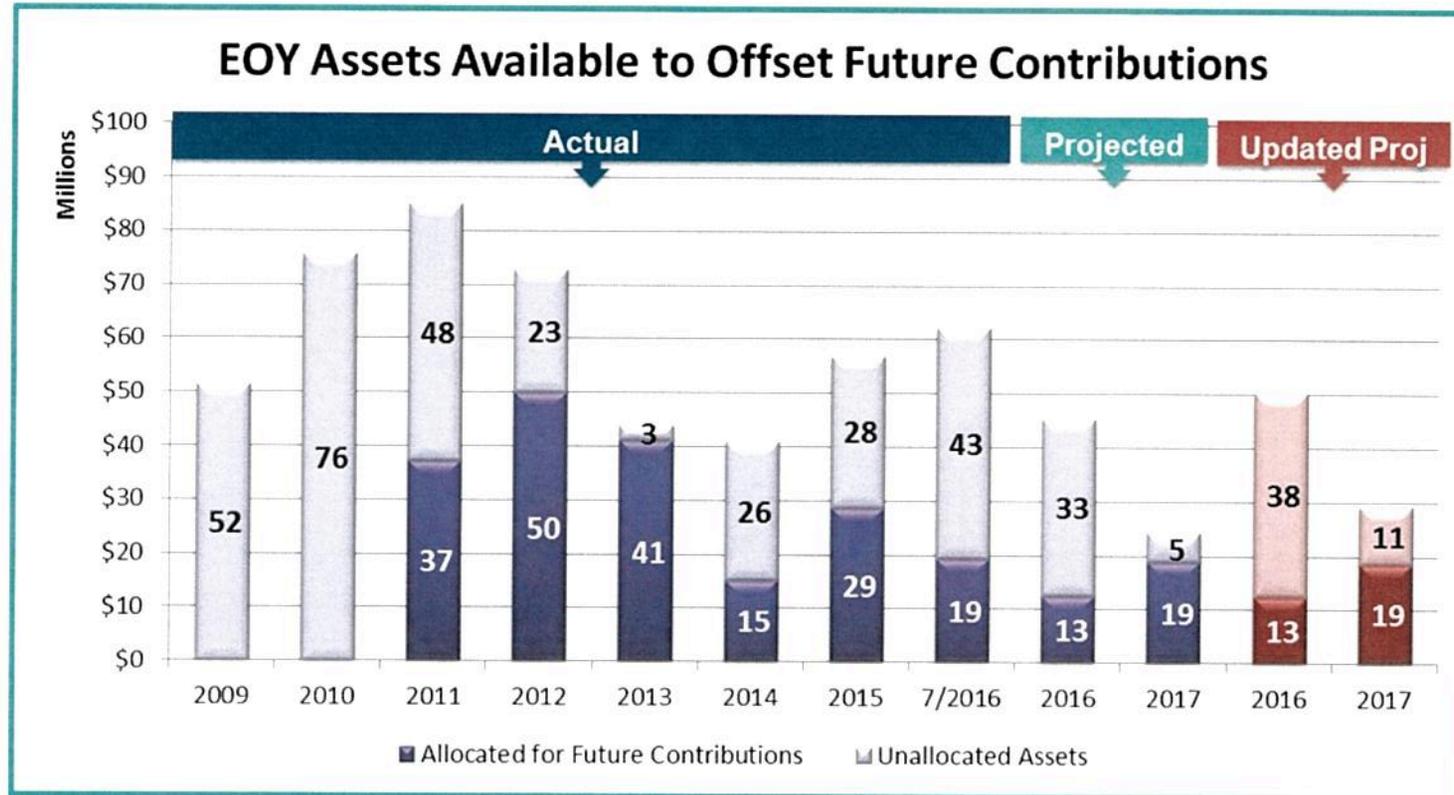
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PSE Updated Asset Projections



2017 figures reflect contribution rates adopted by the Board in July 2016.

ASE Updated Asset Projections



2017 figures reflect contribution rates adopted by the Board in July 2016.

Nondiscrimination Regulation



- Nondiscrimination Regulation under Section 1557 of the Affordable Care Act effective July 18, 2016
- Apply to entities receiving Federal funds from Health & Human Services (HHS)
 - ASE receives Medicare Retiree Drug Subsidies
 - PSE may not be subject to regulation (need to confirm no HHS funds received)

Nondiscrimination Regulation



- Administrative Requirements
 - Designate a compliance coordinator
 - Adopt a grievance procedure
 - Prohibit denial of health care or health coverage based on an individual's sex, gender identity, and sex stereotyping, color, or national origin
 - Offer language assistance timely and free of charge
 - Sex-specific health programs or activities are not allowed unless exceedingly persuasive justification
 - For individuals with disabilities, make all programs and activities provided through electronic and information technology accessible

Nondiscrimination Regulation

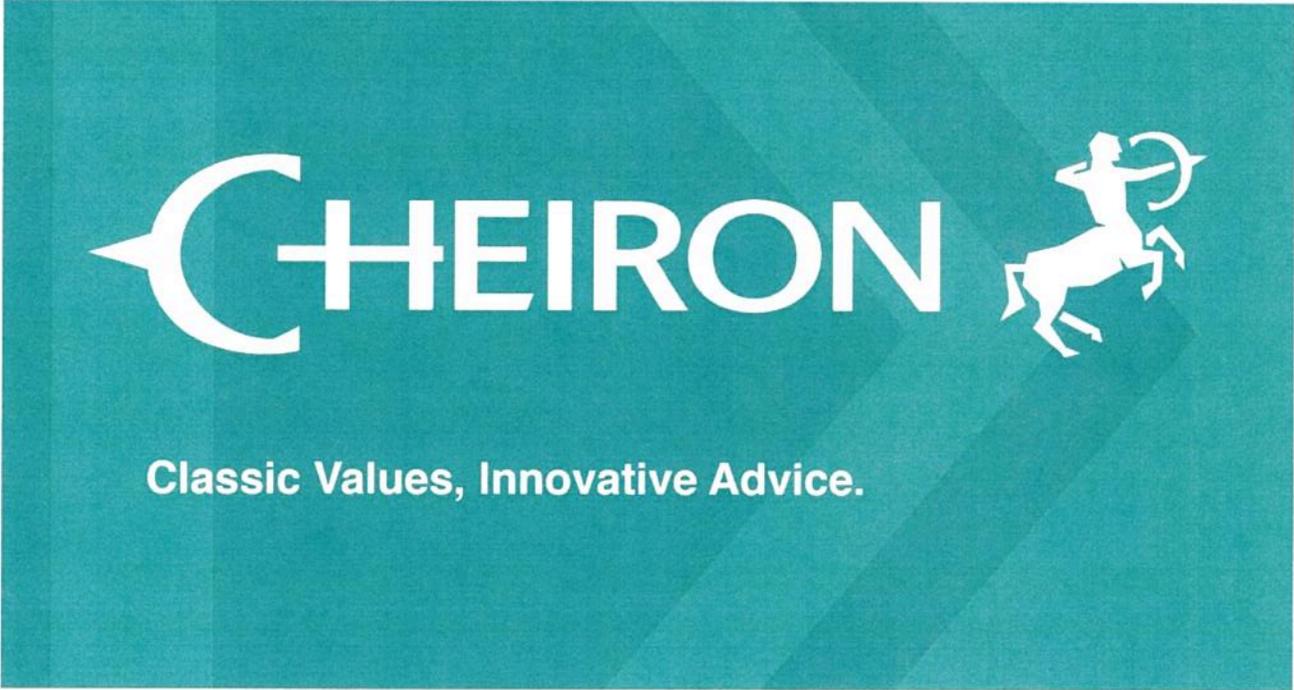


- Notice Requirements (by October 16, 2016)
 - Post notice
 - That it does not discriminate
 - How to obtain appropriate auxiliary aids and language assistance
 - Contact information
 - Entity's grievance procedure, including how to file a complaint.
 - Post taglines (short statements indicating availability of language assistance services free of charge) in the top 15 non-English languages spoken in the state
 - For small-sized publications or communications, such as postcards and tri-fold brochures, can limit to two languages (instead of 15)
 - HHS has provided sample notices and taglines in 64 languages
 - Where notices and taglines must be posted
 - At physical locations where the covered entity interacts with the public
 - On the entity's website
 - In significant publications and communications

Nondiscrimination Regulation



- Plan Design Requirements
 - Effective for plan year beginning in 2017
 - For affected covered entities, this regulation prohibits the blanket exclusion of medically-necessary transgender treatments.
 - We have not evaluated cost impact for ASE (or PSE).
 - Generally cost estimates have been below \$0.50 PMPM (which translates to less than \$400,000 annually for ASE)
 - Other plan design changes may be required if any provisions could be deemed health care or health coverage based on an individual's sex (including discrimination based on pregnancy), gender identity, and sex stereotyping, color, national origin, or disability.
 - An example could be a wellness program where a certain category of disabled participants do not have similar opportunities to comply as the rest of the population.



Cheiron (pronounced kī'ron), the immortal centaur from Greek mythology, broke away from the pack and was educated by the Gods. Cheiron became a mentor to classical Greek heroes, then sacrificed his immortality and was awarded in eternity as the constellation Sagittarius.



From: Information
Sent: Friday, July 22, 2016 6:05 PM
To:
Subject: Cheiron Health Alert: Nondiscrimination Rule Expands Administrative Practices, Notice/Language Requirements and Transgender Coverage for Certain Plans

Dear Cheiron Health Client and Friends,

The Office for Civil Rights in the Department of Health and Human Services has issued a final regulation under the Affordable Care Act on nondiscrimination in health programs and activities. This Alert describes key points in the final regulation.



CHEIRON HEALTH ALERT

Nondiscrimination Rule Expands Administrative Practices, Notice/Language Requirements and Transgender Coverage for Certain Plans

July 22, 2016

On May 18, 2016, the Office for Civil Rights (OCR) of the Department of Health and Human Services (HHS) published its final regulation on Nondiscrimination in Health Programs and Activities, which implements section 1557 of the Affordable Care Act (ACA). A copy of the regulation is at this [link](#) and OCR's summary of the regulation is at this [link](#). On July 20, 2016, HHS has published a presenter's guide and training slides for covered entities available at this [link](#). This Alert summarizes key provisions affecting employers and plan sponsors.

Action Needed Now: Employers and plan sponsors should determine whether they are subject to the regulation. If so, many requirements are already effective. However, they have until **October 16, 2016**, (90 days after the July 18, 2016, effective date) to comply with the notice requirements and until the first plan year beginning on or after January 1, 2017 to make coverage changes to health insurance or group health plan benefit design. The effective dates are discussed below.

Affected Covered Entities: From a plan sponsor perspective, the covered entities affected by the rule fall into three categories:

- *Group Health Plans* (including multiemployer, public sector, and single employer plans regardless of whether fully insured or self-insured) that receive Federal financial assistance from HHS. Generally this will be if they receive Medicare Retiree Drug Subsidies or directly contract with Medicare to receive Employer Group Waiver Plan (EGWP) subsidies. (Check with plan counsel regarding whether your EGWP arrangement requires your plan to comply.)
- *Health Care Employers* that receive Federal financial assistance; for example, a hospital system that receives payments from Medicare. Such an employer will need to comply with

the rule not only for its health care services (for example, a hospital must provide language assistance for its patients), but also with regard to the health coverage offered to its employees.

- **Insurers.** An insurer participating in the Marketplace (Exchanges) or otherwise receiving Federal financial assistance is covered by the regulation for all of its health plans. Employers and plan sponsors can expect that, beginning in 2017, insurers will be including coverage for transgender benefits with insured products. Employers and plan sponsors should also expect that insurers (as well as third party administrators, where applicable) will be following the administrative and notice practices described below.

CHEIRON OBSERVATION: *The determination of what is a covered entity can turn on a few facts. An employer that contributes to a multiemployer plan does not appear to be a covered entity merely because the plan is a covered entity. Plan counsel should be contacted for confirmation of these points or if there is a question of whether an entity is a covered entity under the regulation.*

Effective Dates

- **July 18, 2016** for administrative practices (and anything not specifically subject to the two dates that follow)
- **October 16, 2016** for notice requirements
- The first day of the first policy year or plan year beginning on or after **January 1, 2017** for provisions that require changes to health insurance or group health plan benefit design (including covered benefits, benefits limitations or restrictions, and cost-sharing mechanisms, such as coinsurance, copayments, and deductibles)

Background

Building upon prior Federal civil rights and nondiscrimination laws, section 1557 of the ACA prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities. Section 1557 applies to covered entities that receive Federal financial assistance.

HHS broadly applies this nondiscrimination requirement to all of the coverage and services of issuers that receive Federal financial assistance in which HHS plays a role in providing, whether those issuers' coverage is offered through the Marketplace, outside the Marketplace, in the individual or group health insurance markets, or as an employee health benefit program through an employer sponsored group health plan.

Overview of Key Provisions of the Final Rule

Administrative Practices

- Affected covered entities that employ 15 or more persons are required to a) designate an employee to serve as a compliance coordinator and b) adopt a grievance procedure that affords due process standards and provides for the prompt and equitable resolution of grievances alleging actions prohibited under the final rule. HHS has stated that an existing grievance procedure for disability claims could be used under this regulation as well, and Appendix C to the final rule contains a model grievance procedure for covered entities.
- The regulation prohibits the denial of health care or health coverage based on an individual's sex (including discrimination based on pregnancy), gender identity, and sex stereotyping, color, or national origin. Examples of prohibited practices include
 - Denying a transgender male a pap smear
 - Denying a transgender female a prostate exam

- Not covering treatment for domestic abuse simply because a participant is male
- Affected covered entities must offer language assistance timely and free of charge, to include a qualified interpreter and written translations as appropriate to provide an individual with meaningful access to health care services and coverage.
- Sex-specific health programs or activities are not allowed unless the covered entity can demonstrate an exceedingly persuasive justification, i.e., that the sex-specific program is substantially related to the achievement of an important health-related or scientific objective. For example, HHS has indicated that a breast cancer program cannot refuse to treat men with breast cancer solely because its female patients would feel uncomfortable.
- For individuals with disabilities, covered entities are required to make all programs and activities provided through electronic and information technology accessible to the extent it does not result in undue financial and administrative burdens or a fundamental alteration in the nature of the health programs or activities. Also, covered entities must ensure the physical accessibility of newly constructed or altered facilities and provide appropriate auxiliary aids and services for individuals with disabilities. Examples include:
 - Qualified sign language interpreters
 - Large Print materials
 - Text telephones (TTYs)
 - Captioning
 - Screen reader software
 - Video remote interpreting services

Notice Requirements

- Affected covered entities must post notices for beneficiaries, enrollees, applicants, and members of the public that it does not discriminate in its health programs and activities and that it provides appropriate auxiliary aids and language assistance services free of charge and in a timely manner (including how to obtain such services). Additionally, the notice must contain contact information and inform about the entity's grievance procedure, including how to file a complaint. The regulation provides a sample notice in Appendix A, and HHS has provided translated nondiscrimination language [here](#).
- Covered entities must post taglines (which are short statements that indicate the availability of language assistance services free of charge) in the top 15 non-English languages spoken in the state or states in which the entity is located or does business. HHS has provided sample language in Appendix B. HHS has provided a list of the top 15 languages by state [here](#) and provided the translated taglines [here](#).
 - For small-sized publications or communications, such as postcards and tri-fold brochures, taglines in at least the top two (instead of the top 15) non-English languages spoken in the state or states, along with the nondiscrimination statement.
- Notices and taglines must be posted:
 - At physical locations where the covered entity interacts with the public (such as in an emergency room or physician's waiting room)
 - On the entity's website
 - In significant publications and communications

CHEIRON OBSERVATION: *Multiemployer plans and employers who have employees in multiple states may have the added burden of producing communications that cover more than 15 languages (or more than two languages in the case of taglines) if the top 15 (or the top two) differ from state to state.*

Plan Design Changes

- For affected covered entities, this regulation prohibits the blanket exclusion of medically-necessary transgender treatments.
- Other plan design changes may be required if any provisions could be deemed health care or health coverage based on an individual's sex (including discrimination based on pregnancy), gender identity, and sex stereotyping, color, national origin, or disability. An example could be a wellness program where a certain category of disabled participants do not have similar opportunities to comply as the rest of the population.

Cheiron consultants can assist with your compliance under the final rule and section 1557, as well as any related plan design changes for your 2017 plan year.

Cheiron is an actuarial consulting firm that provides actuarial and consulting advice. However, we are neither attorneys nor accountants. Accordingly, we do not provide legal services or tax advice.

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Appendix B: Assumptions



- Based on actual May 2016 enrollment, medical claims incurred 6/1/2015 – 5/31/2016; pharmacy claims incurred 7/1/2015 – 6/30/2016
 - Net Migration of approximately 600 ASE and 600 PSE active employees from Premium to Basic annually
 - No growth in actives or NME retirees after 2017
 - Annual Growth of 400 ME retirees for PSE and 200 ME retirees for ASE

- Annualized Trend Rates of

	<u>2016</u>	<u>2017</u>
Medical (Actives & NME Retirees)	10%	6%
Medical (ME Retirees)	20%	6%
Pharmacy (all groups)	11%	10%

- Pharmacy reimbursement as approved by the Board in March 2016
- **No changes to State contributions for ASE or PSE**
- 90% wellness participation for PSE; 88% for ASE
- No changes in benefits

Appendix B: Use & Disclosures



- Projections are based on incurred claim experience as indicated. Incurred claims are completed from pharmacy paid experience through June 2016 and medical paid experience through July 2016, adjusted for demographic, benefits, and network changes.
- Estimates of impact of pharmacy changes are intended to be conservative estimates. Our estimates assume the pharmacies' usual and customary rates will be above the discounted AWP or MAC charge, as applicable. Estimates rely on 2015 actual experience without trend and unadjusted for the Medicare Retiree Drug subsidy. Savings for classic and basic are allocated to members according to the member proportion of the original claim.
- In preparing the information in this presentation, we relied on information (some oral and some written) supplied by the EBD and the Plan's vendors. This information includes, but is not limited to, the plan provisions, employee eligibility data, financial information, and claims data. We performed an informal examination of the obvious characteristics of the data for reasonableness and consistency in accordance with Actuarial Standard of Practice No. 23. Unless otherwise indicated, this presentation does not reflect future changes in benefits, penalties, taxes, or administrative costs that may be required as a result of the Patient Protection and Affordable Care Act of 2010, related legislation, or regulations.
- Cheiron's analysis was prepared exclusively for the Employee Benefits Division of the State of Arkansas for the specific purpose of providing projections and options to the Arkansas State and Public School Life and Health Insurance Board. Other users of this document are not intended users as defined in the Actuarial Standards of Practice, and Cheiron assumes no duty or liability to any other user.
- Cheiron is an actuarial consulting firm that provides actuarial and consulting advice. However, we are neither attorneys nor accountants. Accordingly, we do not provide legal services or tax advice. Consult appropriate counsel for legal advice.

John L. Colberg, FSA, MAAA
Principal Consulting Actuary

Gaelle Gravot, FSA, MAAA
Principal Consulting Actuary



Classic Values, Innovative Advice

8/16/2016

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