



AGENDA

State and Public School Life and Health Insurance Board

01/30/2014

1:00 p.m.

EBD Board Room – 501 Building, Suite 500

- | | | |
|-------|-----------------------------------|---|
| I. | Call to Order | John Kirtley, Chair |
| II. | Introduction of New Board Members | Bob Alexander, EBD Executive Director |
| III. | Review of 2014 Meeting Schedule | Bob Alexander, EBD Executive Director |
| IV. | Board Member Stipend | Bob Alexander, EBD Executive Director |
| V. | October 15, 2013 Board Minutes | John Kirtley, Chair |
| VI. | November 4, 2013 DUEC Report | Dr. Kat Neill, DUEC Chair |
| VII. | ASE & PSE Financials– Dec '13 | Marla Wallace, EBD Chief Fiscal Officer |
| VIII. | Director's Report | Bob Alexander, EBD Executive Director |

NOTE: All material for this meeting will be available by electronic means only and are accessible on the ARBenefit's web-site at www.arbenefits.org

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 Minutes January 30, 2014

The 133rd meeting of the State and Public School Life and Health Insurance Board (hereinafter called the Board), met on January 30, 2014 at 1:00 p.m. in the EBD Board Room, 501 Woodlane, Suite 500, Little Rock, AR 72201.

MEMBERS PRESENT

Renee Mallory
Robert Boyd
Dr. Joseph Thompson
Katrina Burnett
John Kirtley, Chair
Carla Wooley-Haugen – Vice-Chair
Dr. Andrew Kumpuris
Angela Avery
Shelby McCook
Dr. Tony Thurman
Janis Harrison

MEMBERS ABSENT

Dan Honey
Lori Freno-Engman

Bob Alexander, Executive Director, Employee Benefits Division

OTHERS PRESENT:

Dwight Davis, David Keisner, Jill Johnson, Jeff Mahes, UAMS; Doug Shackelford, Michele Hazelett, Marla Wallace, Leslie Smith, Lori Eden, Janna Keathley, Tracy Oberste, Sherry Bryant, Erica Harris-Backus, Sylvia Landers, Joe Chang, Eileen Wider, Minnesota Life; Pam Lawrence, AHH; Booth Rand, Arkansas Insurance Dept; Richard Ponder, J & J; Antrice Kay, Pfizer; Steve Singleton, ARTA; Marc Watts, ASEA; Jennifer Smith, ASU; Mike Meadors, BYSI; Wayne Whitely, Ronda Walthall, AR Highway & Transportation Dept; Diann Shoptaw, USable; Kathy Ryan, Takisha Sanders, Ron DeBerry, David Bridges, Kanita Collins, Health Advantage; Ro Summers, ACHI; Andra Kaufman, Mike Stoch, QualChoice; Susan Walker, Ben, Datapath; Karen Henson, AGFC; Jim Chapman, Connie Bennett, RX; Warren Tayes, Merck; Kim Henderson, ADFA; Dwane Tankerslay, Novasys

CALL TO ORDER:

Meeting was called to order by John Kirtley, Chair

APPROVAL OF MINUTES: *by John Kirtley, Chair*

The request was made by Kirtley to approve the October 15, 2013 minutes.

Dr. Thompson made the motion to approve the minutes, Harrison seconded; all were in favor. **Minutes approved.**

INTRODUCTION OF NEW BOARD MEMBERS: *by Bob Alexander, EBD Executive Director*

Alexander introduced himself as the Executive Director of Employee Benefits Division, and requested each member to introduce themselves with their name, position, and tenure with the Board. Alexander welcomed the new members, invited them to attend other committee meetings, and thanked them for coming.

REVIEW OF 2014 MEETING SCHEDULE: *by Bob Alexander, EBD Executive Director*

Alexander requested the Board to review the 2014 meeting schedule. There was a change in the schedule. The February meeting previously scheduled for February 11th was moved to February 18th. Alexander reports he would like to review the three (3) subcommittees to ensure there is representation from the Board on each committee. Alexander reported reactivating the Quality of Care Committee, which is a statutory subcommittee. The Quality of Care Committee will oversee the Payment Initiative Improvement Program. In addition, there will also be a Board only Taskforce for risk management. This is a non-statutory committee therefore, participation is voluntary.

Kirtley encouraged members of the Board to attend other committee meetings as well. There will be many decisions made from prescription drug coverage to benefits coverage. There are many experts attending the committee meetings, which will assist in making the best decisions for the plan from financial aspects to benefit coverage.

2014 BOARD MEMBER STIPEND: *by Bob Alexander, EBD Executive Director*

Kirtley reports the first official meeting of each year the Board must adopt the ability to reimburse the members of the Board for travel & cost.

Harrison motioned to adopt the 2014 stipend amount of \$60.00, Wooley-Haugen seconded; all were in favor. **Motion approved.**

NOVEMBER 4, 2013 DUEC REPORT: *by Dr. Kat Neill, Jill Johnson, David Keisner, UAMS*

The following report resulted from a meeting of the DUEC Committee from November 4, 2013 with Dr. Kat Neill presiding.

1. Recommended Changes to Current Coverage

A. Statin Reference Pricing Review

Keisner proposed changes for statin coverage. Statins are currently reference priced. DUEC recommends Crestor 10 & 20 mg be reference priced and the PA removed. All generic formulations are Tier 1 with PA removed. Crestor 40 mg remains at Tier 2 with PA.

Current Coverage	Recommendation
Tier 1 - atorvastatin 40 & 80 mg with PA, lovastatin, pravastatin, simvastatin	Tier 1 - atorvastatin, lovastatin, pravastatin, simvastatin
Tier 2 with PA - Crestor 10 mg, 20 mg, 40 mg	Tier 2 with PA - Crestor 40 mg
Tier 3 with PA - Lipitor 40 mg, 80 mg	Reference pricing: Altoprev, atorvastatin (10, 20, 40 & 80 mg), Crestor (5, 10 & 20 mg), Lescol, Lescol XL, Lipitor (10 & 20 mg), Mevacor, Pravachol, Zocor
Reference pricing includes: Altoprev, atorvastatin (10 & 20 mg), Crestor 5 mg, Lescol, Lescol XL, Lipitor (10 & 20 mg), Mevacor, Pravachol, Zocor	

B. Niaspan 2nd Review

Johnson reported the most recent data on utilization for Niacin IR, Niaspan, Simcor, & Generic Niacin ER. Previous studies with Niacin Monotherapy demonstrated reduction

in clinical events; however, this was prior to generalized statin implementation. More recent evidence shows that Niacin ER fails to provide a reduction in clinical events when combined with statin therapy and is associated with an increased adverse effect profile. Niacin is available over-the-counter. DUEC recommends excluding all Niacin products.

Current Coverage	Recommendation
Tier 1 – generic niacin products	Exclude all niacin products. Niacin is available OTC.
Tier 2 – Niaspan	

C. Acthar Gel 2nd Review

Johnson reported Acthar Gel is a drug used for a long list of indications. It is a 39 amino acid peptide natural form of adrenocotrophic hormone (ACTH) that works by stimulating the adrenal cortex to secrete cortisol. DUEC recommends that Acthar Gel is excluded. Synthetic ACTH and IV methylprednisolone are alternative therapies depending on indication.

Current Coverage	Recommendation
Tier 2 - Acthar	Exclude Acthar.

D. Bisphosphonate Review

Johnson reported on Bisphosphonates which are used to treat Osteoporosis. A systematic review was completed for the following: Alendronate, Ibandronate, Risedronate, Zoledronic Acid, Denosumab, Teriparatide, Raloxifene, & Calcitonin Salmon. DUEC recommends reference pricing for Alendronate.

Current Coverage	Recommendation
Tier 1 – alendronate	Tier 1 – alendronate
Tier 2 – Actonel	Reference price: Actonel, Boniva, Atelvia, ibandronate
Tier 3 – Boniva, Atelvia	

E. Fibric Acid Review

Fibric Acid Therapy (Gemfibrozil, Fenofibrate, Generic, Antara, Tricor, Lipofen, & Fenoglide) was reviewed. The evidence shows these agents lower LDL, increase HDL, & decrease triglycerides. FIELD study of the effects of long term Fenofibrate therapy on CV events in type 2 Diabetes patients concluded that Fenofibrate did not significantly reduce the risk of the primary outcome of coronary events in Type 2 Diabetes not

initially on statins. It did reduce total CV events, mainly due to fewer non-fatal MIs and revascularisations. The ACCORD Study Group shows the combination Fenofibrate and Simvastatin did not reduce the rate of fatal CV events, NFMI, or NF stroke, as compared with Simvastatin alone. These results do not support the routine use of combination therapy with Fenofibrate and Simvastatin to reduce CV risk in the majority of high risk patient with Type 2 Diabetes. There was no systematic reduction. DUEC recommends excluding all fibric acid therapy except Gemfibrozil.

Current Coverage	Recommendation
Tier 1 – generic fibrates	Tier 1 – gemfibrozil
Tier 3 – Antara, Tricor	Exclude all other fibrates.

F. Anticoagulant Review

Johnson reported on the clinical trials for Rivaroxaban (Xarelto), Apixaban (Eliquis), & Dabigatran (Pradaxa). Apixaban has more indications. Apixaban was Superior to Enoxaparin. DUEC recommends moving the drugs to Tier 2 and removing the PA. Keisner reports the price will be monitored.

Current Coverage	Recommendation
Tier 2 with PA – Eliquis, Pradaxa	Tier 2 – Eliquis, Pradaxa, Xarelto Remove PAs.
Tier 3 with PA – Xarelto	

G. Multiple Sclerosis Coverage

Johnson reported on Multiple Sclerosis. High quality evidence shows Rebif can reduce relapse and disability progression compared to placebo. DUEC recommends:

- Implement step therapy with Rebif for new users with subsequent access to Glatiramer, Fingolimod, Teriflunomide, or Demethyl Fumurate.
- Fingolimod (Gilenya): covered with PA

- Teriflunomide (Aubagio): covered with PA
- Dimethyl Fumarate (Tecfidera): covered with PA

Current Coverage	Recommendation
Tier 4 – Avonex, Copaxone, Betaserone, Rebif MS	Update/Add PA criteria to require Step therapy with Rebif for new users.
Tier 4 with PA – Aubagio, Gilenya, Tecfidera	

Dr. Thompson motioned to adopt section 1, Harrison seconded; all were in favor.

Motioned Approved.

2. New Drugs

Johnson reported on new drugs. The review covered products released July 22 – September 30, 2013.

Recommended Additions:

- Tivicay 50 mg tabs (Specialty) – Tx of HIV Infection. Approved on Tier 4 with a PA.
- Simponi Aria Sol 50 mg – Tx of moderate to severe RA. Added a PA to include new formulation.
- Tarceva (erlotinib) – Specialty Drug. Approved for Tier 4 with a PA.

Recommended Exclusions:

DRUG NAME	Generic	PRICING (AWP)	INDICATION	SIMILAR THERAPIES ON FORMULARY/ AWP
Lo Minastrin Pak FE	10mcg EE, 1mg Norethindrone. 24 active, 4 Fe(without therapeutic use).	\$99/28 days	Oral contraceptive	
Mirvaso gel	brimonidine 0.33%	\$296/30gm	For topical treatment of the facial erythema (redness) of rosacea in adults 18 years or older	Metronidazole 0.75% cm = \$181/45gm
Astagraf XL capsules 0.5, 1, or 5mg capsules (SPECIALTY DRUG)	Tacrolimus XR	\$71 - \$713/30 days	Extended-release form (given once daily) of tacrolimus for transplant rejection prophylaxis	Tacrolimus 5mg immediate release twice daily = \$1380/30 days
Brisdelle 7.5mg	Paroxetine	\$161/30 days	7.5 mg po at bedtime for moderate to severe hot flashes associated w/menopause	AWP generic paroxetine 10mg = 2.53/10mg
Butrans	buprenorphine patch		chronic pain. 1 patch every 7 days	generic & brand fentanyl patch
Enteragam Powder 5GM		\$60/5gm	Prescription medical food product for management of diarrhea - predominant irritable bowel syndrome.	
Epaned Solution	enalapril 1mg/ml enalapril for oral solution	\$342/150ml bottle	Tx of heart failure or hypertension	Enalapril tabs: 2.5mg/\$0.80 5mg/\$1.02 10mg/\$1.07
Fabior Aer 0.1%	TAZAROTENE (ACNE) FOAM 0.1%	\$340/50gm can; \$6.816/gram, 100g & 50g can	Tazarotene (acne) foam	Tazorac Cream 0.05% 60gm tube = \$558 Tazorac Gel 0.05% 30gm tube = \$279
Fioricet cap w/Cod	butalbital/APAP/ Caffeine/Codeine 50/300/40/30mg	\$5.70/capsule	Treatment of headache	Multiple generic versions of butalbital/APAP/ Caffeine/Cod (50/325/40/30). Cost - \$1.49/cap

Gilotrif (20,30, & 40mg tabs)	AFATINIB DIMALEATE TAB 20 MG, 30, 40mg (BASE EQUIVALENT)	\$6,660/30 days.	Approved for first-line tx of metastatic non-small cell lung cancer whose tumors have epidermal growth factor exon 19 deletions or exon21 substitution mutations as detected by an FDA- approved test.	
Injectafer injection 750mg/15ml.	Ferric Carboxymaltose IV solution	\$958/750mg dose	For iron-deficiency anemia (2 - 750mg dose given slow IV push or IV infusion separated by at least 7 days)	
Naftin Gel 2% (new strength)	NAFTIFINE HCL GEL 2%	\$340/45gm	Antifungal	Clotrimazole 1% 45gm - \$48. Ketoconazole cream 60gm - \$43. Tolnaftate 1% cream 30gm - \$10
Podiapn Capsules		\$34/bottle of 60	Dietary management product (medical food)	
Riax 5.5 or 9.5%	benzoyl peroxide foam	\$330/can	Treatment of acne	Benzoyl peroxide 5% gel = \$13/60 gm. 10% = \$21/60gm
Selrx Shampoo	2.3% (selenium sulfide-pyrithione zine - urea shampoo)	\$360/180ml bottle	Tx of dandruff, seborrheic dermatitis, tinea versicolor	Generic strengths of 2.25% available
Tretin-X cream	tretinoin cream 0.075% - new strength	\$284/35gm tube	Tx of acne	
Trokendi XR	topiramate oral extended release caps 25,50,100, or 200mg -	Dose of extended release is 200-400mg/day = \$684-\$1,367/30 days	Oral antiepileptic	generic immediate release topiramate 200mg = \$477
Utopic Cream	Urea cream 41%	\$420/227 gm bottle	Treatment of Xerosis plus pruritus, irritation or inflammation, keratolytic and dry skin.	Generic strengths of 10-50% available.

Vitafol caps ultra		\$26/30 caps	Prenatal vitamins	various generics available
Vytone 1-1.9% cream	hydrocortisone 10mg/iodoquinol 10mg/g of cream	\$200/box of 30	Topical antifungal	

Harrison motioned to adopt new drugs & table Astagraf XL until the next DUEC meeting April 7, 2014, Wooley-Haugen seconded; all were in favor. **Motioned Approved.**

Dr. Thompson motioned to make the change 90 days from February 1, 2014, Harrison seconded; all were in favor. **Motioned Approved.**

3. Discussion Topics

A. Principles for Drug Placement

Johnson reported Dr. Thompson, requested written philosophy for what the principles are for drug placement. DUEC can adopt the final version and present future recommendations to the Board using appropriate codes.

DRAFT: The focus for The Arkansas Drug Utilization and Evaluation Committee when placing drugs new to the market on the tiered formulary is to provide for the coverage of medically necessary drugs by considering efficacy and safety first as evidenced by peer-reviewed and published medical literature when available. The DUEC may exclude drugs from coverage for a variety of reasons coded below:

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:

	<p>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 enterally 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.”</p> <p>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.</p>
6	<p>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.</p>
7	<p>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.</p>
8	<p>Drug has limited medical benefit &/or lack of overall survival data or has overall survival data showing minimal benefit</p>
9	<p>Not medically necessary</p>
10	<p>Peer-reviewed, published cost effectiveness studies support the drug lacks value to the plan.</p>
11	<p>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.</p>
12	<p>Other</p>

B. Mac Pricing List Review

Keisner reported on the MAC list. Since 2004, the plan pays MAC price plus an added 10%. It is not feasible to add 10% indiscriminately. Keisner reports there is active involvement with Catamaran to assist in managing our price paid for drugs and pharmacies are fair. DUEC recommends a comprehensive MAC pricing review.

C. Chemotherapy Sub-Committee Consideration

Keisner reported there is a need for a Committee to review Oncology Meds. In 2012 there were more Oncology Meds released than any other category. There is a need for a clear plan to review Pharmacy and Medical coverage. Keisner recommends a Committee to review all Oncology Meds to include IV through the Hospital Benefit, or Oral Med through the Pharmacy Benefit. The Committee will write policies and determine where drugs fit into the overall Plan. For IV Medical Meds, policy will be reported to the Medical Policy Committee. For Oral Meds, policy will be reported to the DUEC Committee. Keisner recommends members from the DUEC Committee and members from the Medical Policy Committee as Members of the Oncology Committee.

Dr. Thompson motioned for The Delivery Coordination Sub-committee of the DUEC, Harrison seconded; all were in favor. **Motioned Approved.**

D. Specialty Tier Drug Placement

Keisner reported the specialty Drug List from Catamaran has been adopted. The standard for the Tier 4 drug would be \$1000.00 or more. The co-pay will be \$100.00. Excluded medications remain excluded, and generic medications remain T1. DUEC utilized the new tier at the November meeting.

Harrison motioned to adopt Catamaran Specialty Drug List, Wooley-Haugen seconded; all were in favor. **Motioned Approved.**

FINANCIALS: *by Marla Wallace, CFO EBD*

Wallace reported on the plan year 2013 for ASE. There are three plans for members to choose; Gold, Silver, & Bronze. For ASE there are 65,033 members, which includes employee + dependents. Funding for the year was \$291 million. The expenses for the year were \$292 million for a loss of \$1 million for the 2013 plan year. We have assets of \$80 million and liabilities of \$26 million leaving net assets of \$54 million. After the allocation for the reserves to assist with premiums for the next plan years 2014, 2015, & 2016; the net assets are 2.9 million.

The Board decides how much of the reserves can be allocated for future plan years. The first plan year is allocated 50% (7.4 million), the second plan year is allocated for 30% (9 million), & the third plan year is allocated for 20% (9 million).

For PSE there are 84,576 members. Funding was \$339 million. Expenses were \$309 million. The plan received \$43 million from the State. However, it is allocated for plan year 2014. After deducting the \$43 million there is a net loss of \$12.8 million.

Kirtley requested Wallace explains the different sources of funding for PSE. District contribution is the amount the schools contribute for each enrolled member. The employee contribution is what the employee pay after the district contribution. The schools are required to pay \$150.00, however some District's pay more. There are two contributions from The Department of Education in the amount of \$50 million. One is received eleven months out of twelve and the other is received quarterly.

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

Alexander reported on the Legislative Joint Audit Report. The committee viewed the funding balance as claims & administration fees. However, the Board used an allocated reserve amount to keep the rates low for plan years 2009, 2010, 2011, & 2012. The committee also reported on the DUEC Committee, which is a very complex committee.

Alexander questioned if the auditors fully understand the committee. Alexander advised members to view the audit report and email him regarding any questions.

Alexander reported there will be a Taskforce meeting Tuesday, February 4, 2014 Board members are invited to attend. The Taskforce has hired two Consultants; The Osborne Firm and Collier Insurance. Collier Insurance is a software company. They will have the responsibility of researching the financials, and reporting the results to the Taskforce. Alexander reports they are interested in the salaries of the PSE members.

In the special session, a bill was introduced requiring any Entity in the state that received funds designed for their health insurance to join the plan provided through Employee Benefits Division.

Alexander presented several things to the Taskforce. (1) Lap Band Surgery. The projected cost for this Benefit was \$3 million annually. However, the cost for 2013 was \$11 million. Alexander would like to work towards ending this program. Our plan is the only plan by law that must cover Lap Band Surgery. This is a statutory requirement that will require assistance.

Alexander reports on part-time employees. Anyone who works twenty hours in a week in the public school is allowed to participate in the plan. In addition, bus drivers who work any hours are allowed to participate in the plan. Alexander would like for these members to utilize the exchange for their coverage.

Alexander reports Employee Benefits Division hired a consultant to assist the Board and EBD. They will attend all Board, Committee, and Task Force meetings. In addition, they will answer all Benefits related questions. Alexander introduced Mark Meadors, and Brian Davidson.

Alexander reports there will be two open enrollment periods for 2015. It is anticipated in 2015 there will be different plans for ASE & PSE. Open enrollment for ASE will be held in October and PSE in September. In an effort to meet those deadlines Alexander would like for the approval of rates for ASE to be held in August, PSE rates in July, and the plan options for ASE to be decided in July, and PSE plan options in June.

Alexander reports Employee Benefits Division has hired a Communications Director. She will begin employment February 17, 2014.

Alexander reports EBD will have Video's on the website explaining all benefits including the voluntary benefits.

Dr. Thompson suggested published timelines for 2014 are made subject to change.

Dr. Kirtley reminded Board members to file their Statements of Financial Interest with The Secretary of State's Office. Kirtley suggested new Board members review the Arkansas Freedom of Information Act. The information will be helpful when having discussions with individuals and other Board members to avoid violating confidentiality.

Meeting Adjourned:



**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 Committee from November 4, 2013 with Dr. Kat Neill presiding.

1. Recommended Changes to Current Coverage

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Tier 3 with PA -- Xarelto	

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- Fingolimod (Gilenya): covered with PA
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- Dimethyl Fumarate (Tecfidera): covered with PA

Current Coverage	Recommendation
Tier 4 – Avonex, Copaxone, Betaserone, Rebif MS	Update/Add PA criteria to require Step therapy with Rebif for new users.
Tier 4 with PA – Aubagio, Gilenya, Tecfidera	

2. New Drugs

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Recommended Additions:

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- Simponi Aria Sol 50 mg – Tx of moderate to severe RA. Added a PA to include new formulation.
- Tarceva (erlotinib) – Specialty Drug. Approved for Tier 4 with a PA.

Recommended Exclusions:

DRUG NAME	Generic	PRICING (AWP)	INDICATION	SIMILAR THERAPIES ON FORMULARY/AWP
Lo Minastrin Pak FE	10mcg EE, 1mg Norethindrone. 24 active, 4 Fe(without therapeutic use).	\$99/28 days	Oral contraceptive	
Mirvaso gel	brimonidine 0.33%	\$296/30gm	For topical treatment of the facial erythema (redness) of rosacea in adults 18 years or older	Metronidazole 0.75% cm = \$181/45gm
Astagraf XL capsules 0.5, 1, or 5mg capsules (SPECIALTY DRUG)	Tacrolimus XR	\$71 - \$713/30 days	Extended-release form (given once daily) of tacrolimus for transplant rejection prophylaxis	Tacrolimus 5mg immediate release twice daily = \$1380/30 days
Brisdelle 7.5mg	Paroxetine	\$161/30 days	7.5 mg po at bedtime for moderate to severe hot flashes associated w/menopause	AWP generic paroxetine 10mg = 2.53/10mg
Butrans	buprenorphine patch		chronic pain. 1 patch every 7 days	generic & brand fentanyl patch
Enteragam Powder 5GM		\$60/5gm	Prescription medical food product for management of diarrhea - predominant irritable bowel syndrome.	
Epaned Solution	enalapril 1mg/ml enalapril for oral solution	\$342/150ml bottle	Tx of heart failure or hypertension	Enalapril tabs: 2.5mg/\$0.80 5mg/\$1.02 10mg/\$1.07
Fabior Aer 0.1%	TAZAROTENE (ACNE) FOAM 0.1%	\$340/50gm can; \$6.816/gram, 100g & 50g can	Tazarotene (acne) foam	Tazorac Cream 0.05% 60gm tube = \$558 Tazorac Gel 0.05% 30gm tube = \$279
Fioricet cap w/Cod	butalbital/APAP/Caffeine/Codeine 50/300/40/30mg	\$5.70/capsule	Treatment of headache	Multiple generic versions of butalbital/APAP/Caffenine/Cod (50/325/40/30). Cost - \$1.49/cap

Gilotrif (20,30, & 40mg tabs)	AFATINIB DIMALEATE TAB 20 MG, 30, 40mg (BASE EQUIVALENT)	\$6,660/30 days.	Approved for first-line tx of metastatic non-small cell lung cancer whose tumors have epidermal growth factor exon 19 deletions or exon21 substitution mutations as detected by an FDA-approved test.	
Injectafer injection 750mg/15ml.	Ferric Carboxymaltose IV solution	\$958/750mg dose	For iron-deficiency anemia (2 - 750mg dose given slow IV push or IV infusion separated by at least 7 days)	
Naftin Gel 2% (new strength)	NAFTIFINE HCL GEL 2%	\$340/45gm	Antifungal	Clotrimazole 1% 45gm - \$48. Ketoconazole cream 60gm - \$43. Tolnaftate 1% cream 30gm - \$10
Podiapn Capsules		\$34/bottle of 60	Dietary management product (medical food)	
Riax 5.5 or 9.5%	benzoyl peroxide foam	\$330/can	Treatment of acne	Benzoyl peroxide 5% gel = \$13/60 gm. 10% = \$21/60gm
Selrx Shampoo	2.3% (selenium sulfide-pyrithione zine - urea shampoo)	\$360/180ml bottle	Tx of dandruff, seborrheic dermatitis, tinea versicolor	Generic strengths of 2.25% available
Tretin-X cream	tretinoin cream 0.075% - new strength	\$284/35gm tube	Tx of acne	
Trokendi XR	topiramate oral extended release caps 25,50,100, or 200mg -	Dose of extended release is 200-400mg/day = \$684-\$1,367/30 days	Oral antiepileptic	generic immediate release topiramate 200mg = \$477
Utopic Cream	urea cream 41%	\$420/227 gm bottle	Treatment of Xerosis plus pruritus, irritation, or inflammation, keratolytic and dry skin.	Generic strengths of 10-50% available.
Vitafol caps ultra		\$26/30 caps	Prenatal vitamins	various generics available
Vytone 1-1.9% cream	hydrocortisone 10mg/iodoquinol 10mg/g of cream	\$200/box of 30	Topical antifungal	

3. Discussion Topics

A. Principles for Drug Placement

Johnson reported Dr. Thompson, Board Member, requested written philosophy for what the principles are for drug placement. DUEC can adopt the final version and present future recommendations to the Board using appropriate codes.

DRAFT: The focus for The Arkansas Drug Utilization and Evaluation Committee when placing drugs new to the market on the tiered formulary is to provide for the coverage of medically necessary drugs by considering efficacy and safety first as evidenced by peer-reviewed and published medical literature when available. The DUEC may exclude drugs from coverage for a variety of reasons coded below:

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 enterally 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

B. Mac Pricing List Review

Keisner reported on the MAC list. Since 2004, the plan pays MAC price plus an added 10%. It is not feasible to add 10% indiscriminately. Keisner reports there is active involvement with Catamaran to assist in managing our price paid for drugs and pharmacies are fair. DUEC recommends a comprehensive MAC pricing review.

C. Chemotherapy Sub-Committee Consideration

Keisner reported there is a need for a Committee to review Oncology Meds. In 2012 there were more Oncology Meds released than any other category. There is a need for a clear plan to review Pharmacy and Medical coverage. Keisner recommends a Committee to review all Oncology Meds to include IV through the Hospital Benefit, or Oral Med through the Pharmacy Benefit. The Committee will write policies and determine where drugs fit into the overall Plan. For IV Medical Meds, policy will be reported to the Medical Policy Committee. For Oral Meds, policy will be reported to the DUEC Committee. Keisner recommends members from the DUEC Committee and members from the Medical Policy Committee as Members of the Oncology Committee.

D. Specialty Tier Drug Placement

Keisner reported the specialty Drug List from Catamaran has been adopted. The standard for the Tier 4 drug would be \$1000.00 or more. The co-pay will be \$100.00. Excluded medications remain excluded, and generic medications remain T1. DUEC utilized the new tier at the November meeting.

Respectfully submitted,

Kat Neill
Chair, Drug Utilization and Evaluation Committee

Arkansas State Employees (ASE) Financials - January 1, 2013 through December 31, 2013				
	Gold	Silver	Bronze	Total
Actives	44,728	2,409	3,647	50,784
Retirees	3,420	31	91	3,542
Medicare	10,707			10,707
Total	58,855	2,440	3,738	65,033
Revenues & Expenditures				
			Current Month	Year to Date (12 months)
Funding				
State Contribution			\$ 14,319,162	\$ 167,154,548
Employee Contribution			\$ 7,207,061	\$ 86,780,258
Other			\$ 1,186,453	\$ 10,412,853
Allocation for Active/Retiree Plan Year 2013			\$ 2,236,667	\$ 26,840,000
Total Funding			\$ 24,949,343	\$ 291,187,659
Expenses				
Medical Expenses				
Claims Expense			\$ 14,913,439	\$ 187,248,151
Claims IBNR			\$ -	\$ 2,100,000
Medical Admin Fees			\$ 1,112,146	\$ 13,157,408
Refunds			\$ 6,336	\$ 84,695
Employee Assistance Program (EAP)			\$ 56,187	\$ 676,555
Life Insurance			\$ 54,623	\$ 657,589
Pharmacy Expenses				
RX Claims			\$ 6,170,778	\$ 82,091,540
RX IBNR			\$ -	\$ (800,000)
RX Admin			\$ 247,725	\$ 3,050,819
Plan Administration			\$ 348,327	\$ 4,005,348
Total Expenses			\$ 22,909,560	\$ 292,272,105
Net Income/(Loss)			\$ 2,039,784	\$ (1,084,446)
Balance Sheet				
Assets				
Bank Account				\$ 7,732,880
State Treasury				\$ 71,461,427
Due from Cafeteria Plan				\$ 668,305
Due from PSE				\$ 69
Receivable from Provider				\$ -
Accounts Receivable				\$ 279,818
Total Assets				\$ 80,142,498
Liabilities				
Accounts Payable			\$ 2,520	
Deferred Revenues			\$ 4,970	
Due to Cafeteria			\$ 160	
Due to PSE			\$ 516,886	
Health IBNR			\$ 23,200,000	
RX IBNR			\$ 2,400,000	
Total Liabilities			\$ 26,124,536	
Net Assets				\$ 54,017,963
Less Reserves Allocated:				
Active/Retiree Premiums for Plan Year 1/1/13 - 12/31/13 (\$11,190,000 + \$15,650,000)			\$ -	\$ 0
Active/Retiree Premiums for Plan Year 1/1/14 - 12/31/14 (\$7,460,000 + \$9,390,000 + \$9,000,000)			\$ -	\$ (25,850,000)
Active/Retiree Premiums for Plan Year 1/1/15 - 12/31/15 (\$6,260,000 + \$5,400,000)			\$ -	\$ (11,660,000)
Active/Retiree Premiums for Plan Year 1/1/16 - 12/31/16 (\$3,600,000)			\$ -	\$ (3,600,000)
Catastrophic Reserve			\$ -	\$ (10,000,000)
Net Assets Available				\$ 2,907,963

Public School Employees (PSE) Financials - January 1, 2013 through December 31, 2013

	Gold	Silver	Bronze	Total
Actives	35,051	8,288	28,013	71,352
Retirees	2,475	87	1,356	3,918
Medicare	9,306			9,306
Total	46,832	8,375	29,369	84,576

Revenues & Expenditures

Funding	Current Month	Year to Date (12 months)
District Contribution	\$ 8,058,423	\$ 96,836,451
Employee Contribution	\$ 10,693,847	\$ 130,792,442
Dept of Ed \$35,000,000 & \$15,000,000	\$ 3,181,818	\$ 50,000,000
Other	\$ 527,655	\$ 52,947,373
Allocation for Active/Retiree Premiums for Plan Year 2013	\$ 750,000	\$ 9,000,000
Total Funding	\$ 23,211,744	\$ 339,576,265
Expenses		
Medical Expenses:		
Claims Expense	\$ 16,944,388	\$ 213,820,201
Claims IBNR	\$ -	\$ 3,300,000
Medical Admin Fees	\$ 1,637,469	\$ 19,153,067
Refunds	\$ 5,455	\$ 7,428
Employee Assistance Program (EAP)	\$ 80,748	\$ 968,629
Pharmacy Expenses:		
RX Claims	\$ 5,125,338	\$ 64,664,724
RX IBNR	\$ -	\$ (800,000)
RX Admin	\$ 328,417	\$ 3,971,229
Plan Administration	\$ 265,128	\$ 4,294,094
Total Expenses	\$ 24,386,944	\$ 309,379,371
Net Income/(Loss)	\$ (1,175,200)	\$ 30,196,894
Less Reserve for 2014		\$ (43,000,000)
Net Income (Loss) for 2013	\$ (1,175,200)	\$ (12,803,106)

Balance Sheet

Assets		
Bank Account		\$ 14,954,544
State Treasury		\$ 49,103,106
Receivable from Provider		\$ -
Accounts Receivable		\$ 5,758,680
Due from ASE		\$ 516,886
Total Assets		\$ 70,333,215
Liabilities		
Accounts Payable		\$ 642
Due to ASE		\$ 69
Deferred Revenues		\$ -
Health IBNR		\$ 28,000,000
RX IBNR		\$ 1,800,000
Total Liabilities		\$ 29,800,711
Net Assets		\$ 40,532,504
Less Reserves Allocated:		
Active/Retiree Premiums for Plan Year 01/01/13 - 12/31/13 (\$9,000,000)		\$ -
Active/Retiree Premiums for Plan Year 01/01/14 - 12/31/14 (\$43,000,000)		\$ (43,000,000)
Catastrophic Reserve (2013 - \$11,100,000)		\$ -
Net Assets Available		\$ (2,467,496)

Special Report

Legislative Joint Auditing Committee
January 30, 2014

Arkansas State and Public School Employees Health Benefits

Employee Benefits Division
Arkansas Department of Finance and Administration

INTRODUCTION

Health and pharmacy claim payments for Arkansas state and public school employees are administered by the Department of Finance and Administration (DFA) Employee Benefits Division (EBD). This report is designed to provide information to assist in the legislative decision-making process regarding these plans.

OBJECTIVES

The objectives of this report were to:

- Analyze the state and public school employee health and benefit plans' fund balances at June 30, 2013.
- Examine the process EBD uses to select drugs for inclusion in pharmacy benefits.
- Review high-dollar claims and their corresponding case management services.
- Review the EBD/public school invoicing/refunding process for timeliness.

SCOPE AND METHODOLOGY

The review was conducted for the period July 1, 2012 through June 30, 2013. Division of Legislative Audit (DLA) staff analyzed the state and public school employee health and benefit plans' fund balances by reviewing financial data from the Arkansas Administrative Statewide Information System (AASIS). Additional information for this review was obtained from relevant documents, such as contracts, case management files, claims, and invoices, as well as interviews with current and former EBD employees.

The methodology used in preparing this report was developed uniquely to address the stated objectives; therefore, this report is more limited in scope than an audit or attestation engagement performed in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States.



FUND BALANCES

EBD administers the health and benefit plans for both state and public school employees. Benefits are provided through self-funding, a method by which the State takes in contributions from both the employee and the employing agencies. The two funds are as follows:

- Arkansas State Employee (ASE) Health and Benefit Plan General Fund.
- Public School Employee (PSE) Health and Benefit Plan Proprietary Fund.

The purposes of these funds are to pay health and pharmacy claims and to serve as reservoirs to prevent dramatic rate increases for enrollees.

Both ASE and PSE health plans are administered on a calendar-year basis (January to December). During plan year 2012, Health Advantage managed the Gold and Bronze plans, while QualChoice managed the Silver plan. Pharmacy claims were managed by Catamaran.

At June 30, 2013, there were 38,283 ASE participants, an increase of 704 participants from the previous fiscal year. PSE participants totaled 57,655, an increase of 1,670. See **Exhibit I on page 3** for more detail regarding participation by plan.

Arkansas State Employee (ASE) Fund

The primary sources of revenue for the ASE Fund are participant and employer contributions. Participant contributions are based on plan type (Gold, Silver, or Bronze) and coverage selected (employee only, employee and spouse, employee and family, employee and child, retired, or COBRA). **Schedule 1 on page 9** provides employee contribution amounts for monthly premiums for plan year 2013. Employer contributions are based on Ark. Code Ann. § 21-5-414, which requires each state agency to make a monthly contribution for each budgeted state employee position.

The employer contribution amount for fiscal year 2013 was \$4,680 (\$390 per month) per budgeted position. The 34,668 budgeted positions for 2013 increased 217 from fiscal year 2012. The participant contributions increased \$0.2 million, primarily due to increased enrollment, and employer contributions increased \$0.7 million, primarily due to an increase in budgeted positions.

Health and pharmacy claims are the primary source of expenditures for the ASE Fund. Overall, expenditures for claims and other plan benefits increased \$23.9 million over fiscal year 2012, as shown in **Exhibit II on page 4**. Additionally, professional and administrative fees increased \$2.5 million due to the following:

- new vendor contracts implemented in January 2012.
- increased programming costs for implementation of federal health care reform.
- costs associated with a new Condition Management program, which helps members manage chronic conditions.

Overall, the ASE Fund balance decreased by approximately \$25.2 million to \$59.9 million in fiscal year 2013, as shown in **Exhibit III on page 4**. The fund balance grew \$0.3 million in fiscal year 2012. The decline in the fund balance for fiscal year 2013 was primarily due to increased claim costs and higher expenses related to new vendor contracts. EBD anticipated this decline and, rather than raise premiums, allocated part of the prior-year fund balance to compensate for the decline.

Public School Employee (PSE) Fund

Ark. Code Ann. § 6-17-1117 requires each school district to make a monthly contribution of not less than \$131 for each eligible employee electing to participate in the Public School Employee Health Insurance Program. Additionally, in fiscal year 2013, the Arkansas Department of Education provided \$35 million to the PSE Fund in accordance with Ark. Code Ann. § 6-17-1117 and an additional \$15

Exhibit I

**Arkansas State Employee (ASE) and Public School Employee (PSE)
Health and Benefit Plan Enrollees, Including Retirees
At June 30, 2013**

Arkansas State Employee (ASE)					
Enrollees	Gold	Silver	Bronze	2013 Total	Increase (Decrease) from 2012
Employee Only	20,778	711	1,029	22,518	353
Employee and Child(ren)	5,014	190	274	5,478	143
Employee and Spouse	6,132	132	256	6,520	139
Employee and Family	3,255	186	326	3,767	69
2013 Total	35,179	1,219	1,885	38,283	
Increase (Decrease)	(318)	624	398		704
Public School Employee (PSE)					
Enrollees	Gold	Silver	Bronze	2013 Total	Increase (Decrease) from 2012
Employee Only	32,266	2,821	9,668	44,755	1,088
Employee and Child(ren)	3,473	967	2,302	6,742	219
Employee and Spouse	1,503	180	1,114	2,797	139
Employee and Family	773	409	2,179	3,361	224
2013 Total	38,015	4,377	15,263	57,655	
Increase (Decrease)	(8,053)	3,623	6,100		1,670

Source: Employee Benefits Division (unaudited by the Division of Legislative Audit)

million through Act 269 of 2012 for a total of \$50 million. Employees contribute based on the plan type and coverage they select. **Schedule 1 on page 9** provides maximum employee contribution amounts for monthly premiums for plan year 2013.

PSE employer contributions increased in 2013 by \$14.2 million, while employee contributions decreased by \$11.7 million. The primary reason for these changes was that the new software system, implemented in January 2012, allows EBD to designate amounts paid by school districts above the required \$131 as employer contributions. Previously, all contributions above \$131

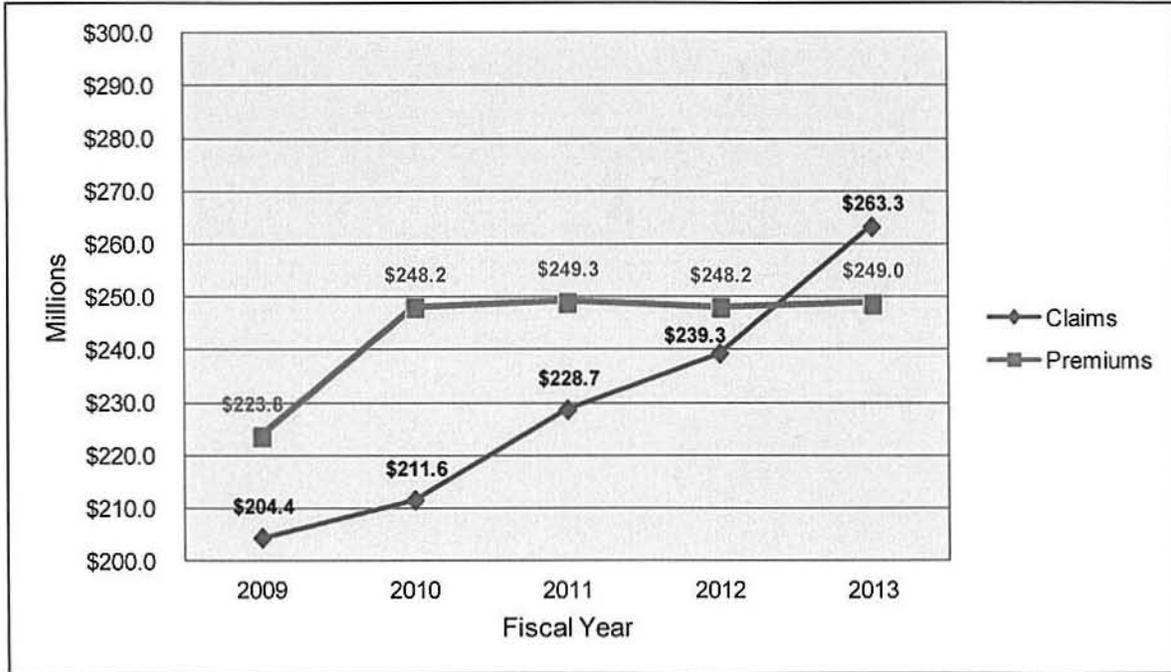
were designated as employee contributions. The net \$2.5 million increase was due to increases in plan membership (as shown in **Exhibit I on page 3**) and premiums for plan year 2013.

Health and pharmacy claims are the primary source of expenditures for the PSE Fund. Overall, claims expenditures increased \$19.7 million over fiscal year 2012, as shown in **Exhibit IV on page 6**. Additionally, professional and administrative fees increased \$3.2 million due to the following:

- new vendor contracts implemented in January 2012.

Exhibit II

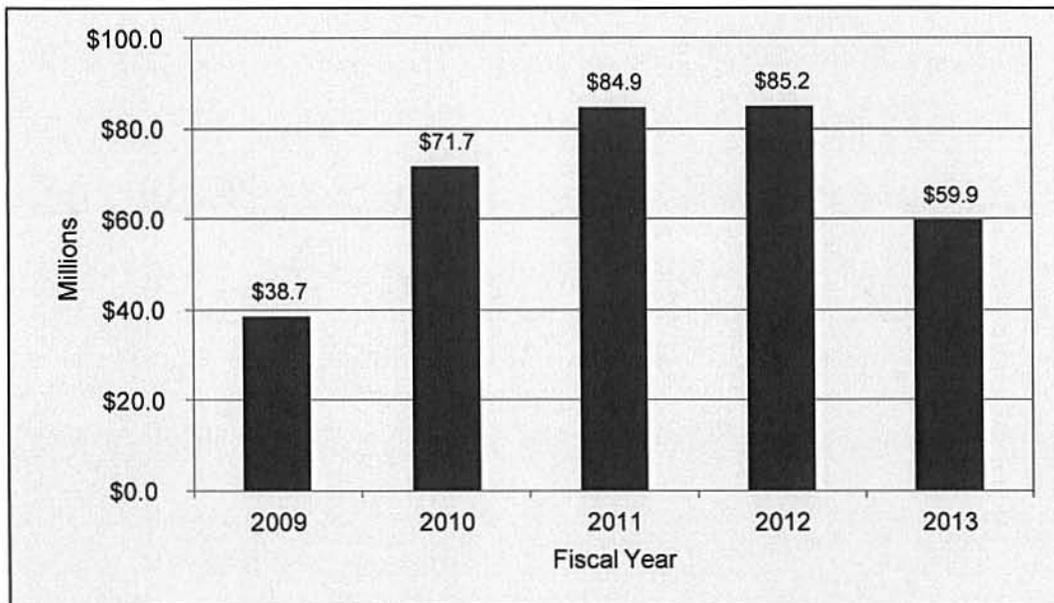
Arkansas State Employee (ASE) Health and Pharmacy Employer and Employee Premiums and Claims by Year For Fiscal Years Ending June 30, 2009 through 2013



Source: Arkansas Administrative Statewide Information System (AASIS) (unaudited by the Division of Legislative Audit)

Exhibit III

Arkansas State Employee (ASE) Health and Benefit Plan General Fund Balance At June 30, 2009 through 2013



Source: Arkansas Administrative Statewide Information System (AASIS) (unaudited by the Division of Legislative Audit)

- increased programming costs for the implementation of federal health care reform.
- costs associated with a new Condition Management program, which helps members manage chronic conditions.

Overall, the PSE Fund balance decreased by \$31.3 million to (\$3.7 million), as shown in **Exhibit V on page 6**, primarily due to an increase in claims costs without significant additional revenue received from participant and employer contributions.

DRUG SELECTION PROCESS

EBD contracts with EBRx (Evidence Based Prescription Drug Program), a program of the University of Arkansas for Medical Sciences College of Pharmacy, to support formulary management, administer pharmacy prior authorizations and appeals, and implement cost savings through long-term pharmacy management. EBRx identifies potential savings through peer-reviewed literature, usage data, and other sources. Potential savings are proposed if more cost-efficient drugs are shown to have no significant differences from more costly alternatives. If there is any significant difference in clinical benefit, EBRx defers to the more effective drug.

Once the EBRx team discovers potential cost-savings, it presents recommendations to the EBD Executive Director for review. After reviewing available options, the Executive Director determines the items placed on the Drug Utilization Evaluation Committee (DUEC) agenda for the upcoming meeting. Items that the Executive Director chooses not to place on the agenda are either deferred until future meetings or removed from consideration.

Recommendations placed on the agenda are presented to DUEC for a review process that the prior Executive Director separated into two components: clinical and financial. Initially, only clinical merit of new drugs and

recommendations is discussed. Once a clinical decision to accept or deny the drug or recommendation is made, the financial impact is discussed. The prior Executive Director decided it was important to emphasize clinical effectiveness over cost and that the cost discussion had tainted the clinical discussion in the past. However, due to the separation of these discussions, DUEC may not make the most cost-effective decisions related to the formulary.

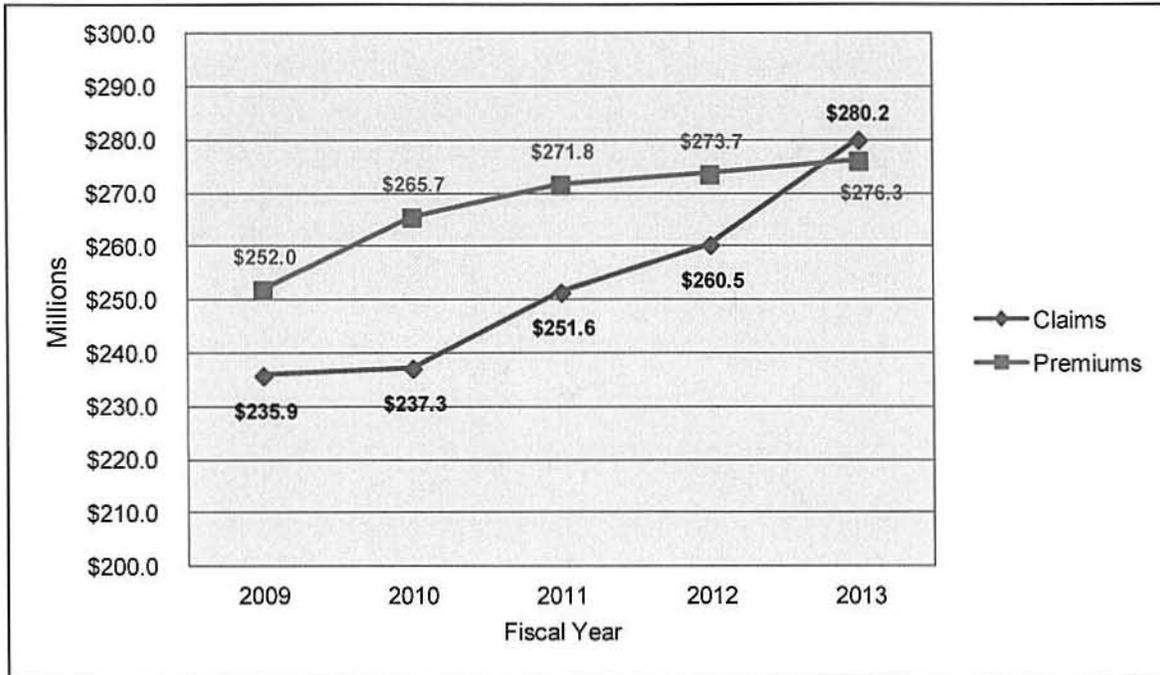
After these discussions, DUEC makes recommendations to the State and Public School Life and Health Insurance Board (Board) for a vote. No Board members serve on DUEC, but the DUEC Chair presents recommendations to the Board for approval.

The prior Executive Director instituted this process when he assumed the position. Previously, the EBRx team created the agenda and brought it before DUEC; the previous Executive Director felt this resulted in too many recommendations being brought to the Board and did not allow for timely and effective discussion of the recommendations. At the beginning of his tenure, the prior Executive Director directed the Board to create a set of Formulary Management Rules to guide discussion of changes to the plan. Under these rules, changes to the plan for existing drugs could only occur at the beginning of the new plan year, except for "significant clinical, access or financial reasons." As a result, the previous Executive Director sought to defer some recommendations to later DUEC meetings, since changes would not take effect until the next plan year.

Additionally, when determining the recommendations to place on the agenda, the previous Executive Director considered any potential for member disruption, "grandfathering in" of changes, and impact on member health claims. Any changes that would result in the plan paying less for a drug or no longer covering a drug would result in either a member paying more out of pocket or being forced to choose a different brand of

Exhibit IV

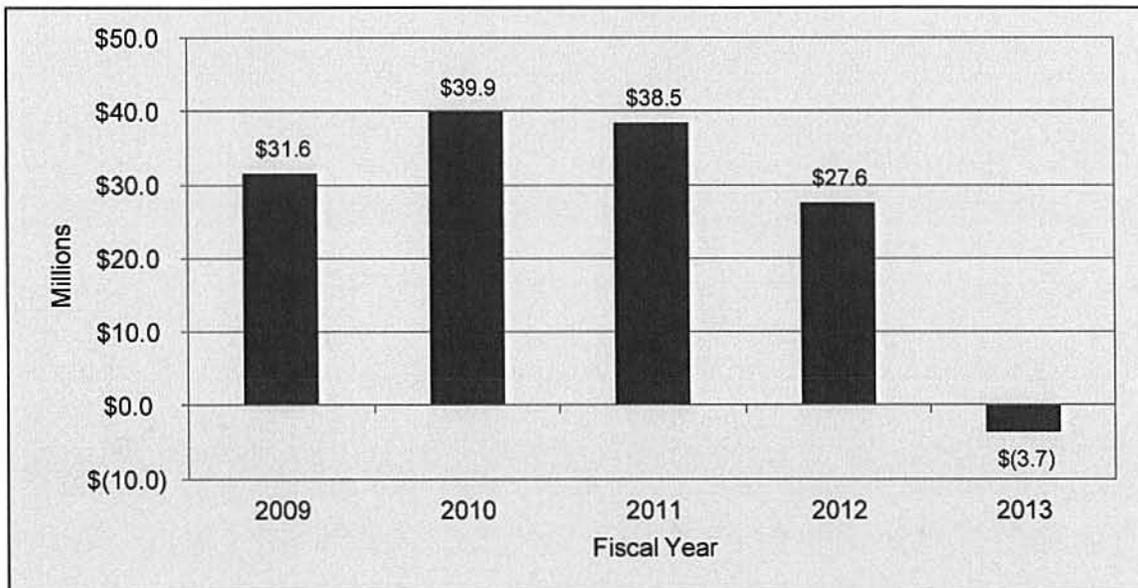
Public School Employee (PSE) Health and Pharmacy Employer and Employee Premiums and Claims by Year For Fiscal Years Ending June 30, 2009 through 2013



Source: Arkansas Administrative Statewide Information System (AASIS) (unaudited by the Division of Legislative Audit)

Exhibit V

Public School Employee (PSE) Health and Benefit Plan Proprietary Fund Balance At June 30, 2009 through 2013



Source: Arkansas Administrative Statewide Information System (AASIS) (unaudited by the Division of Legislative Audit)

drug, which could result in complaints or reduced member confidence in the plan.

The process to determine and limit the DUEC agenda may result in more efficient Board meetings, fewer member complaints, and greater confidence in the plan. However, cost-savings are potentially lost due to the delay or lack of implementation of cost-saving recommendations as well as a lack of transparency before the Board.

LARGE CLAIMANTS CASE MANAGEMENT

Due to funding issues regarding the PSE Health Insurance Fund, especially the number of large claimants in plan year 2012 noted by the actuary, DLA staff reviewed EBD processes for potential reductions in costs of such claims. EBD contracts with a vendor to help with this process, referred to as "case management." Blue Cross Blue Shield was the vendor for plan year 2012, and American Health Holdings is the current vendor.

Case management is the process by which a case manager educates and assists members in navigating the health care system and includes services such as:

- Contacting physicians on the member's behalf.
- Negotiating rates for skilled nursing facilities and hospice care.
- Monitoring the level of care received based on national standards.
- Maintaining regular communication with members with extraordinary needs.

Case managers assess the member's health situation and current treatment level and create a case service plan by collaborating with the member and those involved in his or her care. The case manager monitors the case regularly and ensures the member is receiving the appropriate level of care for his

or her condition. The case manager also re-evaluates the case periodically to determine the level of case management needed.

This process is primarily initiated through a "trigger list" of medical codes. When a claim is filed that contains one of the codes, the member is referred to a case manager, who contacts the member and offers services. This process is also initiated if an individual's total claims exceed \$50,000 in a given plan year. The case management process is entirely voluntary and can be either accepted or declined by the member. If case management is declined, the member continues to follow a doctor's advice for health care, and EBD pays claims based on the health plan administrator's negotiated rates, following standard plan rules.

To ensure this process was followed in plan year 2012, DLA staff determined the six largest PSE claimants based on high-dollar claims testing from current and prior-year audits and requested case management information from EBD regarding those claimants for calendar year 2012. **Exhibit VI on page 8** shows the results of DLA review of documentation for the six claimants, including health claims, pharmacy claims, timely referral to case management by EBD, and documented savings.

PSE INVOICING PROCESS

DLA reviewed the process used by EBD to invoice school districts and issue refunds for health insurance premiums. Invoices are generated on the first day of the month and are due by the last day of the month. Districts may collect premiums from employees in the month of or the month prior to the invoice. Any changes made to the employees' coverage are sent to the districts as soon as EBD receives an election form or a change is made in the ARBenefits system. Additionally, the district also receives a deduction list summarizing all changes for the month. All changes are imported into EBD's accounting system at the end of each month.

On the 15th of the next month, a report is generated to compare the prior-month invoice to any changes that were made. The district is notified if it owes a balance, which is due by the end of the month. If a refund is due to the district, EBD ensures no outstanding balances for prior months are owed, and a refund check is issued to the district within a few days. The EBD invoicing process is designed so that all refunds due are paid out in the month after the overpayment.

To test the payment and refund process, DLA obtained a report from EBD showing the balances for each school district after the August 2013 invoicing period. After reviewing the report, DLA staff selected five school districts for testing: three due refunds from

EBD and two owing money to EBD. As a result of testing, no exceptions were noted. All refunds were issued by EBD on September 17 in a timely manner and in accordance with EBD procedures. The two districts owing money also paid timely.

CONCLUSION

The ASE and PSE Funds are declining, primarily due to increasing health and pharmacy claims costs. EBD may desire to reconsider its drug selection process. In addition, EBD should provide more timely claim management referrals and evaluate the referral process to ensure qualified claimants are directed to case management timely.

Exhibit VI

**Employee Benefits Division (EBD)
Case Management For Six Largest Public School Employee (PSE) Claimants
For January 1, 2012 through December 31, 2012**

Claimant	Health Claims	Pharmacy Claims	Timely Referral to Case Management by EBD	Case Management File Opened	Documented Savings
Member A	\$ 649,092	\$ 0	Yes	Yes	No
Member B	719,907	2,506	Yes	Yes	No
Member C	921,640	789	No	Member declined	N/A
Member D	1,591,868	10,816	Yes	Yes	No
Member E	1,851,694	0	No	No	N/A
Member F	4,136,861	0	No	Yes	No

Source: Employee Benefits Division
N/A = Not Applicable

Schedule 1

**Arkansas State Employee (ASE) and Public School Employee (PSE) Health and Benefit Plans
Maximum Employee Contributions for Monthly Premiums
At June 30, 2013**

Arkansas State Active Employees			
Plan	Gold	Silver	Bronze
Employee Only	\$95.78	\$62.12	\$0.00
Employee and Child(ren)	\$193.64	\$141.44	\$27.84
Employee and Spouse	\$367.74	\$282.52	\$77.22
Employee and Family	\$419.62	\$324.60	\$92.20
Public School Active Employees (Note 1)			
Plan	Gold	Silver	Bronze
Employee Only	\$226.70	\$157.56	\$10.00
Employee and Child(ren)	\$581.48	\$404.10	\$108.32
Employee and Spouse	\$1,027.20	\$713.86	\$242.48
Employee and Family	\$1,029.96	\$715.78	\$245.00

Source: Employee Benefits Division

Note 1: Some school districts contribute more than the required \$131 for each eligible employee electing to participate in the PSE Health Insurance Program.

