State and Public School Life And Health Insurance Board
Minutes
October 20, 2009

The 103rd meeting of the State and Public School Life and Health Insurance Board (hereinafter called the Board), met Tuesday, October 20, 2009 at 1:00 p.m. in the EBD Board Room, 501 Woodlane, Suite 500, Little Rock, AR 72201.

Members Present	Members Absent
Janis Harrison	Vance Strange
Renee Mallory	Robert Watson
Joe Musgrove/ Proxy	William Goff
Dr. Joseph Thompson	
Dr. Andrew Kumpuris	
Anita Woodall	
Shelby McCook	
Charlie Campbell	
Lloyd Black	

Jason Lee, Executive Director, Employee Benefits Division.

Others Present:
Rosalind Minor, AR Ins Department; Dr. William Golden, Medicaid Medical Director; John Colberg, Karen Mallet ,CHEIRON; Leigh Ann Chrouch, Michelle Hazelett, Doug Shackelford, Amy Tustison, Stella Greene, Donna Cook, Paige Harrington, Sherri Saxby, Jane Young, Latryce Taylor, Tracy Collins, Sherry Bryant, Florence Marvin, Pamela Lawrence, Olivia Wilkerson, Erica Jones, Yolanda Winston, Cathy Harris, EBD; Rhonda Hill, ACHI/EBD; Kathy Ryan, Ron Deberry, David Bridges, Barbara Melugin,, ABCBS/Health Advantage; Ronda Walthall, Wayne Whitley, AR Highway & Transportation Dept, Jeff Britt, Pfizer; Karen Henson, Pamela Hickman, AR Game & Fish Commission; Kim Henderson, AR Development Finance Authority; Dwight Davis, Susan Walker, Data Path; Carol White, Pam Wildschuetz, PDB Enterprise; Barry Fielder, Shonda Rocke, Informed Rx; Sharon Marcum, LifeSynch; John Foose, Nancy Archer, Qual Choice; Steve Singleton, AR Retired Teacher Association; Peggy Nabors, AR Education Association; Marc Watts, AR State Employee Association; Judy Prewitt, AR State Highway Employee Retirement System; Christi Pittman, Delta Dental; Vicki Fleming, Doris Williams, AR Department of Health; Joseph Chang, MN Life; Stan King, Carla Wooley, DFA

Call to Order
Meeting was called to order by Janis Harrison, Chairman

Approval of Minutes
The request was made by Harrison to approve the September 15, 2009 minutes. Mallory made the motion to approve minutes. Minutes approved.

Financials *by Leigh Ann Chrouch*
Chrouch presented detailed financial statements for the Arkansas State Employees (ASE) January 1, 2009 through August 31, 2009 and the Public School Employees (PSE) October 1, 2008 through August 31, 2009. Chrouch also presented the ASE Cafeteria Plan Financial 2009 for January 1, 2009 through August 31, 2009.

Chrouch provided a report of the penalties assessed for state and school agencies for August 2009.

DUEC Report *by Dr. William Golden*
Dr. Golden reported the Drug Utilization and Evaluation committee (DUEC) met on October 5, 2009. Dr. Golden said he updated the DUEC on the directions given by the Board on the Brand with Generics availability issue and then the DUEC discussed how they will select the drug products

Dr. Golden presented the following recommendations for Board consideration.

1. **Tabled New Drugs from Previous Meeting Revisited**

   a. **Coartem Tab** is indicated for the treatment of malaria. Typical therapy involves 6 doses total w/4 tabs/dose

      The committee reviewed material from the Center for Disease Control and Preventions (CDC) website.

      Recommendation: Place Coartem Tab on Tier 3 with a prior authorization (PA) with a criteria diagnosis of uncomplicated malaria.

   b. **Asacol HD** is mesalamine delayed release tablets (800mg) indicated to be used for mildly to moderately active ulcerative colitis and for maintenance of remission of ulcerative colitis.

      UAMS Consultant previously consulted with GI docs to get their opinions about the drug and also referenced material from the Cochrane Database comparing sulfasalazine to mesalamine.

      Recommendation: Exclude
      One Asacol HD 800 mg tablet has not been shown to be bioequivalent to two Asacol 400 mg tablets.

   c. **Samsca Tab** is indicated in the treatment of clinically significant hypervolemic and euvolemic hyponatremia that is symptomatic. FDA approved for Hyponatremia. Hyponatremia is a metabolic condition in which there is not enough sodium in the body fluids outside the cells.

Recommendation: Exclude with review in 6 months. At that point the committee will know how many people actually want it and also be able to determine if it is better to PA the drug.

McCook made the motion to accept recommendation for tabled new drugs. Campbell seconded. Motion carried.

2. **Uloric Coverage Review**
   Uloric (febuxostat), a new drug used to treat gout, is currently excluded from coverage based on the recommendation of the DUEC and Board approval. Since the drug has entered the market, EBRx has received a small number of requests from physicians wishing to use the drug. Based on the information in requests and after careful consideration among the physicians and pharmacists at EBRx, they are asking the DUEC to reconsider the coverage status of this product.

   Recommendation: The recommendation from EBRx is to change Uloric's status from excluded to cover with PA required. The criterion for coverage would be documented hypersensitivity to allopurinol. All other requests for coverage would be denied. The anticipation is that allowance of coverage would be rare, but accommodating for this circumstance would be a sound approach from both patient and plan perspectives. This suggestion is based on direct feedback from Drs. Hank Simmons, Mark Helm, and Jill Johnson.

Campbell made the motion to accept recommendation for Uloric coverage. McCook seconded. Motion carried.

3. **Intranasal Steroids**
   There are currently two generic intranasal steroid products available, fluticasone propionate and flunisolide. They currently account for 58.83% and 1.41% of the prescriptions in this category respectively. The committee reviewed the utilization data.

   Two brand products, Nasonex (mometasone) and Rhinocort AQ (budesonide), are in tier 2 today while Nasacort AQ (triamcinolone), Omnaris (ciclesonide), Beconase AQ (beclomethasone), and Flonase (fluticasone propionate) are in tier 3. Veramyst (fluticasone furoate) is currently not covered by the plan.

   Recommendation: Considerable cost savings could be realized by moving all brands to tier 3 and leaving the generics available in tier 1. Moving Nasonex and Rhinocort AQ to tier 3, assuming a 50% conversion from brand to generic and 50% remaining on the brand product, would result in approximate annual savings of $160,000.

   Dr. Golden reported the DUEC discussed reference pricing.

Recommendation: Move all brands to tier 3 and leaving the generics available in tier 1 with consideration for reference pricing for the 2011 plan year.

McCook made the motion to accept recommendation for Intranasal Steroids. Mallory seconded. Motion carried.

4. **Triptan**

Triptan are a family of tryptamine-based drugs used as abortive medication in the treatment of migraines and cluster headaches.

Currently, generic sumatriptan (all dosage forms), Maxalt, Maxalt MLT, Relpax, and Amerge are on formulary for the plan. Frova, Zomig (all dosage forms), and Axert are in tier 3. All products currently have quantity limits in place as well.

Recommendation: Move Amerge to tier 3 with no prior authorization (PA). The Committee will review in one year.

McCook made the motion to accept recommendation Amerge (generic sumatriptan). Mallory seconded. Motion carried.

5. **Testosterone Replacement Products Report**

The DUEC reviewed utilization data for this class of drugs. EBRx pulled together a random sampling of 25 members currently receiving Androgel, Testim, or Androderm and their 24 month history of diagnoses from the medical claims data from Integrail.

Recommendation: Cover Testosterone replacement product with a PA with documentation of a deficient state and allow previous members to continue on it, but if they miss some of their therapy (3 months/90 days) and want to restart they will need a level.

Campbell made the motion to accept recommendation for Testosterone replacement product. Minor seconded. Motion carried.

6. **New Drugs**

Drug	**Tier**
Nucynta	**Exclude**

Is a single molecule with a different approach to pain relief of moderate to severe acute pain in patients 18 years of age or older

Edluar Sublingual	**Exclude**

A sublingual formulation of zolpidem tartrate for the short-term treatment of insomnia characterized by difficulties initiating sleep

Acuvail sol	**Exclude**

Approved for the treatment of Pain and Inflammation Following Cataract Surgery

Aloquin gel **Tabled/review next meeting**
(1.25% Iodoquinol and 1% Aloe Polysaccharides) Iodoquinol is an antifungal and antibacterial agent.

Effient tabs **T2/revisit in 6 months**
Is an antiplatelet agent indicated to reduce the rate of thrombotic cardiovascular events (including stent thrombosis) in patients with ACS who are to be managed with percutaneous coronary intervention

Multaq **T3**
Is an antiarrhythmic drug indicated to reduce the risk of cardiovascular hospitalization in patients with paroxysmal or persistent atrial fibrillation (AF) or atrial flutter (AFL), with a recent episode of AF/AFL and associated cardiovascular risk factors

Triaz cloths 3% **Exclude**
Topical preparations containing benzoyl peroxide for use in the treatment of acne.

Onglyza tabs **T3 w/step therapy- revisit**
Is a dipeptidyl peptidase-4 [DPP4] inhibitor indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.

Zipsor cap **Exclude**
Is indicated for the relief of Mild to Moderate Acute Pain

Fibricor tabs **Exclude**
Is an oral antilipemic agent and is the active metabolite of fenofibrate. It is indicated for severe hypertriglyceridemia, primary hyperlipidemia, or mixed dyslipidemia.

Renvela pak **T2**
Approval of 0.8 gram & 2.4 gram powder packets for the control of serum phosphorus in patients with chronic kidney disease on dialysis

Saphris **Exclude**
Is an atypical antipsychotic indicated for the acute treatment of: (1) schizophrenia in adults and (2) manic or mixed episodes associated with bipolar I disorder with or without psychotic features in adults.

DRUG **TIER**

Tyvaso Sol. **T3 w/PA**
Is indicated to increase walking distance in patients with NYHA Class III symptoms associated with WHO Group 1 Pulmonary Arterial Hypertension.

Sabril **Exclude**
Sabril is indicated as monotherapy for pediatric patients 1 month to 2 years of age with infantile spasms (IS) for whom the potential benefits outweigh the potential risk of vision loss. Sabril is also indicated as adjunctive therapy for adult patients with refractory complex partial seizures (CPS) who have inadequately responded to several alternative treatments and for whom the potential benefits outweigh the risk of vision loss

Financial Monitoring Report *by CHEIRON*
John Colberg and Karen Mallet showed a presentation from an evaluation Cheiron conducted in October 2009.

The ARHealth Quarterly Monitoring for the Public School Employees (PSE) and Arkansas State Employee (ASE) groups.

CHEIRON Comments for PSE 10/01/2008 though 08/31/2009

- Assets have remained fairly constant for the fiscal year which is significantly better than the expect 20% decline.
- Income is about 5% less than expected
- Fund expenditures are about 10% less than expected
- Participation is about 3% lower than expected for active but 6% higher than anticipated for retirees for a total impact of about 2% less than expected.

CHEIRON Comments for ASE 01/01/2009 through 08/31/2009

- Assets have grown steadily over the past two years, with additional growth in July and August 2009.
- Income has been close to expected for the fiscal year, while claims have been well below projections.
- Fund participation is close to projected for actives and above projections for retirees.

Pharmacy Audit Update *by Dwight Davis, Director, EBRx*

Dwight Davis, the Director of the Evidence Based Prescription Drug Program (EBRx) at UAMS College of Pharmacy addressed the Board to provide an update on the pharmacy audit.

Davis explained EBRx provides and manages the call center for prior authorization (PA) for the prescription drug plan and it is staffed with pharmacist and physicians.
EBRx also:

- Participate and support the DUEC process for the prescription drug program.
- Responsible for the procurement of the Pharmacy Benefit Management Company Informed Rx. The relationship with Informed Rx is more of a consultative role between EBD and the PBM.
- Contracts directly with the auditing firm. A PBM Auditing firm that would audit the claims or the performance of Informed Rx. EBRx manages that process through it's entirely.

Davis disclosed to the Board he joined UAMS in December 2008, and prior to that he worked for InformedRx for 15 years as Senior Vice President of Clinical Services. Davis said he wanted the Board to be aware of the relationship and that they are taking every step through disclosure and relationship with Lee and the EBD Staff to ensure that things are done appropriately.

Davis said his job is to act as a facilitator between the audit firm and the PBM to ensure closure and accuracy. The goal is to identify every dollar of overcharged to the fund and to ensure that reconciliation takes place. It's a three way agreement between the auditor, PBM and the Plan and so they are all going to be on the same page with the final results.

Davis reported as of today there is no reconciliation at this point between the PBM and the auditor. There are about three open items that need resolution and analytics are currently being performed on those. They anticipate that those will be resolved in the next couple of weeks and then he will present a final audit report in the next Board meeting. The audit period includes October 2004 through December 2007.

Davis said they have already submitted a Request for Proposal (RFP) to state procurement. Davis said they are looking for two things; a physical retrospective audit to be performed between January 1, 2008 through early 2010 and a prospective audit process conducted on monthly bases so they can stay current. The total finding as of today by the auditors is $1.3M, but 60% are findings that involve classes of drugs like the specialty drugs. Davis said the audit was not consistent and so they are working through those processes, and all of the information will be presented to this Board for a decision.

Davis answered questions from the Board.

Dr. Thompson expressed to lee and to the Board, that he has some discomfort because Davis is the arbitral for the audit for the same period he was a the Senior Executive with the company. Thompson said he is glad Davis shared the information with the Board but he is uncomfortable with the arrangement and it is a mistake from a management prospective.

Lee said EBD is working closely with the College of Pharmacy and other people within EBD are involved with this process as well.

Davis added he learned about three months ago that the responsibility came with the territory of being the Director.

AWP/Prescription Drug Program by Jason Lee, EBD
Lee reference the material sent to the Board members via-email earlier that day that included the recommendations regarding changes to the Pharmacy program.

Lee explained that earlier this year, a lawsuit was settled that had a direct impact on the AWP (Average Wholesale Price) of thousands of drugs. Lee said neither EBD nor anyone associated with this plan was a party to the lawsuit but for how it changed the definition or the repricing of what's called AWP. AWP is published on a weekly schedule by two companies (Medispan and First DataBank) and the list is used across the industries as the standard price of drugs.

The suit alleged that in the early part of this decade (beginning in 2001) the published AWP was artificially inflated by using a market factor of 1.25% as opposed to using the previous factor of 1.2%. This change in market factor caused an increase in the final AWP price because the factor is applied to the WAC (Wholesale Acquisition Cost) of the drug.

As a common practice, health plans (including this plan) pay a discounted AWP for the drugs purchased through a PBM (Pharmacy Benefit Manager) and our discount was increased from AWP – 10% to AWP – 13% in October 2001 by direction of the Board. The discounted drug price came at the same time as the increased AWP so the plan was not impacted to a large degree by the "scheme" to adjust AWP. The net impact to the plan was minimized because of the AWP adjustment, but there was another change made during that time as well, decrease to the "dispensing fee".

The dispensing fee is a flat amount of money paid to the pharmacy for actually dispensing the medication to the member. During the changes in 2001, the dispensing fee for all drugs was reduced from $3.50 per script to $2.50 per script and an incentive program was implemented to encourage generic utilization. The program was created and allowed the pharmacy to achieve up to a $4.50 increase in the dispensing fee on generic drugs if certain criteria were met and generic utilization increased. This has been a significant benefit to the plan and generic opportunity (filling a generic when available verses the name brand) is in excess of 90% and the overall generic utilization (generic drugs as a percentage of all drugs dispensed) is approximately 75%. Although this increased dispense fee is a "cost" to the plan, the benefits far out weight the approximately $5 Million paid annually for this incentive. Maintaining a low trend as we have the past few years has provided the plan with a significant return on investment for this incentive alone.

As a result of the lawsuit, the AWP market factor is reducing back to 1.2%, essentially lowering the net cost of the drugs priced with the AWP formula. This move is at the direction of the court and went into effect September 26, 2009 (little less than 1 month ago). The contract that we maintain with informedRx requires that we price our drugs using the Medispan published list with weekly updates. As such, when the discounted AWP list hit the street, we maintained our current pricing structure until which time that we and the College of Pharmacy did independent analysis of the claims to make an informed recommendation to the Board.

If we continue to use the new AWP with the 1.2% factor and keep our current 13% discount, the plan is positioned to save approximately $4 Million over the next year; however that is not due to any progressive decision from the Board, better management of the plan or healthier members. This savings would be simply based on a cost reduction / recalculation of the AWP price. Because our drug program is tied to a co-pay structure, members would not see any benefit to this cost savings and the only parties to be harmed would be the pharmacies that participate in our network and actually dispense the medications to our members. The pharmacies have been a significant part of the plan's success over the past few years and taking this opportunity

to reduce our costs at their expense is not, in my opinion, in the best interest of the plan.

Lee presented two recommendations for Board consideration.

Recommendation #1

1. That the new AWP price (after the 1.2% factor) continues to be used but that the discount be adjusted from AWP – 13% to AWP – 10%. This approach appears to be the most common approach to address this industry-wide issue for carriers and other states with plans similar to ours. Based on internal calculations using last year's incurred & paid pharmacy claims (September 2008 – August 2009), the plan would have expenses $101,152,030 in claims under a 1.2% factor / 10% discount pricing structure compared to the actual expense of $101,842,030 (savings of $690,000). Assuming that next year's utilization and generic dispensing practice remains similar to last year, this move to a 10% discount will not increase the plan's overall cost.

McCook made the motion to adopt the recommendation. Black seconded.

A discussion ensued regarding E-prescribing and costs shifts to brand.

Campbell said they should make the pharmacist whole and also monitor the results and continue to have the favorable relationship with pharmacist that the plan has enjoyed for a number a years. Campbell said he doesn't expect any cost shifts to brands.

Scott Pace with the AR Pharmacist Association addressed the Board. Pace said Lee and the EBD staff have worked very closely with them in the last couple of months to figure out how to best address this issue. Pace clarified they are talking about the core reimbursement rates as the bases; putting them back where they were on the morning of September 27th before the change on September 28th. The incentives based upon the generic program that EBD has had over the last 5 years have the same on Sept 27th like they would be if we made this change in reimbursement to restore us back to the Sept 27th numbers. Even thought the percentages are changing the total dollars would stay equal.

Chairman Harrison restated the motion that the new AWP price (after the 1.2% factor) continues to be used but that the discount be adjusted from AWP – 13% to AWP – 10%. All were in favor. Motion carried.

Recommendation #2

2. However, this adjustment in AWP discount alone will not provide full cost neutrality with our pharmacy partners (note $690,000 in less claims calculated above). As such, I recommend that we implement a $1 increase in the "brand" drugs dispensing fee, conditional upon the pharmacy's commitment to pursue e-prescribing functionality in their local practice. Those pharmacies that elect not to move toward e-prescribing will remain at the $2.50 current fee while others will

benefit from the $1 additional revenue per non-generic scripts. This is in support of the motion made and adopted at the august 18, 2009 Board meeting which stated that the board "encourage E-Prescribing and explore various incentives for the pharmacists". Again, using last year's utilization from Sept. 08 to Aug. 09, the plan paid for 716,812 brand drugs. Assuming 100% participation in the e-prescribing movement, the plan would have paid $716,812 in added dispense fee with a significant portion of that being paid for by the "savings" in the AWP adjustment ($690,000) from above leaving only a net new cost of $26,812 for the entire year.

Lee said he believes reducing AWP discount to 10% and $1 increase for dispensing fee for e-prescribing pharmacies, to be in the best interest of the plan and provided at a nominal initial cost but with the potential for significant savings in the years ahead as e-prescribing becomes common practice.

A discussion ensued.

Campbell commented the patient has the freedom of choice to go to the pharmacy of their choosing and pharmacies have regulations that address the freedom of choice issue. Campbell said there will be a tremendous disincentive for any pharmacy in AR not to comply with the ability to be able to receive electronic transmission.

Dr. Thompson said by 2011 if physician are not e-prescribing they will lose opportunity to make money from Medicare and Medicaid and so they are just basically looking at this as is this the vehicle we want to give money back to the pharmacist.

McCook said he wants to keep the good relationship they have with the pharmacist because they have better figures than anyone in the country.

McCook made the motion to adopt $1 increase in the "brand" drugs dispensing fee. Black seconded. All were in favor. Motion carried.

PSE Medicare Retiree *by Lloyd Black*

Black reported the Public School Retirees Medicare eligible will not receive a Social Security cost of living this year. It is official according to the newspapers and the news media. Also, Medicaid Part D monthly increase will probably increase at least 10% or more and so many of the retirees are going to really be in a tight.

Black said the Board was very considerate and understanding when setting the rates for 2010 by applying some of the reserve allocation to the premiums for the Medicare Eligible retirees. Black provided an overview of the premiums for PSE Retiree Medicare Eligible for singles, retiree & spouse and family.

Black calculated that to reduce the retiree premium of $50.92 to $41.44 would require an additional contribution from the reserve. The average for all of this will be about $10.64 per retiree per month or costing the plan $58,000 dollars a month for a total of

about $600,000 thousand dollars a year. Black said they want to try to soften the impact of the no cost of living increase from Social Security

Black made the motion to take an additional $600,823 dollars from the reserve and apply it to the PSE Retiree Medicare Eligible insurance premiums; reducing it from $50.92 to $41.44 dollars per month. McCook seconded.

A discussion ensued about the previous recommendation to Allocate reserve of $4 M: 55% to Retirees not Medicare eligible (RNME) and 45% to Retirees Medicare Eligible (RME).

Lee commented the non-Medicare primary members were more heavily weighed for the retiree contributions than the Medicare primary was at that time.
All were in favor of the motion to take an additional $600,823 dollars from the reserve and apply it to the PSE Retiree Medicare Eligible insurance premiums, reducing it from $50.92 to $41.44 dollars per month effective January 1, 2010. Motion carried.

Director's Report *by Jason Lee*
Lee reported the Arkansas State Employee (ASE) open enrollment for Actives is going well. Phone calls consistent- 1% abandonment rate

Lee addressed the question asked about the movement of the PSE to the HD PPO plan. Those members that are in the HD PPO plan after open enrollment – 12% of those members are new to the plan – 88% change from the traditional plan and into the HD PPO plan.

There is a report in your packet provided by Rhonda Hill with ACHI – a very detail analysis of our health risk assessment and the cost to the plan for certain behavioral choices that people make. This was published in the American Journal of Preventive Medicine 2009. This will serve us well to look at the real data to support some of the decisions that members make and the cost associated with it as we move forward.

Charlie Campbell announced this was his last meeting with the Board. Campbell said as of October 1, he completed 36 years with the great state of AR. Campbell said it is about time he rode off into a different direction. *According to the enabling legislation the seat is reserved for an ex officio voting member in which the Executive Director of the Board of Pharmacy and or his/or her designee will serve in this position*

Campbell informed the Board John Kirtley, the Assistant Director with the AR Board of Pharmacy has been appointed the set on the Board.

The Board said farewell to Charlie Campbell.

Meeting Adjourned.