BENEFITS ADVISORY COMMITTEE
MINUTES OF MEETING
MAY 2, 2013

[In these minutes: Prime Therapeutics Annual Review, Proposed Changes to Health Benefits Plan Design]

[These minutes reflect discussion and debate at a meeting of a Human Resources committee; none of the comments, conclusions, or actions reported in these minutes represent the view of, nor are they binding on Human Resources, the Administration, or the Board of Regents.]

PRESENT: Tina Falkner (chair), Pam Enrici, William Roberts, Dale Swanson, Jody Ebert, Sara Parcells, Jennifer Schultz, Sandi Sherman, Sheldon Taylor, Susann Jackson, Joseph Jameson, Karen Lovro, Roger Feldman, Judith Garrard, Richard McGehee, Fred Morrison, Theodor Litman, Rodney Loper, Dann Chapman

REGRETS: Nancy Fulton, Carl Anderson, Amos Deinard,

ABSENT: Kathryn Brown, Aaron Friedman, Keith Dunder

OTHERS ATTENDING: Barb Bezat, Linda Blake, Karen Chapin, Kurt Errickson, Ryan Gourde, Cherrene Horazuk, Kathy Pouliot, Jackie Singer, Curt Swenson, Jody Thronson, Laurie Warner

GUESTS: Prime Therapeutics' representatives: Rebecca Balk, account executive; John Hogue, pharmacist and clinical program manager; and Cory Super, regional vice president

I). Tina Falkner called the meeting to order and welcomed all those present.

II). Ms. Falkner welcomed today's guests from Prime Therapeutics and requested that they introduce themselves. Following introductions, Mr. Super began with a few opening remarks and turned to Ms. Balk, account executive, to provide information about cost of care. Ms. Balk highlighted the following financial information as it relates to the UPlan.

- In 2012, the total cost (UPlan cost plus member cost) per member per month (PMPM) was $79.03, which is higher than Prime Therapeutics' (hereafter Prime) book of business at $67.84. The higher UPlan total cost is attributable to higher utilization than Prime's book of business. Specialty drug total cost PMPM for the UPlan was $21.90, which is also higher than Prime's book of business at $14.77. Again, the higher specialty total cost is also attributable to higher utilization.
- Specialty drug usage is a key driver of trend at 27.6% of total cost PMPM. Specialty drug usage accounted for 24.6% of costs in 2011. Overall specialty drug utilization by UPlan members has remained flat in comparison to 2011, but is still higher than Prime's book of business.

- The generic fill rate for 2012 was 80%. This rate is higher than Prime's book of business and is helping to control non-specialty drug costs.
- The UPlan had an overall 2.4% trend for 2012 (non-specialty and specialty), which is very close to Prime's book of business at 2%. With the increased generic utilization by UPlan members and the programs that are in place for containing costs, the UPlan actually had a negative 1.8% trend for its non-specialty drug utilization, which compares favorably to Prime's book of business with a negative 2.5% trend. Additionally, despite the fact that overall total cost PMPM increased, the member share for these drugs has stayed relatively flat. For 2012, the member share was 12.8% and the plan paid 87.2%. In 2011, the member share was 12.3%.
- Prime and the UPlan worked together in 2012 to set goals around cost containment for the overall prescription drug program. The goals were 2.61% trend and $79.15 total cost PMPM. Both goals were met with the 2012 trend at 2.4% and total cost PMPM at $79.03.
- Generic drug utilization in the UPlan continued to increase in 2012. UPlan members achieved an 81% generic fill rate in fourth quarter 2012. Generic drug utilization helps control UPlan costs. The UPlan exceeded Prime's book of business in generic fill rate. There were major generic drug launches in 2012, e.g., Lipitor, Lexapro, Singulair, which helped to increase the UPlan's generic fill rate.
- Three specialty drugs are on the list of top 10 core categories (therapeutic classes) ranked by spend. In addition, the list of top 20 drugs by total cost was shared. The top three drugs on the top 20 list are specialty drugs and range in cost from about $2,100 - $4,000 per prescription. Lastly, the top 20 drugs by total cost (excluding specialty drugs) was shared.

Moving on, Mr. Hogue, pharmacist and clinical program manager, walked member through the different clinical programs that were launched in 2012 by Prime:

- Blood glucose meter exchange program – The UPlan mailed 662 letters and brochures to members in December 2012 offering them an opportunity to receive a free Nipro Diagnostics TRUEresult Meter. A total of 568 members or 86% of members took advantage of this offer.
- Retro drug utilization review programs, which use claims data to look at members utilization pattern of different drug classes was launched in an effort to identify members who could benefit from drug therapy opportunities. Retro drug utilization review programs for 2012 included – asthma (inhaled steroid opportunity), statin use in diabetes, controlled substances utilization, high dose acetaminophen, statin generic opportunity and PPI generic opportunity.
- Guided Health – Prime implemented a new clinical platform, Guided Health, which provides actionable clinical intelligence to engage members and providers in improving health outcomes and lowering total cost of care. Four 2012 Guided Health clinical health programs were highlighted.
- Vaccine administration network launched – Prime contracted with 726 pharmacies in Minnesota to provide in-pharmacy immunizations. (Prime will

provide information to UPlan members about participating pharmacies in Minnesota.)

- Affordable Care Act (ACA) drug coverage – The ACA stipulates that non-grandfathered plans must provide coverage *without cost share requirements* ($0 member cost share) for evidence-based items or services that have a U.S. Preventive Services Task Force "A" or "B" rating. On August 1, 2011, the U.S. Department of Health and Human Services adopted additional guidelines for Women's preventive services to include contraceptives effective August 1, 2012 upon renewal. Beginning in 2013, ACA $0 preventive drug coverage will include:
    - Aspirin 81mg (men age 45 – 79 and women age 55 – 79).
    - Breast cancer preventive (women only).
    - Fluoride supplements (children 6 months – 6 years).
    - Folic acid supplements (women only).
    - Gonorrhea prophylactic (newborns only).
    - Iron supplements (children 6 – 12 months).
    - Tobacco cessation.
    - Vaccines.
    - Vitamin D supplements (adults 65 years and older).

    NOTE: Medications must have a prescription for claims processing, including over-the-counter (OTC) medications.

    The financial impact of the $0 ACA preventive medications (excluding contraceptives) for the UPlan is projected to be approximately $60,000 annualized in 2013. The financial impact of the $0 co-pay on generic contraceptives and select formulary brands when a generic is not available is estimated to be about $150,000 annualized in 2013. The total, $210,000, is being shifted from members to the plan.

Next, Ms. Balk spent a few minutes providing information on member feedback Prime received. Prime conducted a member satisfaction survey via email in 2012. Survey results indicate 89% of members were either very satisfied (52.1%) or satisfied (36.9%) with their most recent experience with Prime. Member satisfaction with their overall prescription benefits was 79.2%. The survey measured many aspects of the prescription drug program including service, network of pharmacies and PrimeMail, and was targeted at members who used the program in 2012. The survey will be conducted again in 2013.

Regarding UPlan member comments collected by the University and shared with Prime, positive comments increased from 80% in 2011 to 87% in 2012. Ms. Balk shared areas for improvement that Prime is addressing, and these include:

- Identification cards – Over the last year, Prime has worked with its customer service and eligibility staff to ensure accurate and timely identification card ordering.
- Drugs moving from formulary to non-formulary – Whenever there are formulary changes, Prime sends communications to those impacted, updates the formulary listing and enters any prior authorizations, if members are grandfathered.

Members are able to access the UPlan formulary from the Office of Human Resources' website at http://www1.umn.edu/ohr/benefits/pharmacy/index.html#Formulary.

- Prior authorizations – This process can be confusing. As a result, Prime has worked with its customer service agents to ensure they explain the process clearly to members.
- Customer service staff has limited knowledge of the UPlan – Voice analytics were used and training opportunities were found for improving agents UPlan pharmacy benefit knowledge.
- Delays in receiving medications from PrimeMail and poor communication about order status – Concerns have been forwarded to PrimeMail for review and to use for training purposes. Prime wants to ensure all member and physician communications are clear. Prime will confirm that "clean" prescriptions and refills are being shipped within the standard, which is 2 – 10 business days.
- Web refill process confusing – These concerns have been forwarded to the web and communications team. Prime will look into seeing what it can do to make the mail order process easier for members.

Members' questions/comments included:

- Please explain how the trend target is set, what the trend target is for this year as compared to last year, and what happens if the trend target is not reached. Mr. Hogue stated that Prime takes a number of factors into consideration when calculating the trend target, which include but are not limited to the generic and brand pipelines, expected costs and utilization. Mr. Chapman added that once Prime completes its analysis it shares this information with the University, which in turn works with its consultants to determine if the Prime trend target is accurate. Generally speaking, noted Mr. Chapman, the University will push Prime and propose a more aggressive trend target. In the end, Prime and the University come to a negotiated agreement on the trend target. Mr. Hogue stated that for 2013, Prime is projecting a 5% - 8% increase for its book of business. For the UPlan, the increase will likely be higher because the generic usage has almost reached its cap and the higher use of specialty drugs by UPlan members. Ms. Balk stated that Prime is in the process of calculating the UPlan's 2013 targets and will be meeting with the University later this month to go over the first quarter data. Mr. Chapman stated that the University works in partnership with Prime to help them meet their goals because it is to the benefit of both parties.
- How is the University going to respond to/manage the increased use of specialty drugs? Mr. Chapman stated that the University recognizes that despite the high cost of specialty drugs, in many cases they are extremely high value to the member, and, as a result, the University tends to cover them. The University will cover specialty drugs when they are appropriate. Having said that, however, the University will have to put guidelines in place for the use of specialty drugs. Regarding costs, the increased gains the UPlan has gotten from increased generic utilization has more or less offset the cost of specialty drugs up until now. The UPlan is running out of that gain as it gets closer to maximum generic utilization, and there will come a time when the generic fill rate will flat line. Because there

is no foreseen flat line to the cost of specialty drugs, the University will have to deal with the large pharmacy trend that it has been able to manage through the increased use of generic drugs. Mr. Super added that specialty drugs allow physicians to treat diseases that have historically been untreatable and new markets have emerged as a result of these drugs. In addition, there has not been a lot of competition in the specialty drug market, and manufacturers are trying to recoup their investment in these drugs (it takes on average 20 years to bring a drug to market). Until generic biologics come to market, competition is expected to increase, which will allow Prime to deploy tactics it has used in the past in the traditional drug market such as preferring products by garnering rebates, negotiating price protections with the manufacturers, etc. Therefore, a lot of the tactics that Prime has deployed historically across the traditional products will emerge in the case of specialty drugs. Ms. Chapin also pointed out that the University made a conscious choice to retain Fairview Specialty Pharmacy, which helps manage the utilization of specialty medications.

- Please comment on the University's pharmacy plan and the pharmacy plan of the organization that achieved 85.1% generic utilization in slide 7. Would it be possible for the University to have a similar plan design without impacting the quality of the University's current plan? Ms. Balk stated that that organization has a much more restrictive formulary than the UPlan, which is comprised primarily of generic drugs and only a few brand drugs. The UPlan is actually very close to achieving the same generic fill rate while having a less restrictive formulary. Mr. Chapman stated that the University made the purposeful choice of incenting generic utilization rather than imposing a limited formulary. The University has achieved the lion's share of savings through the use of incentives with much more limited member disruption and unhappiness.
- Why does the prior authorization process take so long and can it be shortened? Mr. Hogue stated that Prime's clinical review team generally turns around a prior authorization in 1 – 2 days if it has all the information it needs. Oftentimes, Prime is waiting on the physician for additional information. Mr. Chapman asked if Prime communicates with the member if it is waiting on information from the physician. Ms. Balk stated that it is her understanding that in the event the 1 – 2 day timeframe elapses without hearing from the physician, she believes Prime provides an update to the member, but she will double check and report back to Employee Benefits.
- Who is responsible for the Medication Therapy Management (MTM) program? Ms. Chapin explained that Employee Benefits in conjunction with the College of Pharmacy has put together a network of MTM pharmacists. Prime handles the copay reduction portion of the MTM program, Medica pays the pharmacy claims, and it is the member's responsibility to make their appointment with the pharmacist.

Hearing no further questions, Ms. Falkner thanked the representatives from Prime for their presentation.

III). After the representatives from Prime left, Ms. Ebert stated that more needs to be done to educate University employees about their health and what they can do to improve and manage their health without taking drugs. Mr. Chapman agreed that there is value in doing this, but noted that in addition to education there is an element of personal responsibility that is required. The University's Wellness Program is targeted along these lines in terms of providing education and information to UPlan participants through the programs if offers. In Mr. Chapman's opinion, he believes that the Accountable Care Organization (ACO) model is attempting to get at the underlying issues behind physicians simply writing prescriptions. The ACO model is being built around the notion that the system of care needs to be more systematic about how it provides care by looking at population health and proactively reaching out to patients to better understand their health care needs rather than waiting for patients to eventually come into their office with a medical condition. Ms. Ebert requested more information about the ACO model in general and what the University plans to offer in 2014. Mr. Chapman stated that much more information will be available and that the ACO plan will be an option in 2014, and that it will not be the base plan.

Ms. Sherman asked whether it would be possible to have Medica include HealthPartners' providers in the ACO plan the University will offer. No, stated Mr. Chapman. The University and Medica are not creating the ACOs. The care systems themselves, driven in part by various aspects of health care reform, are building these new care delivery models.

Why does the University need to radically change its plan design for 2014 versus gradually implementing the changes and allowing employees time to adjust given the Cadillac tax takes effect until 2018, asked Ms. Sherman? She added that the health care cost shifts being proposed are onerous. It appears that in order to avoid the Cadillac tax that the University is simply shifting health care costs to employees. Mr. Chapman stated that time was devoted at the April 18 meeting to talk about the ACA and what restrictions health care reform was placing on the University. Following Professor Morrison's health care reform presentation at that meeting, Employee Benefits provided the committee with proposed plan design changes to offset the Cadillac tax. The statement that the financial burden is only being placed on employees is not true, stated Mr. Chapman. While it is true that costs that are being shifted to employees, they are being shifted by the ACA and not the University.

Professor Schultz asked why the University is acting so early because she has heard anecdotally that the Cadillac tax may not be implemented, or, if it is implemented, that the plan value threshold amounts will be higher. She voiced concern that once the plan design is changed, the University would never change it back even if the Cadillac tax was repealed. Mr. Chapman stated that until the law is actually changed, these speculations are just hearsay and the University cannot afford to wait and see if they happen. The University is basing its proposed changes to the plan design based on how the law currently reads. It is imperative that the University has its ducks in a row by 2016 in order to have a safe harbor from the Cadillac tax and to see how the plan changes actually play out in claims and plan costs. Earlier this year, noted Mr. Chapman, there were also

rumors that the Cadillac tax was going to be implemented even earlier than 2018 because the federal government needed revenue to pay for the ACA. If the ACA were to go away that would put the University in a different position than it is in now. The University cannot sit, wait and hope that the law will be changed.

Ms. Jackson suggested continuing with this discussion after Mr. Chapman has had an opportunity to share with the committee the material that was prepared for this meeting. Ms. Ebert interjected that she thinks employees need to contact their legislators to let them know how University employees will be impacted by the proposed plan design changes resulting from the ACA. In addition, Government Relations should be involved. Mr. Chapman stated that Government Relations is already aware of the issue. He added that there is a joint effort by universities across the country voicing their concerns collectively to the federal government.

Before moving forward with the proposed changes to plan design discussion, Ms. Falkner called on Ms. Lovro to summarize the feedback that was collected on Prime Therapeutics. Ms. Lovro stated that it is human nature for people to be quicker to complain than compliment. Having said that, there were more positive comments about Prime than negative. The majority of complaints were about identification cards, delays in receiving prescriptions from PrimeMail, inability to use the auto-refill function to automatically renew multiple prescriptions at the same time, changes to the formulary, length of the prior authorization process, and a non-user-friendly website. Overall, stated Ms. Lovro, the feedback on Prime was quite positive.

Next, Mr. Chapman distributed a handout, which summarized the projected UPlan medical and prescription expenses for 2013 and 2014. He attempted to walk members through the document in detail, but encountered a number of concerns from members about how the numbers were calculated. Professor Morrison stated that based on his calculations, the administration's numbers are wrong and he believes the administration double counted a calculation thus shifting more costs to employees than necessary. Mr. Chapman adamantly disagreed.

Following a lengthy discussion, Professor McGehee summarized Mr. Chapman's detailed explanation of projected UPlan medical and prescription costs by saying that the bad news is that employees will be paying $3.8 million more for their health care in 2014, but because of an accounting technique that allows the University to move money around it is able to lower employees premiums by $1.12 million to help offset some of the increased out-of-pocket expenses that employees will incur. Yes, stated Mr. Chapman. In response to Professor McGehee's comment about why so much detail was shared with the BAC about how the figures were arrived at, Mr. Chapman stated that the reason he shared the detail was because the BAC has historically wanted the detail.

Mr. Chapman then turned members' attention to the portion of the handout that highlighted costs attributable to the ACA. He emphasized that the more than $5 million in additional costs to the plan (University and employees) are being directly imposed on the University by the ACA. The implied accusation that the administrative is shifting

costs to employees in order to save the University a lot of money is not true. The reality is that the administration is responding to pressures being imposed by the ACA. He asked members to recall the UPlan goals of quality, affordability and choice for employees that were discussed at the last meeting, and noted that it is incumbent on the administration to ensure that the University does not pay the Cadillac tax. As a public institution, the University cannot afford to offer a Cadillac-valued plan. He also reminded members about their position of not wanting to shift all of the increased costs on to the sick. For example, if the University were to reduce premium costs further, it would have to impose a $500/$1,000 deductible instead of the $100/$200 deductible that is being proposed. Plans all across the country are in the process of preparing to make changes similar to what the University is exploring. Rather than simply offering a high deductible plan, which the University could do, stated Mr. Chapman, the administration has worked hard to put forward a proposal that meets the UPlan's goals.

Professor Schultz asked about the implications for waiting to impose these changes until 2015 rather than 2014. Mr. Chapman stated that it is likely that the University would not have the information it will need to know whether the plan changes were sufficient because it takes 18 months of "run-out" to know how the changes will impact the plan. In other words, the University would not have enough data to accurately set the rates and plan design. Secondly, 2015 is when the Enterprise System upgrade goes into place, and to make these kind of benefit changes at the same time the upgrade is taking place has the potential to be problematic.

Professor Schultz stated that UMD has exhausted its fringe pool and wanted to know how the cost shift will affect UMD if it is coming out of fringe. While admitting not to be a fringe expert, Mr. Chapman stated that he does not believe it will have an impact because it is moving money from one bucket to another. Because fringe is set looking backward two years, any impact on UMD fringe would not be seen until FY16 and FY17.

Mr. Chapman reiterated his earlier comment that the plan changes that are being proposed are being imposed by the ACA. There is no windfall for the University resulting from the proposed benefit changes. The University's health care costs continue to increase.

As the discussion continued, members asked Mr. Chapman a number of questions about the 2013 and 2014 projected UPlan medical and prescription expenses on the handout. Professor Morrison noted that while he believes it is essential that health care costs need to be shifted to employees in order for the University to avoid the Cadillac tax, he has not been convinced by the accounting spreadsheet that the administration has provided. The math is fuzzy and does not add up based on his calculations.

Professor Feldman stated that he agrees with Professor Morrison that cost shifts are necessary, but would like more detail about how the $3.8 million cost shift to employees resulting from ACA benefit changes was arrived at. Mr. Chapman stated that he is not sure he is prepared to provide this information because he does not understand the relevance. He noted that the spreadsheet that was shared today was developed by the

University's actuaries in conjunction with Ryan Gourde, health programs financial manager. Professor Feldman replied that the BAC is advisory to the administration, and should not be dissuaded from trying to come up with different ideas for saving money and causing less financial pain for the University and its employees. Mr. Chapman stated that he believes the committee has the information it needs to come up with alternate plan changes. He added that the administration is willing to model additional plan changes from members if they make sense, and invited any member to suggest changes they would like to see modeled.

In light of time, Ms. Falkner stated that this discussion would be continued at the next meeting on May 16 in addition to having the Staywell annual review. The May 16 meeting time is from 10:00 – 12:30.

IV). Hearing no further business, Ms. Falkner adjourned the meeting.

Renee Dempsey
University Senate