BENEFITS ADVISORY COMMITTEE
MINUTES OF MEETING
APRIL 7, 2005

[In these minutes: Announcements, Pharmacy]

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

PRESENT: Gavin Watt (chair), Linda Aaker, William Roberts, Karen Wolterstorff, Jody Ebert, Ronald Enger, Rhonda Jennen for Rita McCue, Penelope Morton, Don Cavalier, Joseph Jameson, Michael Marotteck, Carla Volkman-Lien, Carol Carrier, George Green, Carl Anderson, Fred Morrison, Peh Ng, Theodor Litman, Rodney Loper, Dann Chapman, Keith Dunder

REGRETS: Peter Benner

ABSENT: Pam Wilson, Frank Cerra, Richard McGehee

GUESTS: Professor Stephen Schondelmeyer, College of Pharmacy

OTHERS: Bob Altman, Linda Blake, Amos Deinard, Jennifer Durocher, Betty Gilchrist, Shirley Kuehn, Kathy Pouliot, Ruth Rounds, Jackie Singer, Curt Swenson, Phyllis Walker

I). Gavin Watt called the meeting to order.

II). ANNOUNCEMENTS:

- Gavin Watt reported that the RFP Subcommittee signed a report recommending vendors for the 2006 – 2009 UPlan. This report will be presented to the Board of Regents on May 12, 2005. Vendor announcements and plan scope will be shared with the BAC at its May 19th meeting. Mr. Watt thanked all those that served on the RFP Subcommittee for their hard work. He also thanked those that provided support and expertise to the Subcommittee.

  No major plan changes to covered services are anticipated for 2006. Any hospital, clinic and/or provider disruption will be minimized. The plan from the consumer¹s perspective should look similar to what currently exists. However, there will be plan design changes, some of which still need to be discussed e.g. pharmacy co-pay structure, two-tier versus four-tier rate structure, and indexing health care costs based on income.

- Wellness Program Manager Ruth Rounds distributed a handout, which outlined the University¹s spring/summer 2005 wellness events (http://www1.umn.edu/ohr/eb/wellness/wellevents.htm). She also noted that she is in the process of establishing a subcommittee to work on a fall health care consumer campaign. Ms. Round¹s solicited volunteers to serve on this subcommittee.

- A handout summarizing the Governor¹s Fitness Challenge was distributed. Members were encouraged to visit the website for this program at http://www.beactiveminnesota.org/. This site contains a lot of good information to help people be active.

- The Wellness Baseline Survey results are being tabulated. Once this information has been compiled it will be shared with the Committee.

- Until full details of the AWG¹s report to the Board of Regents are made public on May 12th, members were cautioned to look upon any information they may hear with respect to the 2006 – 2009 UPlan with skepticism. While the AWG has a recommendation it will present to the Board of Regents, no contracts have been signed.

III). Gavin Watt introduced Professor Stephen Schondelmeyer from the College of Pharmacy, PRIME Institute. Professor Schondelmeyer provided information on pharmacy drug expenditures, trends and ideas on how to control pharmacy drug costs. He highlighted the following information:

- In 2004, as a society, approximately $235 billion was spent on prescription drugs. This dollar amount only represents prescription drugs administered on an outpatient basis and does not include drugs administered in a physician¹s office, hospital or other settings such as prisons or public health clinics. The expenditure for drugs in all settings is approximately $358 billion.
- Drugs administered in a hospital setting or a physician¹s office are often referred to as ³specialty² drugs. It would be wise for the UPlan to carve these drugs out from other prescription drugs and manage and monitor these expenditures separately to ensure the University is paying a fair amount, but not an excessive amount. In the marketplace, it is not uncommon for PBMs (Prescription Benefits Manager) to overcharge for ³specialty² drugs.
- Drugs currently represent 19% of total health care expenditures. By the year 2010, drugs are expected to represent 24% of total health care expenditures, and by 2012 drugs are anticipated to represent 25% of total health care expenditures, exceeding physician expenditures. Therefore, in order to control costs it is critical that the UPlan manage and monitor what it spends on drugs.
- Two major components play a role in prescription drug pricing – the drug product cost at the manufacturer¹s level and the pharmacist¹s dispensing fee. It is clear that it is not the dispensing fee that is driving the cost of prescription drugs, but rather the drug product cost at the manufacturer¹s level. Oddly enough, many employers choose a PBM based upon the pharmacists¹ dispensing fees and rebate

amounts. Realistically, in order to manage the growth in pharmacy drugs expenditures both the manufacturer¹s costs and the dispensing fees need to be controlled.

- Recent drug price increases can be attributed to:
  - Price inflation.
  - The use of brand versus generic drugs.
  - Directed consumer advertising.
  - Pharmaceutical sales representatives.
- It is important to remember that the newest drugs on the market are not necessarily the best. In fact, whenever appropriate, generic drugs should be used because they are less expensive and safe. In Professor Schondelmeyer¹s opinion, the United States has the best Food and Drug Administration (FDA) system in the world. Generic manufacturers must meet the exact same standards as brand manufacturers when they produce a lot of pills. The only time the use of a brand versus a generic could be argued as medically necessary would be if a patient is allergic to the color of the dye or other inert ingredients in the generic drug.
- The role for generics:
  - Patients should encourage physicians to prescribe generic drugs whenever appropriate.
  - Pharmacies should be encouraged to dispense generic drugs whenever possible. Generics cost anywhere from 25% - 90% less than brand drugs.
  - Patients should be encouraged to request generic drugs from their physicians.
- Overspending is occurring if single source brand name drugs are dispensed when a generic is available. Higher priced brand drugs do not produce better health outcomes.
- The generic fill rate at the University is approximately 41% versus a national average of 46%. The best PBMs have generic fill rates of between 50% - 70%.

Questions/comments from members included:

- What percentages of drug expenditures represent drugs that have been inappropriately prescribed or instances where a fourth generation drug was prescribed when a first generation drug would have worked equally as well? Nationwide estimates indicate that between 5% - 25% of prescription expenditures are inappropriate. Inappropriate utilization of drugs needs to be carefully managed in order to control costs.
- Does the FDA require head to head comparisons when a new drug is being evaluated or do they compare it against a control drug? By statute, the FDAs level of comparison is against a placebo or the first drug in a particular class. The FDA does not require comparisons amongst similar drugs and rarely do drug companies conduct comparisons. Occasionally, however, such comparisons may be conducted in academic settings or by the National Institutes of Health (NIH).
- If a physician writes a prescription for an over-the-counter (OTC) drug, does the UPlan pay for it? It depends. Most plan administrators currently do not pay for all OTC drugs, but may pay for some with a prescription. Starting in 2006, the

UPlan can design its prescription drug plan so that it pays for OTC drugs with a prescription.

- Can the University create its own formulary list and impose this list on its PBM? This is an option, however, in Professor Schondelmeyer¹s opinion a hybrid approach would be a better strategy. Under a hybrid system the University would contract with a PBM that has an established formulary list and processes in place, but who would allow the University to customize this list and the services it delivers.
- What can the University do to educate its population regarding the soaring costs of drugs and the use of generics versus brands? Ideas need to be explored, however, there are several different options including direct mail pieces on drug related behavior patterns. Also, the PBMs that are being considered have ideas on how to appropriately increase the University¹s generic use rate. There needs to be an incentive for people to use generic drugs.
- Do health plans profile their physicians to see who is prescribing fourth generation drugs versus first generation drugs, etc.? PBMs are able to profile physicians and their prescription writing patterns. Once profiling results have been compiled, academic detailing is one approach that is effectively used to educate physicians about alternative prescription drug writing options.
- Do PBMs offer an appeals process to address instances where a patient may require an expensive brand drug as opposed to a generic? Yes, to the best of Dr. Schondelmeyer¹s knowledge all PBMs have an appeals process. However, some PBM¹s appeals or exceptions processes are more effective than others. An appeals or exceptions process is absolutely necessary for a plan with differential co-pays, prior authorizations and formulary lists like the University is exploring.
- Would it be worthwhile for the UPlan to institute a differential co-pay for generic versus formulary and non-formulary brand drugs? Yes, something different needs to be done with the UPlan¹s current pharmacy co-pay structure as it relates to generics. The specifics of such a plan would need to be discussed in further detail. Generic drug usage needs to be encouraged at the University.
- How do we educate physicians regarding their prescription writing patterns? The best approach is to educate all players in the process, physicians, patients and pharmacists and to provide each with an economic incentive for prescribing, using and dispensing generic drugs. Ultimately, the most successful programs require very little patient education because physicians and pharmacists are doing the right thing in the first place.
- What prevents drug manufacturers from giving pharmacists a kickback for filling a prescription with a brand versus generic drug? In Minnesota, this is illegal. Ironically, however, the drug manufacturer can legally pay the PBM to prefer the brand over the generic drug. For this reason, during the PBM interviews, the RFP Subcommittee asked PBMs for all their sources of revenue. The University seeks to have complete transparency of its PBM¹s revenue sources and have the right to audit these sources.
- Can the University require therapeutic substitutions in addition to generic substitutions? Yes, however, this is an area that needs further exploration. There needs to be a balance in the plan design, which would give the physician some

choice/discretion when prescribing a medication, and, at the same time, not have a plan that is too limited in its drug options. It is not a good idea to limit the physician when there are true differences across products.

- How often are drugs prescribed for a condition that is not the FDA approved treatment? An example of this is Neurontin, which was approved by the FDA as an epileptic drug, but is being used to treat many other disease states. [3]FDA approved use[2] means that a drug manufacturer requested the drug be used for a specific purpose and it was evaluated only for that purpose. There are some unapproved uses of drugs that are medically valid and appropriate. There are also some unapproved uses of drugs that are not valid, medically appropriate, or documented by clinical evidence. The UPlan does not want to prohibit use of drugs for unapproved medically valid uses. Off-label, inappropriate use of drugs is a concern, but it is very difficult to monitor.

Gavin Watt thanked Dr. Schondelmeyer for his presentation.

Next, Mr. Watt asked members if they would be willing to consider a different co-pay structure that would save both the University and its employees money. Currently, the University has a two-tier co-pay structure, formulary and non-formulary. Mr. Chapman added that the University[1]s current pharmacy co-pay structure also has a generic incentive on a chemical basis. To illustrate, if a patient chooses to purchase a brand drug when a chemically equivalent generic drug is available, the patient pays the co-pay plus the difference between the generic and the brand drug cost.

The Committee continued its discussion of this topic. Members agreed that something must be done about the University[1]s low generic use rate. The question, which remains on the table for the BAC to weigh in on is whether or not the UPlan pharmacy co-pay structure should have a co-pay differential between generic, brand formulary and brand non-formulary drugs. If so, what should the new co-pay structure look like? Options will be brought forward at the May 5th meeting and the Committee will be asked for its advice.

IV). Hearing no further business, Gavin Watt adjourned the meeting.

Renee Dempsey
University Senate