BENEFITS ADVISORY COMMITTEE
MINUTES OF MEETING
JUNE 20, 2013

[In these minutes: Fairview Specialty Pharmacy Annual Review, Continued Discussion on Proposed Health Plan Benefit Design Changes]

[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, Barb Bezat for Jody Ebert, Sara Parcells, Jennifer Schultz, Sandi Sherman, Susann Jackson, Joseph Jameson, Karen Lovro, Carl Anderson, Roger Feldman, Richard McGehee, Fred Morrison, Theodor Litman, Rodney Loper, Dann Chapman

REGRETS: Jody Ebert, Nancy Fulton, Amos Deinard

ABSENT: Sheldon Taylor, Kathryn Brown, Aaron Friedman, Judith Garrard, Keith Dunder

OTHERS ATTENDING: Linda Blake, Karen Chapin, Kurt Errickson, Dan Fisher, Betty Gilchrist, Ryan Gourde, Kathy Pouliot, Jackie Singer, Laurie Warner, Gavin Watt

GUESTS: Fairview Specialty Pharmacy representatives: Kari Amundson, RPh, director of New Business Development; Ann Mcnamara, Pharm D, clinical development manager; Mike Resvick, RPh, operations manager; Kyle Skiermont, Pharm D, director of specialty/infusion operations; Mary Claire Wohletz, Pharm D, specialty account manager

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

II). Ms. Falkner welcomed guests from Fairview Specialty Pharmacy (FSP) to the meeting and requested they introduce themselves. Following introductions, Mary Claire Wohletz began by drawing attention to national concerns about specialty medications and the reason for these concerns:

- Cost – specialty drugs represent approximately 20% of most pharmacy budgets but are only being used by about 1% of the population. In addition, manufacturers continue to increase their price ceilings.
- Appropriate utilization – specialty drugs are complex medications that require close management and oversight to ensure optimal outcomes.
- High number of specialty drugs in the pipeline.

Next, Ms. Wohletz highlighted the list of UPlan specialty therapeutic areas being treated, e.g., cystic fibrosis, hemophilia, transplant, inflammatory conditions, to name a few. Given the complexity of the disease states and the medications used to treat these

diseases, Ms. Wohletz, noted that specialty pharmacies differ from traditional retail pharmacies in a number of ways. For example, FSP offers:

- Extensive patient education about use of specialty medications.
- 24/7 patient access to clinical staff and services/programs.
- Stocking of difficult to find drugs and supplies.
- Same day and next day shipping and courier services.
- Phones that are answered live.
- No automatic refills or automatic shipping of medications.

Moving on, Kyle Skiermont, director of specialty/infusion operations, shared with the committee member feedback and satisfaction survey results. FSP gets feedback from three sources 1) unsolicited feedback, 2) solicited feedback, e.g., surveys, and 3) quarterly meetings with Employee Benefits. In terms of the unsolicited feedback, Mr. Skiermont noted that most of the unsolicited feedback FSP receives is positive and he cited an example of FSP moving from Styrofoam coolers to a "green alternative," which generated positive feedback from members.

Mr. Skiermont reported that FSP conducted a UPlan-specific patient satisfaction survey during the first quarter of 2013. Of the 177 surveys that were sent out, 54 patients returned the survey, which represents a 30.5% response rate. He then turned members' attention to the survey questions, some of which were customized specifically for UPlan members. Responses to the questions were positive overall, noted Mr. Skiermont, and FSP has shared all the responses with Employee Benefits.

FSP, reported Mr. Skiermont, met all of its performance guarantee metrics that the University monitors. These metrics include:

- Call abandon rate of 5% or less.
- Average speed of answer 45 seconds or less.
- Turnaround time for clean order – 98% or better.
- Prescription accuracy – 99.95% or better annually.

Next, Ms. Wohletz walked members through a slide with 2012 UPlan utilization data. She highlighted the following:

- In fourth quarter 2012, the number of members served increased, which resulted in a corresponding increase in the total number of prescriptions filled, an increase in plan spending and an increase in the average cost per prescription. This fourth quarter spike is typical and is a phenomenon of members wanting to optimize their pharmacy benefit and/or end of year spending.
- The average cost per prescription for the year ranged from $2,590 - $2,881.
- National benchmark comparison data shows that from 2011 to 2012, nationally, specialty drug spending increased 20.1% due in part to cost inflation (9.2%) and utilization (6%). The UPlan specialty drug spending, on the other hand, increased by 16.4%, $6,861,781 in 2011 to $7,989,844 in 2012. Because specialty drugs are used by smaller populations, their trend profiles are unique; small changes can have a significant impact on trend.
- The top five UPlan drug classes that accounted for 90% of spend in 2012 were:

- Inflammatory conditions.
- Multiple sclerosis.
- Oral oncology.
- Growth deficiency.
- Hemophilia.

As compared to the UPlan, the top five drug classes by spend nationally were:

- Inflammatory conditions.
- Multiple sclerosis.
- Oral oncology.
- Other specialty.
- Growth deficiency.

Mr. Swanson asked why the UPlan spend for oral oncology medications increased so much in 2012. Ms. Wohletz stated that there were several new drug approvals in 2012, and an increased awareness on the part of patients about oral oncology medications. She added that FSP is also noticing that once a drug manufacturer goes forward with a price increase, other manufacturers tend to follow suit. Mr. Chapman thanked Ms. Wohletz for bringing this to the committees' attention. He noted that a number of people are under the impression that drugs are expensive when they first come out, but that the price drops with time. This is not necessarily the case, noted Mr. Chapman. Ms. Wohletz stated that most drug manufacturers will continue to increase their prices over time. For example, the cystic fibrosis drug, Tobi, took a 30% price increase from January 2012 to January 2013. Ms. Sherman noted that a number of well-known and highly regarded oncologists, including Dr. Brian Drucker, have written letters denouncing pharmaceutical companies for their unconscionable price increases.

Can the assumption be made, asked Mr. Roberts, that no specialty drugs are generic, which would mean manufacturers have no competition and they can raise their rates whenever they want? In most cases this is true, stated Ms. Wohletz, but not all. The UPlan specialty formulary includes three generic oral chemotherapy drugs.

Ms. Chapin asked Ms. Wohletz to comment on what happens when a specialty drug goes generic. Ms. Wohletz noted that there are some instances when a drug goes generic that its price will decrease; however, because many specialty drugs are injectable (they are a biologic), the likelihood they will go generic in the near future is rare.

Ms. Wohletz introduced her colleague, Ann Mcnamara, clinical development manager, who would be sharing information about patient services. Ms. Mcnamara provided information about the patient services offered through FSP, which include:

- Standard Patient Services.
- Specialty Therapy Management.
- Clinic-Based MTM Management.

Ms. Mcnamara began by stating that a lot of specialty medications are lifesaving medications, and have been proven to improve patient outcomes.

The goal of the Standard Patient Services is to address common barriers that prevent a patient from starting or being adherent to their specialty drug therapy. Potential barriers include 1) cost, 2) complex administration, 3) toxicities/adverse events and 4) missed refills. As part of the Standard Patient Services, FSP has patient financial advocates to address the cost component. Additionally, FSP provides extensive administrative training where appropriate, proactively provides patient education and continual monitoring of known toxic drugs, and conducts courtesy refill reminder calls to patients.

Professor Morrison asked how many of the specialty drugs are in the generic plus category. Mr. Chapman stated that most fall into the generic plus category.

Ms. Mcnamara then outlined the Specialty Therapy Management goals:

- Identify patients who can benefit from extra resources (mandatory for hepatitis C patients).
- Engage patients in the process and keep them engaged.
- Ensure that a specialty medication is effective or is stopped or switched if not effective.
- Refer patients to their care provider before a drug-related problem becomes an expensive medical event.
- Collect outcomes data.

Specialty Therapy Management programs include: Crohn's disease, cystic fibrosis, hepatitis C, multiple sclerosis, oral oncology, psoriasis/psoriatic arthritis, rheumatoid arthritis, solid organ transplant.

Ms. Mcnamara highlighted what has happened with specialty drugs over the past year or so and what is coming down the pipeline. She noted that oral drugs are beginning to replace injectable medications, e.g., oral multiple sclerosis and oral rheumatoid arthritis medications. Additionally, FSP is seeing more targeted cancer therapies as well as orphan and ultra-orphan diseases (rare and very rare diseases).

In terms of what is new on the horizon, Ms. Mcnamara stated that there is an increase in the number of biosimilars (also called follow-on biologic, follow-on protein products or bio-better) and are a successor to biologic medications that have lost patent protection or exclusivity. Biosimilars are expected to increase competition in the biologics market; however, they have not yet received FDA approval. Cost-saving estimates on biosimilars vary. Follow-on biologics are biological medical products whose active drug substance is made with a living organism or derived from a living organism. FSP will continue to monitor biosimilars and provide updated information as it becomes available.

Hearing no further questions, Ms. Falkner thanked the FSP representatives for their presentation. The committee took a short break after the guests left.

When the meeting was reconvened, Professor McGehee stated that it is clear that there is a lot of money on the table when it comes to specialty medications. He asked whether there is any program coordination between pharmacy and wellness, for example. Mr. Chapman stated that Employee Benefits makes sure that all of its vendors know about the

University's Wellness Program and how to refer people to it. The University has chosen to have a lot of drugs covered by FSP because the University believes their services add value to people taking complex and expensive drugs. He added that in his opinion the University made the right choice in bringing FSP on board as its specialty drug pharmacy. Regarding the comments and questions about cost, etc., stated Mr. Chapman, there will need to be discussions with the BAC at some point about the ethical questions related to specialty drugs. Ms. Sherman used the analogy of the "death panel" debate.

Professor McGehee stated that he was struck by the fact that once pharmaceutical manufacturers get a patent on a medication, they more or less have a monopoly and can do whatever they want in terms of pricing. Ms. Chapin stated that is why it is of value to the UPlan to have FSP manage the utilization of specialty medications.

Ms. Falkner called on Ms. Lovro to summarize the FSP comments sent in from UPlan members. Ms. Lovro stated that 19 people commented, and the vast majority were pleased with FSP. Of the negative comments that were received, they had to do with cost and not having automatic refill capabilities. Respondents praised FSP for their excellent customer service and knowledgeable staff.

III). Next on the agenda, stated Ms. Falkner, is to continue the discussion on proposed health plan benefit design changes. As part of this discussion, Mr. Chapman turned to Mr. Gourde, health programs financial manager, to provide information on the 2014 dental rates. Mr. Gourde distributed a summary of UPlan dental employee biweekly contributions comparing 2013 with 2014. He noted that employees in the employee only tier (base plan) pay 12% of the total premium cost and the rest of the tiers pay 48% of the total premium. For 2014, noted Mr. Gourde, premiums will go down in three (employee only, employee plus child/ren, and employee plus spouse/same sex domestic partner (SSDP) and child/ren) of the four tiers. The premium cost in aggregate will go down 2½%. In an effort to keep the dental plan consistent with the medical plan, the employee plus spouse/SSDP tier will see a premium increase.

The 2½% (in aggregate) decrease is comprised of three components:

1. Low trend.
2. Internal administrative fees being moved out of the budget.
3. Negotiated reduction in external administrative fees.

Based on the recent dental RFP, announced Mr. Gourde, the University will retain its two dental providers, Delta Dental and HealthPartners Dental. Both companies submitted competitive bids, and, as a result, the RFP committee recommended that the University retain the two providers. Ms. Chapin noted that four BAC members served on the dental RFP committee, Tina Falkner, Judy Garrard, Sue Jackson and Fred Morrison.

In response to a question, Mr. Gourde noted that the total dental plan budget was approximately $17 million for this year, and the budget will decrease by 2½% for 2014. He agreed to bring exact figures back to a future date.

Is dental included in the Affordable Care Act (ACA) calculations, asked Ms. Sherman? No, stated Professor Morrison, dental is excluded from the ACA. Ms. Bezak (sitting in for Jody Ebert who was unable to attend) suggested taking the dental savings and applying the savings towards offsetting medical plan increases. Mr. Gourde stated that he does not consider the 2½% decrease in dental costs in aggregate necessarily a "savings" per se but rather a shifting of internal administrative fees out of the UPlan.

Moving on, Mr. Roberts requested Mr. Chapman explain how the deductible will work next year. Mr. Chapman explained that the deductible will apply to non-copay items only, e.g., lab work. Put differently, if there is a copay for a service, the deductible will not apply. If a deductible applies to a service, individuals will be billed until they reach their deductible max.

Using an annual physical as an example, asked Mr. Swanson, if a cholesterol test is done as part of a person's annual physical, will the deductible apply? After some discussion, the consensus was that the deductible would not apply in this case as long as the cholesterol check was done as part of the annual exam and would need to be done at the time of the exam visit. Mr. Anderson stated that the diagnostic code used by the clinic drives whether a procedure is considered preventive or not.

Professor Schultz asked because the University is self-insured, would it be possible to negotiate with Medica on what is considered preventive care. Yes, stated Mr. Chapman, the University will need to follow established standard practice guidelines for what is considered preventive care and what is not.

In Professor Morrison's opinion, while the University has no choice but to institute a deductible, undoubtedly doing so will generate administrative costs for clinics rather than reducing costs as the ACA intended. Mr. Chapman stated that a lot of the paperwork will be able to be handled electronically rather than through the mail.

The committee went on to talk about the three benefit design options that have been proposed. Mr. Gourde walked members through a handout outlining the differences in the three options. The new option (alternative proposal #2) being introduced for the first time today reduces copays by increasing the deductible. Under this proposal, the deductible would double (instead of $100 single/$200 family it would be $200 single/$400 family – base plan), but the primary care copays would go down to $20, the specialty care provider copay would be $35, the urgent care copay would go down to $20, and the MRI/CT Scan copay would be reduced to $40.

Professor Loper asked for an update on the status of whether University of Minnesota Physicians (UMP) primary care physicians will be included in the Fairview Accountable Care Organization (ACO) network. Mr. Chapman stated that specialty UMP providers are included in the Fairview ACO but currently not the UMP primary care physicians. He added that deciding which physicians are in the ACO and which are not is a care system decision and not a University decision. The University is having discussions with Medica because it realizes that it would be valuable for the Fairview ACO to include

UMP primary care physicians. To date, no final decisions have been made. Mr. Chapman stated that there will be a distinct difference in how the University relates to providers in the ACO model as compared to its other plans and networks. The University has been very involved in network building of its non-ACO plans, but the ACO model is a completely different method of practice that focuses on population health management. In order for the UMP primary care physicians to be in the Fairview ACO, these two groups have to make this decision, not the University.

Professor Feldman asked if all three proposed benefit design options cost the same. Yes, stated Mr. Chapman and Mr. Gourde.

Ms. Sherman suggested that the committee reject all three proposals and require the University to find another way to cover the cost of quality health care benefits for its employees, particularly lower paid employees. She added that she is also concerned about the ACO option because it will not be available to employees in Greater Minnesota; this creates an inequality in benefits between employees in the Twin Cities and employees in Greater Minnesota. Professor Morrison stated that the University has no choice but to change the plan design in order to avoid the ACA Cadillac tax. The plan value needs to be lowered. If the University refuses to change its plan design, this will mean that the University will add $48 million to its costs, which will undoubtedly come directly out of the compensation pool. Lowering the plan value is a necessary consequence of the ACA. Mr. Chapman added that modifying the UPlan is not something the University has chosen to do, but it is being imposed by the ACA. The University has made every effort to try and minimize the impact on employees. If the BAC chooses not to make a decision on the options being proposed, the administration will, stated Mr. Chapman.

Mr. Jameson asked if an analysis has been conducted on which option would have less of a financial impact on people with chronic illnesses. Mr. Chapman responded by saying that lower copays are obviously better for people that go to the doctor frequently, but if the deductible is too high, lower paid employees may decide to not get the care they need. There is no mathematical way to definitively conclude that one option is better than the other.

Please explain why the changes need to be implemented in 2014 versus waiting until 2018 when the Cadillac tax will be implemented, asked Professor McGehee. The reason the changes are being implemented in 2014 has to do with the plan cycle of when changes can be made to the UPlan, and part of it has to do with the bargaining cycle. Making the changes in 2014 will give the University the opportunity to get plan experience that yields data with enough time to make a course correction if the changes that are implemented are insufficient. The University believes, based on input from its actuaries and Mr. Gourde, that if the changes being proposed are made, it will come very close to being on target for 2018. The University is still taking a little risk and is hoping that its good trend experience will last longer. Eighteen months of experience is needed to get the data it needs to know whether additional changes are necessary or if the changes that will take effect in 2014 were adequate. In theory, the University could wait

to make plan changes until 2016. However, the only way to be safe from the Cadillac tax would require the University to make much more draconian cuts/shifts if it waits until 2016.

Professor Schultz asked whether President Kaler is open to taking the money the University would have contributed to benefits and give it back in the form of higher monetary compensation to employees. She noted that she believes she could get more support for the benefit design proposals from faculty if President Kaler were willing to do this.

Professor Schultz asked for mitigation purposes whether alternative proposal #2 (higher deductible) would be easier to administer. No, stated Mr. Chapman, no proposal is better than any other when it comes to administration. In Professor Schultz's opinion, under alternative #2, the University would know how much people are paying out in deductibles, but in the other proposals it will not be able to know the number of office visit copays an individual incurred, for example. Mr. Chapman stated that under proposal #2 there will be employees who will not go to the doctor, and, therefore, will pay nothing towards a deductible or any copays. Mitigation calculations will be based on the cost amount being shifted to employees.

Ms. Sherman stated that she does not understand how the committee can vote on the proposals without knowing more about the administration's mitigation strategy. She added that she is not convinced the University cannot come up with the money needed to pay the tax liability. Professor Schultz stated that she does not agree that the University should take a tax liability, but that the University should make the cost shift neutral for employees. In Ms. Falkner's opinion, voting can take place before the mitigation strategy discussion takes place. With that said, she called for a straw vote on the current proposal, alternative proposal #1 and alternative proposal #2. The current proposal received three votes, alternative proposal #1 received five votes and alternative proposal #2 received two votes. Professor Morrison made a motion and moved that the BAC recommend to the administration alternative proposal #1. Members voted to endorse this motion; there was one abstention. Ms. Jackson stated that she thinks it is really admirable that the University has agreed to pay the internal administration fees for the UPlan and this should be conveyed to the University community. She added that she believes University employees are fortunate to have such good benefits. More should be done to focus on the positive coming out of the necessary benefit changes than dwelling on the negative. Ms. Sherman stated that she does not mean to be negative, and she agrees that the University's health benefits are very good. However, with that said, to compare the University with other less rich plans only results in a race to the bottom, and this is not the direction to go. Employees should be fighting to protect the rich benefits they get from the University. The University's benefits are great and other employers should offer similar plans. Employees should not feel they have to apologize for the benefits they receive and they shouldn't feel lucky because the same level of benefits should be afforded to all employees. Professor Schultz added that there are a number of people who choose to work at the University, specifically for the benefits it offers. Mr. Anderson suggested the University benchmark itself against changes being made by other

employers to get a sense of the types of changes other employers are making and sharing this information with the committee. Mr. Chapman stated that the University does this, but until the changes that many employers are talking about are actually put in place, it is difficult to get at the benchmark data.

The remaining time was spent talking about the University's mitigation strategy. Mr. Chapman stated that he can share some information but the details have not been finalized. President Kaler has made a commitment to mitigate the cost shifts that employees will incur. The amount in question had been $1.9 million, but that has been reduced now to $1.8 million because of the additional internal administrative fees the University will be paying for the dental plan in order to align the medical and dental plans in terms of administration. Mr. Chapman highlighted the mitigation strategy proposed by the administration:

- One pay period premium holiday during the 2014 plan year. In Mr. Chapman's opinion, this creates an equitable distribution of returning some mitigation back to employees that is proportional to the plan costs they have depending on their coverage tier.
- Couples' tier increases in medical and dental premiums will be phased in over two years.
- Institute a medical cost relief program that will be modeled on the premium relief program that the University has offered in the past. This will be a needs-based program that employees will apply for and will be based on household income.

Mr. Chapman stated that the administration talked about whether the mitigation should be recurring, e.g., divide the $1.8 million among employees and add it to their base salary. The administration has rejected this idea and does not believe it is appropriate for a variety of reasons. For example, not all employees participate in the UPlan. Secondly, this money trends over time at a rate that the kind of cost shifts that are being put into place do not. In other words, while base pay goes up every year due to raises, the out of pocket cost shifts tend to remain flat over time and actually decrease in value over time assuming they stay flat. Mr. Chapman noted that the 2½% pay increase for FY14 actually is a real increase because inflation is only running just over 1%. The administration believes that the type of mitigation that makes sense is mitigation that softens the impact and gives people some transition money.

Professor Schultz clarified that the premium holiday would only be for 2014, and asked about continuing the premium holiday beyond 2014. Yes, stated Mr. Chapman, the premium holiday will only occur in 2014. There is no rationale for continuing to offer the premium holiday beyond 2014. Professor Morrison stated that he finds this to be a very disappointing statement. The one pay period premium holiday is a postponement of shifting $1.9 million in health care cost shifts to employees to make it less obvious, and Professor Morrison stated that he finds this unacceptable. Secondly, the phase-in of the couples' tier increases is zero and comes at the expense of those in this tier for that one-year period. It has nothing to do at all with mitigation and is simply a smoke screen. Thirdly, the cost relief program should be recurring and should be equal to the amount of

money being taken away from employees. Professor Morrison stated that he finds the administration's mitigation offer appalling.

Professor McGehee stated that the ACA requires the University to lower its plan value or incur the Cadillac tax. There is nothing in the ACA that would prohibit the University from paying for the entire UPlan. With that said, the mitigation could be to have the University pay more and employees pay less, which would be in line with the ACA. Professor Morrison stated that this would be consistent with the ACA. Ms. Chapin stated the University is paying more via the premium holiday. Professor Morrison stated that the premium holiday is only for one year, and the administration is hoping employees will forget that $1.9 million in health care costs has been shifted to them by the next year. Mr. Chapman reminded those present that the University continues to pick up the lion's share of the plan cost and, as a result, its costs increase at a higher rate than employees' costs. Professor Morrison objected and stated that the University's share of health care costs has gone down from 90% when he began serving on the BAC to 80% today. As an aside, Professor Feldman noted that when the ACA was signed into law, the Congressional Budget Office assumed that all employers that would be subject to the Cadillac tax would actually take steps to avoid it, and the University is right on target with this assumption. Secondly, they predicted that income that had been paid toward health insurance premiums would go into wages, producing additional revenue for the federal government in the form of income and payroll taxes. In the grand scheme of which the University is only a small part, the federal government has assumed that employers would make employees whole but they are not. Professor Feldman stated that he agrees with Professor Morrison's position. Mr. Chapman commented that members need to remember that percentages don't spend at the bank, and the University needs to look at its budget in terms of real dollars. He is not denying that employees are picking up a bigger percentage of health care costs than they used to, but the University continues to pay more and more every year and this amount grows faster for the University than for employees. Professor Morrison added that the University's commitment to maintaining the health of its employees goes down year after year after year. Mr. Chapman adamantly disagreed, and stated that after all the benefit design changes are implemented, the University will continue to offer one of the best employer health care plans available. The plan will continue to be high quality, accessible, and affordable. He realizes that some people struggle financially and this should be a topic of discussion at an upcoming meeting. For the record, Mr. Chapman noted that he seriously objects to the characterization that the University's commitment to the health of its employees has gone down.

Professor Schultz asked if the University has a better health insurance plan than the State of Minnesota. In Mr. Chapman's opinion, the University has a better plan, but this is a difficult comparison to make.

What is happening with the same sex domestic partner (SSDP) issue, asked Professor Schultz? Mr. Chapman stated that the University will be complying with the law, but it plans to take its time to work out how to handle this issue. Professor Schultz asked if the

University is considering requiring same sex couples to be married in order to be eligible for UPlan benefits. This is under consideration, stated Mr. Chapman.

Ms. Falkner stated that while no July meeting is scheduled, it will likely be necessary to have another meeting. A decision will be made soon and members will be notified if a July meeting will be added.

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

Renee Dempsey
University Senate