

### Executive Summary

Calendar year 2015 was the thirteenth year of operation for the university’s self-administered prescription drug plan. In 2015, the plan made up 21.9% of the university’s \$497M total spend on health benefit programs. Growth in membership, increased utilization, high-cost specialty drugs and inflation contributed to a 14.1% increase in total drug cost in 2015, the highest in 13 years. In particular, specialty drug spending increased 33.8%, representing 37.0% of costs but only 1.6% of claims.

The pharmacy benefit team continues to leverage clinical expertise and innovative strategies to control costs, improve outcomes and support university objectives. While the U-M trend has historically remained below national benchmarks, more aggressive approaches related to specialty drugs and member cost share may be needed going forward as pharmacy spending increasingly contributes to higher healthcare costs for the university.

### 2015 Cost and Utilization Metrics

Below is a snapshot of key performance metrics based on an average 102,605 eligible members per month, a 2.2% increase in membership over 2014. Eligible membership has grown approximately 2% per year for the last five years.

	All Claims		Non-Specialty		Specialty	
	Cost and Utilization	Change from 2014	Cost and Utilization	Change from 2014	Cost and Utilization	Change from 2014
Claim Volume	949,015	-2.0%	933,735	-1.7%	15,280	17.7%
Utilizing Members	79,031	1.7%	78,969	1.7%	2,527	15.4%
Total Drug Cost	\$121,599,628	14.0%	\$80,212,949	5.2%	\$41,346,679	33.8%
Plan Cost	\$109,277,442	15.8%	\$68,881,136	7.1%	\$40,396,306	34.4%
Member Cost	\$12,322,185	0.0%	\$11,371,811	-4.7%	\$950,374	146.9%
Percent Member Total Cost Share	10.1%	-0.8%	14.2%	-0.5%	2.3%	1.4%
Plan Cost PMPM	\$88.75	13.4%	\$55.94	4.9%	\$32.81	31.5%
Member Cost PMPM	\$10.01	-2.1%	\$9.24	-6.8%	\$0.77	141.7%
Avg Number of Claims Per Utilizing Member Per Year	12.0	3.4%	11.8	-3.5%	6.1	2.0%
Avg Day Supply Per Claim	45	0.0%	45	0.0%	32	0.0%

*PMPM = per (eligible)member per month*

### 2015 Tier Utilization

Drug Tier	Paid Claims	% Total Claims			% Plan Cost		
	2015	2015	2014	Change	2015	2014	Change
Tier 0 – \$0 Copay	58,040	6.1%	5.8%	0.0%	10.8% (\$11.8M)	9%	1%
Tier 1 – Generics	790,527	83.3%	83.0%	0.3%	21.2% (\$23.5M)	25%	-3.4%
Tier 2 – Preferred Brands	58,421	6.1%	6.4%	-0.2%	53.2% (\$58M)	49%	4%
Tier 3 – Non-Preferred Brands	41,735	4.4%	4.8%	-0.4%	14.4% (\$15.7M)	17%	-2.6%

*Note: Tier 0 represents claims where the out-of-pocket cost to the member is \$0. Prior to 2013, this only applied to insulin and syringes for diabetes. In 2014, \$0 copay was also applied to preventive care drugs under the Affordable Care Act, including contraceptive products for females.*

## Plan Operations and Administration

### ***Vendors and RFPs***

2015 was the third full year of the university’s contract with MedImpact Healthcare Systems, Inc., for Pharmacy Benefit Manager (PBM) administrative services. In order to procure more competitive pricing and improved services, the Benefits Office conducted an RFP for PBM services with assistance from Pharmaceutical Strategies Group (PSG) in 2015. Five bid proposals received a full quantitative and qualitative analysis. The result was a renewal for PBM services from MedImpact with substantial improvements in drug discounts, fees and rebates, as well as enhanced performance guarantees. Despite the contract renewal and no performance guarantees paid by MedImpact in 2015, ongoing issues related to customer (member and physician) and account service, responsiveness, and prior authorization and appeal turnaround times raise concerns about overall vendor performance.

The total administrative fees for MedImpact (inclusive of all claims processing fees, clinical services, appeals, ID cards, postage, etc.) paid by the drug plan in 2015 were \$1.8M. The plan collected \$2.6M in rebates from MedImpact in quarterly distributions. Annual guaranteed rebates from MedImpact are collected with a six to nine month lag; as of January 2016 additional rebates guarantees on brand and specialty drugs are expected to increase for future periods.

An RFP was also released in 2015 for pharmacy consulting services to provide ongoing benchmarking, data analysis, drug discount price verification and plan design recommendations. The university extended its agreement with PSG for a three-year term. Their scope of work includes delivery of quarterly financial reviews, annual report metrics, verification of MedImpact contract pricing, rebate guarantees and a mail order pricing savings analysis.

### ***Benefits Administration Office Staffing***

The Compliance Officer handling eligibility and escalated claim issues retired in 2015. An experienced HR professional was hired and completed pharmacy tech training and in-house cross-training for several months, resulting in a smooth transition. In addition, the Plan Manager announced his phased retirement to begin August 2016 with a position to rehire. The search for a candidate will begin in spring 2016.

### ***Regulatory Compliance***

Federal and state regulations required the university prescription drug group benefit plan to comply with rules and guidance for employers in 2015. The plan paid \$493,043 for the State of Michigan insurance claims tax in 2015, a decrease of 43.1% from 2014. The tax was reduced in 2015 to a mandated 0.5% of claims cost paid for in-state plan members.

Changes under the Affordable Care Act (ACA) also continued to impact the plan in 2015. The ACA requires coverage of preventive care medications at no out-of-pocket cost to patients, including female contraception,

smoking cessation products, breast cancer prevention, and certain supplements for high-risk patients. Although not required by the ACA, the plan has historically also provided insulin at no out-of-pocket cost to members. Plan expenditures for the \$0 tier copay in 2015 were \$11.8M including \$1.5M in member copay relief. Contraceptives received the majority of copay relief at \$876K, followed by insulin and diabetic supplies at \$432K.

In the past, the plan's infertility benefits were limited to \$5,000 per family per lifetime. Because dollar limits are not permitted under the ACA (effective in 2014), the plan now limits higher-cost fertility drugs to a maximum of five claims per family per lifetime with no limits for lower-cost fertility drugs. In January 2015, the university also implemented a pilot to cover in vitro fertilization (IVF) procedures. Overall plan expenditures for infertility medications increased 213% from \$482K in 2014 to \$1.5M in 2015 mainly due to the expansion of IVF services under the medical plans. Price inflation and changes in the medications available also contributed to the increase. A retrospective review shows that the average plan cost for a member using infertility medications with a five claim limit is approximately \$10,000 per lifetime. A comprehensive review of infertility drug coverage will be conducted in 2016.

The Medicare Part D Retiree Drug Subsidy (RDS) has been administered internally since 2006 and was transitioned to Truven Health Analytics starting in 2015. The Centers for Medicare and Medicaid Services continue to pay the drug plan for the RDS based on eligible claims. For 2015 the amount received was \$1.9M.

## Cost Management

### *Plan Cost*

In 2015, the total prescription drug plan cost including MedImpact administrative fees and state taxes was \$115M. The plan cost based solely on drug and dispensing fees represented 21.9% (\$109M) of the \$497M university cost for medical and drug benefit programs. Price inflation and the introduction of several new very high-cost drugs were the main cost drivers in 2015.

A total of 949,015 prescriptions were dispensed at a total plan cost of \$109.2M, a significant 15.8% increase from 2014. The university paid \$88.75 PMPM (\$1065 PMPY) for drug claims, a 13.4% increase in plan PMPM compared to 2014. The average plan cost for a 30-day prescription increased 18.2% from \$65.60 in 2014 to \$77.50 in 2015. In 2015, the plan administered by MedImpact maintained an overall average discount from Average Wholesale Price (AWP) of 53.7% for combined retail and 90-day retail prescriptions, down from 61% in 2014. While the plan benefited from more aggressive discounts from MedImpact, AWP inflation, particularly among generic medications, drove costs up.

The average ingredient cost of a 30-day supply of single-source brand prescriptions increased by 23.9% in 2015 to an average \$648 per prescription, mainly driven by high-cost specialty drugs. The average ingredient cost of a 30-day supply of multiple-source brand prescriptions increased by 82.7% to an average \$391 per prescription. The average ingredient cost for a 30-day supply of generic prescriptions increased 1.6% to an average cost of \$38.22 per prescription. Price inflation is occurring with generics as shown in average ingredient cost despite aggressive negotiated discounts.

Plan cost for the retiree population was \$28.9M, representing 26.5% of the total plan cost and a 15.2% increase over 2014. The plan cost PMPM for retirees was \$192.55. Expenditures for members in the long-term disability (LTD) program totaled \$4.7M, an increase of 1.6% over 2014. The LTD member cost PMPM was \$413.21, over five times the overall average PMPM of \$88.75.

### *Trend*

Total drug cost (combined university plan and member costs) went up from \$106.6M in 2014 to \$121.6M in 2015, representing a 14.1% increase, the highest increase in 13 years. At present no national benchmarks from

surveys or PBMs have been released for trend comparison, although the expectation is that all plan sponsors will have seen dramatic pharmacy cost increases in 2015.

The following table provides an overview of the factors that impacted plan drug costs in 2015. Further details are provided elsewhere in this report.

**Factors Impacting Drug Cost in 2015 (in order of cost importance)**

Positive	Negative
1. MedImpact renewal – better discounts at retail pharmacies, improved rebate guarantees, including specialty drugs	1. Higher than typical price inflation
2. Medicare Retiree Drug Subsidy	2. Addition of more higher-cost specialty drugs, more indications, and increased utilization for specialty drugs
3. Generic and brand drugs – high generic dispensing rate, less preferred and non-preferred brand use, increased generic availability of top-selling brand name drugs	3. Increase in eligible membership and utilizing members
4. Mail order acquisition cost discounts	4. Fewer patent expirations impacting generic dispensing rate
5. Increased use of UMHHC Specialty Pharmacy discounts on specialty drugs	5. Declining member cost share
6. Prior authorizations and step therapy	6. Increased cost shift of member copays for \$0 preventive drugs and higher prior authorization cost

The average percent of claims dispensed as generic remained consistent near 85% in 2015. In recent years, the patents for a large number of high-volume drugs expired, paving the way for generic competition. The “patent cliff,” which contributed to increases in the generic dispensing rate (GDR), has now run its course. Future increases in the GDR are expected to be smaller.

The slowing of brand to generic releases and savings is overshadowed by the enormous increases in specialty drug costs. As innovation shifts toward specialty drugs, we can expect to see the overall percentage of generic claims decline. The introduction of biosimilar products for biologic medications shows promise for price competition among specialty drugs in the future.

What is clear is the double-digit trend driven by specialty drugs is unsustainable and will become a significant contributor to higher healthcare costs for the university and its beneficiaries. It is expected that specialty drugs alone will represent 50% of all drug plan costs by 2018. The U-M trend, which has traditionally remained below the national average for employer groups, may no longer remain below market due to increased membership, increased utilization for certain drug classes, the addition of dozens of new high-cost specialty drugs, expanded indications for drugs, lower member average copays, and overall higher drug inflation for brands and generic prices.

## Member Cost Share and Utilization

### *Member Cost Share*

Due to a number of high-volume drugs facing generic competition, member cost share has steadily declined since 2003, reversing course briefly in 2014 due to copay increases for generic and preferred brand tiers of drugs. Member cost share declined to 10.1% in 2015, down from 11.5% in 2014. On average, members paid \$12.98 per prescription and the plan paid \$115.15, up from \$97.88 per prescription in 2014. Drug plan members paid \$12.3M in total out-of-pocket costs, the same amount as in 2014. This compares with \$109.2M the plan paid on their behalf, an increase from \$94.3M paid by the plan in 2014. Nationally, the member share of drug cost is approximately double what U-M members contribute.

Unlike many employers, the university has not elected to have a fourth copay tier for specialty drugs. Both member cost share and a specialty drug tier should be evaluated for changes in the near future. The university

goal of increased member contributions to approximately 15% of total cost, still well below national benchmarks of 20-25%, is not likely to be achieved under the current plan design given the disproportionate weight of increased specialty costs, more branded drugs and the cost of \$0 tier copay preventative drugs.

### 2015 Member Copays (30-Day Supply)

Drug Type	U-M Prescription Drug Plan	National Benchmark*
Generic	\$10	\$10.85
Preferred Brand	\$20	\$30.46
Non-Preferred Brand	\$45	\$55.56

\*Source: 2014-15 PBMI Cost and Plan Design Report

Several union groups adopted the standard copay of \$10 for generics, \$20 for preferred and \$45 for non-preferred drugs in 2015. As of January 2016 nursing staff are the sole union group with copays lower than other plan beneficiaries.

### Member Utilization

In 2015, 77% of eligible members utilized the drug plan benefits, unchanged from 2014. The number of eligible members increased to 102,605, a 2.2% increase over the previous year, a normal growth rate. The average number of prescriptions per member slightly decreased from 9.6 per year in 2014 to 9.2 in 2015; 7.3 prescription on average for active employees, 21.6 prescriptions on average for retirees, and 31 prescriptions on average for long-term disability members. The average day supply per claim remained at 45 days.

## Specialty Drugs

Specialty drugs, including self-administered injectables, drugs that require special monitoring and high-cost oral drugs, are of significant concern when assessing cost drivers and future plan cost. The majority of specialty drugs dispensed are brand name products with no generic equivalent. In 2015, specialty drugs represented only 1.6% of all claims, yet more than 37.0% of total drug cost (plan cost plus member cost), up from 31.9% in 2014.

### Growth in Cost and Utilization

In 2015, a total of 15,280 specialty drug claims were paid for 2,527 members at a plan cost of \$41.3M, a 34.0% increase over 2014. Specialty drug claim volume increased 17.7% as the number of members using specialty drugs increased 15.4% over 2014. The average ingredient cost of a specialty drug was \$2,660 per prescription, a 16.1% increase compared to 2014. The average day supply in 2014 remained at 32 days for a specialty drug.

Specialty medications used to treat diseases such as rheumatoid arthritis, Crohn's disease and psoriasis are also known as TNF (Tumor Necrosis Factor) drugs. The TNF category continued to be the number one area of specialty drug expenditures in 2015. The plan paid \$25.6M (62% of all specialty drug costs) for drugs in these three classes, up from \$20.4M in 2014. The number of prescriptions for TNF drugs increased from 346 to 411 between 2014 and 2015.

Multiple sclerosis and orally-administered cancer medication made up the next two most expensive categories. The number of patients treated for multiple sclerosis increased from 172 in 2014 to 185 in 2015, which increased plan costs from \$6.5M to \$7.8M. Oncology drug utilization increased from \$5.4M in 2014 to \$7.1M in 2015, while the number of patients grew from 156 in 2014 to 226 in 2015. Approximately \$534,000 of that increase was from drugs new to the market in 2015.

### Pricing

Aggressive manufacturer price increases contributed to the higher costs of specialty drugs in 2015. The top nine specialty drugs with the greatest impact on rising costs increased an average of 25%. Price increases and the introduction of high-cost medications are expected to continue into 2016.

### ***New Drug Impact***

In 2015, 22 of the 45 new drug entities reviewed by the Pharmacy Benefits Advisory Committee (PBAC) for formulary consideration were specialty drugs. In many cases, the new specialty products provide therapeutic advances in various clinical conditions among small groups of patients, and are therefore priced at a premium cost. These products often do not replace existing therapies but fill a need that was previously unmet. For example, breakthrough hepatitis C drugs that were considered to be cures for the disease were approved by the FDA in 2014. Additional drugs targeting other genotypes of hepatitis C were approved in 2015. As a result, costs related to the treatment of hepatitis continued to rise dramatically from \$1.3M in 2014 to \$3.7M in 2015.

Cardiovascular medicine was the newest category to be added to the specialty medication category. PCSK9 inhibitor drugs (Repatha and Praluent) were approved by the FDA in 2015 due to their ability to significantly lower high cholesterol. Although the indications for this category are primarily for those with inherited or uncontrolled cholesterol, the concern by plan sponsors is that with a price tag of \$14,000 per patient per year, the impact could be quite significant if large numbers of patients are treated with PCSK9 inhibitors rather than lower cost therapies. The use of these drugs is managed with strict criteria developed in collaboration with health system physician specialists.

### ***Orphan Drugs***

Orphan drugs are medications used to treat rare diseases which are generally defined as affecting fewer than 200,000 patients in the United States. The orphan designation was established in the early 1980s in order to provide incentives to pharmaceutical companies that previously avoided investing in research and development for treating those diseases.

Two orphan drugs were reviewed and approved by PBAC in 2015 with strict criteria for use:

- Orkambi (cystic fibrosis) – Of the 30,000 people in the U.S. with cystic fibrosis, approximately 8,500 could potentially benefit from the drug (≈\$300,000/year)
- Strensiq – Long-term enzyme replacement therapy affecting one in 100,000 live births (≈\$1M/year)

No members have been started on either medication at this time.

### ***Biosimilars***

The FDA established new pathways for approval of biosimilar specialty drugs several years ago. A biosimilar is a biological product that is approved based on a showing that it is highly similar to another FDA-approved biological product in terms of safety and effectiveness. The hope is that biosimilar drugs will decrease the costs of therapy in the same sense that generic drugs did in the past.

Express Scripts predicts that \$250 billion could be saved nationally in the next 10 years if biosimilars become available for the 11 most-used specialty drugs. To date, only one biosimilar has been approved and become available. Unresolved issues such as naming convention and interchangeability of products need to be resolved before biosimilars can make a significant impact on the market.

### ***Drug Pipeline***

The drug pipeline will continue to have a significant impact on specialty drug spend for the university. The pipeline is rich with drugs undergoing investigational studies in areas such as cancer, inflammatory conditions, multiple sclerosis and hepatitis C. New areas considered to be specialty that have drugs in the pipeline include muscular dystrophy and cardiovascular medicine. According to the MedImpact Clinical Pipeline report, more than 75 drugs and biologicals are expected to seek FDA approval within the next 12-15 months.

### ***UMHHC Specialty Pharmacy***

The current agreement with UMHHC to provide all specialty prescriptions assures that we are capturing savings for all eligible specialty claims. The university is passing its actual acquisition cost to the plan. Expectations are for greater cost savings to the drug plan as UMHHC increases its volume and purchasing power.

Given the university's buying power, the ingredient cost savings are substantial. The plan pays UMHHC a higher service fee to cover the costs of administering the program, including clinical management programs for select disease states. Development of new clinical management programs by UMHHC each year are designed to better serve our members. In 2015, UMHHC had programs in place for multiple sclerosis and hepatitis C drugs.

### ***Medical and Pharmacy Specialty Drug Evaluation***

A major ongoing initiative is an evaluation of medical and pharmacy specialty drugs to identify opportunities for cost containment and improved management. Approximately 45% of all specialty drugs are covered through the university medical plans and administered in hospitals, outpatient clinics, infusion centers and physician offices. The overlap, gaps and cost differentials for the products and sites of care will be examined. Analysis and efforts to improve coordination between the drug plan and the health plans are ongoing.

## **Clinical Administration**

### ***Leveraging Expertise***

The plan's clinical staff continues to leverage internal and external resources to provide sound, evidence-based recommendations for formulary additions and clinical management. These collaborations will gain importance as the number of specialty and orphan drugs come to market at an increasingly rapid pace in the future.

Consulting with specialist physicians within the university helps establish rational guidelines for the use of medications that are consistent with practices used in the health system. We have found that by consulting with experts, particularly those who may have participated in clinical studies on drugs or disease states, we have been able to make better informed decisions. In addition to collaborating with specialists in the health system, plan pharmacists attend the monthly Pharmacy and Therapeutic (P&T) Committee meetings at UMHHC. The specialty pharmacist is now a member of the university Cancer Pharmacy Committee, a subcommittee of the P&T Committee.

Plan pharmacists also observe quarterly P&T Committee meetings at MedImpact, where they are exposed to the expertise of nationally recognized specialists in a variety of disease states. MedImpact's Clinical Program Manager assigned to the university account is another excellent source of clinical expertise, drugs in the research pipeline, benchmarks and competitive insights.

### ***Drug Reviews, Indications and Utilization***

The clinical pharmacists review newly approved drugs and other changes each week to identify drugs that will require review by the Pharmacy Benefits Advisory Committee (PBAC). Formulary recommendations and clinical guidelines are presented to PBAC during monthly meetings. In 2015, the drug plan reviewed 45 newly approved drugs, of which 22 were specialty drugs and 23 were traditional medications. Drugs for several common disease states including chronic obstructive pulmonary disease (COPD), tamper resistant opioids, HIV and a new class of oral drugs for diabetes represented a large portion of traditional drugs approved.

The top three traditional therapeutic classes used during 2015 included drugs to treat diabetes, anticonvulsants and drugs to treat HIV infection. Prices for insulin have skyrocketed at a rate in excess of 20% per year for the past several years. During 2015, new single source brand insulins were approved. Insulin and syringes are provided to plan members at no out-of-pocket cost. During 2015, the plan spent \$11.8M for diabetes treatments. In 2016, more new insulin products, including a new generic, are expected to be available. A class review of insulin products is planned to explore new coverage and copay options for patients with diabetes. The plan paid \$2.6M on treatments for HIV and \$2.4M for anticonvulsants, 18% and 24% increases over 2014 respectively.

In addition to new drug reviews, the team monitors the market for new indications for old drugs and plan utilization to assess the appropriateness of use by plan members. During 2015, several prior authorization guidelines were revised based on these changes. For example, late in 2014, concern was raised about the potential cardiovascular risk associated with testosterone replacement therapy. At the same time, several new testosterone replacement products for topical use had been introduced to the market and were heavily advertised. An

estimated \$1M was being spent on these products annually by about 300 plan members. A testosterone class review was conducted in 2015 and the testosterone guidelines were updated to address safety concerns.

Potential inappropriate use of Xyrem, a medication for narcolepsy, was identified in 2015 due to unusually high utilization compared to national use rates. The estimated plan paid amount for Xyrem was \$1.2M in 2015, with approximately 12 members using the drug. Prior authorization criteria were developed and implemented. Several other prior authorization criteria were revised to address newly approved uses for existing drugs or to reduce member disruption where inappropriate use has not been observed. Approximately 61% of prior authorization requests were approved in 2015.

A significant change in coverage for compounded medications was implemented in August 2015, triggered by increased utilization and high prices for compound claims, some in excess of \$5,000 per claim. Many of the compounds contained bulk chemicals, which are not reviewed, approved and monitored by FDA. Reviewing individual claims revealed that nearly all of the compounds being prescribed lacked scientific evidence for safety and efficacy; as a result, these prescriptions did not meet the plan's principles for covering pharmaceutical compounds. In 2015, a decision was made not to cover compounded medications made from bulk chemicals. The only exceptions include pediatric compounds where the formulation has been endorsed by the State of Michigan Standardized Oral Liquids for Pediatrics collaborative. Prior to the change, approximately 250 members were utilizing compounded prescriptions at a total cost of approximately \$27,000 per month. After the change, the plan now pays around \$5,000 per month for about 30 members.

### ***Monitoring and Managing Inflation***

A trend toward price inflation has been observed among brand and generic medications. Two especially meaningful examples include Daraprim and Glumetza.

Daraprim is an antiparasitic agent that has been on the market for over 50 years. Its original use was to prevent malaria; more recently, it is used off label to treat toxoplasmosis in patients with compromised immune systems due to HIV or cancer. Better drugs to prevent and treat malaria are now available, and because of its low demand, only one company was producing Daraprim at a low cost without generic competition. In 2015, Turing Pharmaceuticals purchased Daraprim and increased the price from \$12 per tablet to \$750 per tablet. The plan has one utilizing member who takes three tablets daily, making the monthly cost for the medication over \$65K.

Glumetza is a time-released formulation of metformin, an oral medication used to manage type 2 diabetes. Until recently, it was only available as a branded medication, but a number of other formulations of metformin are available as generics. Valeant Pharmaceuticals purchased Glumetza in 2015 and raised the price, increasing the plan cost for a 30-day supply increased from around \$550 to around \$4,000. During 3Q15, approximately 20 plan members were using Glumetza. After review by PBAC, a decision was made to exclude Glumetza and cover other forms of metformin for our members. Members currently using the medication were notified two months in advance.

### ***Drug Use Evaluation (DUE) Programs***

Quarterly drug utilization reviews are conducted to assure safe and effective utilization of prescription drugs by plan members. DUE programs look at past pharmacy claims to identify potential safety and utilization management issues in order to improve the quality of care and avoid potential complications of drug therapy. In some cases, the goal is to reduce drug utilization, thus reducing cost. In others, drugs are used to better manage health, increasing drug cost while improving overall health and reducing the need for medical intervention.

The university has three retrospective DUE programs: Opioid Overutilization, Asthma Management and Controlled Substances Overutilization. Physicians are notified via letter of any patients that have been identified using the prespecified criteria.

The Opioid Overutilization DUE Program identifies members receiving > 120mg morphine-equivalent doses (MED) per day of opiates for  $\geq 90$  consecutive days in the previous six months. Physician mailings were sent quarterly starting 1Q15. Quarterly outcomes reported success rates between 18% and 21%.

The Asthma Management Program identifies members with four or more claims for asthma rescue medications without medications to prevent asthma exacerbations over a 12-month timeframe. Claims data for asthma medications are analyzed annually in the second quarter. In 2015, 211 patients were identified as meeting the above criteria and letters were mailed. Reevaluating claims utilization from letters mailed in 2014 shows that 46% of the patients had added preventive medications to their treatment regime.

The Controlled Substances Overutilization Program identifies members filling 10 or more controlled substance prescriptions over a three-month time period. Approximately 75 members per quarter were identified as meeting these criteria.

## **Special Initiatives**

### ***Mail Order Pharmacy***

NoviXus Pharmacy Services, the university's mail order pharmacy provider, is the largest volume pharmacy for the plan. In 2015, 80,652 prescriptions (8.5% of total) were dispensed via mail order at a cost of \$12.53M, a 0.5% increase in volume and \$3.1M increase in cost over 2014. Members paid \$1.6M in copays at the mail pharmacy. NoviXus completed its fourth full year of service in 2015 and the agreement was extended for one year. A full mail order pharmacy RFP will be required in 2016.

Members consistently rate NoviXus as excellent. In 2015 over 16,893 customer calls were handled by NoviXus staff. The average speed to answer a phone call was 13.5 seconds. The majority of prescriptions are transmitted by e-prescribing. NoviXus dispensed 80,652 prescriptions in 2015 with most prescriptions requiring no intervention and 9,137 requiring intervention to clarify information from the patient or prescriber. The average turnaround time for a prescription filled at NoviXus is less than one day, even when intervention is required. Since NoviXus is located in Michigan, prescriptions arrive in the mail more quickly than with the university's previous mail order providers.

In 2015 the university continued a major communication plan developed by the UHR Communications group to increase voluntary use of mail order. Promotions are ongoing with print, home mailings, campus ads, electronic media, animated enrollment video, email, social media and campus presentations. A modest increase of new enrollments and prescriptions has occurred but far from the goal of doubling participation to 16% by the end of the year. In 2015, 5,770 benefits-eligible active employees were surveyed about the mail order program, with a 9.6% response rate (556 responses). Respondents reported a high level of awareness of the program. NoviXus users cited cost as the most important factor in where they fill prescriptions, while non-users reported valuing convenience more highly; they may perceive mail order as less convenient than retail. Based on the survey data and outcomes to date, the university may consider more aggressive promotions and targeting certain medications for savings.

### ***Medication Therapy Management***

In 2013, the UMHHC Patient Centered Medical Home pharmacist group was selected with data support from the College of Pharmacy faculty to provide Medication Therapy Management (MTM) and Comprehensive Medication Reviews (CMR) for drug plan members on a pilot basis. The intervention focuses on medication effectiveness, safety and cost with goals to improve medication adherence, control costs and determine whether MTM should be included as a standard operational component of quality prescription drug plan management for our members.

The pilot began with retirees, who are at greater risk for drug-related problems because they take a large number of medications, and was later expanded to include active employees. The pilot is in its third and final year of delivering services at nine large UMHHC health centers. To date, over 3,427 patient profiles have been reviewed, 1,557 patients have been contacted to participate in the program, and pharmacists in the program have completed 547 CMRs.

The patient completion rate for the program is one of the highest numbers reported in the literature, and patients report extremely high satisfaction rates. The College of Pharmacy is evaluating data for medication changes and associated impacts to be presented in the spring of 2016. In 2016, CMR services will also expand to include members on long-term disability, the group with the highest average prescription use and cost each year.

### ***Safe Drug Disposal Events***

Drug plan staff supported the U-M Campus-Wide Safe Drug Disposal working group and provided an incubator, publicity and communications for spring and fall drug "take back" days on the Ann Arbor campus. College of Pharmacy faculty and U-M Police Department community relations worked with The Great Lakes Clean Water Alliance and Village Apothecary to help pharmacy students collect and destroy a total of 169 pounds of unwanted medications during the two days, including 39 pounds of controlled substance drugs. The "take back" events take place biannually in April and September.

### ***E-Prescribing***

UMHHC physician e-prescribing was implemented in 2010 and continues to improve accuracy, efficiency, safety and member convenience. E-prescribing represents 61.7% of all claims in 2015, down slightly from 65.3% of claims in 2014.

## **2016 Priorities**

Major projects targeted by the drug plan for 2016 include:

1. Conduct an RFP on mail order pharmacy and market price check on specialty pharmacy.
2. Conduct an RFP on prior authorizations and appeals, outsourced from MedImpact, to improve responsiveness with customers and prescribers, enhance efficiency and reduce member disruption.
3. Establish the first prescription drug plan managed care pharmacy residency program.
4. Assist the Benefits Office Administration to rehire the Plan Manager position, with an expected August 2016 transition to begin cross-training.
5. Implement MTM expansion to include LTD members.
6. Conduct an eligibility audit of membership with MedImpact.
7. Revise the plan dashboard and required reporting for plan performance monitoring.
8. Prepare a presentation of cost containment options in the prescription drug plan for university leadership.
9. Continue to refine the analysis by Artemetrx of specialty prescription drug use managed under the medical plans and pharmacy plan for best value, administration and opportunities, and propose an action plan. The focus will be the engagement of coordinated efforts with the health plan pharmacy teams to discuss overlaps, criteria for use and opportunities.
10. Monitor mail pharmacy utilization and assess the effectiveness of the communication campaign to encourage the use of mail order and capture additional savings.
11. Revise the process for processing preferred network discounts for specialty drugs.
12. Conduct an analysis to determine the feasibility and benefits of moving from the current RDS subsidy payment to the EGWP PDP model.

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