HUMAN RESOURCES
BENEFITS OFFICE
UNIVERSITY OF MICHIGAN

2019 Prescription Drug Plan Annual Report
March 1, 2020

Executive Summary

Calendar year 2019 was the seventeenth year of operation for the university's self-administered prescription drug plan. In 2019, the pharmacy plan cost represented 25.7% of the university's $650M total spend on health benefit programs. Growth in membership, generic drug cost, specialty drugs and inflation contributed to a gross 6.5% increase in total drug cost in 2019, a decrease from the 16.0% increase seen in 2018. On a per-member basis, total drug cost increased 4.4% in 2019. Specialty drug spending continues to grow despite representing only 1.8% of all claims. Gross total cost for specialty drugs rose 14.8% (or 12.5% on a per-member basis) in 2019, representing 44.3% of total pharmacy costs, an increase of 3.2% over 2018.

The university has remained committed to controlling rising drug costs with sound, evidence-based formulary design. Additional clinical programs, utilization management strategies, and comprehensive class reviews have allowed the plan to keep overall growth less than seen in 2018. While the prescription drug plan will implement a new pharmacy benefit manager (PBM) in 2020, we anticipate minimal disruption and additional, high-value pharmacy services for our members. Going forward, the pharmacy benefit team will continue to leverage clinical expertise and innovative strategies to mitigate cost increases, improve member outcomes, and support university objectives. .

Report Contents

2019 Cost and Utilization Metrics

Key performance metrics based on an average 114,843 eligible members per month, a 2.02% increase in membership over 2018, are reported in Tables 1 and 2. Eligible membership has grown on average 2.7% per year for the last five years.

Table 1: Cost and Utilization Metrics, 2019

	All Claims		Non-Specialty		Specialty	
	Cost and Utilization	Change from 2018	Cost and Utilization	Change from 2018	Cost and Utilization	Change from 2018
Claim Volume	1,030,207	2.0%	1,011,161	2.0%	19,046	16.6%
Utilizing Members	87,901	0.5%	87,775	2.7%	2,676	16.8%
Total Drug Cost	$167,366,651	6.5%	$93,187,641	0.7%	$74,179,010	14.8%
Plan Cost	$135,480,717	6.4%	$79,785,432	-0.4%	$73,695,285	15.0%
Member Cost	$13,885,934	4.8%	$13,402,209	7.7%	$483,725	-11.6%
Percent Member Total Cost Share	8.3%	0.4%	14.4%	7.0%	0.7%	-0.2%
Total Drug Cost PMPM*	$121.45	4.4%	$67.62	-1.3%	$53.83	12.5%
Plan Cost PMPM	$111.37	4.3%	$57.89	-2.4%	$53.48	12.7%
Member Cost PMPM	$10.08	4.8%	$9.73	5.6%	$0.35	-13.4%
Average Number of Claims Per Utilizing Member Per Year	9.0	0.0%	11.5	-0.8%	7.1	0.0%
Average Day Supply Per Claim	49	2.0%	49	2.1%	32	0.0%

**PMPM = per (eligible) member per month*

Table 2: Tier Utilization, 2019

Drug Tier	Paid Claims	% Total Claims			% Plan Cost		
	2019	2019	2018	Change	2019	2018	Change
Tier 0 – $0 Copay	111,323	10.8%	11.2%	-0.4%	8.8% ($13.4.M)	11.9%	-3.2%
Tier 1 – Generics	830,443	80.6%	79.7%	0.9%	17.4% ($26.6M)	17.5%	-0.1%
Tier 2 – Preferred Brands	57,853	5.6%	6.1%	-0.4%	58.4% ($89.1M)	56.3%	2.1%
Tier 3 – Non-Preferred Brands	30,382	2.9%	3.1%	-0.2%	15.4% ($23.5M)	14.2%	1.2%

Note: Tier 0 represents generic and brand 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 (ACA) including contraceptive products for females. Cholesterol lowering statins were added to ACA $0 copay preventive care drugs in November 2017. Excludes 'paper' claims.

Plan Operations and Administration

Requests for Proposals

The university's request for proposal (RFP) for pharmacy benefit manager (PBM) services was released on April 8, 2019 to nationally recognized PBMs or health plans and proposals were received by May 6, 2019. The RFP release provided adequate time for a review, contracting and transition to a new vendor if needed. A national pharmacy consultant, Pharmaceutical Strategies Group (PSG) was employed to assist with development of the RFP, conduct financial and qualitative analysis of the RFP responses, participate in finalist interviews on-site, and make recommendations and presentations on the final selection.

The process involved pre-RFP interviews (8 vendors), a pre-bidders conference call (8 vendors), critical evaluation of RFP question responses (6 vendors), post RFP finalist interviews (4 vendors), and post RFP finalist capabilities demonstrations (2 vendors). After the comprehensive review of the proposals, the bid process was narrowed to one vendor finalist: MagellanRx Management, who presented the strongest combined financial, capabilities, flexibility and performance guarantee offer. MagellanRx Management personnel were interviewed by members of the Benefits Office Pharmacy Team, Pharmacy Benefits Advisory Committee Chair, Michigan Medicine Pharmacy, PSG and Procurement on several dates, followed by their providing of their best and final financial proposals and improvements in performance guarantees and other account and clinical areas important to the university.

MagellanRx Management was selected to be the university's new PBM in December 2019, effective July 1, 2020. The agreement is for thirty-six months, with the potential for two one-year extensions. The initial three-year term will cover over $600M in drug expenses, with total projected savings during this period of $40.4M, or -7.1% to the University over current pricing.

Regulatory Compliance

Since 2015, Truven Health Analytics has administered the Medicare Part D Retiree Drug Subsidy (RDS) for the drug plan. The Centers for Medicare and Medicaid Services (CMS) continues to pay this subsidy based on eligible claims. The plan received $4.9M from CMS in 2019.

The plan continues to be compliant with all Affordable Care Act (ACA) requirements. 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, use of statins for primary prevention of cardiovascular disease, aspirin, folic acid, iron, and other supplements for high-risk patients. Although not required by the ACA, the plan has historically also provided select insulin products at no out-of-pocket cost to members. Plan expenditures for the $0 tier copay products in 2019 were $13.3M, including over $1.9M in member copay relief.

The plan continues to actively monitor the legislative and regulatory landscape in order to be as prepared as possible to respond to any changes that may occur.

Cost Management

Plan Cost

A total of 1,030,207 prescriptions were dispensed at a total plan cost of $153.5M in 2019, a 4.32% increase PMPM from 2018. Plan costs by employee type are reported in Table 3. Long-term disability (LTD) participants represent only 0.9% of the plan member population.

Table 3: Plan Cost, 2019

	Plan Paid	Plan PMPM	PMPM Change from 2018	% of Plan Paid	Change in % Plan Paid from 2017
Overall	$153.5M	$111.37	4.32%		
Active Employees	$103.3M	$86.70	3.73%	67.3%	-0.4%
Retirees	$45.3M	$258.39	6.62%	29.5%	0.9%
LTD	$4.9M	$437.06	-3.97%	3.2%	-0.4%

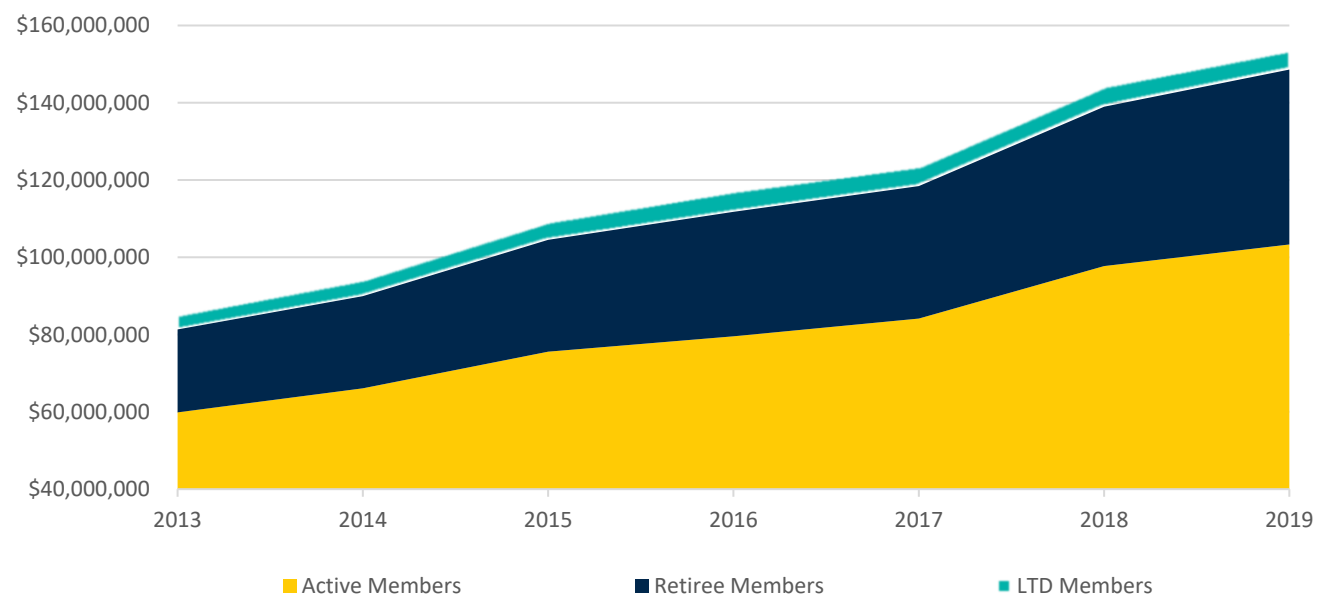

Figure 1: Plan spend across active members, retirees, and LTD members, 2013 – 2019.

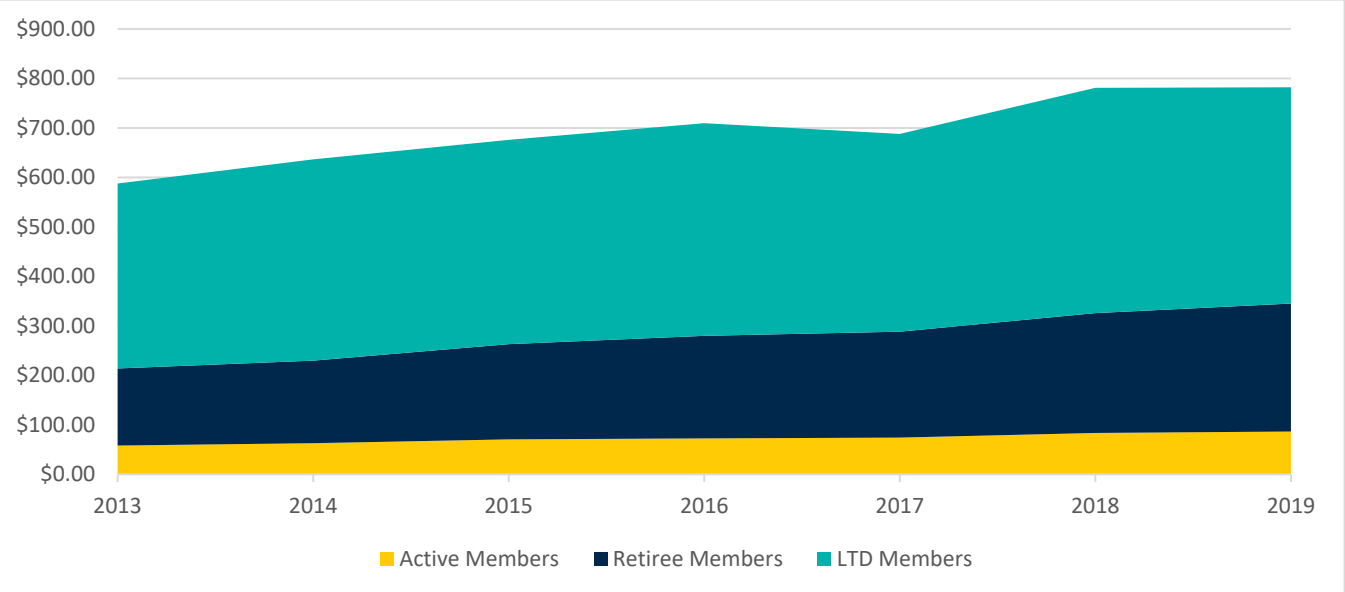

Figure 2: PMPM costs for active members, retirees, and LTD members, 2013 – 2019.

The average plan cost for a 30-day prescription increased 1.1%, from $90.19 in 2018 to $91.21 in 2019. The aggregate discount from Average Wholesale Price (AWP) for combined specialty, retail, and 90-day retail prescriptions was -56.0%; a one point decrease from 2018.

Price inflation is occurring with brands, as shown in the average ingredient cost, despite aggressive negotiated network discounts. The average ingredient cost of a single-source brand prescription increased by 26.52% in 2019 to an average cost of $1,220.65 per prescription. This increase was mainly driven by high-cost specialty drugs. The average ingredient cost of a multiple-source brand prescription decreased by -38.4% to an average cost of $418.06 per prescription. The average ingredient cost for a generic prescription increased by 8.38% to an average cost of $41.40 per prescription.

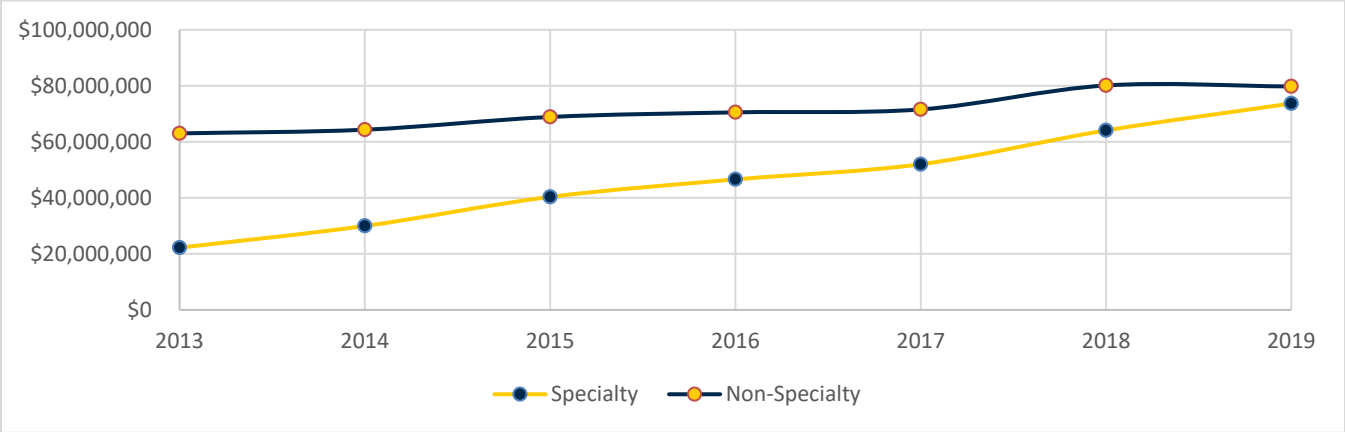

Figure 3: Plan spend on specialty and traditional prescription drug products, 2013 – 2019.

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 (Figure 4). Member cost share remained at 8.3% in 2019. On average, members paid $13.48 per prescription and the plan paid $148.98, up from $143.07 per prescription in 2018. Drug plan members paid $13.8M in total out-of-pocket cost, an increase of 7.0% from 2018. In comparison, the plan paid $153M on their behalf, an increase from $144M paid in 2018. The university continues to provide value to our members with cost share significantly lower than national values.

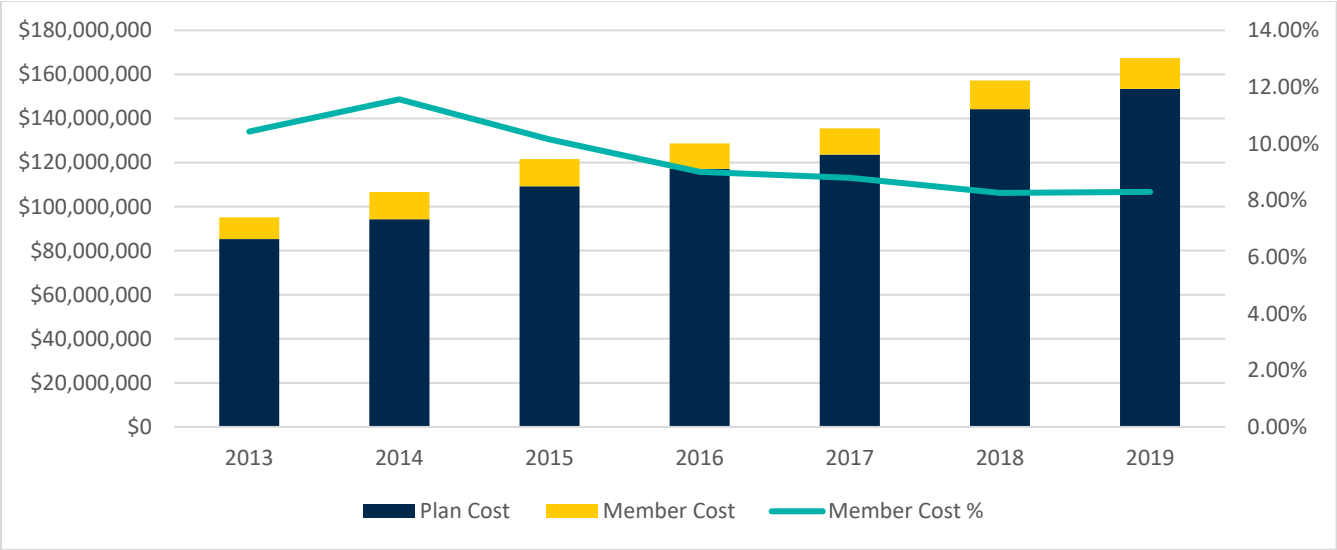

Figure 4: Member cost share, 2013 – 2019.

Table 4: Member Copays (30-Day Supply)

Drug Type	U-M Prescription Drug Plan	National Benchmark*
Generic	$10	$12.21
Preferred Brand	$20	$31.99
Non-Preferred Brand	$45	$57.12

**Source:2018 PBMI Trends in Drug Benefit Design*

Currently, all union groups have our standard copayment structure, except for the Michigan Nurses' Association, which currently has lower copays than other plan members.

Member Utilization

In 2019, 76.5% of eligible members utilized their drug plan benefit, an increase of 0.5% from 2018. The number of eligible members increased to 114,843, a 2.0% increase over the previous year. On average, an eligible member filled 9 prescriptions per year (the same as in 2018); 7.0 for active employees, 20.8 for retirees and 28.4 for long-term disability members. The average day supply per claim was 49, an increase of one from 2018.. When prescriptions are normalized to a 30-day supply our overall utilization rate increased 1.0%, from 14.2 30-day prescriptions per member in 2018 to 14.6 30-day prescriptions in 2019.

An on-going strategic goal for the plan is to increase the day supply percentage of maintenance drugs filled at 90-day retail and mail order for better patient adherence and reduced cost. Studies have shown that 90-day supply claims are associated with better patient adherence and the distribution channels of 90-day retail and mail order provide the best contracted rates. To improve our 90-day fill rate on maintenance drugs, we have engaged in strategic quarterly member lettering promotions. The percent of prescriptions filled at 90-day supplies in 2019 was 38.3%. This percentage has steadily increased since 2013 (Figure 5).

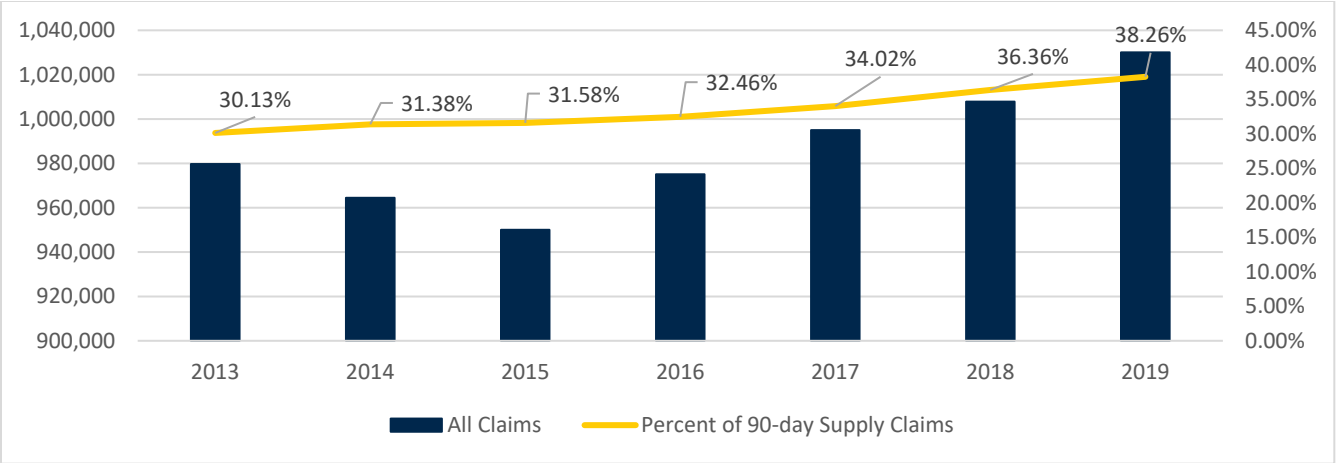

Figure 5: Percentage of 90-day supply claims filled at retail and mail order, 2013 – 2019.

Table 5: Top Trends Affecting Drug Costs, 2019

Positive (Mitigated Trend)	Negative (Increased Trend)
1. Generic dispensing rate improvement of 1.9% 2. Formulary management of high-cost generics 3. Medicare Retiree Drug Subsidy 4. Generic and brand drugs – high generic dispensing rate; less preferred and non-preferred brand use 5. Prior authorizations, step therapy and quantity limits, assuring appropriate use	1. Higher than typical price inflation 2. Addition of more high-cost specialty drugs, more indications, and increased utilization for specialty drugs 3. 2.0% increase in eligible membership and 0.5% increase in utilizing members 4. Fewer patent expirations impacting generic dispensing rate 5. Increased cost shift of member copays for $0 preventative drugs with the addition of statin medications

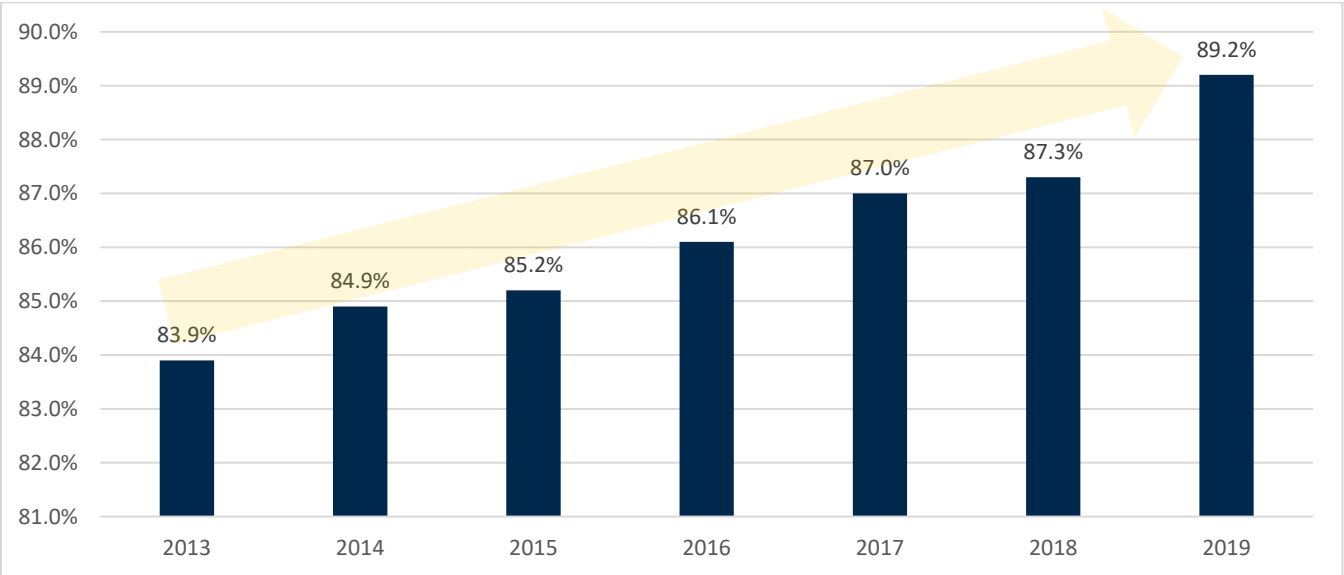

Figure 6: Generic fill rates, 2013 – 2019.

New Drug Impact

Of the 41 newly approved FDA drug entities in 2019, 26 fall under the pharmacy benefit, and 15 of these are considered specialty. New branded products approved in 2019 contributed $656K in plan spend (Table 6), while new to market generic entries yielded an estimated $1.9M in savings for the year (Table 7). Notable new generics include pregabalin (generic for Lyrica) and Fluticasone/Salmeterol (generic for Advair). These two generics have saved the plan $1.6M in 2019, and are expected to save over $3.3M annually.

Table 6: New branded products with plan utilization, 2019

Generic Name	Brand Name	Use	2019 Plan Spend
Elexacaftor/Tezacaftor/Ivacaft	Trikafta	Cystic Fibrosis	$418.8K
Risankizumab-Rzaa	Skyrizi	Plaque Psoriasis	$80.9K
Tafamidis	Vyndamax	Heart Disease	$53.9K
Fedratinib Dihydrochloride	Inrebic	Myelofibrosis	$40.7K
Alpelisib	Piqray	Breast Cancer	$22.6K
Solriamfetol Hcl	Sunosi	Excessive Daytime Sleepiness	$2.7K

Table 7: Top new generic products with plan utilization, 2019

Generic Name	Brand Name	Use	Estimated 2019 Savings
Fluticasone/Salmeterol	Advair Diskus	Asthma	$1.1M
Pregabalin	Lyrica	Neuropathy	$541K
Icatibant	Firazyr	HAE	$91K
Mesalamine	Delzicol	IBS	$31K
Febuxostat	Uloric	Hyperuricemia	$24K

Traditional Pharmacy

Top Therapeutic Classes

The top three traditional therapeutic classes for cost during 2019 included drugs to treat diabetes ($19.9M), asthma/COPD ($8.7M), and anticoagulation ($6.6M).).

The plan spend on diabetes drug treatments increased $948K (4.8%) from 2018, representing 13.2% of plan cost in 2019. While the plan paid $1.3M less for insulins, the GLP1, SGLT2, and DPP4 classes contributed an addition $2.2M in plan spend (Table 8).

Table 8: Top Diabetic Drug Classes Driving Cost, 2019

Diabetic Drug Class	2019 Cost	Unit Cost Inflation	Utilizers/100 Eligible	Utilizers
Insulins	-$1.3M	-8.3%	1.8	+1.9%
GLP-1 (Diabetes)	+$1.3M	+18.7%	0.6	+31.9%
SGLT2	+$681K	+5.0%	0.5	+37.2%
DPP4	+178K	+3.6%	0.6	+1.4%

In January 2019, the plan moved brand-name insulins with biosimilar or follow-on alternatives to a tiered position, encouraging members to use the lower-cost, therapeutically equivalent options such as insulin lispro (Admelog), and insulin glargine (Basaglar, Lusduna). This initiative resulted in approximately $3.6M savings to the university, in addition to allowing members to obtain these products with zero copay. Additional plan savings are expected in 2020 with the generic availability of insulin aspart (Novolog). Insulin aspart accounted for $3M in plan spend in 2019.

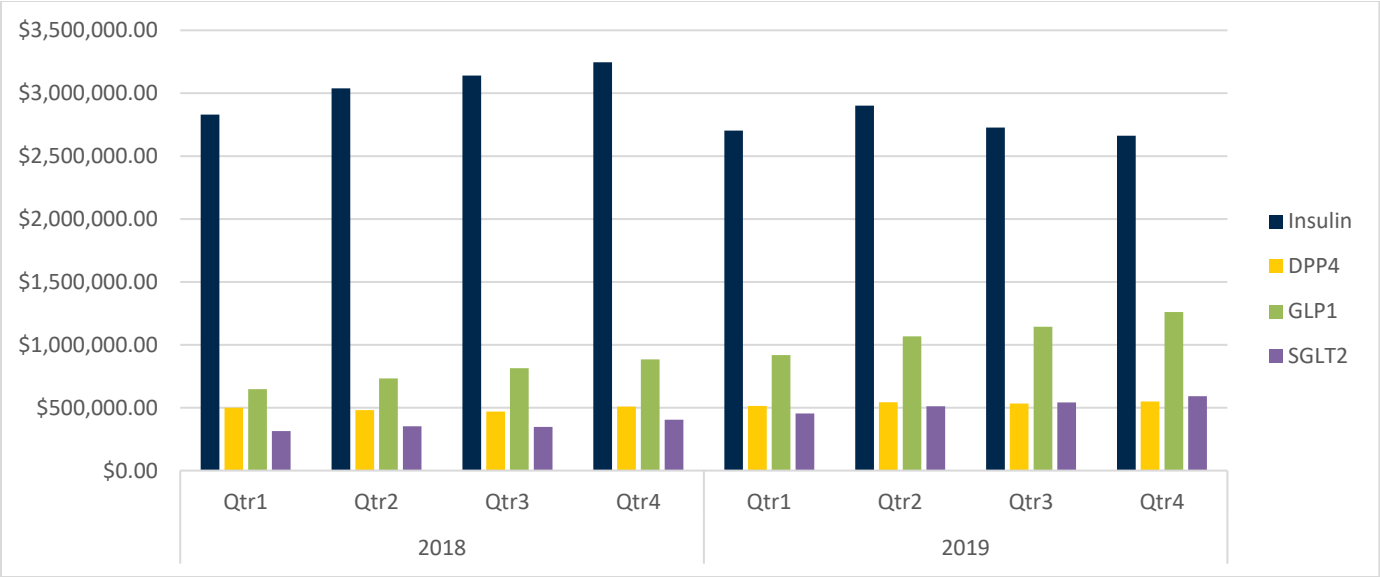

Figure 7: Plan spend on insulin, DPP4, GLP1, and SGLT2 products, 2018 – 2019.

The plan spend for asthma/COPD products decreased by $1M or 11% in 2019. This decrease was driven by the generic market entry of fluticasone/salmeterol inhalers, generics to AirDuo and Advair Diskus. As with the insulin class, further decreases in 2020 are expected with the generic launch of budesonide and formoterol (Symbicort).

Plan costs for anticoagulants increased $1.3M in 2019, or 25%, primarily due a 2% increase in claims and a 22% increase in cost per claim. This increase is largely attributed to utilization of apixaban (Eliquis), which contributed $3.8M to plan spend in 2019.

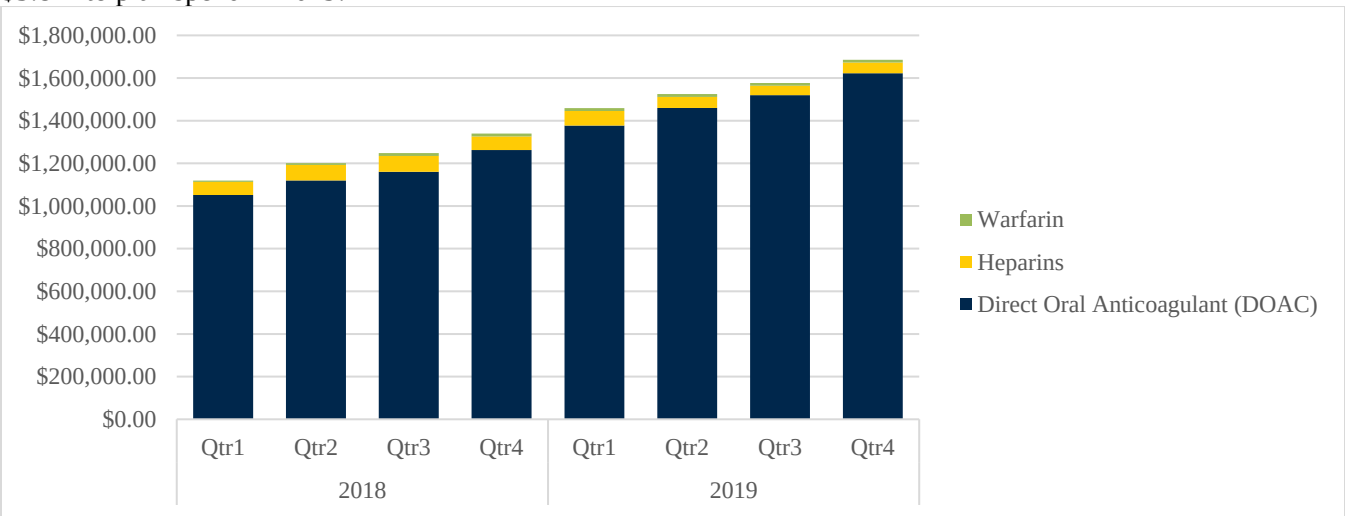

Figure 8: Plan utilization of anticoagulants by plan spend, 2018 – 2019.

Mail Order Pharmacy

NoviXus Pharmacy Services completed its eighth full year of service in 2019, and is the largest volume pharmacy for the plan. In 2019, 93,803 prescriptions (9.1% of total) were dispensed via mail order with a total drug cost of $15.9M, an increase of 7.1% in volume with no increase in spend from 2018.

Members consistently rate NoviXus as excellent. In 2019, 4,662 customer calls were handled by NoviXus staff. The average speed to answer a phone call was 15 seconds. The majority of prescriptions are transmitted by

e-prescribing. The average turnaround time for a prescription filled at NoviXus is less than one day, even when intervention is required. In many cases, members receive their refill the day after ordering their medication.

Specialty Pharmacy

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. In many cases, the new specialty products provide therapeutic advances in various clinical conditions among small groups of patients and are priced at a premium cost. Despite much promise for the emergence of biosimilars and lower-cost generics within this category, the majority of specialty drugs dispensed continue to be brand-name products with no generic equivalent or interchangeable biologic.

The University partners with Michigan Medicine's Specialty Pharmacy to provide high-touch, value added services for members in need of specialty pharmaceuticals. These services include, but are not limited to, personalized onboarding, financial assistance coordination, clinical pathways assessment and prescription verification, proactive refill outreach to all patients for adherence enhancement, and utilization of patient care monitoring platforms for clinical reassessment by highly trained pharmacist staff members. The Michigan Medicine Specialty Pharmacy was awarded URAC accreditation in 2019, a reflection of their commitment to quality, operational, and clinical excellence. Since 2013, the Michigan Medicine Specialty Pharmacy has processed specialty medications for members, with few exceptions for limited distribution drugs that are only fillable through manufacturer-designated pharmacies.

Specialty drugs represented only 1.8% of all claims in 2019, up from 1.6% in 2018, yet accounted for more than 44.4% of total drug cost, up from 41.1% in 2018. A total of 19,046 specialty drug claims were paid at a plan cost of $73.7M, a 19% increase in cost over 2018. The average ingredient cost of a specialty drug was $3,894.54 per prescription, with an average day-supply of 32.5 days.

Top Therapeutic Classes

The top three specialty therapeutic classes by cost during 2019 included drugs to treat inflammatory disorders ($31.8M), oncology ($15.7M), and human immunodeficiency virus (HIV) ($5.5M).

Anti-Inflammatory Agents

The self-administered, oral or injectable anti-inflammatory drugs used to treat disease states such as rheumatoid arthritis, Crohn's disease, ulcerative colitis, psoriatic arthritis and psoriasis continued to be the number one area of specialty drug expenditures in 2019. The plan spent $31.8M for these products, an increase of 16.8% compared to 2018. Utilization of these agents increased 8.1% in 2019, and the average prescription plan cost increased by 8.1%.

Oncology

Orally administered cancer medication was the next highest specialty drug class in plan cost.. Oncology drug spend increased 15.6% from $13.6M in 2018 to $15.7M in 2019. The three top oncology products in 2019 were lenalidomide (Revlimid, $3.5M), ibrutinib (Imbruvica, $1.7M) and omisertinib (Tagrisso, $1.3M).

Human Immunodeficiency Virus (HIV)

HIV remained the plan's third highest cost specialty disease state in 2019, with $5.5M in spend for HIV associated drug products. This represents a $400K, or 8.3%, increase over 2018 figures. Since 2017, the plan has had more members utilize pre-exposure prophylaxis (PrEP) therapy for HIV than were treated for active HIV infection. In June 2019, the US Preventative Services Task Force made an A-grade recommendation that all persons who are at high risk of HIV acquisition be treated with PrEP. Beginning in June 2020, the plan will cover emtricitabine/tenofovir (Truvada) for members with $0 copay. This benefit design change will help continue the plan's trend for PrEP utilization into 2020.

Cystic Fibrosis

While not one of the top three specialty classes, the cystic fibrosis transmembrane conductance regulator (CFTR) modulators have remained the fastest-growing drug class in terms of cost per treatment and will continue to grow in 2020. A novel CFTR product, elexacaftor/tezacaftor/ivacaftor (Trikafta), was approved by the FDA and added the plan's formulary in November 2019. The addition of Trikafta is anticipated to add $3.6M to the plan's overall spend in 2020, or an additional $2.54 per member per month.

Current and Future Specialty Strategies

Specialty pharmaceuticals continue to dominate the FDA approval landscape with more than half of the 2019 FDA approvals, covered under the pharmacy benefit at the University, meeting this designation. The high proportion of specialty approvals, and thus specialty claims, is a reality that appears to continue as we look into the 2020 pipeline and beyond. This trend continues to elicit creativity, collaboration and innovation within the prescription drug plan and among our partners. The plan is dedicated to managing these costs while continuing to maintain our commitment to provision of evidence-based access for our membership.

The university is currently working on several new, novel utilization management initiatives designed for sustainable health care cost while maintaining comprehensive coverage and access to care for our members. Several evaluations of the clinical and economic impact of plan coverage policies were completed and presented in 2019, and the plan will continue to investigate opportunities in tier strategy, value-and outcomes-based agreements, medical drug/pharmacy copay parity, new start wastage mitigation, oversight and management of specialty spend.

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 at Michigan Medicine. 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. Plan pharmacists attend the monthly Pharmacy and Therapeutic (P&T) Committee meetings and the Cancer Pharmacy Committee at Michigan Medicine, in addition to collaborating with specialists.

Plan pharmacists' professional development, networking, and continuing education activities include membership and conference attendance for Academy of Managed Care and Specialty Pharmacy (AMCP), Asembia, Pharmacy Benefit Management Institute (PBMI) and various preceptor conferences.

Drug Reviews, Indications and Utilization

The plan's clinical pharmacists review newly approved drugs and other changes each week to identify drugs that will require review by the Pharmacy Benefit Advisory Committee (PBAC). Formulary recommendations and clinical guidelines are presented to PBAC during monthly meetings. In 2019, the drug plan reviewed 80 drugs (FDA newly approved; previously FDA approved, but newly available in market; significant administrative dosage form changes) for formulary consideration.

In addition to new drug reviews, the team monitors the market for new approved indications and plan utilization to assess the appropriateness of use by plan members. In 2019, 22 drug prior authorization guidelines and utilization management changes were brought to PBAC for consideration.

The drug plan also conducts periodic reviews of various drug classes for the purpose of ensuring safe, appropriate, and cost effective utilization. These reviews incorporate professional input from the plan's clinical staff as well as subject matter experts from Michigan Medicine. In 2019, the plan developed and presented 11 drug class reviews to PBAC.

Drug Use Evaluation (DUE) Programs

Quarterly drug utilization reviews are conducted to assure safe and effective utilization of prescription drugs by plan members. The goal of these DUE programs is to improve the quality of care and avoid potential complications of drug therapy.

The university has three continuous retrospective DUE programs: Asthma Management, Opioid Overutilization, and Controlled Substances Overutilization. These programs look at past pharmacy claims to identify potential safety and utilization management issues. Physicians are notified via letter of any patients that have been identified using the pre-specified criteria.

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 each year during the second quarter. As of July 2019 2018, 182 patients were identified as meeting the above criteria and letters were mailed, an 6.5% increase from 2018. Of the members who received a letter, 46% went on to either require less rescue medication, or added a preventative medication to their regimen.

The Opioid Overutilization DUE Program identifies members receiving an average of greater than 90 mg morphine milligram equivalent (MME) doses per day of opiates in the previous six months. Physician mailings were sent quarterly. Quarterly outcomes reported an average success rate of 33.5% in 2019, where success was defined as the member not meeting criteria in the outcomes measurement period.

The Controlled Substances Overutilization Program identifies members filling 10 or more controlled substance prescriptions over a three-month period. The controlled substances overutilization program yielded an average 60% success rate. Similarly to the opioid overutilization program described above, success was defined as the member not meeting criteria in the outcomes measurement period.

Comprehensive Medication Reviews

For all members, except Medicare-eligible retires, Comprehensive Medication Reviews (CMR) is included in our medical plan rates. In 2013, the Michigan Medicine Medical Group (MMMG) was selected to provide CMR services for Medicare-eligible members on a pilot basis. The pilot intervention focused on medication effectiveness, safety and cost with goals to improve medication adherence, control costs and determine whether CMR should be included as a standard operational component of quality prescription drug plan management for our members.

The pilot program yielded an outstanding 46.0% CMR completion rate (only 6.8% of CMS Medicare Part D plans had completion rates greater than 40.0% in 2015). Successful interventions included improved disease control (57.3%), safety (27.5%), and cost (15.2%). The plan was able to save $2.12 for every $1 spent on the program. Participating members consistently rate the experience as very helpful, saying they are satisfied and would be very likely to recommend a CMR.

Active Switch Programs

In 2007 and 2008, during the "generic cliff" period, the Benefits Administration Office engaged the Michigan Medicine Pharmacy Innovations and Partnerships group (previously known as the Medical Outcomes Program) to conduct provider and member intervention switch programs to move members from brand drugs to lower cost, therapeutically equivalent, in-class generics. Based on the success of these previous switch programs, we completed contracting with Michigan Medicine for ongoing active switch programs as opportunities arise.

The first active switch program initiated under the new contract in late 2017 was for brand DPP-4 inhibitors to generic alogliptin for the treatment of diabetes. In 2018, this program was estimated to save the plan $0.17 PMPM. An abstract and poster presentation of this program was awarded a gold-ribbon at the 2019 AMCP Annual Meeting. Additional active switch programs initiated in 2018 included converting members to lower-cost insulin and fluoxetine products. In 2019, the Michigan Medicine pharmacists attempted to convert 215 members to lower-cost alternatives.

The plan is currently evaluating several future active switch program opportunities for 2020, including brand combination inhaled corticosteroid/long-acting beta agonist inhalers to generic fluticasone/salmeterol or budesonide/formoterol for COPD/asthma treatment and, pending generic availability of exenatide (Byetta) in 2020, a program focused on GLP-1 utilization.

E-Prescribing

Michigan Medicine physician e-prescribing was implemented in 2010 to improve accuracy, efficiency, safety and member convenience. Overall prescriptions submitted electronically represented 79.4% of all claims in 2019, up 2.3% from 77.2% in 2018. We continue to monitor the ongoing legislative activity around mandating specific drug classes or all prescriptions to be e-prescribed.

PGY-1 Managed Care Residency Program

In support of the University of Michigan's academic mission and key partnerships with the College of Pharmacy and Michigan Medicine, the Benefits Administration Office is in the fourth year of hosting an ASHP/ACMP-accredited Post-Graduate Year 1 (PGY1) Pharmacy Residency program. The residency program offers real-world learning in all aspects of pharmacy benefit management, including member support and communication, formulary management, and network and vendor management. This program underscores our commitment to education, training leaders and being a national leader in pharmacy benefits. All prior graduates of the program have successfully obtained roles within large health systems and managed care organizations.

2020 Priorities

Major projects targeted by the drug plan for 2020 include:

1. Successfully transition PBM services from MedImpact to MagellanRx on July 1, 2020.
2. Design and implement additional clinical programs and drug utilization reviews.
3. Continue evaluation of medical and pharmacy specialty drugs to identify opportunities for cost containment, cost share parity and improved management.
4. Evaluate the impact of adding a specialty copay tier level.
5. Evaluate medical drug to pharmacy copay parity.
6. Evaluate new start wastage mitigation strategies.

For additional information on the prescription drug plan, contact:

- Dawn Parsons, RPh, MBA, Plan Manager – dparsons@med.umich.edu
- Stephen Lott, PharmD, MS, CSP, Lead Clinical Pharmacist – stlott@med.umich.edu
- Michael Phalen, PharmD, CSP, Clinical Pharmacist Specialist – mjphalen@med.umich.edu