Maine's Public Universities

UNIVERSITY OF MAINE SYSTEM

Maine Prescription Drug Affordability Board Presentation

January 8, 2021

- Established in 1968
- Seven distinctive public universities
- Comprising 10 campuses and numerous centers

the common purpose is to provide quality higher education while delivering on its traditional tripartite mission of teaching, research, and public service

The University System

- UMS is self-insured
- Provides coverage to 4,300 active school employees, their families, and retirees
  - Retirees over age 65 are offered a choice of the fully insured group Medicare Advantage Plan (Aetna) or individual coverage on the AON Marketplace
- UMS contracts with CIGNA to provide comprehensive medical and pharmacy benefits
- Express Scripts, Inc (ESI) is the Pharmacy Benefits Manager

UMS: Role of Employee Health Plan Task Force (EHPTF)

2010 | UMS established a multi-stakeholder Task Force to address ongoing increases in health plan costs

EHPTF includes:

- Finance
- Human Resources
- Campus Presidents
- Leadership of all 5 unions (Faculty, Service & Maintenance, Police, Professional Staff and Administrative Staff)

- EHPTF has established Mission Statement and has common effort to address quality & cost of coverage through 4 pillars (plan design, health improvement, quality networks and communications/ engagement)
- Effectiveness of group's efforts are measured via a Scorecard
- Medical & Rx plan has consistently outperformed published trend

UMS : Health Plans

Traditional PPO plan

- Offering varies by cohort group and are collective bargained into union contracts

IRS Qualified High Deductible Plan (HDHP)

- Employees electing a HDHP receive a University contribution ($1,000 single/$2,000 family) into a Health Savings Account (HSA)

- Pharmacy benefits also vary by cohort group and are collectively bargained into the union contracts
- Although cost sharing varies by cohort group, the carrier (CIGNA) PBM (ESI), formulary and clinical management is consistent across all enrollees

UMS : Pharmacy Benefits

Cigna Medical Plan	Non-Rep	USCUM & UMPSA & Police	S&M Plan	AFUM	IRS Qualified HDHP
Annual Deductible	$250/$500	$250 / $500	None	$250 / $500	$1,500 / $3,000
Out-of-Pocket Max (Med)	$1,500 / $3,000	$1,500 / $3,000	$1,500 / $3,000	$1,500 / $3,000	$2,500 / $3,000
Out-of-Pocket Max (Rx)	$1,300 / $1,950	$1,300 / $1,950	$1,300 / $1,950	$1,300 / $1,950	Incl. in Medical
Rx Copays (Retail 30 days)	**Deductible does NOT apply**				**After Deductible**
Preferred Generic	$10	$10	$10	$5	10%
Generic	$10	$15	$15	$10	10%
Preferred Brand	$30	$25	$30	$25	10%
Non-Preferred Brand	$50	$40	$50	$40	10%
Specialty	$75	$40	$50	$40	10%

- All plans use CIGNA “Value Formulary”, with the exception of Service & Maintenance (S&M)
- All plans use full suite of Clinical Management programs (Prior Authorization, Step Therapy, Dose Optimization, Opiod Abuse Program, etc).
- 90-day supplies are available for 2-copays

Vendor Management

2018

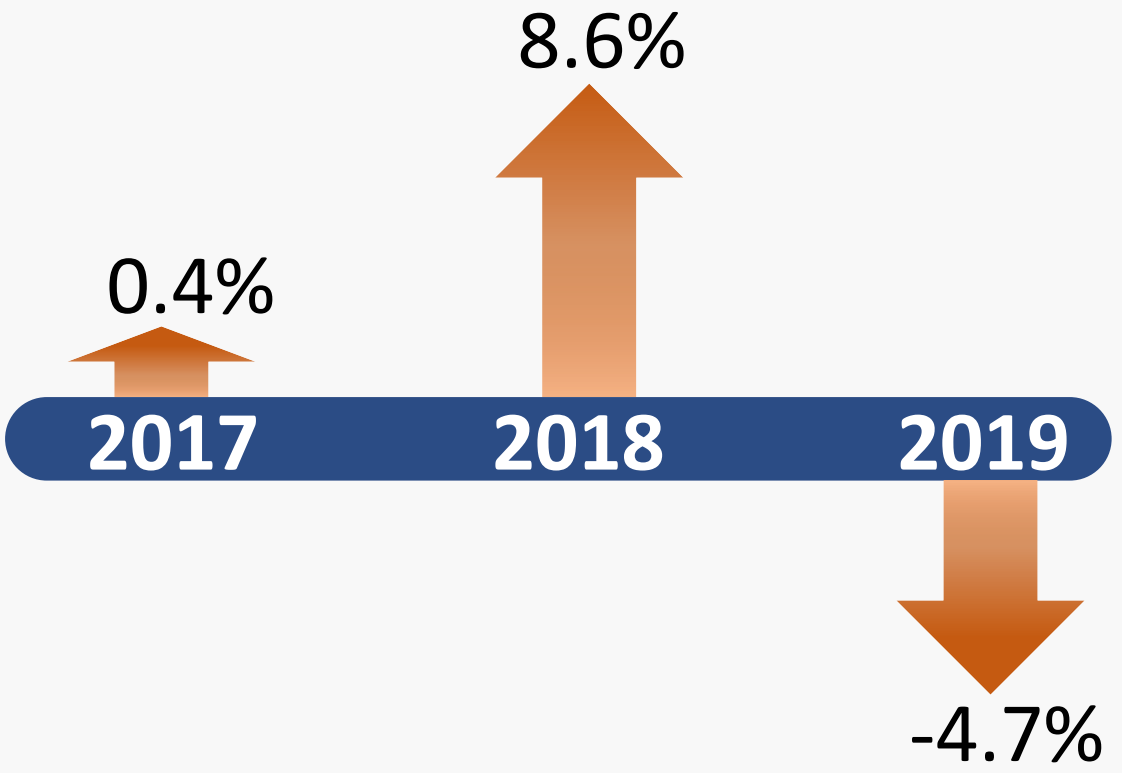
an extensive RFP was conducted for medical and pharmacy benefits

- new three-year contract effective 1/1/2019
- Improvements in terms secured mid-term to ensure contract stays competitive within a quickly evolving marketplace

- Advantages and efficiencies with an integrated medical and pharmacy program:
  - **Clinical first** – focusing on outcomes and patient experience
  - **Total view** – pharmacy claims occur both on the medical side and through the pharmacy benefit
  - Site of care optimization
  - Consistent clinical criteria across medical and pharmacy
- Medical program fees reduced due to “integration credits”
- Stop Loss coverage covers both Medical & Rx claims costs
  - Stop loss has added layer of protection to fully insulate UMS & employees from the costs from specific types of gene therapy (program is called EMBARC)

UMS: Plan Performance

Three Year Trend outperforms published norms

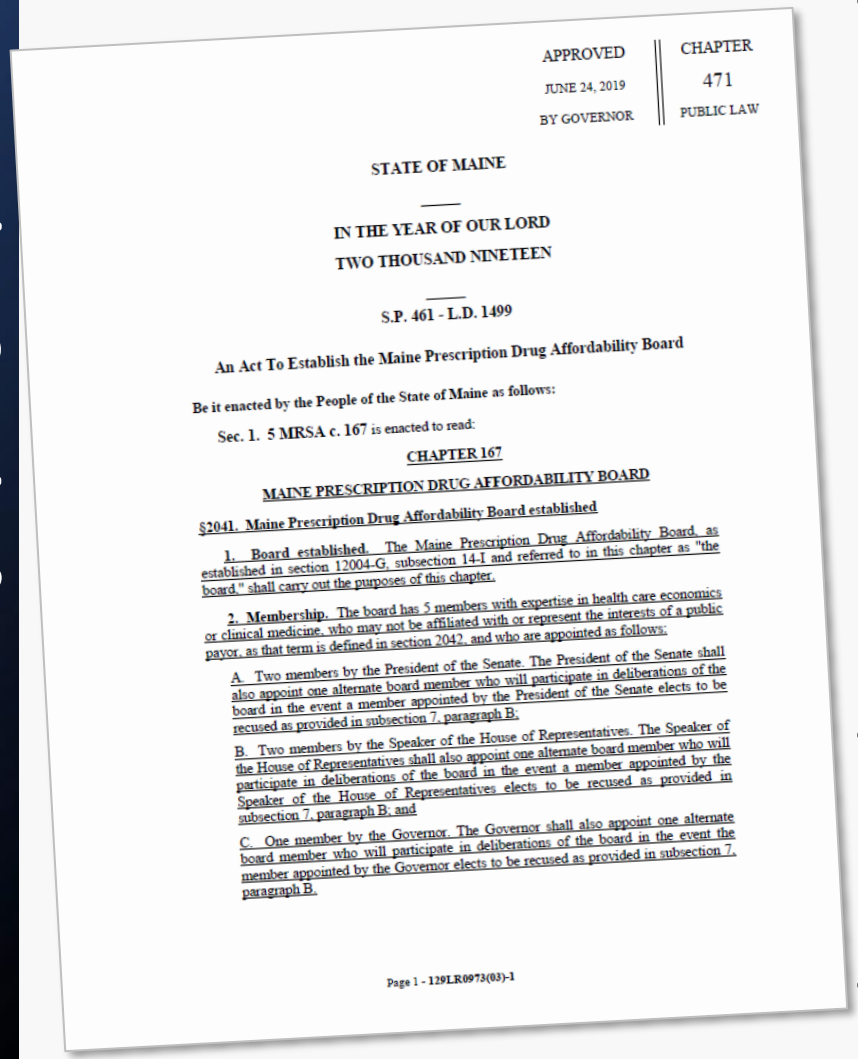


Generic Dispensing Rate	Mail / Retail 90	Medication Adherence
92%	**70%**	**91%**

Rx Rebates per Quarter

- Pharmacy contract terms are aggressively negotiated at each renewal term
- Rebates are based on brand name & specialty drug usage; have steadily increased over the course of the relationship
- UMS credits 100% of the rebates received back to the Plan

LD1499 -- MPDAB Powers & Responsibilities



APPROVED
JUNE 24, 2019
BY GOVERNOR

CHAPTER
471
PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD
TWO THOUSAND NINETEEN

S.P. 461 - L.D. 1499

An Act To Establish the Maine Prescription Drug Affordability Board

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 5 MRSA c. 167 is enacted to read:

CHAPTER 167

MAINE PRESCRIPTION DRUG AFFORDABILITY BOARD

§2041. Maine Prescription Drug Affordability Board established

1. Board established. The Maine Prescription Drug Affordability Board, as established in section 12004-G, subsection 14-I and referred to in this chapter as "the board," shall carry out the purposes of this chapter.

2. Membership. The board has 5 members with expertise in health care economics or clinical medicine, who may not be affiliated with or represent the interests of a public payor, as that term is defined in section 2042, and who are appointed as follows:

A. Two members by the President of the Senate. The President of the Senate shall also appoint one alternate board member who will participate in deliberations of the board in the event a member appointed by the President of the Senate elects to be recused as provided in subsection 7, paragraph B;

B. Two members by the Speaker of the House of Representatives. The Speaker of the House of Representatives shall also appoint one alternate board member who will participate in deliberations of the board in the event a member appointed by the Speaker of the House of Representatives elects to be recused as provided in subsection 7, paragraph B; and

C. One member by the Governor. The Governor shall also appoint one alternate board member who will participate in deliberations of the board in the event the member appointed by the Governor elects to be recused as provided in subsection 7, paragraph B.

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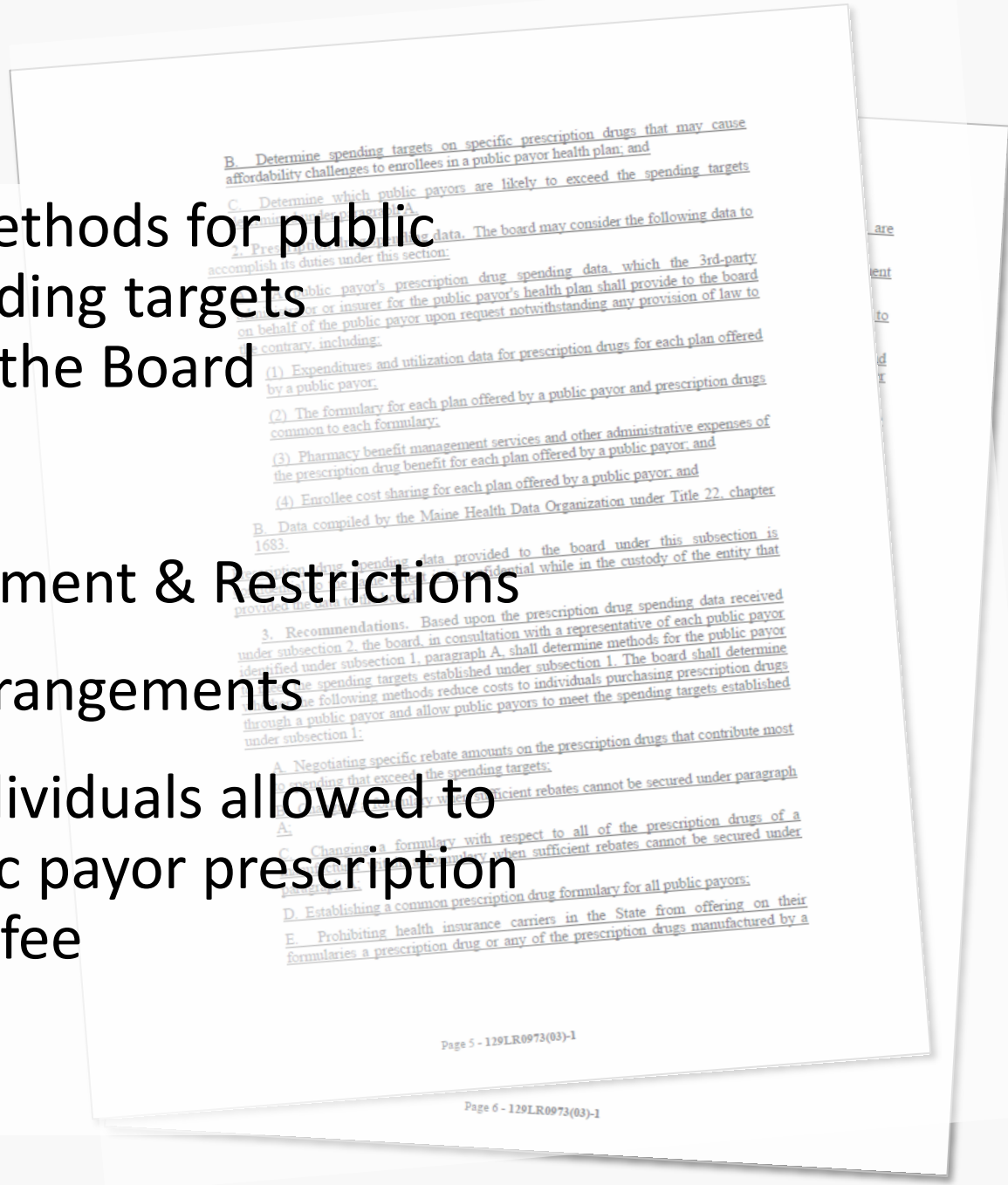
- Determine annual spending targets for prescription drugs purchased by public payors based on a 10-year rolling average of the medical care services component of the USDOL, Bureau of Labor Statistics CPI medical care services index plus a reasonable percentage for inflation and minus a spending target determined by the board for pharmacy savings;
- Determine spending targets on specific prescription drugs that may cause affordability challenges to enrollees;
- Determine which public payors are likely to exceed the spending targets

LD 1499 MPDAB Recommendations

LD1499 proposed methods for public payors to meet spending targets established through the Board

- Rebates
- Formulary Management & Restrictions
- Bulk Purchasing Arrangements
- Small Groups & Individuals allowed to participate in public payor prescription drug benefits for a fee
- Actuarial Services


B. Determine spending targets on specific prescription drugs that may cause affordability challenges to enrollees in a public payor health plan; and

C. Determine which public payors are likely to exceed the spending targets

2. Prescription drug data. The board may consider the following data to accomplish its duties under this section:

(1) Expenditures and utilization data for prescription drugs for each plan offered by a public payor;

(2) The formulary for each plan offered by a public payor and prescription drugs common to each formulary;

(3) Pharmacy benefit management services and other administrative expenses of the prescription drug benefit for each plan offered by a public payor; and

(4) Enrollee cost sharing for each plan offered by a public payor; and

B. Data compiled by the Maine Health Data Organization under Title 22, chapter 1683.

3. Recommendations. Based upon the prescription drug spending data received under subsection 2, the board, in consultation with a representative of each public payor identified under subsection 1, paragraph A, shall determine methods for the public payor to meet the spending targets established under subsection 1. The board shall determine whether the following methods reduce costs to individuals purchasing prescription drugs through a public payor and allow public payors to meet the spending targets established under subsection 1:

A. Negotiating specific rebate amounts on the prescription drugs that contribute most to spending that exceed the spending targets;

A;

C. Changing a formulary with respect to all of the prescription drugs of a manufacturer when sufficient rebates cannot be secured under paragraph

D. Establishing a common prescription drug formulary for all public payors;

E. Prohibiting health insurance carriers in the State from offering on their formularies a prescription drug or any of the prescription drugs manufactured by a

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UMS Challenges with Legislation

- Reality of union contracts
- Desire to be mindful of EHPTF : collaboration & effectiveness
- Impact on Medical Plan integration & pricing
- Impact on Stop Loss coverage
- Treatment of Rebates