

Public Employees Benefits Board
Meeting Minutes

June 7, 2018
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 3:45 p.m.

Members Present:

Sue Birch
Harry Bossi
Greg Devereux
Tim Barclay
Carol Dotlich
Yvonne Tate
Tom MacRobert
Myra Johnson

PEB Board Counsel:

Katy Hatfield

Call to Order

Sue Birch, Chair, called the meeting to order at 1:36 p.m.

Pursuant to RCW 42.30.110, the Board met this afternoon in Executive Session to consider proprietary or confidential non-published information related to the development, acquisition, or implementation of state purchased health care services as provided in RCW 41.05.026 when public knowledge regarding the discussion is likely to result in an adverse legal or financial consequence to the agency. The executive session began at 12:00 p.m. and concluded at 1:26 p.m. No action, as defined in RCW 42.30.020(3), was taken during Executive Session.

Sufficient members were present to allow a quorum. Board and audience self-introductions followed.

Meeting Overview

Dave Iseminger, Director, Employees and Retirees Benefits Division, provided an overview of the agenda.

Follow-up Questions from Prior Meetings

Dave Iseminger: I have information from five questions that were asked at the April 25 meeting. The first two are related to the deferral rule for retiree coverage. At the April meeting, Barb Scott presented information about ChampVA because

of requests and information in public comment that was provided to the Board earlier this year. In presenting that information, the Board had a question about how many members have deferred coverage and historically accessed that coverage rule. I can't provide you with numbers today. The Pay1 System we use does not have an indicator to track when an individual defers. When an individual defers coverages, they submit their form indicating they intend to defer. We do not create an account for them in Pay1 until they come back and enroll in coverage. There is not an indicator in our system to tell us they came back from deferral status. The only way we could provide numbers at this point is if we did a manual review of all accounts and the paperwork within the system. Automatically tracking this is something we're thinking about as we replace our system going forward. When the deferral rule was created in 2001, the system wasn't set up to be able to track it that way. Our administration over the last 17 years doesn't afford us a way to give you that type of information.

The second piece related to Slide 4 in Barb Scott's April 25 presentation that went through the different ways an individual can go through the deferral process. There was a Board question about which options are one-time opportunities and which ones can happen more than one time.

The first one is an individual able to defer because they have employer-based group medical coverage as an employee or a dependent of another employee. If I'm a retiree enrolling on my spouse's employer-sponsored plan, that's a multiple trip ticket. You can do that many times. You can come in and out under the deferral rule through PEBB retiree coverage with other employer-sponsored insurance or group medical insurance.

The second deferral policy relates to federal retiree medical plans such as Tricare. This is a one-time ability to return from deferral status and enroll in PEBB medical plans.

The third opportunity is if you're enrolled in Medicare and Medicaid and come back into PEBB retiree coverage. That is as many times as the circumstances present themselves. That can happen multiple times allowing someone into and out of deferral status.

The fourth one is a reminder that individuals who are enrolling in Health Benefit Exchange coverage have a one-time opportunity to come back into PEBB retiree coverage after having gone to the Exchange.

At our next Board meeting, Barb will bring back resolutions related to ChampVA. Any questions about the two I presented on first? Because those are deferral related and I'm going to shift topics.

The next two questions related to a presentation on the Centers of Excellence (COE) bundled payment program, which is the payment program for total joint knee and hip replacement (TJR). One question asked about the total spend for TJR for both non-Centers of Excellence and Centers of Excellence compared to

prior years. According to the data, we've actually seen an increase in TJRs in 2017. It's 48 more than in the prior three-year average. The total spend has also increased along with the utilization increase. The differential and average cost between 2017 COE and non-COE was \$25,000 compared to \$32,000. If the additional 48 TJRs had been performed in the non-COE under those rates, the total TJR spend would have been \$22.6 million instead of \$21.9 million.

The second question was about the average out-of-pocket cost for total joint replacement in the Medicare setting. The average between 2014 and 2017 was \$883.12. In 2017, we actually saw that figure drop a little from the prior years to around \$828.00.

The last question was how many Medicare members are in the Uniform Medical Plan. As of May 2018, there were approximately 40,000 subscribers and 53,000 members in the Uniform Medical Plan. The total Medicare population is about 67,000 subscribers and 93,000 members. For non-Medicare UMP, there are about 3,500 subscribers with 6,000 members. The total non-Medicare retiree population is about 5,600 subscribers and 9,400 members.

UMP Value Formulary Follow-up and Proposed Resolution

Ryan Pistoresi, Assistant Chief Pharmacy Officer, Health Care Authority. I will follow-up on questions from the May 21 meeting. Slide 3 and Slide 4 defines the terms "medically necessary" and "clinically appropriate." The Board asked for clarification.

Slide 3 defines "medically necessary," which is derived from the 2018 Certificate of Coverage (COC).

Sue Birch: The last state on the Slide 3 is important. *"The fact that a physician or other provider prescribes, orders, recommends, or approves a service or supply, drug, or drug dose does not, in itself, make it medically necessary."* I think it's important to call that out.

Ryan Pistoresi: Thank you for highlighting that. Slide 4 defines "clinically appropriate." This is not a defined term in the Certificate of Coverage. You won't find "clinically appropriate" used. However, the definition on Slide 4 is used in the Tier 3 exception process. When designing the value formulary, we looked at how we could use existing functions of the UMP pharmacy benefit in this formulary. We looked at the existing Tier 3 exception process for grandfathering and thought that could carry over. Section A is verifying all preferred therapeutic alternatives for a medication failed to produce a therapeutic response and Section B is all preferred therapeutic alternatives provide an adverse event or are otherwise intolerable.

Slide 5 responds to the question of the Tier 3 exception process and why many requests are denied. Moda Health indicated most denials are because the members have not tried the preferred medications. If members step directly into the non-preferred drug, they don't qualify for the exception process. They don't

meet the criteria for a Tier 3 exception and will be directed to take the preferred medications.

A member will also be denied if they don't submit the required documentation that the preferred medications fail to produce a response. For example, if the patient does not take a medication for the anticipated duration to see a response or if they don't titrate up to the correct dose. If someone is starting on Simvastatin, five milligrams, it's not that Simvastatin doesn't work, you need to titrate up until you can find an effective dose. If you reach the maximum dose and it's not effective, you can then switch to another medication.

Carol Dotlich: I have a question about the clinically appropriate slide. Can you define for me what "all preferred therapeutic alternatives" means?

Ryan Pistoresi: Yes. All preferred therapeutic alternatives are all of the drugs in the Value Tier, Tier 1, or Tier 2 within that drug class or drug subclass. For example, for GOP1 agonists, the preferred medication is Byetta. In that class, there is one preferred drug. If someone uses Byetta and either has an intolerance to the medication or it does not produce a therapeutic effect, the member meet the definition of clinically appropriate. In other drug, classes there may be more medications.

Carol Dotlich: What if there are seven different drugs in the Value Tier for a condition that my doctor prescribed a more expensive drug. Do I have to try seven different brands of the same thing?

Ryan Pistoresi: Yes, if they're all in the same subclass.

Dave Iseminger: Ryan, in the current Value Tier, which is different than the value formulary, are there lots of drug classes that have a plethora of drugs or does the Value Tier tend to have a fewer number of drugs and drug classes?

Ryan Pistoresi: Drugs currently on the Value Tier are somewhat limited. For antidepressants, I believe there are three drugs in the Value Tier. In the same antidepressant class, we also have drugs that are Tier 1, Tier 2, and Tier 3. We've identified a couple to be very cost effective. They are in the Value Tier to promote access and adherence, but there are others placed at Tier 1 and Tier 2.

Donna Sullivan, Chief Pharmacy Officer, Health Care Authority. Back to Carol's comment, "Do I have to try seven drugs of the same thing?" To clarify, we won't make you go back and try the same drug over again if you've already tried it. But if there are seven unique drugs within the class, you would have to take those seven unique drugs before you would be approved for the non-preferred. I want to make sure you aren't thinking we would make you take the same drug seven different times. There are five hydrochlorothiazide for diuretics on the market and five manufacturers. We wouldn't make you take each one of those manufacturers to get the branded diuretic.

Carol Dotlich: That was my question.

Tom MacRobert: In our past conversations, we've talked about Tier 1, Tier 2, and Tier 3 drugs. I have not seen Value Tier before. Are you referring to a different class of drugs? We still have Tier 1, Tier 2, and Tier 3, and Value Tier?

Ryan Pistoresi: Yes. In the UMP formulary, there are the Value Tier, Tier 1, Tier 2, and Tier 3.

Dave Iseminger: To clarify, Tom, I think we had Value Tier in our presentations but there's so many presentations between two Boards at this point, I can't remember what words are in every presentation.

Ryan Pistoresi: There are currently four tiers, as well as preventive medications like birth control, which is at a zero dollar cost-share to members.

Dave Iseminger: That's really five tiers: Preventive, Value, 1, 2, and 3. There already exists a Value Tier. Ryan, will you describe what the Value Tier in the current formulary means just to reset for the Board?

Ryan Pistoresi: The drugs in the Value Tier have been identified as very cost effective drugs. The cost-share for that is set at 5% for the member with a \$10 maximum for a 30-day supply. For Tier 1, the cost-share is 10% up to \$25 for a 30-day supply.

Dave Iseminger: Ryan, just to confirm, the Value Tier already exists today as part of the formulary the Board has previously approved. What we're talking about with the value formulary which unfortunately has the same word "value," does not change anything about the Value Tier.

Ryan Pistoresi: Yes, under the proposed value formulary, the Value Tier would still exist.

Tom MacRobert: I have another question from what Carol was talking about. If my doctor decided I should be taking Lyrica, what Tier would that be?

Ryan Pistoresi: Lyrica, I believe, is set at Tier 2 because it is a single-source brand medication.

Tom MacRobert: So is there a Tier 3 equivalent, a Tier 1 equivalent, and a Value Tier equivalent to Lyrica?

Ryan Pistoresi: For Lyrica, since it is a single-source brand, there are no generic alternatives. It is set at Tier 2. Within a drug class to treat the condition that Lyrica treats, there could be a Value Tier or a Tier 1 alternative. For example, Gabapentin has a similar mechanism of action and is a Tier 1 alternative. That could be used in place of Gabapentin if that's appropriate for your condition.

Tom MacRobert: If my doctor prescribes Lyrica, would I then have to try Gabapentin first before I took Lyrica, or would I be covered because it's a Tier 2 drug?

Ryan Pistoresi: I would have to check to see how Lyrica is covered, but for this example, since it is a Tier 2 drug, you could pay for it out of pocket. You don't have to necessarily step through Gabapentin for that medication.

Dave Iseminger: To level set, Ryan, because the value formulary principles we're talking about are addressing the differences between Tier 2 and Tier 3. The exception process gets you from Tier 3 to Tier 2 cost-shares. But because in this scenario, there is no Tier 3 piece for Lyrica, there is no Tier 3 exception scenario to talk about. Is that right?

Ryan Pistoresi: Yes. Slide 6 responds to the question about whether a physician or pharmacist reviews the pharmacy cases for UMP. I was able to confirm that it is a doctor of pharmacy, a PharmD, who reviews the pharmacy cases. These are the prior authorizations, the Tier 3 exceptions, and appeals. These licensed pharmacists are able to work in collaboration with physicians, either medical directors or specialists, on some of these cases. If a pharmacist receives a very complex chemotherapy regimen they are not sure of, they can consult with an oncologist in order to get clarification before making a decision.

Carol Dotlich: I have to take you back again to the decline clinically appropriate slide. I'm looking at part B and the language says, "including the required number of manufacturers of the same generic drug." That sounds like if Johnson and Johnson made furniture wax, some other company made furniture wax, and another company made different furniture wax, I would have to try all of those furniture waxes from different manufacturers before we could agree that furniture wax is not good for me. Am I misunderstanding the language?

Donna Sullivan: You're reading it correctly. But there's a particular situation when that language actually applies. We have some very high cost medications, like Fortamet, which is metformin product. It's an extended release product and it's upwards around \$30 a tablet. There are generics. There's also a drug called Glucophage XR, which is also extended release metformin and there's a generic to that drug. The generic drugs are less than \$1 per tablet. We have created a way to say you can't get Fortamet unless you try five generic manufacturers of another extended release Metformin and then it did not work or you could not tolerate that product.

Ryan Pistoresi: Slide 7 responds to the question of how many UMP members are affected by the inequity issue. Unfortunately, we are not able to determine the exact number of members because we would need to review their electronic medical records to determine how they may fit into this process. We have provided an estimate based on some of our numbers. There are approximately 47,000 UMP members using Tier 3 drugs. If we applied the Tier 3 exception approval process and we assume in this general population, if it's similar to the

population that applied for the Tier 3 exceptions, then that could be an anticipated 14,500 members. However, it's worth noting that only about 3.6% of UMP members using Tier 3 drugs have applied for that exception. This is a limited subset of members using Tier 3 drugs who have applied for this process and an even smaller amount who were granted the exception. It's challenging for us to determine what type of impact the Tier 3 exception process would have on this member population.

Slide 8 is a follow-up to Greg's question about the non-Medicare numbers. The next three slides are the 12 drug classes presented at the April 25 meeting, however, we've expanded this to include the non-Medicare numbers as well as a third column with a total, so summing both the Medicare and the non-Medicare numbers. In Option 2A we would grandfather all Tier 3 drug users in at Tier 2. The Option 2B scenario is if we grandfathered all existing Tier 3 users, and if they applied for an exception similar to the Tier 3 exception process, they could pay at a Tier 2 cost-share. Option 2C is if we did not grandfather any members and required them all to go through the request process.

It's also worth noting that the numbers in Options 2B and 2C are estimates based on the anticipated number of requests, approvals, and appeals that UMP would have. These numbers could increase and the cost avoidance shown would decrease. If the amount of requests and approvals begins to approach 100%, those cost avoidances would become more similar to what is in Option 2A. In the event it was 100%, it would actually be more costly to the plan because the cost avoidance would be the same as Option 2A, but the administrative cost of the requests and appeals would outweigh what would be achieved in Option 2A.

Carol Dotlich: I need you to repeat what you said about 2B.

Ryan Pistorosi: Option 2B is if we grandfather in the existing users but they continue to pay the same cost-share they currently pay. In this situation, members new to the plan who may be stepping into Tier 3 would not be able to use the Tier 3 drugs until they use the preferred products, whereas existing members would be grandfathered on their current medications and continue to pay the same cost-share tier.

Dave Iseminger: I believe the recommendation put forward in the draft proposal in May, and at this meeting, is really rooted in Option 2A. I want to make sure we're clear as to where the proposal comes from and where the primary conversation has been. We're still giving you the thoroughness of what has been provided all along for both the non-Medicare numbers, per Greg's question. We started this journey describing a wide range of options. We've been trying to hone in to give you our official recommendation, honing in on Option 2A.

Ryan Pistorosi: In the tables, the red numbers with the parentheses are negative numbers and the black are positive numbers.

Sue Birch: The red actually is cost avoidance since it's a deficit?

Ryan Pistorosi: Increases the plan cost.

Sue Birch: So just a reminder, the numbers in red actually drive --

Ryan Pistorosi: Drive costs up for the plan. If you look at that top one, you see Ophthalmologic in 2A would increase the plan costs \$312,000 in 2019 and \$136,000 in 2020, to orient you about how this table is presented.

Slide 11 responds to the question of what drug classes would be included in the value formulary? We are still in the process of gathering our current drug spend and utilization. As I mentioned at the last meeting, the model is based on 2017 drug usage and drug spend. This is continuing to change as we approach what the value formulary may be for 2019. Throughout this year, new drugs were approved, and new generics entered the market, which changes the dynamics of the existing drug classes. For example, in the GOP1 agonist class mentioned earlier, the preferred product will be going generic. We are evaluating this to see what this does to management of this drug class and how it would affect the value formulary. We continue monitoring the plan spend and utilization.

Bullet 3. HCA would manage the formulary and direct members to the preferred products. July of each year, HCA will determine which drug classes will be in the value formulary the next plan year. The likely drug classes for the value formulary in 2019 are diabetes, cholesterol, beta-blockers, androgens, blood pressure, antidepressants, psychotherapeutic/neurological, and Parkinson's disease. If you look at Slides 8-10, the twelve drug classes are listed and they have smaller member impact, but have cost avoidance over the two-year period.

Slide 12 discusses members' cost-share. The value formulary has the potential to reduce member cost-share by taking members currently using Tier 3 drugs and changing to a Tier 2 cost-share. The members paying for these drugs could see a reduction in their out-of-pocket costs, especially if they switched to a Value Tier drug, Tier 1, or Tier 2 drug. New members granted appeals would pay a Tier 2 cost-share and would have reduced out-of-pocket costs.

Bullet 2 is an example of what those reduced costs would be, going from a 50% cost-share to a 30%, with a maximum of \$75 per 30-day supply.

Slide 13 responds to a question on the 2013 analysis of capping the Tier 3 cost-share for members. As I mentioned on the last slide, the patients on Tier 3 traditional drugs pay 50% with no cap. We performed an analysis in 2013 about what this would do to the plan. According to our analysis, the cap shifts the cost from the members to the plan. It really only benefits the members using Tier 3 drugs that don't hit the maximum \$2,000 out-of-pocket per year. To help illustrate, a \$150 cap on a Tier 3 drug equates to about \$1,800 per year. If they're spending about \$200 more on other drugs, they will hit the out-of-pocket maximum. This does not impact their overall out-of-pocket costs during the plan year.

Slide 14 was a question about which drug classes have copay coupons. On my review, every drug class that has a single-source or a multi-source brand has copay coupons or other patient assistance programs available.

Slide 15. At the May 21 meeting, I made the comment that the Consortium went into automatic negotiations as a result of the third party audit, showing that the rates were outperforming the contract. A question was asked as to when the new rates go into effect? I was able to confirm the rates went into effect January 1, 2018.

Slide 17 is a reminder of the principles for designing the value formulary. We focused on the drug classes that have cost savings without reducing the quality of care to members, to make a difference to the premiums without sacrificing care, to grandfather members who have used these medications for a long time or who are in refill-protected drug classes.

Slide 18 is the crosswalk to help bridge information from the January 2018 Retreat to the April and May meetings.

Slides 19 and 20 are the proposed policy resolution PEBB 2018-01 - Value Formulary. Some of the language was updated to clarify the concept of grandfathering, specifically in the third and fourth clauses. These two clauses were updated based on discussions at the May 21 Board Meeting. The updates do not change the intent of what was proposed in May.

Dave Iseminger: Typically, when we bring resolutions to the Board, we bring one proposed resolution and ask you to take action at the next meeting. You've seen us working on the iterative process of this one longer because of the nature of the discussion with the Board. This is the official proposal and now we're back in synch with our standard process for presenting resolutions. This is the proposal we will ask you to take action on at the next Board meeting. It's important that you do take action at that next Board meeting regardless of the outcome. That will enable us to finalize the rate process in July. The goal for the June 20 meeting is to be able to implement some sort of value formulary for the 2019 plan year. If you don't pass the resolution that is equally important information for the rate build process.

Myra Johnson: Ryan, thank you for this presentation. Can we go back to Slides 8, 9, and 10? I have one question but I think it's embedded a couple of times. For example, under the diabetes Option 2A, for cost avoidance in 2019, it's \$330,000 in the red, which would end up being a higher premium, correct?

Ryan Pistoresi: Not necessarily a higher premium. It would increase the plan cost \$330,000 for that year and shift into the positive for the plan, so cost avoidance, in 2020.

Myra Johnson: Why such a big change?

Ryan Pistori: What's interesting about the diabetes class is the high utilization in terms of some of the non-preferred drugs. If you look at how we structured the list, it's ordered from the highest member impact to the lowest member impact. The twelve drug classes are ordered by the amount of members using the Tier 3 drugs. The diabetes class is the second most prevalent of the non-preferred drug usage. There are many users using these Tier 3 drugs so there will be a high impact in the cost shift between them. Diabetes is also the highest drug spend class for UMP, traditional drug class. This has the highest cost impact and the highest per member per month (PMPM) for the plan of all the traditional drug classes. We identified this as an opportunity to save the plan money in future years by shifting to the value formulary because there's a lot of this utilization on some of the higher cost, lower value non-preferred drugs. If we're able to direct the member utilization to the preferred lower cost, higher value drugs, we identified there would be that cost savings. In the 2A scenario, we would be grandfathering the existing users on those drugs and shifting the focus on the utilization for future years.

Tim Barclay: Can I throw out an alternative? As I look at the numbers you've provided, I can understand the desire to offer grandfathering for the 47,000 people using the Tier 3 drugs we're talking about making ineligible. That seems very disruptive to me not offering a grandfathering opportunity. At the same time, by your own estimation, 69% of those people, which I think is also optimistic, it's probably higher, would not be eligible for the exception process for the Tier 2 copays. It seems like a substantial price to pay to lower the copays for those 32,000 people for no reason to solve a problem that might exist for people who have not gone through the exception process.

I'm wondering if as an alternative to the proposal you suggested, we offer grandfathering without the copay reduction, still allow the exception process, and do a better job of communicating its availability to people, thereby putting us in the 2B scenario instead of the 2A scenario, whereby we are not directly disrupting anybody's care. We're also not spending a huge amount of state money to accommodate a lack of communication on the exception process. It would also allow us to put additional drug classes into the value formulary, such as the ophthalmologic category, which would then produce savings in both years for the state as well as correcting a problem.

For example, in diabetes, where even two years out, if I read the numbers correctly, the proposal to use 2A would cost the state a half a million dollars, aggregating 2019 and 2020 together versus saving a million and a half. It's a \$2 million swing in that drug class alone to essentially not give away copays to people who have not followed the process of testing feasible drug alternatives. I'm wondering if an alternative proposal for the Board to consider at the next Board meeting would be one that mimics category 2B instead of category 2A.

Donna Sullivan: I want to clarify a misnomer that we probably didn't do a good job of discussing previously. When we talk about grandfathering, there are certain drug classes where we will grandfather a person indefinitely. We also use the

term "grandfathering" when we're going to give them just three to six months to switch to a preferred drug. What we didn't talk about previously was when we would grandfather people forever and when we would grandfather them for a short period of time so they could engage with their provider and talk about the alternatives and then decide whether or not they needed to request an exception.

If you look at the resolution on Slide 20, in the example of diabetes for that particular class, it would be my recommendation to only grandfather for a short amount of time for the exact reason you just mentioned. There are other drug classes like anticoagulants or seizure medications if we were to ever do antipsychotics that I would grandfather everybody forever because there's a clinical reason why you wouldn't want that person to switch just for the sake of switching. I wanted to make that clear that when we say 2B is "grandfathering," it's not that everybody will be grandfathered forever if they're on a non-preferred drug when we go to the value formulary.

Tim Barclay: I appreciate that and that's helpful. I guess I would ask the question again then as to why the reduction in the copay in the interim period. It seems even less important to me than to lower the copay. I guess I'm just not seeing the reason why during this transitional period we're reducing the cost-share. It doesn't make sense to me.

Donna Sullivan: You bring up a good point. I don't think our model is sophisticated enough to look at if we were to grandfather people forever, we're not going to make them ever go through an exception process, maybe for those people we change their copay. If we're grandfathering them for three to six months, do we change the copay for those people while they're in their transition period and then only change it if they get the exception granted? If we keep that Tier 3 cost-share in place, though, we then have the inequity issue where some people are paying 50% of their drug and some are paying as little as \$75, which could be 30% or less.

Tim Barclay: I'm trying to understand the problem if we take your proposal as it sits without eliminating the Tier 3 cost-share in the interim. Does that make sense? It seems like that could be a more fiscally responsible way to transition into the value-based formulary.

Ryan Pistoresi: Are you proposing we change the third clause of the proposed policy resolution?

Tim Barclay: No, not at all. I think one of the things missing from the proposed resolution is really what happens to cost-sharing. It's not mentioned in here that I see.

Sue Birch: Page 12.

Tim Barclay: Well I'm talking about Pages 19 and 20, which are the resolution.

And I don't think what happens to member cost-sharing is mentioned here. It's assumed but it's not mentioned. I think we should be clear that it's our intent not to change member cost-sharing at the same time we implement the value-based formulary and transition to it, doing exactly as you described how we want to transition to it. But we don't do a wave of member cost-share reductions from Tier 3 to Tier 2 as of January 1.

Donna Sullivan: Just a question back to you, Tim. So we have a person that's on a Tier 3 medication that's being grandfathered and given a six-month transition time. I'm not going to use the word "grandfathered." They're paying the Tier 3 coinsurance. They request an exception. It's denied. Do we continue to cover that drug at Tier 3 or is it then no longer covered? I mean, that's kind of the question you'd have to address. What do we do then? Otherwise, what you're suggesting, I don't see much difference in it from what we're currently doing.

Tim Barclay: Well, if I'm reading the numbers correctly, no. We're not communicating. I'm not suggesting that person can continue to be on the Tier 3 drug, which is not what you're proposing either, right?

Donna Sullivan: Correct.

Tim Barclay: We're in agreement on that.

Donna Sullivan: Okay, I just wanted to make sure that when you say we don't reduce their coinsurance in the interim, but the result is if the exception is denied, it results in "not covered" as opposed to "I just get to keep taking it at the Tier 3 cost-share."

Tim Barclay: No.

Donna Sullivan: Okay. So I wasn't sure that everybody else understood that either.

Tim Barclay: No. So I'm saying what the policy resolution says, I'm fine with. But we're just lacking clarity on what happens to the copays. And if we don't reduce the Tier 3 copay for everyone as of January 1, it eliminates a lot of those red numbers and allows us to, like I said, be more fiscally responsible making the transition to the new system as well as implementing additional drug classes that those red numbers are making us shy away from, potentially.

Dave Iseminger: So I'm curious about the other Board members' perspective on this idea as to whether or not to reduce the cost-shares as part of the proposal. We certainly can be more explicit about this in the final resolution that's brought to you, but additional dialogue from the Board would be helpful.

Harry Bossi: This is Harry. If I understand the chart correctly, there's a proposal that eight of these drug classes would be incorporated. I did my own quick math without a calculator that says the cost avoidance in 2019 would actually be an

increase in cost because of those first couple, particularly the diabetes. Of course, the payback would come in 2020, but the payback in 2020 is just over a million dollars. I don't know what the total drug spend is off the top of my head. I don't know what the total spend is for the entire PEBB. But it seems to me a very small savings in proportion for what we're asking folks to go through.

Ryan Pistoresi: You were right on both numbers. Under the current proposal, the plan increase would increase under the first year by a few hundred thousand. Then it would switch to a plan savings of about \$1.3 million in 2020 for those eight drug classes. We could always continue to evaluate other drug classes and add them into the value formulary as we're looking to implement. Right now, the current proposal is looking at these eight classes, which would impact about 2,100 members. There are about 86 total drug classes with Tier 3 drugs. We're only showing you the twelve we identified as having a potential for cost avoidance in the future. We could continue to look at some of the other drug classes as well, especially in the future as new drugs are approved and costs shift. As we continue to look at specialty drugs, those could be other options.

Dave Iseminger: Ryan, can you also describe what our model projects in further outlier years, potential cost avoidance for the plan? I know the further out you project, the fuzzier the lines get. But if you could describe a little bit more about the potential trend that comes from the outlying years in the model.

Ryan Pistoresi: We only presented the numbers for 2019 and 2020. We have looked at what occurs in 2021 and 2022. The plan does continue to have cost avoidance in these future years. As we're able to direct these members earlier by 2019, it saves the plan the cost avoidance in future years. It would continue to increase, especially as drug costs continue to rise and we continue to see new drugs come out with a potential for a member to shift utilization or create new drug utilization.

Sue Birch: In response to your call, Dave, I have two comments. I like, and this is back to Page 12, the notion that we're creating a potential reduction for the member cost-share for medication. I like that principle. I think the second issue of evening out the payment is what I'm struggling with because I thought I had it until Tim talked about his proposal. I'm trying to reconcile in my mind, Tim, what you're proposing because I think it is at the heart of how they would pay 30% cost-share with maximum of \$75. I think you're proposing something but I guess I need to understand what you're proposing. Is that correct? I like the principles of trying to even things out and get greater value to the member but I'm struggling with what Tim is proposing.

Donna Sullivan: The math of it is, we're going from paying 50% of the cost of the drug to 70% or more of the cost of the drug on the plan side because of the copay. If the drugs cost the same, they both cost \$500, the member's going to pay \$75 for the Tier 2 drug and we're going to pay the \$425. For the non-preferred drug, we're going to pay \$250 for that drug. That's why the cost goes up but the member cost goes down.

Tim is proposing not doing that, of just keeping the member's cost-share at 50% until we make them switch, if we're going to make them switch.

Sue Birch: I see. That was the bullet I was trying to get my head wrapped around.

Tim Barclay: My point was people have been cruising along for years, taking this drug, paying the cost-share. We're going to force them into this transitional phase where they need to do something, right? Why at the beginning of that transition would we crank down their cost-share as we head into it? Just let the train keep going into the transitional phase; and then how it resolves itself, it will resolve itself based on them and their physician and their care plan. It's this interim tweak to the cost-sharing that doesn't make sense to me.

Sue Birch: And you're suggesting taking the 50% and force everybody through the –

Tim Barclay: My suggestion isn't to make them do anything different than the proposal as is.

Donna Sullivan: So for those patients that are going to be grandfathered forever, their copay would immediately change to the Tier 2. For those patients given a transition period until they get to switch, they would continue to pay the 50% coinsurance. If they requested an exception and it was approved, they would then get the Tier 2 cost-sharing. If it was denied, they would have to change medications or pay for it out of pocket themselves.

Greg Devereux: I guess I'm with Harry in terms of \$1.5 million on a \$1.5 billion spend just seems miniscule. I mean I appreciate all the tweaks that help members out, but it seems like not even a dimple on the back of an elephant in terms of what we're trying to do. It seems like our time would be better spent in other areas really pushing the pharmaceutical companies in other ways.

Dave Iseminger: I'm going to borrow a phrase that I hear Sue say a lot: there's no silver bullet but there's lots of silver shrapnel here. Although in the projection that's happening right now based on the drug spend of a year ago, the additive effect looks like \$1.5 million in year two, with growing cost avoidance in future years. We've tried not to convey to the Board that we think this is the only piece of the puzzle. There are other strategies we've talked about along the way but we've been focused on what are things the Board could put into place in 2019 to get things in motion. I hope the Board doesn't think this is not the only piece and that after June 20, whatever happens with this resolution, we're done talking about pharmacy. I think Ryan, Donna, and I are going to be attached at the hip for years, along with all of you as we try to tackle this in a couple of different arenas.

Greg Devereux: Dave, I appreciate that very much. But I think this size of the shrapnel matters and working on getting other Consortium partners in might have way more impact than this.

Sue Birch: Greg, I guess as a nurse, I would argue that this does create a shift in thinking in the drive towards value. It creates the shift with the providers, the members, the plans. I do endorse moving forward. I still want to see if there's anything more creative we can do between Tim's proposal and staff proposal. But that is just my opinion. Other thoughts or did you want to respond? I do think the movement towards value-based is very important.

Donna Sullivan: I would like to respond to Greg's comment. How the manufacturers price their drugs to groups purchasing together, it's not just on volume. It's about how closely you're monitoring the formulary and what is their potential market share. The more restrictive formulary, if you want to use a bad word for calling it a formulary, the more likely the manufacturers are going to give you a bigger discount on their drugs. If they're the only drug in that class that's preferred or they're one of two drugs that are preferred, they're going to give you different prices depending on how you have your formulary positioned. I would say to you that moving to this formulary would position us to get better pricing from manufacturers should other companies or programs join and we were to try to get a common formulary.

Carol Dotlich: I want to be on the record stating that for the members I represent, the retirees, anything they can save in terms of their pocketbook is critically important. The coupling of the increase cost of living plus the increase in premium that UMP members have paid was very significant to their ability to manage their health care. If you can save them money, that's what I'm in support of. Anything that increases their cost, I'm opposed.

Ryan Pistoresi: To respond to Greg's comment, another aspect is this provides us another tool in which we can continue to monitor and manage the pharmacy benefit. To Donna's point, it would allow us to have, potentially, better pricing. But it's also a question about turning the dial. To your point, if you want us to turn up the dial, we can look at potentially adding even more drug classes in the future and continuing to move towards that.

Greg Devereux: I guess what I'm saying is \$1.5 million for the amount of disruption seems a high price. And moving the dial even more causes more disruption. I just think there may be other things we can do. I understand Sue's point about this sends a message to pharmaceutical companies, but I think there are other things we might be able to do that would have more impact than this, financially.

Carol Dotlich: I also remain concerned about putting people through multiple manufacturers of the same or similar drug. I think grandfathering the people that have been compliant and responsive to the medications they're on is really important. I don't want to see people have to change their medication numerous times to prove that they need the medication they're already on. I can understand if somebody has a new condition and their doctor wants to start them out on the television advertised brand and you'd like to see them do something similar at less cost. I can understand that and I could support that. But to take people who are

already successfully being treated on a medication they've been on for years and force that move, I'm opposed to that.

We did a survey of our membership. It's only been in the works for a couple weeks. We have a good response but not 100% response that we'd like to see from our membership. From the results that we've gotten so far, many, many of our members, most of them, are already using the generic brand of the medications they're on. The people not using the generics probably are not for a good reason. As I said, the members we represent already struggle financially. They're not going to take expensive drugs if they feel they can do well on something less expensive. That's proven in the survey results. I don't want this kind of disruption for the other members who are taking drugs already that have been working for them for years.

Dave Iseminger: Sue, I'd like to go back to the question Tim put on the floor, which is being clear in a final resolution that we ask the Board to take a final vote on next meeting. Being clearer about the cost-share pieces. Tim's question is, there's the dial and there's the extra added twist of the dial of not changing the cost-share in the short term. The question for the Board, if you want to go forward with this value formulary, how hard do you want to turn that dial? I think what we're hearing, and this is one of the challenges, is we've been talking about this for over a year and a half. Donna's been talking about it here at the agency for over two years. We've been talking about it and it's a tough issue to crack and to get consensus among a body about how to move forward on different pieces. All of you have good faith efforts with what you're bringing to the table and the positions that you have.

The question really is, is there a consensus among you about whether to move forward on this piece of the puzzle that can be put in place for 2019 or not put something like this in place for 2019. Then we continue to work on the other pieces of the puzzle. It would be helpful for us because it sounds like we should be bringing you back in the final resolution something that is clearer on cost-shares.

Yvonne Tate: I like to give staff broad flexibility. I look at these as policy issues and I don't like to drill down the detail that much. I like to look at it more from a broad policy perspective. I think there are 50 bazillion ways to look at this and I don't want to drill into all of them. I guess what I'm saying is I'm comfortable with what you've recommended here. I recognize all of this work is very, very difficult and there really isn't a silver bullet. It will continue to be difficult as we go forward. I like to be able to give staff flexibility. But from a policy standpoint, I'm comfortable with the resolution as proposed.

Tim Barclay: I agree with Dave's comments. I hope we can come away today with a general idea of what it is this Board expects so we can have a productive discussion next time and have a productive vote on a resolution. With that in mind, I'd like to take Carol's point and drill into it a little further because I think it's a very good point. I want to be clear because I think I'm hearing a different answer

today than what I heard the last time we met. The expectations for someone who is on one of these Tier 3 medications that we're saying we're not going to cover in the future, is the expectation the same for them as it would be for a new person coming into the program? The fact that they would have to revert and try all of the alternatives? I thought I heard last time there was, what I might call an expedited process by which they could stay on that Tier 3 medication as opposed to essentially behaving exactly like a new member, essentially. I want to be clear on what it is we're asking people to do. Are we really going to disrupt 47,000 people or not?

Donna Sullivan: It depends. Some of those patients have already tried the preferred alternatives. If they were to submit a request for an exception and submitted documentation indicating they tried all the other drugs and they didn't work, that would be approved. If they were just started on the drug two days before they entered the plan and they hadn't tried all of the preferred drugs, we would make that person go back and try all of the preferred drugs first.

Tim Barclay: You and I had a conversation ten minutes ago about the transitional aspect, whether people could stay on Tier 3 and pay the Tier 3 copay forever. You and I were on the same page and said no. I'm wondering if in light of Carol's comments if a better answer isn't yes. I'm curious to hear your thoughts on why that's a bad idea.

Donna Sullivan: I want to clarify. To make them pay Tier 3 forever, that puts us in an inequity position where if a new person was approved for that drug, they would be approved at Tier 2. They'd be paying \$75 and this other member would continue to pay \$250.

Tim Barclay: Well, they could always go through the exception process.

Donna Sullivan: Yes, they could go through that exception process.

Tim Barclay: I'm wondering, and Carol, this is a question for you, too if this would solve your concern. If we say it's our intent to transition to this value formulary, it's going to apply to new people, which I think you said was okay, new people come in, we want you to try the lower cost alternatives first, and we encourage people to transition off. We advertise the process by which they can transition to a lower copay and stay there. We allow them, but for whatever reason, they don't want to, they don't have the documentation, they don't want to try other drugs, rather than a hard line in the sand, which is how this is written and you and I agreed, no, after six months, you're done. It's not covered at all. We give them an out and say you can stay with this Tier 3 copay as is today and grandfather them forever. Just thinking out loud.

Donna Sullivan: That's no different than what we currently do.

Sue Birch: So, then it's unfair because of the differential on the cost-share, \$250 versus \$75.

Yvonne Tate: Exactly.

Donna Sullivan: I think to Tim's point is that maybe it's not widely known enough in our membership that there is this exception process, that if they have tried all of the preferred drugs and can't take them for whatever reason, they have this opportunity to take an exception. If we grant those exceptions, they'd get a lower cost-share tier. If they choose to stay on the drug because they want to switch, they would have to pay the higher cost-share. That's what we currently do today. The fairness would be making sure everybody's aware of it and has the option so when we make our formulary changes, they know they have the opportunity to request that exception and it's made loud and clear.

Tim Barclay: In terms of thinking what's in the best interest of the member, when I think about Carol's illustration, I've got this person who's on a drug that we're about to say is not covered. It's working for them, they don't want to try the other drugs. Are we being a little bit more compassionate if we tell them you can stay on the Tier 3 copay? Or as the proposal's written, six months from now, no, we're not covering it at all. You're paying 100% if you don't want to go down this other path, which is the hard line we're uncomfortable with. I wonder if as they transition into this new world, if we don't have to offer the lifetime grandfather clause on some of these things.

Donna Sullivan: Would a newly diagnosed user who hasn't tried any of the non-preferred drugs go to a non-preferred drug and do they get 50% coinsurance or do they go through the formulary exception process?

Tim Barclay: I would say new users, it's not covered. That's why this is grandfathering. They have to go through the process.

Donna Sullivan: Okay, got it.

Yvonne Tate: Well, my question would be whatever strategy we use, does it actually achieve the objective of reducing the overall cost of purchasing drugs? That's my concern. If you let somebody stay on forever without having the opportunity to try cheaper options, are we really going to achieve the overall goal that we have, which is trying to reduce the costs of our drug spend?

Greg Devereux: I think under Tim's latest scenario, there still would be savings. Just not as much.

Tim Barclay: And to Greg's point earlier, it's not like we're solving the problem here, right? We're trying to move in the right direction. We're trying to create a tighter formulary. And my initial point was I'd like to not spend more in doing it. To Carol's point, we don't want to inconvenience everybody and make them uncomfortable who's comfortable in their drugs. What I'm trying to do is finagle a scenario where we save something, we're not unreasonable to our membership, we're moving in the right direction, we're creating another tool where we can manage our formulary. We can tighten things down. I'm trying to come up with a

solution that satisfies everybody without negative consequences. It's very difficult to do that. I guess I'm sympathetic to Carol's point about what we're going to be telling people that have to do with their care.

Donna Sullivan: As a follow-up comment, with that proposal, what would happen over time is through attrition, people would transition off those Tier 3 drugs. Eventually, we would get to a situation where we were in our value formulary without this Tier 3. I think several years out we might be at that position. I think this does help get us to where we're trying to go without causing a lot of disruption.

Sue Birch: I want to be very clear. Tim's proposal is for anyone new coming in, no grandfathering, but all current folks grandfathered continue and phase out over time.

Tim Barclay: I think I would be clear on what we mean by new coming in. I think new coming in is, what you mean is not new to the plan but new to the drugs.

Sue Birch: Yes. So is everybody clear about Tim's proposal?

Donna Sullivan: I think I want to caveat what you said. Tim's proposal is not that everybody gets grandfathered. It's some people will get grandfathered forever and we agree they will get the lower cost-share up front because there's a clinical reason not to make them change. The people that would have been in that transition phase, their copays will not change during the transition phase. If they're approved, it'll go down, if not approved, they will continue on the Tier 3 coinsurance indefinitely.

Sue Birch: It sounds to me like we are achieving the value of savings that we were in pursuit of and the value movement. It sounds like we've got an equity position. It sounds like we've got compassion for the client satisfaction, the least client disruption. Is that fair to encapsulate?

Dave Iseminger: Sue, to Donna's point, the bullet might have gotten a little bigger in the outlying years under that proposal.

Sue Birch: Yes. I think the Board needs to take a hard and fast look at no grandfathering three or four years out. This Board might have to decide if that is serving us well because I think we'll have client disruption in those out years. There's an exception process so it's uniform and it will be more well known.

Tim Barclay: I hope through this process we can market this as something very different and can push that exception process. There are people in Carol's cohort who could qualify for the exception process. It would be nice if they knew it. They could pay 30% instead of 50%. That would be a good thing.

Carol Dotlich: I would like to know looking into your crystal ball, do you see an opportunity for the monthly premiums people pay for health insurance to decrease at some point?

Ryan Pistori: At the last meeting, we did present what cost avoidance we would need to target in order to reduce the premiums based on our initial estimates. If we continue to pursue this option, we'll be able to have that cost avoidance continue to grow in future years and that should help reduce premiums in future years.

Dave Iseminger: I do want to caveat when you say "premiums." The cost of drugs for the Medicare retiree population is the current part of the pie that's exploding plan cost - and plan cost equals premium cost. There are a lot of moving parts. The value of the retiree subsidy from the Legislature is one piece. There's medical trend, although it's not the big piece right now. For Medicare, the plan is the secondary payer, so Medicare retirees are feeling the full brunt of increased drug costs. I think Ryan could have oversimplified it because he's looking at it from the optics of the pharmacy piece of the puzzle. That's the current flavor of where the plan costs are exploding. Ryan is looking through a lens of a part of the benefit structure.

Greg Devereux: Just to add to that, I think Carol was referring to the overall premium. What you're saying is Ryan was addressing the pharmacy piece. I could see this reducing the increase. But I don't see premium overall going down. I wish that were true.

Dave Iseminger: Correct.

Carol Dotlich: Our president has been on television talking about reducing the cost of drugs. The Legislature granted a little increase to the subsidy. That should have impacted the premiums for the retirees to some degree. There's talk of expanding the size of the Consortium. What other measures can we take to reduce the costs of the overall premiums for the members?

Dave Iseminger: Carol, you have highlighted a couple pieces of the puzzle. Again, this is just one component for the short term. Another area that I think there's been a lot of focus, and our Legislature's been trying to tackle this issue, is transparency in drug pricing. Even that simple step of exposing the light on where exactly drug costs are these days. There have been bills proposed in the Legislature and debated for the past couple of years that really increases transparency on drug pricing, which can help inform.

Another piece, at the federal level, if there was the ability for the federal government to have direct drug negotiations on the Medicare drugs. That's not something this Board can control. Sometimes there's lobbying from states and often Legislatures pass resolutions saying we hope the federal government takes action on x and y. There's a strong belief that would be a significant piece to help crack this nut. I'm not sure if there's other pieces that you think you could add to the list.

Sue Birch: I think looking at administrative simplification and cutting waste. There's a study by the Health Alliance showing there's nearly \$400 million a year

in unnecessary preoperative testing and blood testing. A new engaged consumerism, people to say, no, I don't want that or I just had that x-ray, I don't need a second one. Creating some of the efficiencies, administrative simplifications, and efficiencies, the use of telehealth. There's a multitude of other strategies, Carol. But it's going to take a lot of time. Obviously, there's just an enormous amount of effort in this state building up more prevention in primary care, lessons in over-institutionalization, less over medicalization. A number of other strategies but I don't see it happening quickly.

Tom MacRobert: Does Washington State have a gag rule or not? The gag rule, as my understanding, is that pharmacists are not allowed to tell you what a cheaper alternative is to whatever drug it is you're taking.

Donna Sullivan: What you're talking about is what some pharmacy benefit managers put into their contracts with their pharmacy networks. The Northwest Consortium, our vendor, MedImpact, who negotiates our network, does not have those gag clauses in our Consortium contracts. There are PBMs in the state of Washington that operate outside of our arena that do have gag clauses in their contracts. I think you might see legislation around that.

Tom MacRobert: Let's say I live in Spokane and there are all these different places I can get my prescription filled. Do we identify the cheapest places in Spokane? In other words, if I go to Fred Meyer, I go to CVS, I go to whatever the different places are, and this one pharmacy is the cheapest by far in the area for most of my medications, do we know who those companies are and can we identify them and get them to our membership?

Ryan Pistoresi: The way that the pharmacy reimbursement is set is we are contracted with the different pharmacies for the different rates. If you go around to different pharmacies, they may have different cash prices but the contracted rate for the network pharmacies is agreed through contract through those pharmacies. Paying through the UMP benefit, it's not different between those pharmacies.

Donna Sullivan: There is a price check tool on our website. You can actually type in your drug and select the drug you're taking. It will bring up a default pharmacy. I thought you could actually change the pharmacy and select the actual pharmacy that you want to go to and it will tell you the difference. You'd have to search each pharmacy differently, but you will be able to tell if there's going to be a significant difference from pharmacy A to pharmacy B on that price check tool.

Ryan Pistoresi: As well as mail-order pharmacy.

Sue Birch: Dave, at this point and with our pharmacy staff, do you feel like you have enough direction from this Board for us to close this issue and for the Board to be prepared to take action at the next Board meeting? Do you feel like you've received enough feedback and guidance about how to come back for a proposed resolution?

Dave Iseminger: Short of asking you to take a straw vote right now, I think we've gotten most of the insight we can get. It did seem there was a lot of possible consensus around what I'll call Tim's proposal for purposes of shorthand that Donna understands very well now. I think there was good insight.

Sue Birch: Just to encapsulate, I saw a lot of head nods and everybody feels strongly about the least client disruption and some empathy and compassion about the transition, correct? We'll call that the Carol amendment.

Dave Iseminger: Yes.

Sue Birch: I think there was agreement about the value proposition and getting the best cost containment strategy, moving towards value-based design. The second element, a uniformity or fairness about the copay. Is that correct? I think we agreed to those three principles, what I think Tim brought forward. Copay was in our years more consistent and uniform. Anything to add, change, or edit about that?

Emerging Medications Update

Ryan Pistori: Another pharmacy-related topic, although separate from the value formulary. Emerging medications are new drugs approved by the Food and Drug Administration (FDA) that can have the potential to impact member health care and UMP plan costs. Today we'll provide information about our new process as well as providing the potential cost impact of a new drug approved earlier this year.

Slide 2 is the purpose for providing this information. There is growing concern about rising drug spend, not only within the Uniform Medical Plan, but around the state and around the nation, especially with how new drugs and new drug classes may impact UMP. After rates are established, you'll be talking about in July when you're approving your rates for 2019, new drugs will continue to be approved throughout 2018 and 2019 that can impact how plans spend for those years. It's difficult to look out and project what drug may be approved in August of 2019 that could be impacting the rates you may be looking at next month. One of the major challenges is that we don't necessarily have cost information for drugs until they are approved by the FDA and on the market. While we can anticipate new drugs coming to the market based on clinical trials and when the FDA anticipates their approval, we don't necessarily know what the cost impact will be until the drug is actually approved and on the market.

The Legislature placed a provision in the 2017-2019 operating budget requiring HCA to perform comprehensive cost impact analyses of any new drug placed into a new drug class. The cost impact will be presented to the PEB Board to promote transparency about emerging drug classes and their fiscal impact to UMP costs. Our plan for today is to present some basic clinical information about these new drugs and the potential cost impact to the Board. We do have one drug to highlight at the end of this presentation. It's important to understand the

underlying context of this and how new drugs and new drug classes are reviewed and approved by the FDA.

Slide 3 – Background. There is no set time for when the FDA is reviewing and approving new drugs. In fact, every day at some point, they are in the process of reviewing all the new drugs submitted to them, whether they're Tier 3 drugs, new generics, or new strengths. In 2017, the FDA approved 46 new drugs, which is almost one per week and 80 first-time generics. A new generic means a first-time generic for that medication. They're also doing other reviews so we're also seeing new combinations of drugs. Existing drugs are approved for new indications. If they're being studied for a different disease state, their labels can get updated. There are new formulations so there could be extended release products. There could be new strengths.

The new drugs can impact plan spends because they can change the cost we're currently spending on other drugs as alternatives. They can shift the utilization from existing drugs to the new drug, or they can create new drug utilization and new drug classes. Drugs that meet previously unmet therapeutic need have the greatest potential for changing that utilization and spend. As these drugs are undergoing review, HCA is researching these drugs and determining how they may be covered by the health plan.

The process is outlined on Slide 4. Each week, HCA receives a report, a weekly drug file of all the new drugs loaded into the pharmacy claims system. These systems are how drugs are able to be billed at the pharmacy to the health plan. Each time new drugs are added into that system, we get a report to know they are on the market and ready for members to potentially use.

It's the job of the HCA pharmacist to review these new drugs and determine whether they constitute a new drug class. To clarify, new drug class really is a term of art. Drug classes can be very broad. It could be as broad as the organ system for which they treat, cardiovascular or neurological, the disease state for which they treat, hypertension, or insomnia. Or it could be as narrow as the specific mechanism of action of how the drug works in the body. That drug, its site of where it works, and how it improves the condition. It could be angiotensin ii receptor blockers are a drug class. Or it could be the non-benzodiazepine sedative hypnotics as a drug class. It's up to the pharmacist to be able to look and evaluate, is this really a new drug class.

Once new drug classes are identified by an HCA pharmacist, we begin to perform that comprehensive review, really looking at the safety, the efficacy, the relative effectiveness of these drugs, as well as the cost and potential value of these medications to HCA leadership. As part of this, we'll be looking at the cost analysis to see what type of impact it might have to the UMP budget. Once that process is complete, we'll be able to present a summary of these new classes and the projected UMP budget impacts to the PEB Board, which is where we are today.

Slide 5 is the first of the drugs going through this new process. The medication we're highlighting today is called Ibalizumab-uiyk, also known as Trogarzo, which was approved by the FDA on March 6, 2018. This drug is a new drug class because it treats a subset of HIV patients that had very few treatment options available to them. This drug is approved for patients who have multidrug resistant HIV and who have failed other drug classes of HIV treatment. Patients have tried multiple other HIV treatments. Their HIV is not under control. They still have viral load in their body. This medication is approved for these types of patients. In our cost analysis, we anticipate maybe two to four UMP members may be appropriate for treatment after reviewing the safety and efficacy from the clinical trials. Our cost estimates to treat these two to four members could cost UMP between \$200,000 and \$400,000 in 2018. This is a lifelong treatment because HIV is a lifelong disease and this treatment would continue for these patients in future years.

Carol Dotlich: Is that an annual cost or is it a six-month cost, this \$200,000 to \$400,000?

Ryan Pistorosi: The cost projection is for 2018. It is anticipated some patients may start treatment this month and others may start treatment in November. It's looking at the annualized cost for 2018. This budget impact is looking at how members may be transitioning into using this drug.

Harry Bossi: What's the dosage and what's the cost of the dose?

Ryan Pistorosi: That's a good question. The cost of an annual dosage is about \$100,000.

Harry Bossi: If there's ever any good news like something coming off of patenting on a generic and it's a big one for us, throw that in there too! [laughter]

Ryan Pistorosi: We'll look to present good news for the plan, too.

Dave Iseminger: Donna passed me a note for clarification. Earlier today there were drug examples discussed and Donna confirmed Lyrica is Tier 3 not Tier 2, as was discussed earlier. I want to correct that on the record.

Carol Dotlich: When I asked you about the cost per year, I should have asked you, what is the copay for these members for this drug?

Ryan Pistorosi: The drug is administered under the medical benefit. It depends on where the member is in their medical deductible, and potentially what the out-of-pocket maximum is. I believe for this medication, it is 15%, although I can verify that for you.

Sue Birch: Donna is saying yes.

Ryan Pistorosi: Okay, yes, 15%.

Dave Iseminger: We'll try to include member cost-share information for future emerging drug updates. That's a good update for future presentations.

Proposed Annual Procurement Plan Changes

Beth Heston, PEBB Procurement Manager, ERB Division. We are in the annual procurement phase. We received proposals for the fully insured plans. I'll start with Kaiser Permanente of Washington, formerly Group Health. They have come to us with a proposed bundle plan change. The first bundle is to expand the network for SoundChoice. SoundChoice currently operates in Snohomish, King, Pierce, and Thurston Counties and they would like to add Kitsap and Spokane Counties to their coverage areas. They would also like to make the following SoundChoice plan changes:

- Lower the deductible from \$250 to \$125 per person and from \$750 to \$375 per family. For wellness participants, if they received the \$125 incentive, the individual would have zero deductible.
- Lower primary care visit coinsurance from 15% to a zero dollar copay.
- Change inpatient hospital services from \$200 per day up to \$1,000 maximum. They want to change that to a \$500 per admission with no maximum.
- Remove massage therapy from the traditional physical therapy, occupational therapy, speech therapy category, which has restrictions on the number of visits and make it unlimited number of visits.

Harry Bossi: Beth, about the massage therapy. They want to remove it from a limitation?

Beth Heston: Yes.

Harry Bossi: But charge the same price? There's a copay so it's the same way, right?

Beth Heston: Yes. But there would be no limit. Now, I believe you get twelve.

Harry Bossi: But is it not coded and billed as specialty as opposed to --

Beth Heston: Yes, and that's what they would move it out of.

Sue Birch: I want to ask a clarifying question about the massage. It's medical massage.

Beth Heston: It has to be prescription.

Sue Birch: It still needs to be a medical necessity.

Beth Heston: Yes. Exactly. It would still have to be approved by your primary care physician. It wouldn't be self-referring. Also, those changes are a bundle package they've offered us.

Slide 5 – Plan Design Changes. Please ignore the first bullet under the Classic Plan because there is an error.

Dave Iseminger: Except, Beth, would it represent a change, impact members, or is it really clean up?

Beth Heston: It's clean up. It's a mistake in the benefit chart. Their next plan design change is to add a virtual diabetes prevention program offered through Omada. It's the one with the wireless scale available for people who don't have a YMCA nearby. They already offer the in-person diabetes prevention program at the YMCAs. This would be in addition to the in-person program.

Carol Dotlich: If you live near a YMCA, would you not be eligible for the virtual?

Beth Heston: You could still choose to use the virtual. It would be whichever one you prefer.

Kaiser Permanente of the Northwest changes. Their first proposal was to add Lane County, Oregon to all plans. I've received an update from them that I missed two words in their response, "Medicare to follow." They've applied for permission from Centers for Medicare and Medicaid Services (CMS) to offer this in Lane County to Medicare subscribers but they haven't been approved yet. For now, this change would only apply to active employees and to the plans active employees are enrolled in, so CDHP and Kaiser Classic. We have about 101 members, the majority of them are Medicare but I believe there are 47 active members who live in Lane County. This would enable them to see local doctors.

Slide 8 – Plan Design Changes. They would like to add a fitting fee of \$30 to all contact lens exams. KP Washington already does this. The UMP pays \$65 and any amount over that for the fitting is out of pocket. It's not really a set amount. It depends on the Optometrist, Ophthalmologist. They also would like to add a prescription drug tier and cost-share up to a maximum of 15%, and that is after deductible on CDHP for self-administered chemotherapy. That was to align themselves with legislation that was passed.

Slide 9 is the change to durable medical equipment (DME). They would like to add a 20% coinsurance to these durable medical equipment items: antral pump, formulas and supplies, continuous ambulatory drug delivery pumps, osteogenic phone simulators, osteogenic spine stimulators, and ventilators. There is a 20% coinsurance in KPWA. We believe there's 15% in UMP, but UMP also has a preferred network for DME. We'll have details at the next meeting.

Tom MacRobert: Beth, is the CADD, is that for a diabetic where they wear --

Beth Heston: That's an insulin pump most often. There are other drugs it could be used for, but insulin pump is the one we're most familiar with.

Sue Birch: I want to clarify. I don't think it's the continuous glucose monitor part. I think it's the pump part.

Beth Heston: Yeah, it's the pump.

Sue Birch: Two different devices.

Beth Heston: Yes, as opposed to monitor.

Sue Birch: I think I'm correct.

Dave Iseminger: We'll follow up at the next meeting.

Beth Heston: Yes, to make sure it's the pump and not the monitor.

Greg Devereux: How does the 20% compare to now?

Beth Heston: There's no cost-share now.

Dave Iseminger: KP Northwest Plan design right now is zero. There are cost-shares in some of the other plans.

Beth Heston: Yes. The other changes are ones you're familiar with from the January Retreat. We spoke to you about adding to the Uniform Medical Plan a virtual diabetes prevention program. For the Uniform Dental Plan we wanted to reduce the limit on Class III restorations from seven years to five years. Those are this year's proposed changes and we are still negotiating.

Greg Devereux: I'm going to show my ignorance because I have never used contact lenses. Back on Slide 8, would this be a \$30 charge every time you get fitted?

Beth Heston: Every time you get a new prescription, they fit your contact lenses. If your prescription doesn't change, you wouldn't have to pay the fee.

Greg Devereux: It's just \$30?

Beth Heston: Yes.

Katy Hatfield: May I say something before you go to public comment? I wanted to correct one thing on the agenda and correct something Chair Birch said at the beginning of the meeting regarding Executive Session. It was only to discuss proprietary and confidential non-published information. We did not have any discussion regarding any current or litigation with council. There are two things listed on the agenda of why we met in Executive Session, but it's only one of them, that was the actual reason for Executive Session. I wanted that to be clear.

Dave Iseminger: For the record, you actually said it the right way. It's the agenda that's wrong because I have my annotated agenda, which you read that sentence. And I remember correcting it for the annotation.

Katy Hatfield: I just want to make it clear we did not talk about litigation.

Public Comment

No public comment at this meeting.

The next meeting of the PEB Board is June 20 from 1:30 p.m. to 4:30 p.m.

Preview of June 20, 2018 PEB Board Meeting

Dave Iseminger: At the June 20 meeting, you are going to take a vote. That's one of the primary parts of that meeting. I do want to be very clear, whatever your decision is, it is critical to have a decision on June 20 to be able to complete rates and bring you rates during the July process. Whatever your action, we will know the answer to the UMP value formulary question that we've been talking about for several months and several years at this point. We will bring back follow-up questions that Beth was eluding to regarding the fully insured plan proposals.

Carol Dotlich: Will we receive well in advance the amended resolution?

Dave Iseminger: We will provide the Briefing Book on the same timeline we always do.

Carol Dotlich: I'm not asking about the Briefing Book in total. I'm simply asking about the resolution itself.

Dave Iseminger: We'll see what we can do to provide the proposed resolution to the Board as early as we possibly can.

Sue Birch: But certainly, it will be the Friday before the meeting at the latest.

Meeting adjourned at 3:31 p.m.