Public Employees Benefits Board
Meeting Minutes

April 13, 2016
Health Care Authority, Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 3:30 p.m.

Members Present:
Dorothy Teeter
Greg Devereux
Yvonne Tate
Harry Bossi
Gwen Rench
Marilyn Guthrie
Tim Barclay

Members on the Phone:
Myra Johnson

Members Absent:
Mary Lindquist

PEB Board Counsel:
Katy Hatfield

Call to Order
Dorothy Teeter, Chair, called the meeting to order at 1:30 p.m. Sufficient members were present to allow a quorum. Board and audience self-introductions followed.

Approval of June 24, 2015 PEBB Meeting Minutes
Dorothy Teeter: The Board requested clarification on page two, third bullet. This section was rewritten for clarification. It was moved and seconded to approve the June 24, 2015 PEB Board meeting minutes as amended. Minutes approved by unanimous vote.

Approval of July 22, 2015 PEBB Meeting Minutes
It was moved and seconded to approve the July 22, 2015 PEB Board meeting minutes as written. Minutes approved by unanimous vote.

Approval of August 6, 2015 PEBB Meeting Minutes

Greg Deveraux wanted clarification on what minutes the earlier amendment was referring to.

Lou McDermott: The amended minutes were the June 24, 2015 meeting minutes.

It was moved and seconded to approve the August 6, 2015 PEB Board meeting minutes as written. Minutes approved by unanimous vote.

Legislative Update

Carl Yanagida, Deputy Chief Financial Officer, Finance, provided an overview of the resulting budget that came from the most recent Legislative session.

One of the budget provisions that changed was our funding rate for Fiscal Year 2017. It went from $894 per member per month to $888 per member per month. There were no changes to the Medicare explicit subsidy, which remains at $150. Tobacco and spousal surcharges remain at $25 and $50 per month respectively.

There was an iteration of the budget that would have terminated the Limeade contract. Limeade is the vendor that developed and maintains our SmartHealth website. The final compromise budget did maintain that funding, however, it did include language that requires the HCA to submit quarterly reports to the Legislature regarding the effectiveness and wellness of the program. The first report is due June 30, 2016.

Lou McDermott: We are also required to present that information to the Board. You'll see the same information that's presented, most likely at a June or July meeting.

Greg Deveraux: Is the six dollar per month funding rate change for 2017. Did they change it for one year or two?

Carl Yanagida: It was changed for Fiscal Year 2017 only.

Senate Bill 6475 is noteworthy as it impacts the PEBB Program. Prior to this bill, counties and political subdivisions that wanted to join the PEBB Program had to demonstrate that their employee populations are as healthy as existing PEBB Program populations. With Senate Bill 6475, the PEBB Program can accept employees of these groups with the caveat that if their employee populations do have higher costs than the existing population, the Health Care Authority is authorized to develop a rate surcharge to apply to those counties and political subdivisions.

Gwen Rench: There was a proposal to force retirees into advantage programs? I believe it is part of the budget process. Can you tell me who was behind that? Or where that came from?

Lou McDermott: When those things appear in the budget, we provide the analysis. We usually don't know which member is driving that issue or where it's coming from. We deal with it as cleanly as possible from an agency perspective to provide the requested information and the impacts of that policy decision.

Lou McDermott: It's almost better not to know. We just go through the process trying to answer the questions. We're not lobbying or trying to find out who is behind it. We want to be responsive and answer the questions.

Dorothy Teeter: Gwen, we will try to provide you with a contact point that could talk with you if you're interested if you don't have your own pathway to find out.

Gwen Rench: We do have some pathways but I'd be interested in the specific data that was supplied. Was it pro or con? I'd be interested in that.

Lou McDermott: I'll see what we can come up with.

Accountable Care Program (ACP) Expansion Update

Cade Walker, ACP Coordinator, provided an update on the Accountable Care Program (ACP), known to our members as Uniform Medical Plan Plus (UMP Plus). For 2017, we are looking at expanding our current two networks into additional counties through the state of Washington. Those counties have not been finalized. As negotiations are ongoing, we are held by confidentiality rules to not disclose those counties until they are final. We hope to have negotiations completed by June, ahead of open enrollment for 2017. When the final list of counties is available, we will share that it with the Board.

Currently UMP Plus is available in five counties in the Puget Sound Region; Snohomish, King, Pierce, Thurston, and Kitsap Counties. We hope to add additional counties for 2017. We re-engaged and negotiated with Providence to add a third network to the ACP for 2017, but we were unable to reach an agreement. We have since ended those negotiations. For 2017, we will continue with our two existing high quality network partners; Puget Sound High Value Network and UW Medicine Accountable Care Network.

Programmatically, for the Accountable Care Program, we are looking forward to an HCA website redesign, which will include redesign to the PEBB Program website, as well as to the UMP website. It will give us an opportunity to reorganize and hone the information we provide our members on UMP and UMP Plus. We continue to work with our marketing firm, Desautel Hege, who helped us develop products for our members last year. They provided assistance on what we call the "kitchen table tool kit" that was received by PEBB Program members. This year we look forward to their expertise in honing our message to members about our paying for value and value-based purchasing plans moving forward. They will be assisting us with a mid-year survey of members who are enrolled in UMP Plus to see how things are going. We would like to incorporate their feedback for open enrollment 2017.

For open enrollment this November, we anticipate doing additional webinars, benefit fairs, online and printed materials based on the survey results and what our members want. They've indicated that's how they want us to communicate with them. We will continue to reach out to them through those channels, ahead of open enrollment through 2017.

Harry Bossi: Group Health has a SoundChoice network which is accountable care. I think they had one less county than UMP did. Are you discussing expansion with them or is it too early?

Cade Walker: It's too early. I have not heard.

Lou McDermott: The RFRs are going out soon. Suggestions like that come back in the RFR process.

Dorothy Teeter: That's a great question because we had that as our third accountable care change. We'll continue to bring back information and results from surveys and quality monitoring.

Total Joint Replacement (TJR) Centers of Excellence (COE) Update

Marcia Peterson, PEB Division Benefit Strategy and Design Section Manager, provided an update on the Total Joint Replacement Centers of Excellence Program. At our last discussion, we were just beginning to send out a survey to providers across the state asking them where they were with being prepared to meet the BREE criteria. We've made a lot of progress since then. The RFP was released for Total Joint Centers of Excellence in November of 2015. In the RFP we said that we were going to consider having up to five Centers of Excellence which would provide services to our members statewide. For a bundle, the providers would need to meet the BREE criteria laid out within the BREE Collaborative. The BREE Collaborative is an organization that includes providers and others from across the state that takes on issues of health care, health care safety, and other areas where there's a lot of variation. They provide recommendations. One of the recommendations they came up with was around bundled payments, or bundled episodes for total joint. Our key criteria is around quality. We were looking for providers who could provide high quality, evidence-based care that had integrated programs of care. We wanted to see integrated clinical teams that were led by physicians, evidence-based, and who were using data to improve their outcomes.

We went through a competitive procurement process and selected one Center of Excellence. Virginia Mason Medical Center was selected. As Dr. Dan Lessler indicated to the applicants that were not selected, "we set a really high bar for quality for our members." There were some great applications, but Virginia Mason was the leader. They exceeded the Bree criteria. We were looking for team-based and shared decision-making tools, also part of the BREE criteria. We've learned that through shared decision-making a certain percentage of people decide not to go through with the surgery, or at least postpone it. Virginia Mason had a lot of experience with shared decision-making. Virginia Mason is our Center of Excellence.

In the course of doing this process, we worked very closely with Regence, our Third Party Administrator (TPA). They provided us with support, but it became very clear to both Regence and HCA that with their current operations, they could not bundle payments across the whole episode of care including the physicians, the anesthesiologists, and the hospitals. We came to an agreement that HCA wouldn't force them to do it and they wouldn't try.

We did another procurement for a TPA specifically to handle these bundled episodes. The TPA in this capacity has to provide almost a case management approach to the

members. They're working with the members sometimes before they even get to the surgeon to help guide them to as to whether or not they've gone through conservative treatment, are they meeting the criteria for BMI, etc. We were looking for a TPA that could provide member education. They need to be able to bundle payments and coordinate with our current TPA Regence, our provider Virginia Mason, and HCA as we go forward with this innovative approach.

We've had one protest from the Center of Excellence applicants. We're confident that we'll get through that soon so we can begin contract negotiations with Virginia Mason. We're moving ahead with both Premera and Virginia Mason in defining the benefit and incentives. We're trying to remove as many barriers as possible for members to go ahead and use this benefit. We'll be defining what's included in the bundled episode. For instance, what aspects of Durable Medical Equipment (DME) will be included, how far ahead of surgery and how far post.

Greg Deveraux: In the selection of Virginia Mason, what does total joint replacement mean for the average member? Are we driving them to Virginia Mason? Is it discounted to go to Virginia Mason? What happens if you don't want to go to Virginia Mason?

Marcia Peterson: We're defining that benefit now. We're trying to remove barriers. We've discussed the possibility of no out-of-pocket cost share. That's common for these types of services where people need to travel far. We're also discussing the possibility of including travel and lodging. Virginia Mason has a facility that they own next to them. It's an integrated type of care. Virginia Mason is a Center of Excellence for Walmart and other large employers. People fly across the country to come to them.

Lou McDermott: When we started this process, we anticipated accepting up to five Centers of Excellence throughout the state. It became very evident in the process that Virginia Mason was head and shoulders above, so we selected only one. We will work with the TPA and Virginia Mason to discuss how to remove these barriers. What if the person lives on the other side of the state? Virginia Mason deals with people who live all over the country, so we should be able to overcome that.

To your point, what happens if someone doesn't want to go to Virginia Mason? Members are free to go to their local facility and have the procedure done. They will pay the normal cost share associated with it. We are not removing any other part of the benefit in lieu of this benefit. It'll accompany it.

Greg Deveraux: So there is some incentive to go to Virginia Mason, potentially.

Lou McDermott: Absolutely. I think there will be, not just from a fiscal standpoint, but also from a quality standpoint. The quality results are remarkably higher at Virginia Mason. We'll be articulating that to members and explaining this isn't just about cost. It's about the quality of service. Hopefully between the TPA and Virginia Mason, we can outline the benefit and what it looks like. We can't get to the negotiation process until the protest is resolved.

Gwen Rench: If it's over so many miles, would there be the possibility of paying for relatives to stay in Virginia Mason's accommodations?

Lou McDermott: We're looking at removing all barriers. This is not new to Virginia Mason and they can talk to us about how it's working today.

Dorothy Teeter: For bundled payments, depending on the procedure, there can be dramatic differences in both cost and quality. We want to continue to advocate for our members to ensure that with good education and information in front of them, they can make the choice that's right for them.

Harry Bossi: My understanding is bundled payments are not something new. Is it this kind of bundle that adds a complexity that Regence is unable to do?

Marcia Peterson: HCA is taking a slightly different approach than Medicare. They've been piloting this for a while and have different approaches of what they bundle. Most recently, on April 1, they started a change in approximately 67 metropolitan areas of the United States, where hospitals will be required to do a bundled payment. How Medicare rolls out their bundled payment approach is different from what we're doing. Their providers continue to provide care as usual and are paid in the same way on a fee for service basis. At the end of the year, Medicare will indicate whether or not they are above or below the target price that was set. They will either pay back or realize a savings.

What HCA chose to do is what Medicare has talked about doing but has yet to implement. It's referred to as a prospective payment. A price is set and the TPA would then pay the Center of Excellence. It's up to the Center of Excellence to determine how to divide the payment between the physicians, the anesthesiologist, and the hospitals. This approach gets the appropriate people talking to each other.

Dorothy Teeter: I've participated on national payment reform committees and the prospective approach is more administratively simple once you get started. There's less post reconciliation and determining who gets what. For the purchaser, it's a better way to go in terms of finances because it's a set price for a high level of quality. It provides a more stable financial base. This is the national direction.

Lou McDermott: One of the aspects of the bundle is the warranty. In fee for service, if something goes wrong after you've had a procedure, you do another procedure and continue to be billed. The more that goes wrong, the more the provider is paid. There is a warranty associated with this bundle which prevents that from happening. It incentivizes the provider to do it right the first time. It helps to ensure picking the right candidate for the right procedure. Your team is organized together and they've demonstrated they're doing it right. Virginia Mason has demonstrated this ability, their numbers reflect it, and their complication rates reflect that.

Virginia Mason walked the HCA on-site visit team through the total joint replacement procedure starting from when a patient shows up to the facility, through the procedure in the operating room, to the patient taking their first steps after the procedure, and then

their discharge. We walked through the entire process with the team that handled each part of the procedure. They demonstrated the handoffs and how everything works on their side. It was very impressive. At the same time, seeing how it worked at different facilities was also very alarming.

SmartHealth Update

Scott Pritchard, PEB Benefit Strategy and Design Section, provided an update on the SmartHealth Program. I was struck by the bundled payments and how that is behavior change for provider systems. I want to talk about behavior change for us in our lives, which I think is harder, but just as impactful.

We just finished our first year of SmartHealth 2015. We'll review the document provided, starting with our SmartHealth goals. Our long-term goals are 70% registrations, 65% Well-being Assessments, 60% incentive qualifications. The 70% goal for registrations is evidence-based on when you begin to see changes in a culture. In 2015, we reached 39% registrations, 37% Well-being Assessment completions, and 24% incentive qualifications. Our targets for 2016 are a 15% increase from 2015, moving us toward our ultimate 70% target.

With approximately 132,000 SmartHealth eligible employees, just over 31,000 members earned the incentive in 2015. Our goal is to reach our goal of 70% incentives earned in 2018. So where are we at 2015 versus 2016: In 2015, we introduced a new program. We had one significant bump due to a Seahawk Ticket giveaway. In 2016, we're not at the levels we were in 2015, but we have a longer time to reach the incentive goal. For 2016, the deadline to reach the incentive goal is September 30. We have a plan to bring those numbers up and ahead. We're hoping to find another reward to get us a bump in 2016. We have a good idea will bring forward at another time. We need to attract people and then show value.

In 2015 we focused on participation. We'll continue to work that focus throughout the life of SmartHealth, but we're now adding a second focus. We will look at the risks in our population. These risks are identified from the Well-being Assessment completions in 2015. The top four areas of risk that we need to improve are: healthy weight, back health, sleep, and exercise and fitness. Of those completing the Well-being Assessment, 65% were in the "some risk" or "at risk" for healthy weight, 43 % for back health, 53% for sleep, and 43% for exercise and fitness. What you'll see in 2016 is that we were able to take this data and move the activities toward those areas of risk. We're getting fairly high engagement in these activities, such as "Three Meals a Day," "Track Your Zzzzs," and "Healthy Pantry." Sleep is an emerging issue nationally. It's not just state employees. We're not an anomaly. There's a lot of work going on in this area of sleep. It goes from having a hard time sleeping tonight all the way up through the CPAP machines. Science is being defined as to what you can do to make a difference. There's good evidence indicating sleep impacts cardiac risk, weight, and work performance. We have activities that can really make a difference.

We're looking to increase participation and engagement. We have a strong communication plan and HCA PEB is very good at communicating details. We've engaged a marketing firm to help us accomplish that. We want to get people's attention. We'll include success stories. One of our first success stories involves a

state employee who indicated she used cigarettes. In doing so, the "Quit for Life" tile came up as an option for her. She had not realized there was an aid to help someone quit smoking, even though we had communicated it multiples times. She decided to try it. Then her husband decided to try it, too. They were thrilled with the service and said it wasn't as hard to quit as they thought it would be. They quit for their grandchild so they'll be there as she grows older! It's great to see data, but it's even better to hear about the people and their successes.

Wellness coordinators are a passionate group, a volunteer army! The more training we can provide, the more they can help engage and integrate SmartHealth into their programs and their programs into SmartHealth. We'll focus on the large agencies first. The University of Washington and DSHS make up 34% of our SmartHealth eligible population. Agencies of a thousand or more employees make up 57%. We will focus on everyone, but we'll put a special focus on the larger agencies.

Dorothy Teeter, Director of HCA, and John Wiesman, Secretary of DOH, assisted in getting Cabinet participation. They provided Cabinet with registration numbers and Well-being Assessment completion numbers. Cabinet really responded so we're ready for Dorothy and John to make a return engagement.

We are preparing the final draft of Well-being Assessment completion rates and rankings for all agencies and higher education institutions. The final draft of the Well-being Assessment results was sent to all qualifying work organizations with 50 or more employees so they can see where their agency may have some issues. The Ethics Board did conclude that state employees can use state time and state resources for wellness as long as their agency has current wellness policy in place.

Harry Bossi: In the health risk assessments, I was under the impression that they would be connected to labs so that if someone had lipids or maybe even blood pressure it could be tied into that, but I guess it's not.

Scott Pritchard: Industry-wide some organizations choose to include the biometric measures. In labs, you normally don't get blood pressure but you get cholesterol, triglycerides, and blood sugar. We could choose to do that. We'll continue to discuss it.

Harry Bossi: I saw that healthy blood sugar is low risk in the chart focused on risk reduction.

Scott Pritchard: It's self-reported.

Harry Bossi: What's missing is any indicators of risk for blood pressure and cholesterol, which I intuitively think are probably a high risk. Is there a way to capture it, or you can, but not through this.

Scott Pritchard: We could make a choice to do biometric measures.

Harry Bossi: I'm not suggesting that but can you get this information from the health plans in aggregate data?

Lou McDermott: The health plans wouldn't have it directly. It is not part of claims data. Clinical data is kept at the clinical level, such as in Electronic Health Records (EHRs). It would be a fairly significant lift to extract that information from the EHR, normalize it, and embed it within Limeade's database. There's a fine line of how deep you dig into someone's information. Technically it is feasible, but we haven't decided to go there.

Life Insurance Procurement Results

Beth Heston, PEB Procurement Manager, provided an update on life insurance procurement results. For a little history, our current life insurance benefit was purchased in 1977 by the State Employees Insurance Board, which was the organization that became the State Employees Benefits Board, which in turn became the Public Employees Benefits Board. The contract had not changed in all those years even though the PEBB Program changed significantly. We attempted to re-procure in 1993, but with no success. In 2012 there was a benefit change to simplify the plan design by removing a salary based plan and to re-enroll existing participating members into a non-salary based plan.

Our goals for the current re-procurement were to align the benefit with Results Washington, procurement reform law, and to be more transparent about how we manage the contract. We wanted to explore more modern, efficient, and cost effective options for benefit administration; to improve the benefit design, cost, and bring the benefit current with industry standards and practices. We want to maximize the benefit.

The current life insurance plan has a basic life benefit of $25,000 for every employee paid by the employer and $5,000 in accidental death and dismemberment. For voluntary supplemental plans, the employee is offered guaranteed issue of $250,000 when they first become eligible and enroll. They can go up to $750,000 with evidence of insurability, with underwriting. Spouses get 50% of that and can have $100,000 in guaranteed issue. Anything over $100,000 requires evidence of insurability. There is a retiree life plan starting at $3,000 with an age reduction schedule attached to it. At 65-69 it's reduced to $2,100, at 70 and it's reduced to $1,800. There is a supplemental accidental death and dismemberment plan up to $250,000 for the employee, 40% of that for the spouse, and either 5% or 10% percent for the dependents depending on how the family is made up.

MetLife is the apparently successful bidder. We are currently in negotiations with them discussing plan design and premium cost.

Marilyn Guthrie: Does PEB have a schedule for reviewing contracts?

Beth Heston: We're currently re-evaluating all of our contracts and trying to determine how long is too long, what is long enough? We anticipate this new contract will be for five years, renewable for two more five-year terms, with a 15-year limit.

Lou McDermott: Normally when contracting in the modern era, you have a schedule for a set number of years, and then it can be year-by-year up to a defined limit. There are some contracts that have slipped behind that and this was one of those. When Beth took the position, she went through all of the contracts and asked why Life was so old. It took a while, but we finally got to the RFP process.

Yvonne Tate: Have you thought about raising the Basic Life policy amount for employees? It's a meager amount.

Beth Heston: We've thought about a number of ways that we can maximize the benefit. We hope to have really good news for you next time.

Greg Deveraux: Just for history, the amount was $5,000 for many, many years until my union sued the state and the settlement increased it to $25,000 and increased it for retirees. It hasn't always been at that level.

Harry Bossi: I agree with Yvonne that maybe the $25,000 is too low. I think the AD&D doesn't strike me as being quite right either. If it's $5,000, typically they're the same. I think the guaranteed issue seemed pretty high. It seems to me that would be a cost driver, that high guaranteed issue.

Beth Heston: Actually, the $250,000 is fairly typical in today's marketplace. We'll be looking at that as well.

Pharmacy Trends and Challenges

Donna Sullivan, Chief Pharmacy Officer, provided an update on national pharmacy trends and Uniform Medical Plan (UMP) specific trends. Trends in general we're seeing specialty drugs replace traditional drugs. As an example, the medication class called PSK9 inhibitors used to treat cholesterol cost about $14,000 per year. They potentially could replace the oral statin medications such as Lipitor and Crestor, which are generic, or about to be generic. The annual cost for these generic medications range anywhere from $300 to $1,000. We're seeing a transition from low-cost effective drugs to potentially high cost specialty products.

Yvonne Tate: Are PSK9s the ones that minimize the effect on the muscles?

Donna Sullivan: They don't minimize the effect on the muscles. They work through a different pathway so there's potential that they would be useful in patients that wouldn't be able to take one of the traditional statin medications because they've had muscle related side-effects.

We're also seeing consolidation of manufacturers within the marketplace. With that consolidation, we've seen associated strategic pricing strategies that have budget issues. Those pricing strategies and consolidations dilute the impact of products going generic, as well as current lower cost therapies. As an example, Turing Pharmaceuticals increased the price of Daraprim, a drug to treat toxoplasmosis, from $13.50 per pill to $900 per pill. That was an overnight increase. They have been invited to talk to congress about that. In addition, another pharmaceutical company, Valiant, increased the price of Glumetza, a branded version of Metformin used to treat diabetes, over 800% before that brand product went off patent and a generic product became available. Now the generic product is about $3,00 per year. There are alternative extended release Metformin products that are a generic of a different brand that are within a couple hundred dollars a year. We're seeing that type of pricing strategy on the market.

With biological products that you see advertised on television, like Embrel and Humira that treat rheumatoid arthritis, or some medications that treat multiple sclerosis, we will eventually have an interchangeable method similar to a generic for a biologic. What we don't know is how big a cost break those products will have compared to the traditional biologics that we see today. We know it won't be the significant 60-70% discount off of brand that we see with the current generic products.

We've also had new breakthrough treatments come onto the market like the Hepatitis C drugs. These are highly effective drugs that have had a positive impact on our membership, but they've also come with a Hefty price tag that has budget implications as well. We have cancer which is turning into a chronic disease. People are living longer. The medications are turning from six week cycles of really toxic injections to oral products that you take on a daily basis for the rest of your life. Of the 50 new drugs that came onto the market last year, 19 of those were cancer products.

What we've seen in the course of the last six years with the Uniform Medical Plan is an increase of total drug spend of 48%, which is the plan paid amount. Between 2014-15, 36.5% of the total drug cost saw a 15% increase in the cost of drugs. The slides shared show the total drug cost and the proportion of plan payment versus member payment. The plan proportion is slowly growing over time while the member portion is decreasing over time. It decreased approximately 20% in 2010 to approximately 12% in 2015. Our benefit structure is designed to protect patients from the catastrophic costs of medication. We have tier one, tier two, and tier three where there's a percentage co-insurance up to a certain amount, such as a preferred brand at $75 a month. As the percentage of the total cost of the brands per month go higher, the member's portion is shrinking. We're trying to break down the components of a drug trend. What is driving the increased cost? Part of it is the unit cost of the medication like inflation; the high prices when new products come on the market; utilization, which is the number of people using drugs and the number of prescriptions they're using; and then a mix the types of medications being used, brands, generics, or specialty medications.

Overall on a national perspective, last year drug spend increased 17.8% on a unit cost increase of 11%. In 2015, nearly one third of all branded drugs had a price increase of 20% or higher. The largest contributor to that spend is the increased utilization of specialty drugs. One graph shows the component drug mix brand generic and specialty and the cost increase over time. The second graph on the right is the average monthly cost of specialty, generic, and brand name drug. Generic drugs barely register because they're so inexpensive. The average is about $50, whereas the cost of the specialty drugs average $5,000 a month. It's skewing the graph. With our UMP experience, we're increasing about 16% of brand traditional cost and 17% percent per month on the specialty cost. A month's supply for the generic drugs decreased 7%.

How did utilization play in our pharmacy trend? I looked at the growth of the uniform medical plan membership from 2010 to 2015. There was 8.6% growth. However, utilization isn't changing, it's the number of prescriptions per thousand members, which normalizes the utilization habits of the entire population. As it grows over time, total utilization is relatively flat, and generic utilization is moving up, which is a good thing. Brand drug utilization is going down over time, which is also a good thing. The increase in specialty drug utilization was 19%. It was the fastest growing increase of utilization in our population. Nationally, the specialty drug costs, or utilization, rose only 7%.

Lou McDermott: That is one aspect I'd like the Board to notice. The numbers continue to indicate that the cost of specialty drugs is driving the program. When we meet with MODA and they say there's been a 15% increase in specialty drugs, generics are stable, and brands have gone up a bit, that's what drives it home. It's a very small utilization with massive impact on the program. Anytime there's an increase in cost, it's having a significant impact on us.

Donna Sullivan: Our overall pharmacy trend is not being driven by utilization increases. It's driven by increased unit cost and the drug mix. In 2015, the percentage of all specialty prescriptions was 0.6% of the utilization. So 0.6% of our utilization accounts for 40% of our total drug spend. That's what Lou is alluding to. We're seeing the same thing nationally. At the national level, 37.7% of drug spend is specialty drugs. That is expected to increase to at least 50% of total drug spend by 2015. That is just the outpatient portion, not medications we're paying for under the medical benefit.

I split the top drugs we're paying for into two categories, tradition drugs versus specialty drugs. On the traditional side insulin products have increased in cost significantly over the past six years. Atlantis and Humalo, which are insulin products, are really driving our tops drugs. We spend the most on those drugs which treat diabetes. The diabetes population is pushing us upwards on our trend. The Uniform Medical Plan experiences trends similar to the national picture with six of the national top ten drugs appearing in UMP's top 25 drug list for 2015.

Harry Bossi: I would just like clarification. When it says "Express Scripts," that sounds like something that surveyed among all other people, KBNs or whatever, that's just within express scripts.

Donna Sullivan: Yes. That is within Express Script's report on their book of business, which is several million people. The last slide compares the top ten specialty drugs for Uniform Medical Plan compared to those in the Express Scripts report. Again, there's duplication on both. UMP is experiencing the same thing we're seeing across the country nationally. The entire country is trying to figure what can be done to help control the spend going forward.

Dorothy Teeter: This is a somewhat bleak picture in terms of on how to control pharmacy.

Greg Deveraux: Do we know of new specialty drugs coming on the market versus just outrageous increases in existing specialty drugs.

Donna Sullivan: I don't know, but that is something we could bring back. I can look into the utilization of new products hitting the market at high prices versus the high price increases over time.

Dorothy Teeter: How much of the cost related to pricing are new drugs on the market? Are they being priced like Hepatitis C, for example? How much are specialty drugs that have been on the market that somebody overnight changed the price? Is that what you're asking? It's the pricing strategy?

Donna Sullivan: Yes.

Yvonne Tate: Another related issue to me is the fact that unfortunately, or fortunately depending on how you look at it, some of these specialty drugs are making a huge difference.

Donna Sullivan: They are.

Yvonne Tate: I have an 88 year old friend who has leukemia. The traditional chemotherapy wasn't showing good results so they put her on a new specialty drug that costs $3,000 a month. She's had incredible results. Lucky for her Group Health found a way to cover the cost for her, but I can't imagine an 88 year old being able to afford $3,000 a month for a drug that really works but is just so expensive. There's got to be a solution to this that makes more sense.

Dorothy Teeter: Your point is well taken. That's why this is not just a financial conundrum, it's an ethical conundrum. Hepatitis C drugs, for example, are priced in a crazy way from our perspective. If everybody had access to those drugs, there is a potential, that over time, the whole disease could be eradicated. We are struggling with this and this will get tackled at the national level. We're also bringing people together at the state level to see what can be done in the short term.

Tim Barclay: Donna, from your description of the problem, it doesn't sound to me like you believe benefit plan design is really a key part of the solution.

Donna Sullivan: I really don't see how benefit plan design can be a key part of this solution. We can make small increases in member share, but we don't control the cost of the drugs. It's either going to come out of the member's pocket, or it's going to come out of the plan's pocket (or the state's pocket). The state needs to fund it. Where we have challenges is if we don't get the needed funding rate from the state Legislature. Then our options would be plan design changes which may impact the Collective Bargaining Agreement if it has identified limitations. Sometimes it's difficult to balance the budget to make ends meet and still provide the needed care to the patients.

Tim Barclay: Right, but it doesn't sound like member behavior is the key to this trend.

Donna Sullivan: No, it's not member behavior. It's really the cost of drugs. One of the strategies we used for the Valiant product, Glumetza, was to block it. We are not going to pay for it. There is a product that is almost an identical copy that is a tenth of the cost, if not less. That drug doesn't have any value in our new value-based purchasing strategies and methodologies.

Dorothy Teeter: I think that's a really good question. If you look at utilization, it answers that question about whether or not it's a benefit design. We'll look forward to continued updates on this topic. We will continue to wrestle with how we manage these costs as they continue to rise.

Meeting adjourned at 3:15 p.m.