Washington State Health Care Authority

Public Employees Benefits Board
Meeting Minutes

May 28, 2014
Health Care Authority, Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 3:30 p.m.

Members Present:
Dorothy Teeter
Greg Devereux
Mary Lindquist
Gwen Rench
Harry Bossi
Yvonne Tate
Marilyn Guthrie
Marc Provence
Melissa Burke-Cain

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 April 16, 2014 PEBB Meeting Minutes
It was moved and seconded to approve the April 16, 2014 PEB Board meeting minutes as written. Minutes approved by unanimous vote.

Agenda Overview
Lou McDermott, PEB Division Director, discussed the ongoing activities in the PEB Division and gave a brief overview of today's agenda. The PEB Division has been busy with the surcharges and wellness activity attestations. Our call volume has doubled and the number of documents processed is up 65%. We continue to work to smooth out the Diabetic Prevention Program and the Diabetic Control Program. The procurement process in ongoing with our wellness vendor, Limeade, as well as the RFR process with our vendors to procure health insurance for 2015.

Today's agenda will cover surcharges, the wellness program, attestations, and our long-term care benefit. We will also discuss our Tier 3 benefit, pharmacy benefit, and the maximum out-of-pocket issue. Dr. Lessler will discuss the very public issue of Hepatitis C drugs.

At the last meeting, compelling testimony was made about gender reassignment surgery and whether that should be a covered benefit. Dr. Lessler will discuss a timeline for benefit changes with the Board.

Changes to the wellness program will necessitate we sunset the Health Counts Program to make way for SmartHealth.

There is much activity around the Accountable Care Act. We are reviewing Requests for Information (RFI) and trying to determine how it applies to the PEB Program. There are mechanisms in place to evaluate and look at a timeline for implementation. Value-based purchasing is always our goal.

We continue to go down the clinical path to look at our data, the community, and delivery systems to ensure we are getting the best value for our members and then looking at how we communicate with our members.

PEBB Program Update

Mary Fliss, PEB Division Deputy Director, provided an update on the wellness program, the surcharge implementation efforts, and long-term care coverage.

The Governor's Order 13-06 requested that the Health Care Authority implement a comprehensive wellness program. This impacted 129,000 non-Medicare accounts. Once the Board approved the direction PEB would take, systems were designed and a comprehensive communication campaign was started. It included a change management effort across the state.

From April 1 to May 15, we asked all 129,000 people to go into My Account and take an attestation related to how we defined tobacco and tobacco use, walk through what spousal coverage meant, and do the three activities voted on by the Board in January for their wellness activities.

We enabled them to make changes to their account similar to those changes that they can make during Open Enrollment. The Pay1 system was programmed to accept that information. We also provided an option for them to complete this process in paper form.

The current phase required us to reprogram the system to enable members to complete their wellness attestation through June 30, 2014. However, they cannot make attestations for surcharges or make account changes. We are in the midst of keying the attestations received in paper form to make sure we hit the June cutoff period for the July payroll cycle and that records are accurate for all eight payrolls that we work with.

Phase four is an adjustment period. We are enabling those members who did not participate from April 1 to May 15 the ability to attest once they realize they have been charged a surcharge. We will reopen the Pay1 system so My Account people can make their attestations that will be retroactively applied to the July 1 cutoff, and then the adjustment will occur in accordance with the attestation they make.

Finally, during our August through November open enrollment period, people with prospective changes to their surcharges can go into the Pay1 system through My Account to attest that they quit smoking and are no longer using tobacco products. As we look at operationalizing this, we will revisit some of those decisions, systems, and communications to make sure we are accurate as we look at Special Open Enrollments and people's changes in their spousal coverage.

We were very pleased with our response. 121,000 people signed up for My Account. This project started with 27,000 users of My Account. We achieved 94% participation. 112,000 people attested to tobacco use, or 87% of those with an active account. 90% of those who cover spouses went into the system and attested to the spousal coverage; and so far, 95,000 of the members have participated in the wellness attestation, 74%.

Dorothy Teeter: The 94% participation is incredible. The efficiency we now have with people using My Account is great going forward. I know that this was a huge stretch for your team and the folks that answer calls, etc., but it will really help us going forward when everybody has moved over to this system.

Mary Fliss: I want to share three of my biggest takeaways as we wrap up a major phase of this project. The first takeaway: the Health Care Authority is very fortunate for the team it has. It's typical that we have one open enrollment a year and we do things on a routinized basis. We use this time of the year to look at reinventing our systems and doing projects. It really took a state effort for us to pull this project off. It required state leadership and labor leadership, the PEB team, and the HCA team. We produced member agency and stakeholder communications, trained those agencies, and visited staff sites.

The second takeaway: members now know and respond to PEB requests. When I started here about ten years ago, our members related to their agencies and retirees related to PEB. They didn't need to respond to us. That dynamic has changed. A lot of the response we got back from members was that they felt rushed as they went through this process. I went to one of the employee education fairs and was struck by the role of being a translator of a foreign language; that we speak in a lot of acronyms and don't use language that is common to people. Health literacy and having easy to use systems are going to be hallmarks of our success moving forward.

The final takeaway: I was very pleased to see and hear the number of people who gave up tobacco use because of this project. It was striking to me the number of people who relayed that and the number of stories I've heard. This was, in many ways, a public health effort for us. I think we have an opportunity to continue to build on this effort and continue to drive towards helping our members free themselves from tobacco use.

Gwen Rench: It looks like a very small percentage of people indicated they do smoke compared to the percentage in the general population. What monitoring can there be as far as the accuracy of these figures?

Mary Fliss: We will not have a routinized monitoring effort. It will be up to state agencies, as always, to determine if employee attestations are true and accurate statements. The yeses may be understated in this circumstance because about 15,000 people have not attested. It could be that those are people that would attest yes; and instead of going through the attestation process, they'll just default as a smoker and not actively participate. I don't think the answer of "yes" is necessarily a representation of the populations. Even if you cover five people on your account and all five people smoke, there is one answer of "yes" to tobacco use. It is a per account surcharge.

Harry Bossi: I want to compliment all concerned. This is a remarkable achievement given the time constraints and the systems that you have to operate with. I know everybody congratulates you and the staff, all concerned. Do you know how many chose to change health plans, add spouses, or drop? Is there a sense for how many accounts that impacted?

Mary Fliss: I don't know how many people have switched plans. We do know that about 1,100 people removed dependents during this time. Half were spouses and half were children dependents.

Greg Devereux: I also want to compliment you and your team on the wellness part of it, very much. Was there a target for the wellness percentage? 74% seems quite high.

Mary Fliss: We had a target number of those who answered yes as 55% in the budget. The percent, the 95,000, are people who attested and of those 72,000 said "yes, I have done the three requirements." 15,000 said "no, I haven't done the three requirements." What we are hoping is that a large percentage of them will have read that they have to do their health assessment as one of those activities, answered no during the initial time period, go back in and do their health assessment, and then come back into My Account and redo their attestation where they can say "yes." We are waiting for the final numbers, but the budgetary target of 55% we met.

Dorothy Teeter: Are we able to check to see how many people say they are now not smoking and have accessed their smoking cessation benefit? It would be great if people are actually using this benefit.

Mary Fliss: We do know there has been an increase of at least 200 people now participating in the smoking cessation program through April 2014. For each of the plans that is a free service. Even if they are continuing to use tobacco, if they are participating in a smoking cessation program, they are not subject to the smoking surcharge. We are hoping they become successful graduates from those programs.

Moving on to long-term care, we were notified in April that John Hancock is closing its long-term care product to new members effective August 1, 2014. Our enabling statute, 41.05, contains a legal requirement specific to a fully insured groups products and what is offered to all state employees. This includes state agencies, higher education institutions, and all political subdivisions. This is broadly offered and available to them, their spouses, their parents, and their spouse's parents. We looked into what's available in the market.

In 2009, there were six group carriers licensed by the OIC. Currently two companies are offering group long-term care benefits. We contacted them and neither is currently offering group long-term care products. So, at this time, we are unable to procure for this product because it is not available in the market place.

This is a product that has had flat enrollment since the time we began offering it. In 1998 when we introduced this product, we had 1,800 subscribers. A couple years ago we had a targeted communication in an effort to make people aware of this benefit offering. We now have 1,676 current subscribers. We plan to communicate to members, both those that participate in the product as well as those who do not, about the product's closure as of August 1, 2014 for the state agencies and higher education institutions. We will document the status of the marketplace and how it works in conjunction with our statute so there's documentation around the impossibility of fulfilling this statutory mandate. We will also continue to perform due diligence during our yearly procurement cycle to monitor the marketplace for any new offerings.

UMP Pharmacy Benefit

Elizabeth James, Special Assistant to the Chief Medical Officer: Elizabeth introduced a new pharmacy benefit and updated the Board on the Maximum Out-of-Pocket (MOOP) for the pharmacy benefit.

Elizabeth discussed the Tier 3 benefit exceptions. Our current Tier 3 drug coverage is 50% coinsurance for our brand-name/non-specialty drugs and there is no Maximum Out-of-Pocket cap for each individual prescription for Tier 3 drugs other than a $150 cap for a 30-day supply of a specialty drug. We are proposing to have an Exceptions' Policy whereby members who qualify will be given their Tier 3 prescription at the Tier 2 coinsurance, which is a 30% coinsurance with a cap of $75 per 30-day supply. The drugs that will be eligible for the review are Tier 3 non-specialty drugs. They will not include drugs that have an FDA approved generic equivalent. That is not the same as an alternative.

The Exceptions' Policy process is still under development. We're looking for the most streamlined process whereby we can also be the most consistent in approaching the reviews and then giving the exceptions to the appropriate members. The initial request can be made by either the provider or the member. It will be reviewed by Moda Health as clinical prior authorizations. Providers will be required to submit documentation just like with any prior authorization. They will have to outline the member's circumstances for requiring this Tier 3 drug as opposed to another alternative that might be in Tier 1 or Tier 2.

We are still developing the criteria for these approvals; but in general, the approvals will be based on documented adverse events that are often reported to the FDA as adverse events with the medication, and if there is also a lack of therapeutic response with the particular Tier 2 or Tier 1 drug the member has already tried. This has a negligible administrative/financial impact.

The Board will be voting on this proposal on July 23, 2014.

Marc Provence: What is the turnaround time for Moda to review?

Kristin Sisourath, Moda Health representative**:** Moda Health is the prescription drug administrator for the UMP Prescription Drug Plan. Our goal is to have prior authorizations reviewed by our clinical team within 72 hours. We also have an urgent process where those can be reviewed sooner if the prescriber indicates their request is urgent.

Greg Devereux: Who is Moda and how did we get to Moda?

Kristin Sisourath: Moda went through a rebranding about a year and a half ago. We were formerly known as ODS, Oregon Dental Service. We started out as a dental insurance company in 1955. Over the years, we've expanded our offerings and now we have a full array of services that we offer expanding not only to pharmacy, but also a full service of medical benefits. We chose a name that better represented our company and the services and products we offer. That's how we came up with the name Moda Health.

Elizabeth James: Moda has the same CEO, staff, and folks that we've worked with since 2007. New name.

Harry Bossi: Does this impact only the Uniform Medical Plan?

Elizabeth James: Yes, I am presenting Uniform Medical Plan benefits only today.

Harry Bossi: Understanding that the Group Health and Aetna are fully insured, as far as consistency, is the benefit going to be similar in terms of limitations or opportunities for members who are in those fully insured plans?

Elizabeth James: I can't speak for Group Health or Kaiser, but they do have a very different structure to their prescription benefit.

Harry Bossi: How is a member able to sift through this. Do I want to try to move to UMP because of this or do I have a similar benefit? Is this an enhanced benefit with UMP that they might not have in a fully insured plan?

Elizabeth James: Again I don't want to speak for the other plans. How UMP has differed in the past is that UMP has always been an open formulary. We have covered every drug with the exception of the exceptions, things that aren't FDA approved, things that have over-the-counter equivalents and such. This is an enhancement and will positively impact those members who have had cost prohibited experiences with a Tier 3 drug where they need it. So, again I can't speak to the other plans, they have different formularies entirely.

Dorothy Teeter: That's an excellent question. Maybe we can do the research on the others. For clarification, in order to receive this different benefit or enhanced benefit, you have to go through a prior authorization process, correct?

Elizabeth James: Anyone who takes a Tier 3 drug will be eligible to appeal or to go through the prior authorization process, but then they will have to meet the criteria to actually get the waiver.

Dorothy Teeter: This is a really important clarification. I think your point here is one that we are trying to do increasingly across all three of our plans within PEBB, to start comparing what's different and what's the same about them so we end up with more consistent clinical policy. We'll look into that.

ACTION ITEM: We need to compare this benefit with all three plans, UMP, Group Health, and Kaiser. Compare what's different and what's the same between the plans.

Elizabeth James: Elizabeth discussed the proposed 2015 non-Medicare Maximum Out-of-Pocket (MOOP) for pharmacy for UMP. Having a Maximum Out-of-Pocket for pharmacy costs is an Affordable Care Act requirement that has to be put into place in 2015. PEBB's response has been to have a separate MOOP for pharmacy of $2,000. Currently, there's a MOOP for members on the medical side of $2,000 and there is not a MOOP on the pharmacy side. But there is an adherent MOOP when we have caps on the Tier 1 and Tier 2 prescriptions, and the Value Tier.

Greg Devereux: Presumably under this Out-of-Pocket Maximum, you could spend more than you currently are on pharmacy if the maximum is medical now, including pharmacy.

Elizabeth James: The maximum now does not include pharmacy. The maximum right now is only for medical benefits.

Based on 2013 data, approximately 645 non-Medicare subscribers would be impacted. We've done a couple different data pulls trying to get just right on the number, so somewhere around 1,300 or 1,400 non-Medicare members would be impacted and would have spent more than $2,000 out-of-pocket for their pharmacy costs, including the deductible.

The financial impact, again based on 2013 data, indicates it's a very small increase in expenditures at the moment. It is less than a .2% increase in overall expenditures and just under 1% increase in pharmacy expenditures for UMP under PEBB. The financial impact to the members of costs is lower out-of-pocket costs for high utilizers. What I'm hoping to have for you at the next meeting is a little bit of a description, some sort of a categorization or characterization of some of the members who might be impacted. It could be all over the board, so I can't promise it will be a real clean description, but as always in the past when I have presented changes to the pharmacy benefit, I like to give some pictures of what our members look like that might be impacted.

ACTION ITEM: Elizabeth will provide a brief description, categorization or characterization of the members who might be impacted by this change.

Dorothy Teeter: This gets pretty complicated, so I want to make sure people understand. I think the concept of financially benefitting members is really the fact they have better access to the drugs that they need. It's not the term financial benefit, but more of a clinical benefit.

Elizabeth James: Perhaps for the Tier 3 exception. In the Tier 3 exception process, there would be better access. For the Maximum Out-of-Pocket, under the assumption that members would continue to take the same drugs, it will be a purely financial impact because they will not be spending any more money once they reach the limit.

Marc Provence: Are we on a formulary? It sounded like we basically cover anything, but do we have a formulary that applies to this?

Elizabeth James: We call it a preferred drug list and it is basically an open formulary which means we do cover essentially everything. The things that we don't cover are either in a rule or a policy that's been long standing. We have a very rich benefit and we allow access to our members to virtually everything based on the Tier scale. We have a Value Tier which is the least expensive tier, Tier 1, Tier 2, and Tier 3.

HCA Medical Director Update

Dan Lessler, Chief Medical Officer: Dan briefed the Board on two important clinical topics. The first topic is Hepatitis C, which is caused by a virus. It's actually caused by a particular type of virus that's called an RNA virus. This virus was not identified until relatively recently. Prior to 1989, Hepatitis C was known as Non-A and Non-B Hepatitis. That's when it was discovered, but it took several years to develop mechanisms to actually be able to screen the blood supply for the virus. When I was in residency, when I would see patients with abnormal liver function tests and couldn't find any underlying reason for it, we would say it must be Non-A or Non-B. Now we know a lot of those people actually had Hepatitis C.

The virus comes in multiple types named Type 1, 2, 3, and 4. There are types 5 and 6, but 1 through 4 are overwhelmingly the ones we see; and of those, the most common is Type 1. That's roughly 80% of people who are infected with Hepatitis C.

Some of the risk factors for Hepatitis C are: blood to blood contact (e.g., IV drug use), blood transfusion prior to 1992, those who received hemodialysis, body piercings or tattoos with non-sterile instruments, known exposure to Hepatitis C virus (HCV), infected with HIV, and vertical transmission from infected mother to child in less than 10% of pregnancies.

A frequently asked question is about vertical transmission from mother to child and breastfeeding. Vertical transmission does occur from infected mom to child in about less than 10% of pregnancies, but it is not spread by breastfeeding.

Epidemiology is the most common cause of chronic Hepatitis in this country because people with this disease who are infected are at risk of developing scarring, and ultimately progressing to fibrosis. It is the leading cause of cirrhosis and liver cancer and liver transplantation in this country. Somewhere around 1%, or slightly over 1%, of the entire United States population is infected with Hepatitis C. We're talking on the order of 3 million or more people in this country.

Not everyone who is infected actually goes on to develop a chronic infection. About 20% of people who are infected are able to clear the virus. They'll have evidence of previous infection, but when you look for the virus in their blood, you won't find it. They're very lucky. One in five people actually clear the virus now because the blood supply wasn't screened until 1992. The end result of that is that the prevalence of Hepatitis C is greatest in people born between 1945 and 1965.

This gives you a sense of the clinical epidemiology or the clinical course. We don't know exactly, so between 15-25% will clear the infection and will not go on to develop chronic liver disease. They are not at any risk. However, the remaining 75-85% will develop chronic infection; and of these, 60-70% will go on to develop chronic liver disease. And by chronic liver disease we are talking about some degree of scarring which can be moderate or it can be more severe. When it becomes very severe we call it cirrhosis. 5-20% will go on to actually develop cirrhosis. It also plays out over many years. From the time somebody is infected to the time, if they are going to develop complications in terms of from scarring, it will take 20-30 years. It plays out over a long time span, and ultimately one to five patients from that original number will die from cirrhosis or liver cancer.

There was a point in time when Hepatitis C had no treatment, but then treatments did come along using the drugs interferon and ribavirin. Interferon in particular has a very high rate of toxicity associated with it. People develop anemia, low white blood cell counts, and they feel like they are walking around with the flu because that is what your body produces when you do have the flu. Unfortunately, not only are ribavirin and interferon toxic, they're not nearly as effective, or weren't nearly as effective, as we would like and would clear the virus in less than 50% of the people. And that was the 50% of people who could actually tolerate the months of treatment. More recently there have been breakthrough drugs that have come to market such as Sofosbuvir, which goes by the trade name Sovaldi, and Simeprivir, that goes by the trade name Olysio.

For the most common type of Hepatitis C which is Type 1, and again that is about 80% of people, one or other of these drugs are used in combination with interferon and ribavirin. I'm going to focus on Sofosbuvir here because that is the drug that is seeing the most play. I do want to emphasize this terrain is rapidly changing.

What we talk about today will be different this autumn. In my New England Journal of Medicine over the last six weeks there have been one to three articles about newer treatments,

all demonstrating remarkable effectiveness against Hepatitis C. This is a changing field to be sure. With respect to what is available now, with Sovaldi, this is in combination with ribavirin and interferon, and that's where we are talking about Type 1. This appears to be considerably more effective than prior available treatments. For genotypes 2 and 3, it actually enables treatment without the use of interferon. So, in 2 and 3 you can use just ribavirin and Sovaldi. The other point is for genotype 1, the most common, and 4, which is less common, you still need to treat with interferon and ribavirin, but the treatment is only for 12 weeks. So, whereas other treatments require 24-48 weeks of being on fairly toxic drugs, this really shortens up the length of time that someone is on a toxic drug.

The downside is that Sofosbuvir costs $1,000 a pill and people need to be treated for 12 weeks. When you calculate all the costs of treating somebody with Type 1, the most common for example, including the interferon which itself is not cheap but considerably less expensive than Sofosbuvir and ribavirin, the total cost is about $90,000. So, it is very expensive. To put this in a national context, we're talking about a country that has 3 million people infected with Hepatitis C.

Dorothy Teeter: That's 3 million by $90,000, more than a billion!

Greg Devereux: I assume there are off-setting costs, though.

Dan Lessler: The best cost effective analysis of Hepatitis C treatment, based on some of the earlier treatments, shows that there are off-setting costs, but ultimately it's unlikely that you'll recoup your investment. I have friends and colleagues at Stanford that are working on an updated cost effectiveness analysis. They did the initial work a couple years ago. You recoup some costs, but it's not cost-saving. In clinical economic terms we refer to this as a cost-effective drug; and I think the Iser Group, a Harvard-related technology assessment group, provided a report to the California Technology Assessment Program. Essentially they reviewed this and came up with numbers for treating people with more severe liver disease, $25,000-$30,000 per life year saved, which is comparable to many things that we pay for in medicine. This will add to net cost. I don't think the final word is in on this. So there are off-setting costs, but it is not at all clear that this is going to be cost-saving.

Greg Devereux: I'm not completely clear what cost-savings would be. It would seem to me that if the alternative to this is taking toxic drugs which could land you in the emergency room, and you're no longer taking those drugs, then clearly it's not a net $90,000 cost.

Dan Lessler: Comparing the current treatment, that is true. What you're talking about is the cost per sustained viral response because sustained viral response means equivalent to clearing the virus. So how many people do you need to treat, and at what cost, to get a sustained viral response? It appears that the cost for sustained viral response with this drug at this cost is about equivalent to what the cost is for sustained viral response using older treatments because the older treatments are less effective, but they're less expensive as well.

Harry Bossi: The $1,000 cost for a pill, is that retail or wholesale or through Moda?

Katie Scheeler, Clinical Pharmacist, Moda Health**:** That price tag is the AWP price before any discounts would apply.

Marc Provence: Does it make any difference in terms of the course of treatment, the efficacy, or the cost, how early in the course of the disease this is applied?

Dan Lessler: That's an important question. It's one that we'll probably be coming back to the Board for discussion. It turns out that the further along you are in terms of degrees of fibrosis, the less likely you are to respond to the drug. That said, you'll recall that there are many people who are chronically infected who will never go on to develop the disease. They will never have any fibrosis and they will live long lives and die of other causes. That population is much bigger. If you start treatment in folks that have no evidence of liver disease, you'll be treating many people that ultimately would not need to be treated. Whereas if you wait, you'll then be treating people who need treatment but are less likely to respond. How much less likely they are to respond is something that we don't fully understand at this point and will likely change as new treatments become available.

So how many people are we talking about in PEBB? I have approximate numbers. They give you a ballpark because there's a confidence interval around these due to assumptions about how similar the PEBB population is to the general population. Even the general population numbers are subject to a range. Approximately 3,400 people across PEBB would have chronic infection. If you treat those people who have moderate or more severe liver disease, then about 1,100 or more of those would potentially be eligible for treatment. The other complicating factor is that only 30-50% of people who are infected know they are infected and it will be 25 years before you present with symptoms. Many people will never develop the disease. They haven't gone to the doctor and asked to be checked for Hepatitis C or there haven't been reasons that the doctor said you should be checked. The United States Preventative Services Task Force is now recommending people born between 1945-1965 be screened now that we have good treatment available. This is an opportunity for PEBB.

As I mentioned, the landscape is rapidly evolving and that newer highly effective and relatively safe treatments will be available in 2014. What's important about the newer treatments is that they will enable interferon and ribavirin free treatment but they will be very expensive.

Greg Devereux: Are interferon and ribavirin expensive?

Dan Lessler: Relative to these drugs, no. Hydrochlorothiazide, a blood pressure medicine, is less than a penny a day. A 12-week course of interferon is around $4,000 or $5,000, and ribavirin would be considerably less expensive than that. [UPDATE: Approximate cost $16,600 for 3-months of interferon and ribavirin]

Marc Provence: Of the risk factors you listed, a couple you could classify as preventable; IV drug use and body piercing and tattooing with non-sterilize instruments. There would be opportunities for other kinds of intervention. Do you have any sense of how much those two contribute to the overall incidence?

Dan Lessler: Its overall prevalence, it's relatively small. Most of the infection that exists across this country and in the PEBB population is amongst people that were probably infected through other means. But going forward what sustains the virus in the population in terms of transmission now is by far and away IV drug use. The last CDC estimate I saw was about 17,000 new infections per year in the United States, mostly through IV drug use. I would say that the PEBB and Medicaid plans are using more criteria to treat people, and that criteria, importantly involves identifying people with moderate or more severe liver disease. We are very carefully monitoring utilization of the medications to make sure they are being used appropriately. Because this is a rapidly changing landscape, we see this as a good

opportunity to convene our payers in short order to talk about how best to deal with the newer medications as they become available.

Dorothy Teeter: One comment that you alluded to, Dan, and I think it adds to Greg's question, is if you can imagine a world where all those folks could be found that have Hepatitis C and treated, you've pretty much eradicated a disease. In the long term it's an investment now that's huge, but yet in an interesting way it is a public health investment for the population going forward.

Dan Lessler: I think that is just such a profoundly important point. Frankly I would never have thought even ten years ago, maybe five, but ten years ago that there would be a very real possibility of eradicating the disease, and we really are on the cusp of that. It has incredible public health implications.

Moving to a different topic, at the April PEB Board meeting, we heard from members of, and advocates for, the transgender community regarding coverage for transgender care. We were asked by the Board to review this topic and make a recommendation on how to proceed.

I first want to provide some clinical context and definition around gender dysphoria. There are three key points that define gender dysphoria; 1. a person's persistent feelings of gender discomfort and inappropriateness of their anatomic sex, 2. a strong and ongoing cross gender identification, and 3. the desire to live and be accepted as a member of the opposite sex. This is a formal diagnosis that is defined in DSM. The range of prevalence seen in the literature is quite wide, predominately because gender dysphoria is relatively rare. Somewhere on the order of 1 in 11,000, 1 in 12,000, or 1 in 45,000 for male to female and 1 in 30,000 to 1 in 200,000 for female to male. Diagnosis and treatment recommendations for gender dysphoria have been developed by an organization known as the World Professional Association for Transgender Health (WPATH). This is an authoritative body that has developed evidence-based recommendations. The proposed framework by WPATH in terms of diagnosis is initial psychotherapy, hormonal therapy, and ultimately surgery. After diagnosis, a careful psychiatric assessment, particularly looking for other co-morbid psychiatric or mental illness that should be treated such as depression, is necessary. And then in a shared decision-making approach, a decision might be made to treat initially with hormonal therapy and then gain a period of time living as the opposite gender to gain experience before making a decision to proceed with surgery. This is the usual evidence-based framework.

I want to underscore that in 2008 the American Medical Association passed a resolution that recognized gender dysphoria as a serious medical condition. This resolution further states "An established body of medical research demonstrates the effectiveness and medical necessity of sex reassignment surgery." That would be an assertion with which I would agree. With respect to transgender surgery, per se, we are talking about surgical procedures by which physical appearance and function of a person's sexual characteristics are changed to those of the other sex in an effort to resolve or minimize gender dysphoria and improve quality of life. The kinds of procedures that might be included are, from male to female surgery: feminizing genital surgery, breast augmentation, feminizing facial surgery, fat transplantation; and from female to male can include mammoplasty or phalloplasty. It is becoming increasingly common for public entities and big companies to provide transgender care benefits. In summary, the diagnosis and treatment of gender dysphoria is consistent with best evidence and should be considered medically necessary.

At the April meeting the Board asked us to propose where we go from here. For the PEBB Program, that would be defining what this benefit would include in terms of hormones, surgery, and so forth. A proposed design and decision-making timeline was shared in terms of design of the benefit. This will require careful, thoughtful work on our part and due diligence to develop a comprehensive, evidence-based benefit to ensure the highest quality of care to people with gender dysphoria. We propose that this benefit would launch January 1, 2016.

Marc Provence: Could this result in a benefit exclusive to UMP or would this be a benefit requirement for other carriers? How would that work?

Dan Lessler: I think our intent is to work with and speak with Group Health and Kaiser as well.

Lou McDermott: Normally when we go through the RFR process, we're indicating what we're doing in the UMP product. We can request the other products make a proposal. We do give them that information as with any benefit change we are making. We also ask them to give us any benefit changes they would like to make in their product.

Dorothy Teeter: Building on that, as you can see with the Hepatitis C issue, we are trying to get to more consistent clinical policy for all folks that we cover. To that end, we are going to work hard to set a clinical policy and then take the steps that Lou mentioned going forward.

Harry Bossi: In the treatment plan, it talked about the initial diagnosis psychotherapy, hormonal therapy, and ultimately the surgical procedure. If someone had a diagnosis now of dysphoria, could not those psychotherapy, psychosocial, or psychiatric needs be met through the health plan? Or would that be denied based on some kind of CPT or code?

Dan Lessler: My understanding is we don't provide hormones much less surgery. I'm not sure if we would pay for services if someone saw a mental health provider with a diagnosis of gender dysphoria. I would need to double check that. I want to be clear that the reason for engaging mental health services is to help clarify the diagnosis and work with the individual around the diagnosis. Psychotherapy is not how you would treat gender dysphoria.

Greg Devereux: I appreciate the timeline. I talked to Lou about it and asked for a timeline. I would just hope that this is as quickly as we can do things. I assume it is because that is what you put together, but I would hope that we could move this benefit as quickly as possible and in a manner that maintains high quality.

Lou McDermott: There are a lot of other steps that need to take place. We have our authorizing environment and we need to research appropriately. I think there was some discussion about centers of excellence. As with any benefit, our benefit design portion of the year is in the fall when we begin to vet these issues. It does take a period of time. As we get into our procurement cycle of notifying our partners of what we're going to do and how we're going to do it. The way this discussion landed was at the tail end of that process which is why it's taking us to the next cycle.

Greg Devereux: The last point about not covering the mental health aspects of dysphoria seems like a problem to me.

Dan Lessler: Greg, I am not sure that that's the case, so I would want to check.

Greg Devereux: My point is that I am not sure we segregate out anything else in the mental health world and I think legally that would be a problem if we do that now.

Lou McDermott: We will take a look and get back to the Board on that issue. I don't see that we are doing that but we'll take a look.

Dorothy Teeter: Just to double check, this looks like the right direction from the Board's perspective? Hearing the urgency, to push the timing on these next steps? Ok, the consensus is yes.

ACTION ITEM: Does the PEBB Program pay for services if someone saw a mental health provider with a diagnosis of gender dysphoria?

2015 Wellness Program

Michele Ritala, PEB Division Strategy and Benefits Design Section Manager, updated the Board on the wellness strategy and the need to sunset the UMP Health Counts Program.

Health Counts is a UMP specific program. It's primarily an online wellness program started in 2006. It is available to all UMP members who are 18 years and older. That includes subscribers, spouses, children who are 18 or older, and Medicare retirees. The program has been administered through the health plan. Health Counts is housed on MyRegence.com and there's a section of MyRegence.com that's customized to feature the Health Counts Program. It's a points-based system that emphasizes all the same things that are being emphasized in the new SmartHealth Program. The incentive is in the form of gift cards ranging from $30 to $60. The participation level has been relatively low but consistent with other employer-sponsored wellness programs with a similar incentive amount. Statistics for participation in 2013 were: 16.4% of all eligible members participated. They at least took the health assessment. Of participants, employees were twice as likely to participate as other groups:

- 23% of all eligible employees participated
- 12% of all retirees participated
- 11.5% of dependents participated

The cost for Health Counts, using last year as an example, is about 2.5 million per year in administrative costs. Most of that is the per-subscriber per-month administrative fee for the services that Regence provides, the customization of the program on the website. They do offer paper health assessments, customer service, promotional costs, and all that goes along with it. In 2013 we spent about $1.4 million on incentives. We predict it's going to be over $2 million this year. The bump this year is because of the SmartHealth Program where we had higher participation. Members do get a $30 gift card for taking the health assessment so we'll be spending more money on incentives this year.

We need to sunset Health Counts due to the new SmartHealth wellness program that was established by the Governor in Executive Order 13-06. It basically replaces the Health Counts Program. Moreover, SmartHealth is targeted to all state employees and not just those enrolled in UMP. The fiscal year budget for 2015 does not include any funding for Health Counts. It does include funding for SmartHealth. The administrative costs that I mentioned for last year are on par with what we would anticipate spending for the administrative costs overall for SmartHealth services. We're currently managing two programs and that's not sustainable.

Keeping Health Counts going this year is helping members transition to SmartHealth because the activities a member can do to earn the incentive is the same for both programs. Those participating in Health Counts now can get incentives this year in Health Counts. For SmartHealth, this year is the participation year but members won't get the SmartHealth incentive until next year so it does provide a smooth transition in terms of incentives.

The UMP populations impacted by this change are UMP Medicare subscribers and UMP spouses, domestic partners, and dependents 18 and older. They will not have access to a wellness incentive in 2015. However, we are adding the Group Health and Kaiser non-Medicare subscribers for 2015, so we will be able to offer a wellness program to all employees, a broader slice of PEBB members. While UMP spouses and the Medicare retiree group will not have access to Health Counts next year, they can still access all the same tools on myRegence.com that they can access this year.

Employees PEBB-wide will have access to an incentive program. That's given a big boost to participation. The incentives make it much easier to promote, makes it easier for workplaces to get involved, and a much easier program for wellness coordinators to promote.

For UMP Medicare retirees, spouses, and other adult dependents, they'll still have access to all of the online wellness tools that are currently on MyRegence.com. It just won't have the Health Counts customization or incentives. Regence does have a Regence Rewards wellness program so part of the customization is Regence Rewards becomes Health Counts and they can add the incentives that we want them to add. So when Health Counts ends, there will still be the Regence Rewards program that offers a $25 gift card for everyone enrolled in a plan offered by Regence. If you earn at least 70,000 points, you can earn a $25 gift card. The program will end at 12/31/2014, but members can continue to earn points and gift cards in the Health Counts Program through the end of 2014.

Greg Devereux: Is the reason that Medicare subscribers, spouses, domestic partners, and dependents aren't covered merely a financial?

Michelle Ritala: I think there are a couple reasons. Financial is definitely part of it, but the executive order that was passed is focused on employees, so the costs are roughly equivalent to shift the program over to employees. We have higher participation among employees. This is primarily an online program. A key place to promote it is going to be at the worksites so the participation level would be a lot lower for retirees. We did research years ago to determine why more people weren't participating and folks who were retired were much less likely to have internet access and they cited that as a barrier to participation. They also don't have the connection to the workplace so we will continue to research these issues; but in the first year, we want to do it right and we want to focus on the charge that we were given by the Governor.

Dorothy Teeter: We had that same conversation in reviewing this issue. We agreed that for UMP and for Group Health or Kaiser, we would reassess the program for domestic partners, spouses, and dependents once we get the program launched and smoothly operating for employees, and understand that we need to determine what the costs and benefits would be of that.

Public Comment

Bobbi Dalley: Good afternoon. I'm Bobbi Dalley. I'm faculty at University of Washington. I'm a physician. I'm transgender and I'm also a member of GLMA, which is a national LGBT

health care organization. I've reviewed the proposal that was made earlier today and I personally know a number of Washington State employees who need transgender health benefits and it seems like the eighteen-month timeline is awfully long from our point of view because people are suffering now and could use health care earlier.

Another point I'd like to make is that while the presentation talked a lot about surgery, genital surgery and the other surgeries, it's not just about surgery. It's also about coverage for hormone therapy; psychotherapy, which would not be covered if you used the gender identity disorder CPT code; as well as routine health care, including the historically gender procedures, such as a PAP smear, rectal examination for prostate, prostate examination, and also breast augmentation, no mammograms. So basically, these are typically gender exams that if a male person gets a mammogram, it may be denied since it's not typically associated with that gender. Those things can be denied under the current system.

Next, I'd like to say that there's a consensus among major medical organizations as we mentioned earlier, the AMA, American Psychological Association, and many others, W-Path, that this is medically necessary and should be covered under both private and public insurance. I think the evidence is out there. These organizations have done due diligence. They've done evidence-based medicine and I don't know if PEBB needs to reinvent the wheel and go through all the evidence all over again. We have provided references and we'd be happy to be consultants in that process.

Finally, I think we've passed around a memo from the University of Washington Faculty Senate that Danielle and I pushed through. It was voted on May 1. The resolution basically says that transgender health care benefits should be covered by the programs that cover the University of Washington. So, that's my comment.

Public Testimony

David Ward: Hello, my name is David Ward. I'm an attorney at Legal Voice, an organization that works to advance women's rights and LGBT rights in Washington, and I appreciate the

opportunity to testify very briefly. First, I want to thank the Board and Dr. Lessler for moving so quickly on this and for putting together such a good presentation. It was very well researched and I think it captured many of the same key points. There's really no question about the medical necessity and effectiveness of these treatments, yet they're being denied. It does seem an awfully long time to wait, eighteen months, for coverage for services that there is no dispute about their medical necessity or effectiveness.

There's also a legal component to this. As I've mentioned when I was here last month, the state of Oregon's PEBB was sued a couple years' ago for failing to offer, or for having exclusions in its policies that denied transgender people appropriate and medically necessary health care. The state of Oregon settled that lawsuit favorably and they removed all exclusions from their plans in January of 2013. That strikes me as an option here. I mean, right now, plans all have exclusions for these procedures and they do exclude, at least in my experience from clients I've seen, they exclude things like psychotherapy, if you have a gender dysphoria diagnosis. It's pretty hard to say why that should not be covered, something that's regarded as medically necessary that anyone else would be covered if they had a different diagnosis.

And I think as Bobbi or Danielle can talk to more, you get into the situation where doctors are searching for codes that they can get covered so somebody can get the exact same treatment but doesn't have the name on it. We would encourage you to find a way to move more quickly, to make some progress on this in the 2015 benefit year. We appreciate the need to do a good design and it would be wonderful to have a very well designed benefit; but removing the exclusions would be an obvious first step and one that Oregon did, just by entering into a settlement agreement. But we do think there are models, City of Seattle, the Group Health plan, that do offer well-designed benefits already that are evidence-based and based on clinical efficacy. So, thank you.

Public Testimony

Danielle Askini: Thanks, David. My name is Danielle Askini. I'm the policy director at Basic Rights Oregon in Portland and the Advocacy Director at Gender Justice League in Seattle and I would just reiterate what both David and Bobbi said. So, I've prepared a pretty extensive brief for you all that includes a significant amount of clinical research which last time we presented on the financial impacts of this decision; but here I've really gone deeply into highlighting some of the very graveness and seriousness for transgender people, particularly highlighting suicidality and the impact of that on PEBB members and the costs that that has to the benefits to the plan itself. So, I've highlighted that. I've also talked pretty extensively in here about why both, from a medical perspective and a mental health perspective, access to care, both psychotherapy and hormones as a first step, are very urgent and are something that are currently provided for non-transgender people. So you currently provide to non-transgender women estrogen therapy for instance, or non-transgender men, testosterone. That's not something that would be new. Psychotherapy is provided for anybody who needs psychotherapy in your plans that would not be something that's new. And in fact other benefits like surgical benefits that you might consider to be provided specific to transgender people are actually currently under your plan provided to non-transgender people. So there are people who are, for instance, born without vaginas who would need vaginoplasty. I haven't scoured all of the documents, but in almost all plans is currently covered as a benefit.

So these exclusions are specific to the healthcare that is provided if you are identified as a transgender person and that is a key distinction for us from a legal perspective which is that the 2006 non-discrimination law which I've highlighted here, really clearly delineates out that exclusions that specifically target a protected category of people are not permissible under Washington State law. I can't reemphasize enough how important that is that these exclusions exist in that target a group. So it caveats out people with a particular medical diagnosis or group of people for exclusion from benefits that are currently offered to non-transgender people. So I just wanted to reiterate that point for you. I also feel, as David does, that the eighteen-month timeline is not an acceptable length of time to ask transgender people to wait for these benefits. Removing these exclusions is something that can be done in a much swifter timeline; and then if more time is needed to design a more complex benefit, I think that that's possible. But Group Health for instance, who you already contract with, has a benefit plan design in existence that they provided the City of Seattle and to their employees. Kaiser also has a benefit plan that they provide in Oregon State. I know because I work with them down there. And so these designs already exist both in Washington and in Oregon. I think adopting that for the UMP, if that's what's needed, would be a more relatively straightforward step than a lengthy study that would take eighteen months.

I thank you all for examining this issue last month and taking time this month to go over it again. I certainly know that many of the folks who approached the three of us and that we've

heard from appreciate you all taking the time to address this. So I would just again urge you all to consider removing these exclusions now and then looking at the plan design happening more rapidly, hopefully for the 2015 plan year. Thank You.

Board Comments

Greg Devereux: I don't have a follow-up question, just to comment. It seems to me that if Group Health and Kaiser have plans already, that we, the Health Care Authority, have much more control over the UMP design and so it seems to me that we could potentially expedite this quite a bit. I think we ought to look at anything we can do to expedite this step and various procedures or processes and move this as fast as we can.

Marilyn Guthrie: Well it seems to me, minimally, removing the exclusions is a logical first step. I don't know what's involved in making that type of benefit design change to our current plan but that would be, to me, the most reasonable first step.

Yvonne Tate: I think it would be helpful if staff could give us updates along the way as to where they are in developing this plan.

Dorothy Teeter: Based on these comments, let's plan to come back at our next meeting having looked at what we can and cannot do. We can't do that right now but have a follow-up to this at the request of the Board so we keep this moving and see if there are any ways in which we can at least look more quickly at some of the answers, recognizing as Dan said, we want to do a really good job of this and not rush, but that's different than taking too long.

Our next meeting is June 28, 2014 here at Cherry Street Plaza. [Next meeting is June 25, 2014]

Meeting adjourned at 3:15 p.m.