Washington State Health Care Authority

Public Employees Benefits Board Retreat

January 17, 2017

Washington State Health Care Authority

Public Employees Benefits Board Retreat

January 17, 2017
10:00 a.m. – 4:00 p.m.

Health Care Authority
Sue Crystal A & B
626 8th Avenue SE
Olympia, Washington

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TAB 1

AGENDA

Public Employees Benefits Board Retreat
January 17, 2017
10 a.m. – 4:00 p.m.

Health Care Authority
Cherry Street Plaza
Sue Crystal Rooms A & B
626 8th Avenue SE
Olympia, WA 98501

THEME: ***"Adjusting the Sails"****

9:30 a.m.	**Coffee**		
10:00 a.m.	**Welcome** **Introductions and Purpose**		Dorothy Teeter, Chair
10:15 a.m.	**"Repeal, Replace, or Delay?** **What can we expect from the new Administration?"**	TAB 3	Sally Wineman, JD Senior Vice President, Arthur J. Gallagher & Company
11:15 a.m.	**Break**		
11:30 a.m.	**"Washington Market Overview: Employers, Plan Members, Payers, and Providers: Reluctant Participation, Inevitable Evolution"**	TAB 4	Alex Rule Northwest Regional Vice President Arthur J. Gallagher & Company
12:30 p.m.	**Working Lunch**		
1:30 p.m.	**PEBB Program Benefits:** **2016 Open Enrollment & Updates**	TAB 5	David Iseminger, Deputy Director Public Employees Benefits Division Health Care Authority
2:00 p.m.	**SmartHealth Results – 2015 to 2016**	TAB 6	Scott Pritchard, Health Management Public Employees Benefits Division Health Care Authority
2:15 p.m.	**Break**		
2:30 p.m.	**Overview of Purchaser Strategies to Address Pharmacy Costs**	TAB 7	Robert Judge, Pharmacy Director Katie Scheelar, Pharm.D Moda Health
3:30 p.m.	**Closing Remarks**		Dorothy Teeter, Chair
4:00 p.m.	**Adjourn**		

*"I can't change the direction of the wind, but I can adjust my sails to always reach my destination." Jimmy Dean

Washington State Health Care Authority

PEB Board Members

Name	Representing
Dorothy Teeter, Director Health Care Authority 626 8th Ave SE PO Box 42713 Olympia WA 98504-2713 V 360-725-1523 dorothy.teeter@hca.wa.gov	Chair
Greg Devereux, Executive Director Washington Federation of State Employees 1212 Jefferson Street, Suite 300 Olympia WA 98501 V 360-352-7603 greg@wfse.org	State Employees
Myra Johnson* 6234 South Wapato Lake Drive Tacoma, WA 98408 V 253-583-5353 mljohnso@cloverpark.k12.wa.us	K-12 Employees
Gwen Rench 3420 E Huron Seattle WA 98122 V 206-324-2786 gwenrench@covad.net	State Retirees
Mary Lindquist 4212 Eastern AVE N Seattle WA 98103-7631 C 425-591-5698 maryklindquist@comcast.net	K-12 Retirees

PEB Board Members

Name	Representing
Tim Barclay 7634 NE 170th ST Kenmore WA 98028 V 206-819-5588 timbarclay51@gmail.com	Benefits Management/Cost Containment
Yvonne Tate 1407 169th PL NE Bellevue WA 98008 V 425-417-4416 ytate@comcast.net	Benefits Management/Cost Containment
Marilyn Guthrie 1640 W Beaver Lake DR SE Sammamish WA 98075 V 206-715-2760 maguthrie52@gmail.com	Benefits Management/Cost Containment
Harry Bossi* 160 E Soderberg RD J-27 Allyn WA 98524 V 360-689-9275 udubfan93@yahoo.com	Benefits Management/Cost Containment

Legal Counsel
Katy Hatfield, Assistant Attorney General
7141 Cleanwater Dr SW
PO Box 40124
Olympia WA 98504-0124
V 360-586-6561
KatyK1@atg.wa.gov

*non-voting members

1/26/16

Washington State Health Care Authority
Public Employees Benefits Board
P.O. Box 42713 • Olympia, Washington 98504-2713
360-725-0856 • TTY 711 • FAX 360-586-9551 • www.pebb.hca.wa.gov

2017 Public Employees Benefits Board Meeting Schedule

The PEB Board meetings will be held at the Health Care Authority, Sue Crystal Center, Rooms A & B, 626 8th Avenue SE, Olympia, WA 98501. The meetings begin at 1:30 p.m., unless otherwise noted below.

January 17, 2017 (Board Retreat) 10:00 a.m. – 4:00 p.m.

March 16, 2017

April 12, 2017

May 18, 2017

June 21, 2017

July 12, 2017

July 19, 2017

July 27, 2017

If you are a person with a disability and need a special accommodation, please contact Connie Bergener at 360-725-0856

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: August 11, 2016
TIME: 11:06 AM

WSR 16-17-045

TAB 2

Washington State Health Care Authority

PEB BOARD BY-LAWS

ARTICLE I
The Board and its Members

1. Board Function—The Public Employee Benefits Board (hereinafter "the PEBB" or "Board") is created pursuant to RCW 41.05.055 within the Health Care Authority; the PEBB's function is to design and approve insurance benefit plans for State employees and school district employees.

2. Staff—Health Care Authority staff shall serve as staff to the Board.

3. Appointment—The Members of the Board shall be appointed by the Governor in accordance with RCW 41.05.055. Board members shall serve two-year terms. A Member whose term has expired but whose successor has not been appointed by the Governor may continue to serve until replaced.

4. Non-Voting Members—Until there are no less than twelve thousand school district employee subscribers enrolled with the authority for health care coverage, there shall be two non-voting Members of the Board. One non-voting Member shall be the Member who is appointed to represent an association of school employees. The second non-voting Member shall be designated by the Chair from the four Members appointed because of experience in health benefit management and cost containment.

5. Privileges of Non-Voting Members—Non-voting Members shall enjoy all the privileges of Board membership, except voting, including the right to sit with the Board, participate in discussions, and make and second motions.

6. Board Compensation—Members of the Board shall be compensated in accordance with RCW 43.03.250 and shall be reimbursed for their travel expenses while on official business in accordance with RCW 43.03.050 and 43.03.060.

ARTICLE II
Board Officers and Duties

1. Chair of the Board—The Health Care Authority Administrator shall serve as Chair of the Board and shall preside at all meetings of the Board and shall have all powers and duties conferred by law and the Board's By-laws. If the Chair cannot attend a regular or special meeting, he or she shall designate a Chair Pro-Tem to preside during such meeting.

2. Other Officers—*(reserved)*

ARTICLE III
Board Committees

(***RESERVED***)

ARTICLE IV
Board Meetings

1. Application of Open Public Meetings Act—Meetings of the Board shall be at the call of the Chair and shall be held at such time, place, and manner to efficiently carry out the Board's duties. All Board meetings, except executive sessions *as permitted by law*, shall be conducted in accordance with the Open Public Meetings Act, Chapter 42.30 RCW.

2. Regular and Special Board Meetings—The Chair shall propose an annual schedule of regular Board meetings for adoption by the Board. The schedule of regular Board meetings, and any changes to the schedule, shall be filed with the State Code Reviser's Office in accordance with RCW 42.30.075. The Chair may cancel a regular Board meeting at his or her discretion, including the lack of sufficient agenda items. The Chair may call a special meeting of the Board at any time and proper notice must be given of a special meeting as provided by the Open Public Meetings Act, RCW 42.30.

3. No Conditions for Attendance—A member of the public is not required to register his or her name or provide other information as a condition of attendance at a Board meeting.

4. Public Access—Board meetings shall be held in a location that provides reasonable access to the public including the use of accessible facilities.

5. Meeting Minutes and Agendas—The agenda for an upcoming meeting shall be made available to the Board and the interested members of the public at least 10 days prior to the meeting date or as otherwise required by the Open Public Meetings Act. Agendas may be sent by electronic mail and shall also be posted on the HCA website. Minutes summarizing the significant action of the Board shall be taken by a member of the HCA staff during the Board meeting, and an audio recording (or other generally-accepted) electronic recording shall also be made. The audio recording shall be reduced to a verbatim transcript within 30 days of the meeting and shall be made available to the public. The audio tapes shall be retained for six (6) months. After six (6) months, the written record shall become the permanent record. Summary minutes shall be provided to the Board for review and adoption at the next board meeting.

6. Attendance—Board members shall inform the Chair with as much notice as possible if unable to attend a scheduled Board meeting. Board staff preparing the minutes shall record the attendance of Board Members at the meeting for the minutes.

ARTICLE V
Meeting Procedures

1. Quorum— Five voting members of the Board shall constitute a quorum for the transaction of business. No final action may be taken in the absence of a quorum. The Chair may declare a meeting adjourned in the absence of a quorum necessary to transact business.

2. Order of Business—The order of business shall be determined by the agenda.

3. Teleconference Permitted— A Member may attend a meeting in person or, by special arrangement and advance notice to the Chair, A Member may attend a meeting by telephone conference call or video conference when in-person attendance is impracticable.

4. Public Testimony—The Board actively seeks input from the public at large, from enrollees served by the PEBB Program, and from other interested parties. Time is reserved for public testimony at each regular meeting, generally at the end of the agenda. At the direction of the Chair, public testimony at board meetings may also occur in conjunction with a public hearing or during the board's consideration of a specific agenda item. The Chair has authority to limit the time for public testimony, including the time allotted to each speaker, depending on the time available and the number of persons wishing to speak.

5. Motions and Resolutions—All actions of the Board shall be expressed by motion or resolution. No motion or resolution shall have effect unless passed by the affirmative votes of a majority of the Members present and eligible to vote, or in the case of a proposed amendment to the By-laws, a 2/3 majority of the Board .

6. Representing the Board's Position on an Issue—No Member of the Board may endorse or oppose an issue purporting to represent the Board or the opinion of the Board on the issue unless the majority of the Board approve of such position.

7. Manner of Voting—On motions, resolutions, or other matters a voice vote may be used. At the discretion of the chair, or upon request of a Board Member, a roll call vote may be conducted. Proxy votes are not permitted.

8. Parliamentary Procedure—All rules of order not provided for in these By-laws shall be determined in accordance with the most current edition of Robert's Rules of Order [RONR]. Board staff shall provide a copy of *Robert's Rules* at all Board meetings.

9. Civility—While engaged in Board duties, Board Members conduct shall demonstrate civility, respect and courtesy toward each other, HCA staff, and the public and shall be guided by fundamental tenets of integrity and fairness.

10. State Ethics Law—Board Members are subject to the requirements of the Ethics in Public Service Act, Chapter 42.52 RCW.

ARTICLE VI
Amendments to the By-Laws and Rules of Construction

1. Two-thirds majority required to amend—The PEBB By-laws may be amended upon a two-thirds (2/3) majority vote of the Board.

2. Liberal construction—All rules and procedures in these By-laws shall be liberally construed so that the public's health, safety and welfare shall be secured in accordance with the intents and purposes of applicable State laws and regulations.

TAB 3

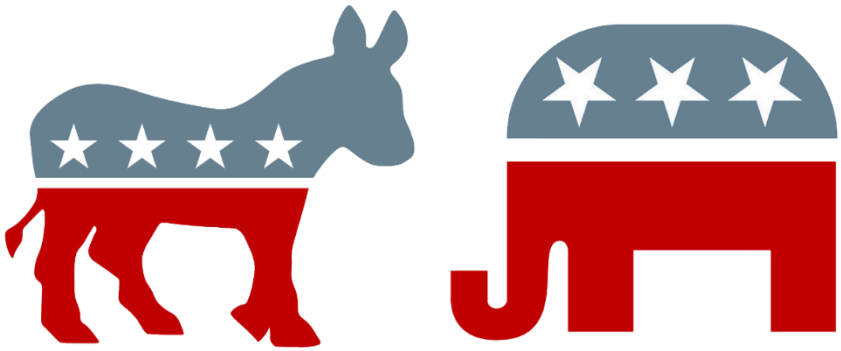
Arthur J. Gallagher & Co.
BUSINESS WITHOUT BARRIERS®

The Future of the ACA

JANUARY 2017

New Leadership

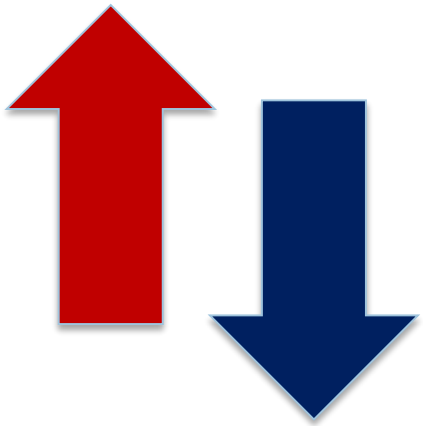
- President-Elect Trump will be sworn into office on January 20, 2017
- Congressional leadership and the President-Elect have indicated that they plan to repeal and replace the ACA



Healthcare Challenges

Cost of Coverage Increases

Benefits Provided



Number of Individuals Covered

Cost of Coverage Decreases

Healthcare Reform

Repeal and Delay

VS.

Repeal and Replace

Affordable Care Act

The ACA includes the following provisions:

- ★ Health insurance exchanges
- ★ Subsidies
- ★ Expansion of Medicaid
- ★ Individual Mandate
- ★ Employer Mandate
- ★ Reporting under 6055 and 6056
- ★ No lifetime or annual dollar limits
- ★ Cadillac tax
- ★ SBCs
- ★ Extension of dependent coverage
- ★ Preexisting condition exclusion
- ★ Prohibition on rescission
- ★ Patient protections
- ★ Preventive services
- ★ Claim appeal and external review process
- ★ Cost sharing standards
- ★ W-2 reporting
- ★ PCORI Fees
- ★ Guaranteed availability of coverage
- ★ Prohibition on excessive waiting periods
- ★ Medical loss ratios
- ★ Over-the-counter restrictions on FSAs, HSAs and HRAs
- ★ Fully-insured plan nondiscrimination
- ★ Transitional Reinsurance Fee

Affordable Care Act

The Marketplace

- 8.8 million individuals enrolled through the federal Marketplaces at the end of December 2016
  - Compared to 8.6 million last year at the same time
  - 2.2 million new consumers
  - 6.6 million returning consumers
- 20 million adults have gained health insurance due to ACA
- Uninsured rate down to 9%, which is the lowest level ever

Affordable Care Act

ACA Challenges

- Cost of Coverage
  - Median increase for monthly premiums for benchmark silver-level plans was 16%
  - 77% of current enrollees would still be able to find ACA plans for less than $100 a month, once subsidies are taken into account

Affordable Care Act

ACA Challenges

- Number of Insurance Policies Offered
  - Fewer insurance carriers are participating in 2017
  - Estimated that:
    - 62% of enrollees in 2017 will have a choice of three or more insurers (vs. 85% in 2016)
    - 19% of all enrollees, could have a choice of a single insurer in 2017 (vs. 2% in 2016)

Compliance Continues

Compliance is Still Required

- Employers must continue to comply with existing requirements until guidance is issued that changes the rules, including:
  - Employer Mandate – Ongoing requirement
  - Reporting (Sections 6055 & 6056)
    - Due to Individuals – Mar. 2, 2017
    - Due to IRS - Feb. 28, 2017 (Mar. 31, 2017 if e-file)

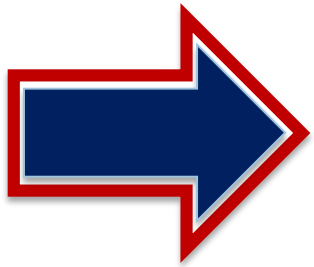
Compliance Continues

Compliance is Still Required

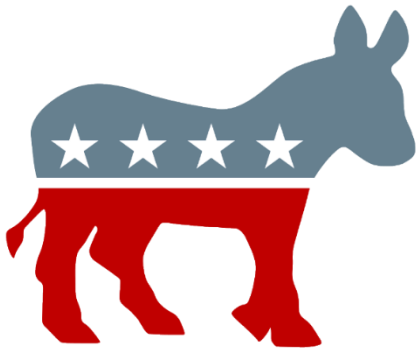
- Immediate changes are NOT expected for other existing benefit laws such as:
  - COBRA
  - HIPAA
  - ERISA
  - Cafeteria Plans

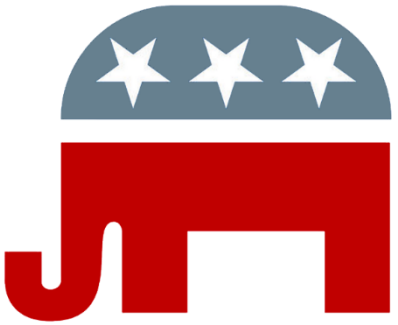
New Proposals

Mandatory Universal Coverage



Universal Access





Presidential Proposal

President-Elect Donald Trump

- ✓ Repeal and replace ACA, but
  - Would keep pre-existing condition prohibitions; and
  - Allow parents to cover their children until age 26
- ✓ Sale of health insurance across state lines
- ✓ Deduct health insurance premium payments

"We don't want anyone who currently has insurance to not have insurance."

- **Kellyanne Conway , Trump White House Counselor**

Presidential Proposal

President-Elect Donald Trump

- ✓ Promote HSAs
- ✓ Price transparency from healthcare providers
- ✓ Greater control for states in administering Medicaid
- ✓ Remove barriers for drug providers

Congressional Approach

Potential Short-Term Approach

- HHS Nominee – Senator Tom Price sponsored ACA repeal bill (H.R. 3762)
  - Passed House and Senate in 2015
  - President Obama vetoed it
- Included:
  - Repealed premium tax credits and cost-sharing reductions - 2 year delay
  - Eliminated the individual mandate, employer mandate, and Cadillac tax – immediate
  - Repealed Medicaid expansion – 2 year delay

Congressional Approach

If that approach is taken:

No individual or employer mandates for 2017 and 2018

Subsidies and Medicaid expansion continue until the end of 2018

ACA reporting, age 26 coverage, health plan/insurance market reforms, and additional benefits remain

Insurance carriers are committed for 2017, but not necessarily for 2018

Congressional Approach

Open issues

- Would individuals voluntarily drop coverage?
- Will employers change eligibility to exclude variable hour employees?
- Do carriers continue to offer coverage for 2018?
- What happens to the cost of coverage?
- Does the uninsured rate go up?
- What is the impact on employer-sponsored plans?
- Will there be non-enforcement for reporting?
- Will any other changes be made through Executive Orders or agency guidance?

Congressional Approach

Potential Long-Term Approach

- Repeal ACA
  - Would eliminate provisions such as Marketplace, individual and employer mandates, health plan/insurance market reforms, etc.
  - Would have a transition period to give patients and markets stability
  - Would implement new approach as soon as possible

Congressional Approach

Potential Long-Term Approach

- Provide a tax credit to help buy health insurance in the individual market
  - If no access to job-based coverage, Medicare, or Medicaid
  - Not based on income level
  - Would be adjusted for age and increase over time
  - Provided at beginning of each month
  - Large enough to purchase pre-ACA health insurance plan
  - If pick a less expensive option, difference would go into an HSA-like account

Congressional Approach

Potential Long-Term Approach

- Cap the exclusion for employer-sponsored health plans
  - Differentiate from Cadillac tax
  - Appears to impact both employers and employees
  - Would include regional variations
  - Employees' HSA contributions would be excluded
- Allow sales of health insurance across state lines

Congressional Approach

Potential Long-Term Approach

- Encourage use of HSAs and HRAs
  - Increase HSA limit to the amount for annual deductible and out-of-pocket expense limits
    - e.g., increase from $3,400 to $7,850 for self-only coverage; and $6,750 to $15,700 for family coverage (based on 2017 amounts)
  - Allow spouses to make catch-up contributions to the same HSA account
  - Allow qualified medical expenses incurred before HSA-qualified coverage begins
    - Account must be established within 60 days
  - Expand accessibility for HSAs to those who get services through the Indian Health Service and TRICARE

Congressional Approach

Potential Long-Term Approach

Permit groups to band together to form “association health plans” and “individual health pools”

- Would be formed by small businesses and voluntary organizations, such as alumni organizations and trade associations
- Could not only pick healthy participants
- Could charge higher rates for sicker people to the extent already allowed under the state rating law

Congressional Approach

Potential Long-Term Approach

- Remove EEOC's lower limits for wellness programs subject to ADA and GINA
- Prevent stop-loss insurance from being redefined as group health plans
- Medicaid block grants

Congressional Approach

Potential Long-Term Approach

- Pre-existing condition protections
  - Could not be denied coverage or have benefits excluded
- Protections if have continuous coverage
  - Not rated by insurers in individual market if have continuous coverage
- One-time open enrollment if uninsured
  - Receive continuous coverage protections

Congressional Approach

Potential Long-Term Approach

- Age 26 dependent coverage
  - Currently provided through ACA
- No lifetime limits
  - Currently provided through ACA
- No rescissions
  - Cannot deny renewal due to illness

Congressional Approach

Potential Long-Term Approach

- 5:1 age ratios
  - ACA requires a 3:1
  - Designed to encourage enrollment by younger individuals
- State innovation grants
  - Would provide at least $25 billion to develop health reforms
  - Reward based on performance
- High risk pools
  - Premiums would be capped
  - Wait lists would be prohibited

Action Steps

Be prepared

- ✓ Track legislative and regulatory, etc. developments
- ✓ Identify which plan provisions were adopted due to ACA and determine whether want to keep them
  - ✓ Plan provisions will not change until plan is amended
- ✓ Explain to employees which provisions you are changing and the reason
  - ✓ Expect that some employees may lose benefits
  - ✓ Handling of employees' hours worked may also change
- ✓ Need to review contracts with vendors

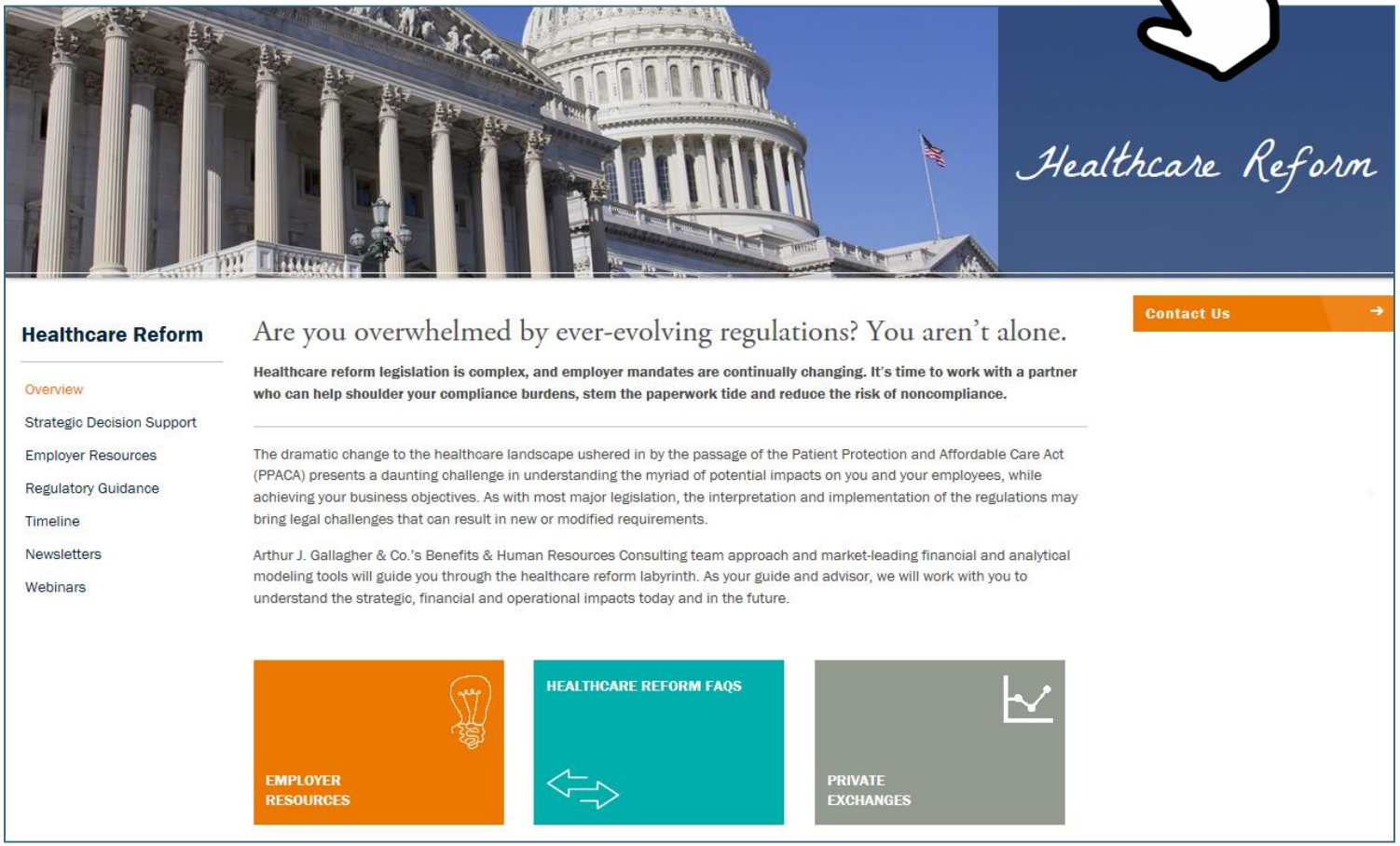
Affordable Care Act

For PEBB Plans:

- ★ Employer Mandate
- ★ Reporting under 6055 and 6056
- ★ No lifetime or annual dollar limits
- ★ Cadillac tax
- ★ Over-the-counter restrictions for FSA
- ★ Dependent coverage to age 26
- ★ Preexisting condition exclusion
- ★ Prohibition on rescission
- ★ Health plan/insurance market reforms
- ★ Preexisting condition exclusion
- ★ Fully-insured plan nondiscrimination
- ★ Preventive services
- ★ Claim appeal and external review process
- ★ Cost sharing standards
- ★ W-2 reporting
- ★ SBCs
- ★ Guaranteed availability of coverage
- ★ Prohibition on excessive waiting periods
- ★ FSA maximum limits
- ★ PCORI Fee
- ★ Transitional Reinsurance Fee

Additional Resources

ajghealthcarereform.com



Arthur J. Gallagher & Co.
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Thank you!

TAB 4

Washington Market Overview

Employers, Plan Members, Payers & Providers:

Reluctant Participation, Inevitable Evolution

Alex Rule, CLU, ChFC, CEBS
Northwest Regional VP, Sales

Employer Challenges/Opportunities

HR and C-Suite **distractions**

- Booming economy/Labor market competition
- Perspective on their role as change agent
- General lack of understanding
- Brokerage/Consulting role
  - ✓ Transform challenge into opportunity
- Payer capabilities
- Scaling relevance

Plan Member Challenges/Opportunities

Laws of **supply and demand** don't apply to healthcare

- Limited access to actionable information
- Consumer experience contrast (Amazon/Expedia)
- Low healthcare literacy
- Primary care relationship lacking
- Skewed expectations/definition of good healthcare
  - ✓ Unfettered access
  - ✓ No financial responsibility
- Low/No personal accountability

Payer Challenges/Opportunities

Where to **invest** and how to **evolve**

- Define current and future value proposition
  - ✓ Network relevance/Medical management
  - ✓ Diversify business model (Aetna ACO/Vivacity/Provider Purchase)
  - ✓ Consolidate value proposition (ornaments on the tree)
  - ✓ Simplified member experience
  - ✓ Reimbursement model
  - ✓ Risk takers vs. Health system business partner
- Marketplace segmentation
  - ✓ Exchange vs. Small & Large Group vs. ASO
- The Landscape
  - ✓ Aetna/Cigna/Premera/Regence/UHC/GH
  - ✓ TPA Market

Provider Challenges/Opportunities

Reimbursement model **evolution**

- ✓ Bridging care delivery chasm (primary care and BH)
- ✓ Access to timely, actionable patient data
- ✓ Agreement on a consistent quality matrix

- Cost Structure certainty
- Payer mix membership flow
- Development of consumerism strategies
- Focus on control points
- Resource deployment (can’t be good at everything)
  - ✓ Facilitating Center of Excellence collaboration

TAB 5

Washington State Health Care Authority

PEBB Program Benefits: 2016 Open Enrollment & Updates

Dave Iseminger
PEB Deputy Director
January 17, 2017

Washington State Health Care Authority

Total Members Served

367,143

Avg. Age: 46

December 2016 Enrollment

Active and Self-pay Members

267,889

Avg. Age: 36

- *State Agency: 121,423*
- *Higher Ed/CTC: 111,348*
- *Employer Groups/Political subs (includes some K-12): 34,128*
- *Self-Pay: 990*

Retiree Members

99,254

Avg. Age: 72

- *State Agency, Higher Ed/CTC Employer Groups/Political subs: 56,097*
- *K-12: 43,157*

Washington State Health Care Authority

November 2016 Open Enrollment – Highlights

- 6,690 subscriber medical/dental plan changes made online in November
  - 25% less plan changes compared to November 2015, but double November 2014 and November 2013 open enrollments
  - 2,181 (32.6%) changes were in the last 3 days of enrollment
  - Saturday and Sunday are the least popular days to make an enrollment change online via *MyAccount*

Washington State Health Care Authority

PEB Customer Service (PCS)

During November 2016:

- PCS fielded over 12,000 phone calls related to plan changes, eligibility questions, and premium increases. This represents a 15% increase in members' calls compared to last open enrollment.
- The Average Speed of Answer increased by 16.3 minutes in November 2016 compared to November 2015.
- A 39% increase in lobby customer visits, including a record-breaking 56 visits to our lobby on 11/28/16. PCS saw a 12% overall increase in lobby visits for the plan year compared to 2015.
- Processed nearly 2,000 documents during open enrollment.

Note: PCS staff had 4 fewer fully-trained staff available to fully-assist customers on the phone due to a 33% turnover in PCS staff in Summer/Fall 2016.

	NOV 2015	NOV 2016	% DIFFERENCE
Total Calls Received	10,905	12,487	15%
Calls Abandoned	3,759	7,743	106%
Calls Answered	7,146	4,744	-34%
Percentage of Total Calls Answered	66%	38%	
Average Speed of Answer (Minutes)	14.3	30.6	16.3

Medical Plan Net Enrollment Trends

(through 12/31/16)

- Largest Net Subscriber Increases
  - UMP Plus PSHVN: +24.44%
  - UMP Plus UW ACN: +22.62%
  - Group Health Sound Choice: +9.88%
- Net Subscriber Decreases
  - Group Health Classic: -7.06%
  - Group Health Value: -2.02%
  - Kaiser Permanente Classic: -1.43%
  - UMP Classic: -0.10%

Medical Plan Net Enrollment Trends

(through 12/31/16)

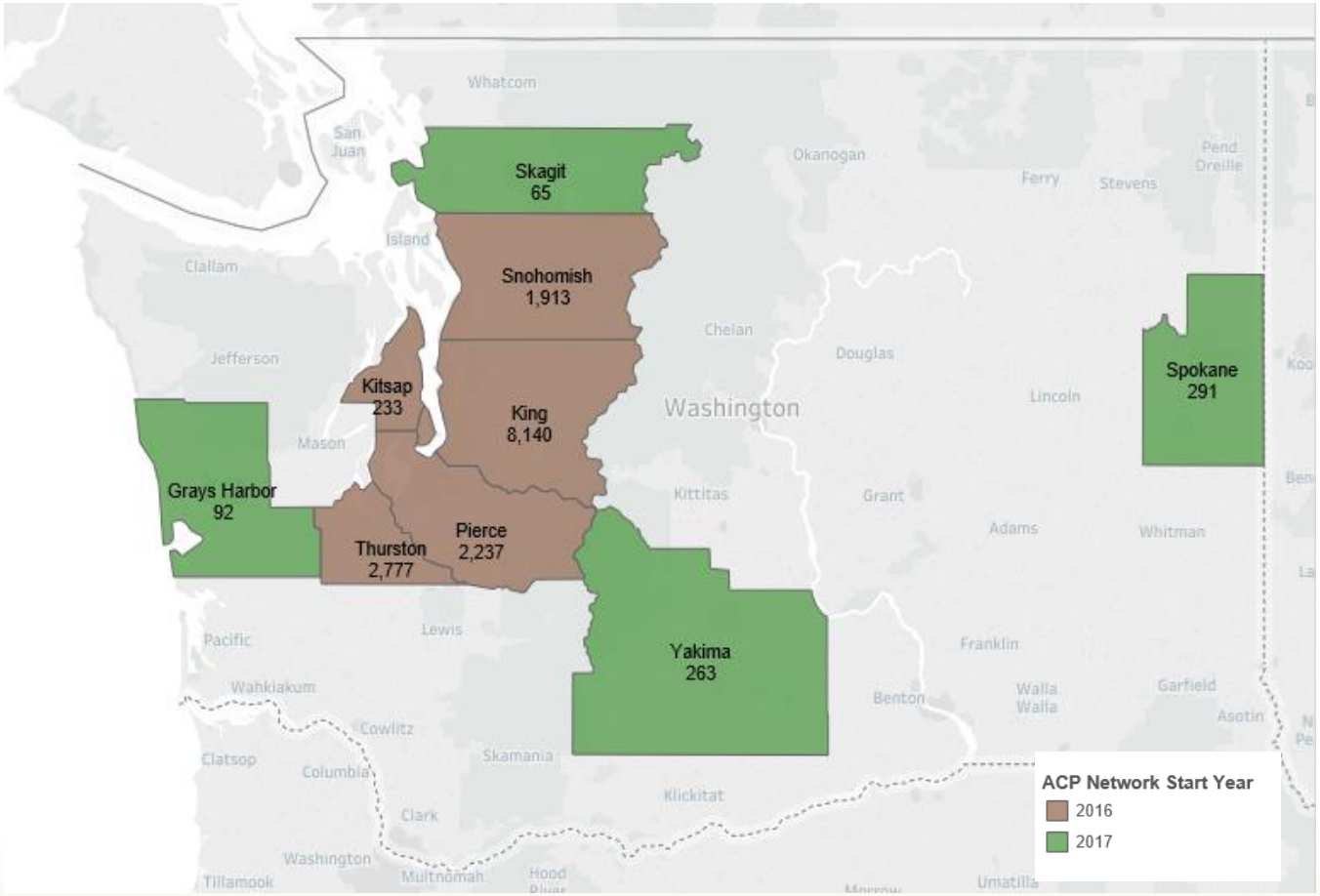
- +~115 subscriber to Group Health Sound Choice
  - Primarily from Group Health Value
- All CDHPs had modest subscriber enrollment increases
  - UMP +4.94%; Kaiser Permanente +2.12%; Group Health +1.42%
- Medicare Plan subscriber enrollments
  - Premera Supplemental Plan F +5.36%
  - Group Health +0.28%

Washington State Health Care Authority

UMP Plus

(through 1/10/17)

- For 2017, there are ~8,000 subscribers enrolled in and ~16,000 covered lives



Centers of Excellence: Total Joint Replacement

(through 1/11/17)

- Virginia Mason is our COE; Premera Blue Cross is our TPA
- 156 member calls about program to Premera Customer Service
- 30% of the members who call are interested in proceeding toward a surgery at the Center of Excellence
- Premera is currently preparing 20 member referrals to Virginia Mason for review
- So far, two UMP members have been referred for surgery:
  - One is awaiting a care conference with surgeons at Virginia Mason
  - One underwent surgery on January 9

Washington State Health Care Authority

Dental Enrollment Trends

(through 12/31/16)

- ~191,500 subscribers for 2017
- Minimal net plan changes:

Plan	2017 Subscribers	% Change from 2016
Deltacare	~16,500	+0.56%
Uniform Dental Plan	~156,600	+0.71%
Willamette Dental	~13,750	-0.43%

Washington State Health Care Authority

Life Insurance

(*preliminary data*)

- Current Voya participation estimates
  - Approximately 60,000 employees and 13,250 retirees
- Open Enrollment with Guaranteed Issue from 11/1-12/16
  - 76,660 unique registrations on MetLife's *MyBenefits* website

	11/1–11/30	12/1–12/16	Total
Online Elections	64,355	18,890	83,245
Paper Elections	~5,200	~16,800	~22,000
Total	~69,555	~35,690	

Life Insurance

(*preliminary data*)

- ~175 retirees cancelled life insurance and will not transition to MetLife for coverage

- MetLife Call Center
  - More than 23,000 phone calls
  - Excluding 11/28 and 11/29:
    - Call abandonment average of 16.7 calls
    - Call to answer speed under 30 seconds
  - Increased call center (and server) capacity support for December

Washington State Health Care Authority

Surcharges

(through 1/11/17)

Tobacco

	December 2016	January 2017
Total	11,374	11,581

Spousal Coverage

	December 2016	January 2017
Total	2,838	1,819

Medical Flexible Spending Account (FSA) & Dependent Care Assistance Program (DCAP) Enrollment Estimates

(as of 1/10/17)

	2016	2017	Subscriber Difference
Medical FSA (max $2,500 annual election)	13,210	14,110	+900
DCAP (max $5,000 annual election)	2,195	2,444	+249
Unique Participants	14,133	15,178	+1,045

Domestic Partner Policy Update

- Grandfathered Domestic Partnership Eligibility Change
  - Originally estimated impacted ~113 domestic partners
  - Actually impacted 92 domestic partners
  - After program outreach:
    - 55 subscribers provided documentation of dependent eligibility
    - 15 subscribers voluntarily terminated coverage
    - 22 individuals disenrolled by PEBB Program effective 1/1/2017
- Those disenrolled eligible to continue coverage on an individual basis for up to 36 months (COBRA).

Washington State Health Care Authority

Questions?

TAB 6

Washington State Health Care Authority

Smart Health

PEB Board Retreat
January 17, 2017

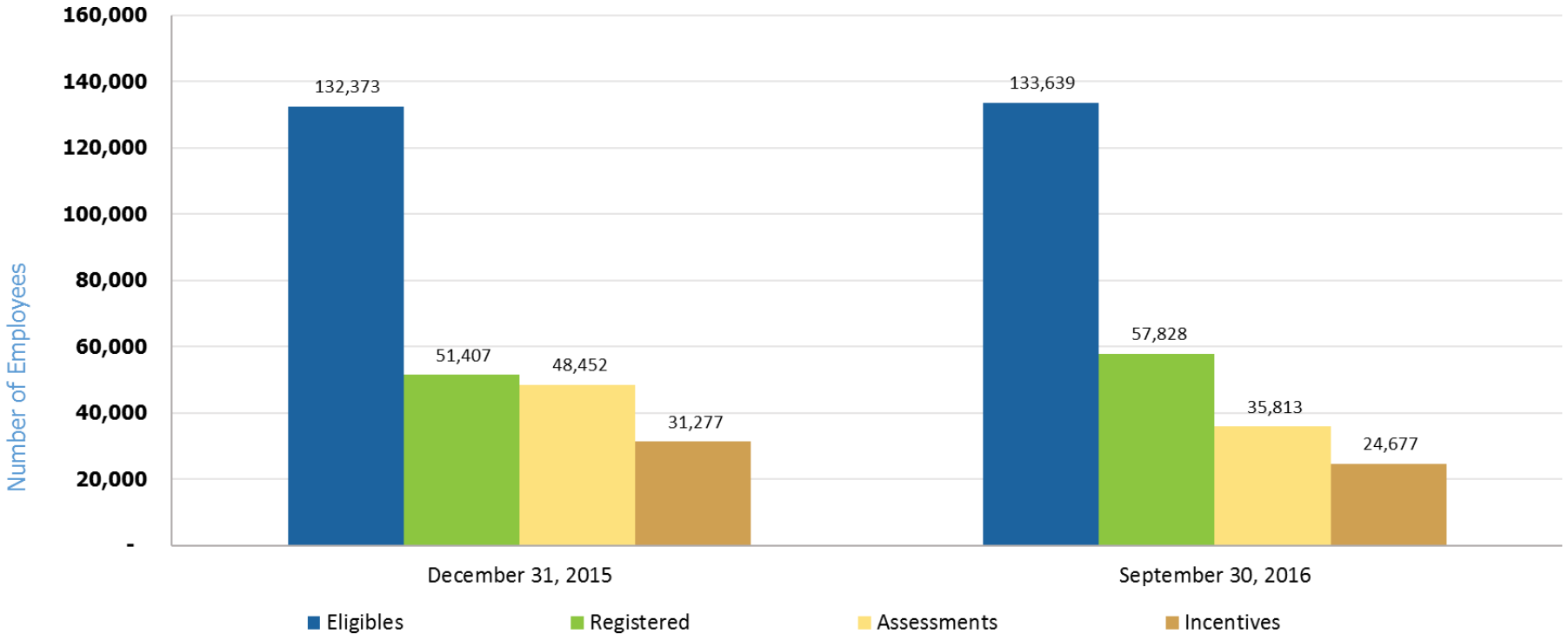
Scott Pritchard
Washington Wellness
PEB Division

Topics for Discussion

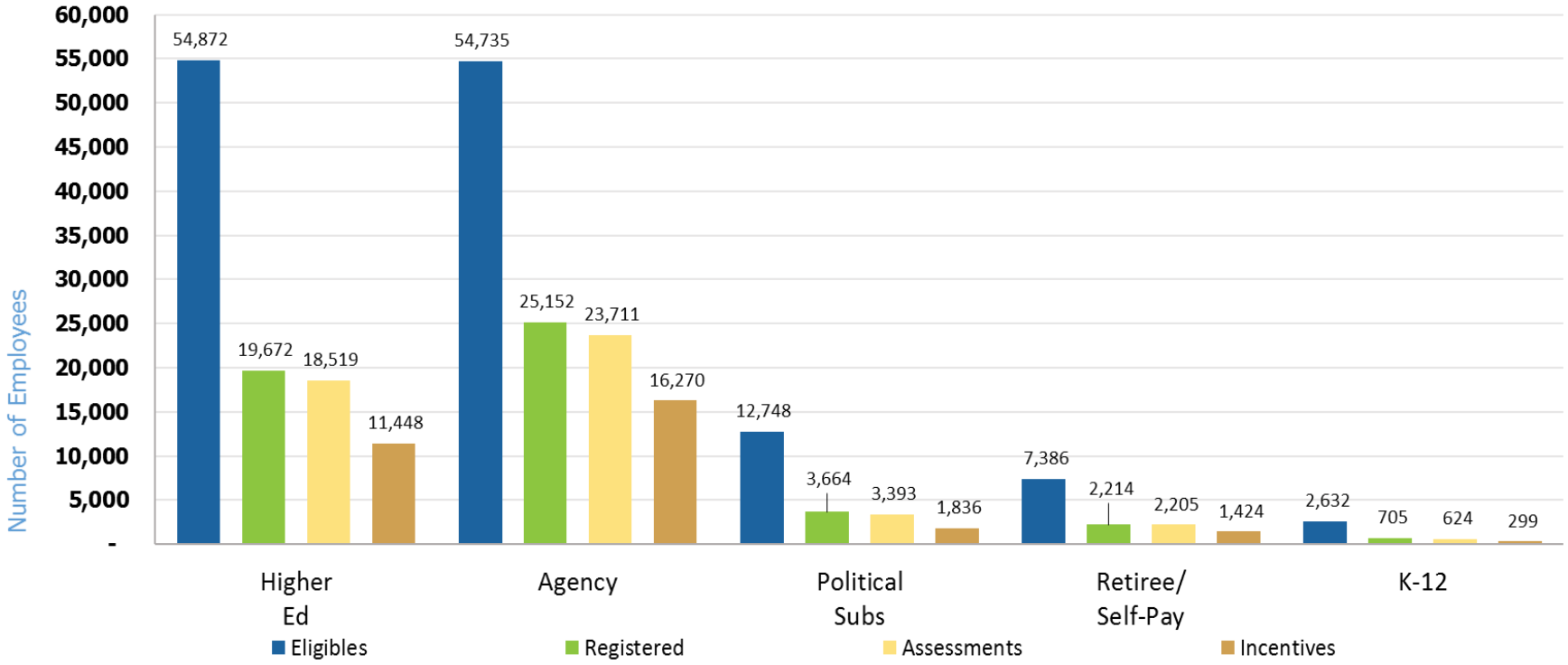
- Levels of Participation: Individual and Employer
- Initial WBA Results Comparison: 2015 – 2016
- Operational Changes
- Marketing Plan

Levels of Participation: Individual and Employer

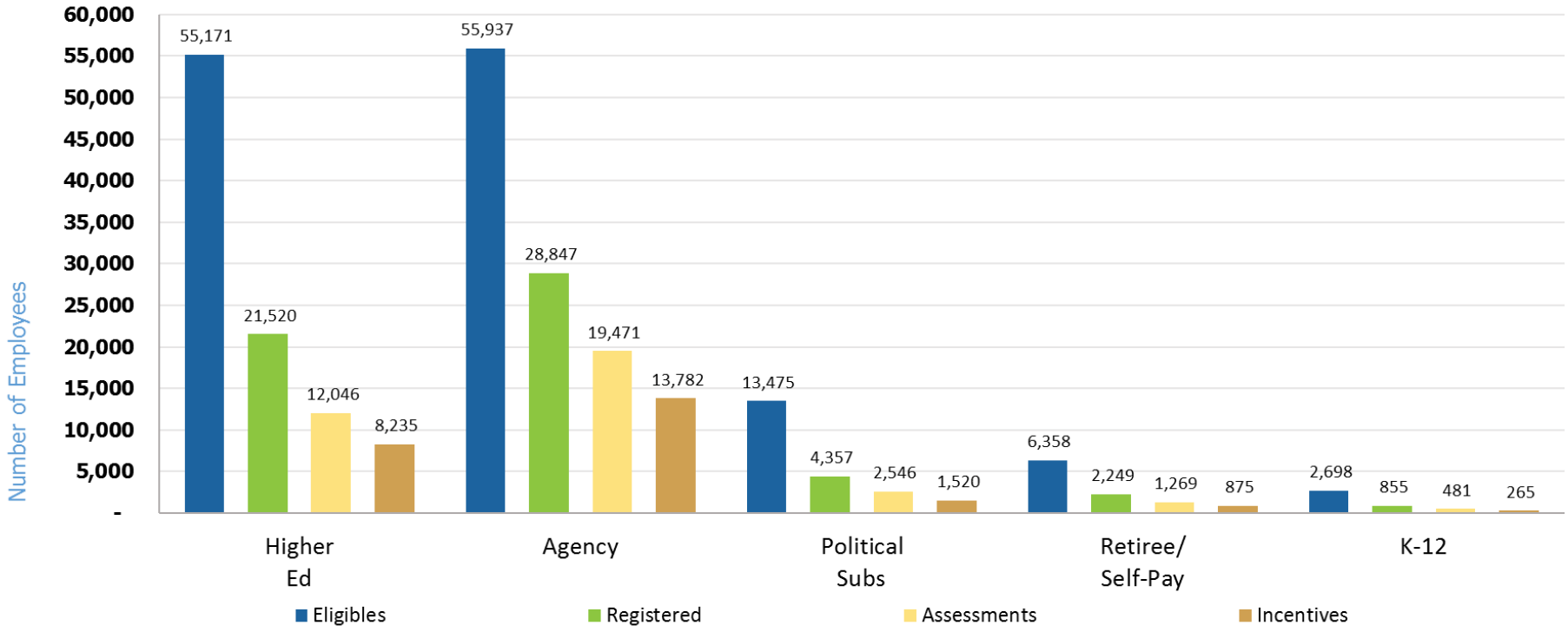
Levels of Participation Among SmartHealth Eligible Employees 2015 vs 2016



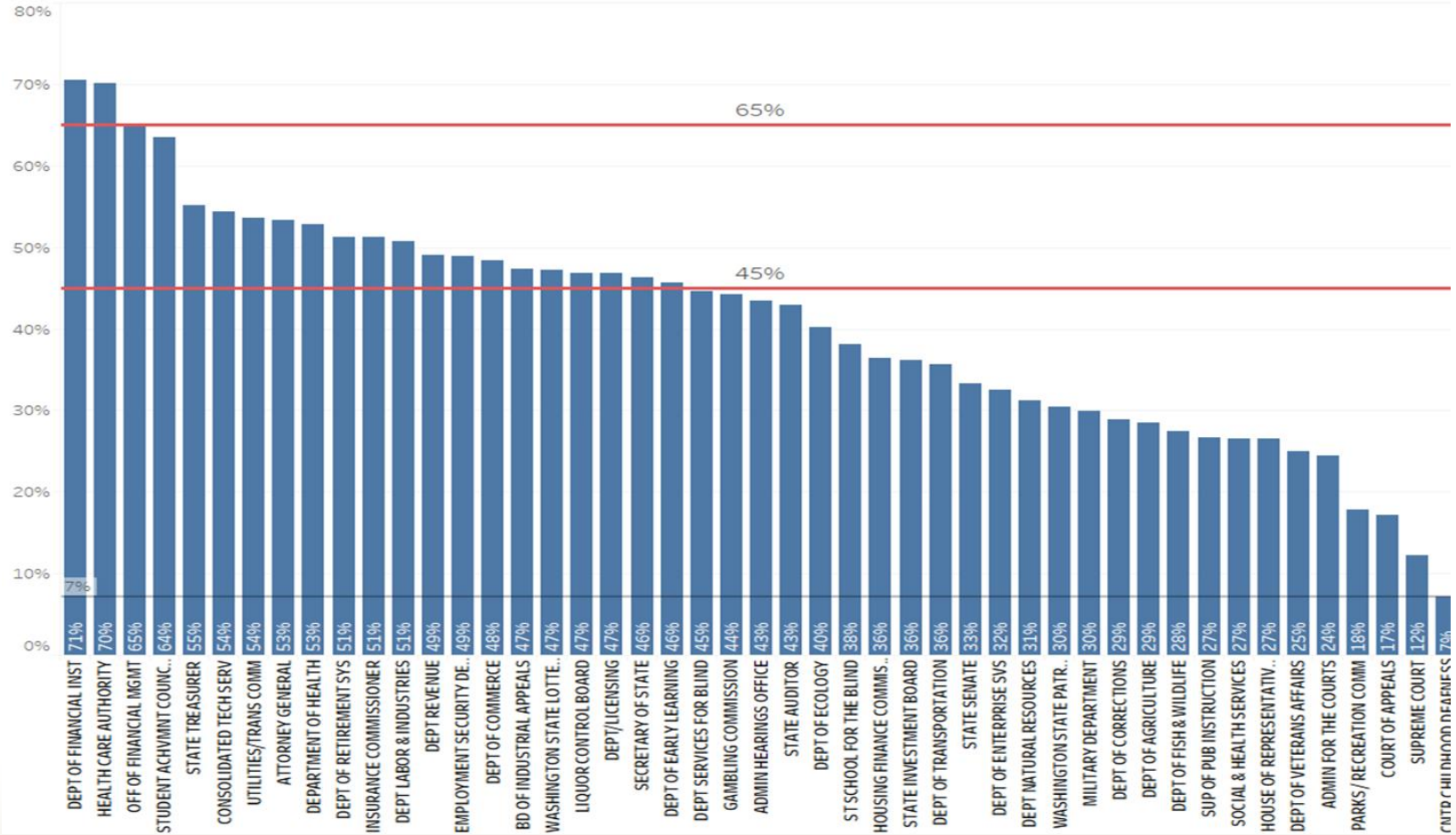
Levels of Participation Among Eligible Employees By Employer Type 2015



Levels of Participation Among SmartHealth Eligible Employees By Employer Type September 30, 2016



Agencies WBA Completion SmartHealth Eligible Employees September 30, 2016



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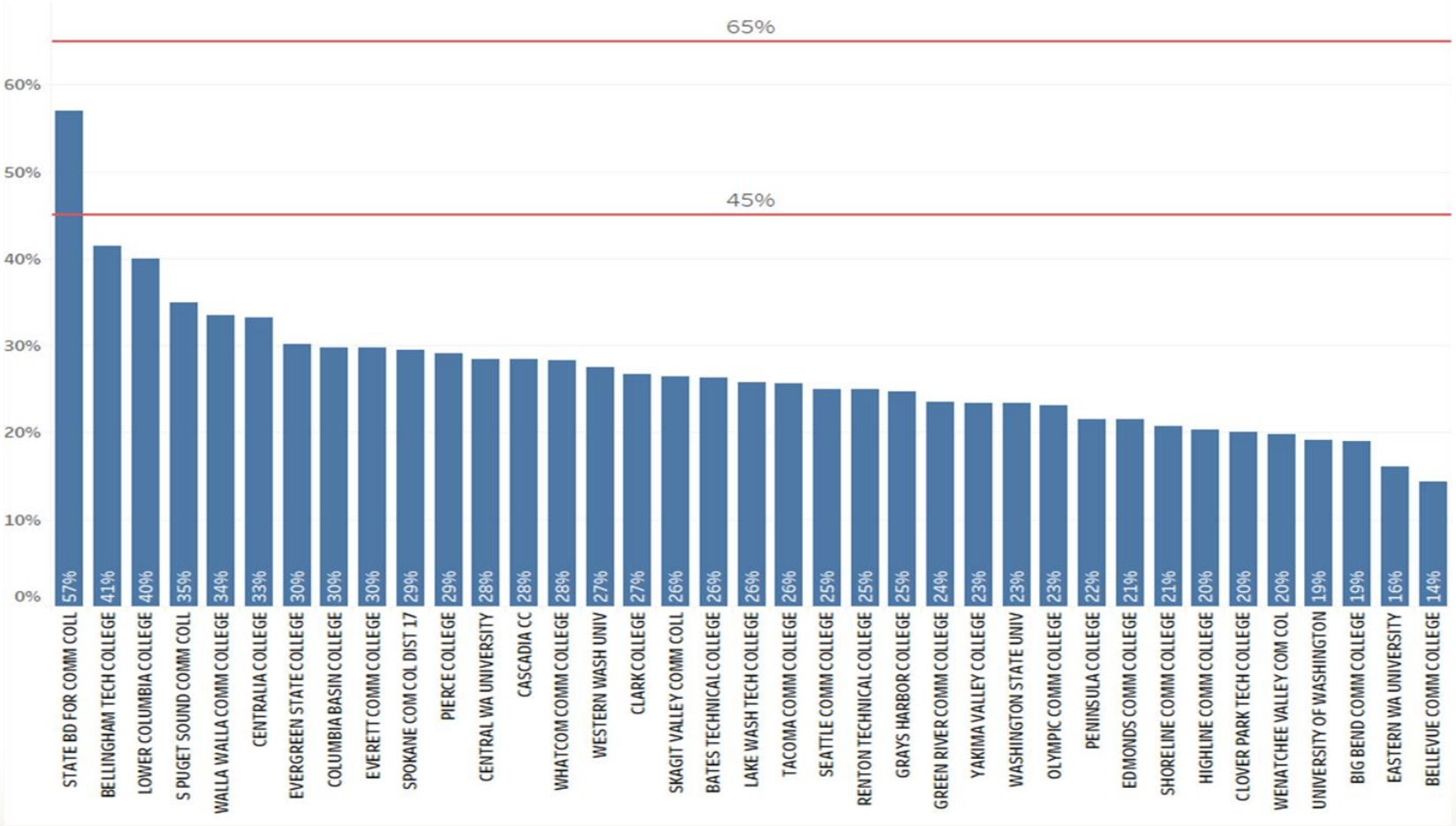
Higher Education WBA Completion SmartHealth Eligible Employees September 30, 2016



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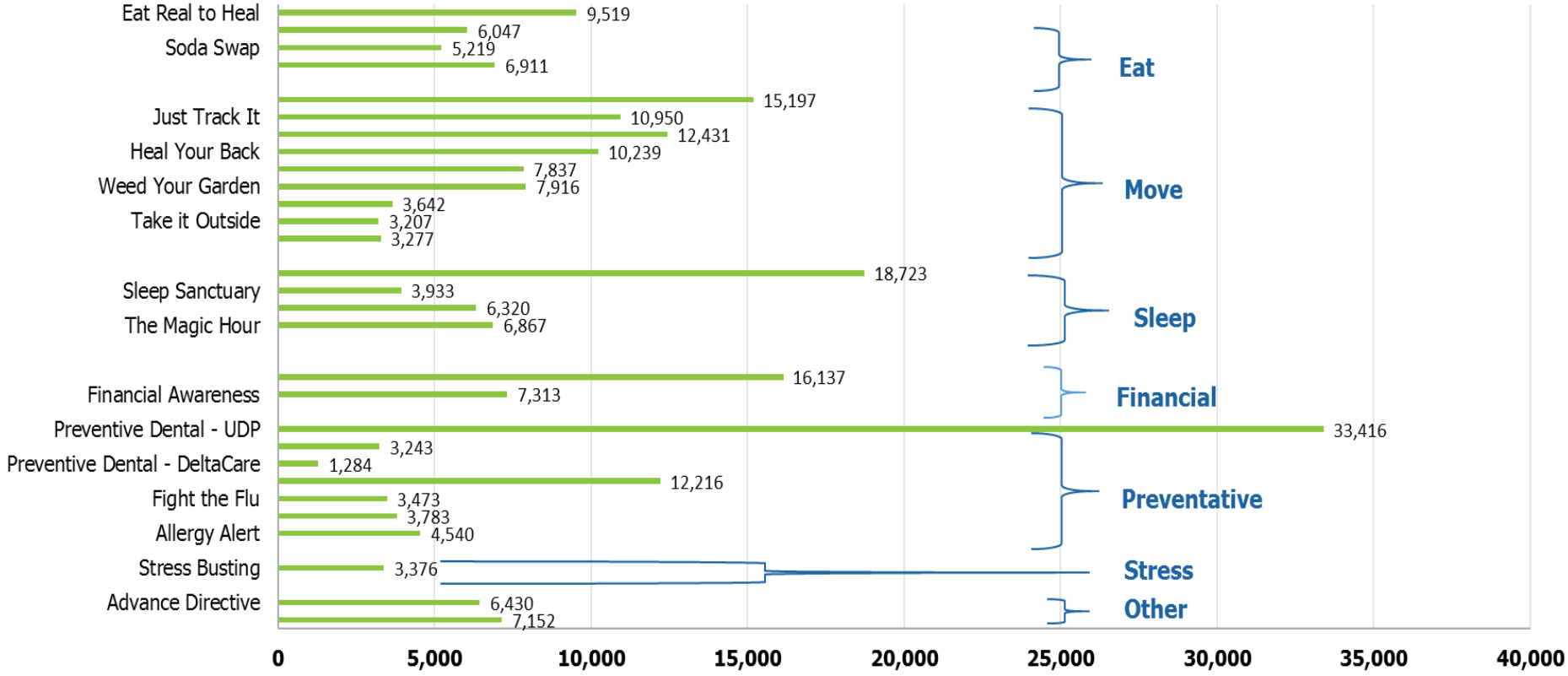
SmartHealth Activity Participation by Category September 30, 2016



Initial WBA Results Comparison: 2015 – 2016

WBA Results: 2015 vs 2016

- Participants with a well-being score of less than 3.5 improved in every one of the 34 dimensions
- Notable increases:
  - Life Meaning: +29%
  - Healthy Blood Sugar: +23%
  - Back Health: +22%

Operational Changes

2017 Operational Changes

- Levels
  - Level 1: WBA completion plus 2,000 points (qualify $125)
  - Level 2: 3,500 points (incentive)
  - Level 3: 5,000 points (incentive)

2017 Operational Changes

- Incentives
  - Quarterly incentives for individuals to complete WBA, to reach incentive qualification level, and to continue on past 2,000 points
  - Adding incentives for Wellness Coordinators based on work organization participation
  - Shifting from sports tickets to gift cards (REI and Amazon) and “getaway” credits (Hotels.com)

Marketing Plan

Marketing Plan: Individuals

- Quarterly Campaigns
- Agency promoted Activities
- Additional Incentives
  - Q1: **Early Bird** – Complete WBA by 3/31
  - Q2: **Summer Bonus** – Complete WBA by 6/30
  - Q3: **"Getaway" Grand prize** – WBA / 2,000 points by 9/30
  - Q4: **SmartHealth Survey** – Complete yearly survey by 10/20

Marketing Plan: Organizations

Organizations

- Senior Leader "Value Proposition"
- Large Organizations
- Higher Education

Wellness Coordinators

- Turnkey marketing materials
- Communication through SmartHealth site
- Incentives
  - Q1: Early Bird – Most WBA completions by **number** and by **percentage**
  - Q3: Incentive Qualification – by **number** and by **percentage**

Questions?

More Information:

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Washington Wellness

PEB Division

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TAB 7

OPDP Oregon Prescription Drug Program
WPDP™ Washington Prescription Drug Program
Northwest Prescription Drug Consortium
Integrating Solutions for Best Value

moda HEALTH

High Cost Prescription Medications:

What is Driving Prices and How Can Plans Manage Them

Robert Judge, Director of Pharmacy Services
Katie Scheelar, Pharm.D, Manager of Pharmacy Clinical Programs
Moda Health
January 17, 2017

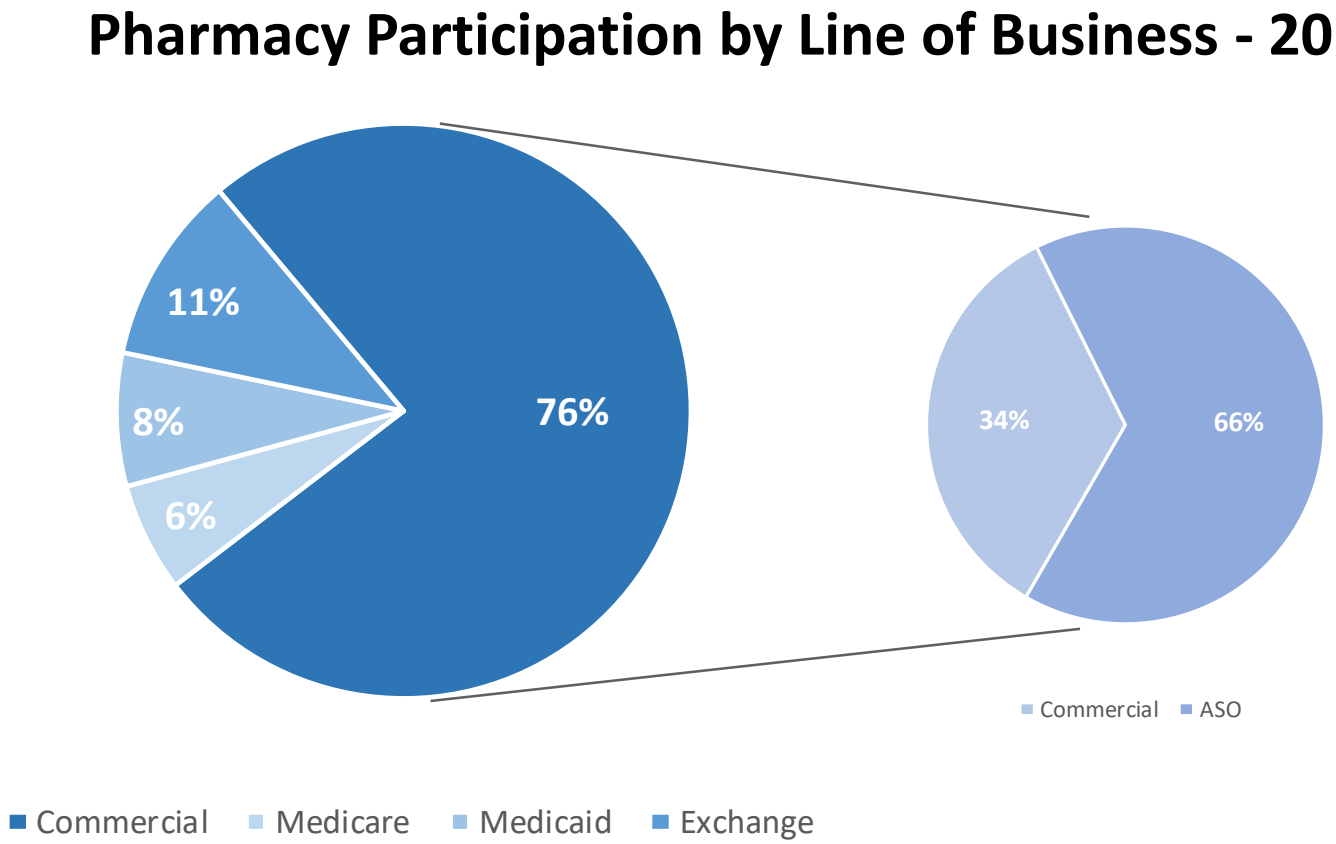
Agenda

- Moda overview
- Specialty medications – what are they?
- Forces driving higher specialty medication costs
- What does the future look like?
- Management strategies

About Moda Health

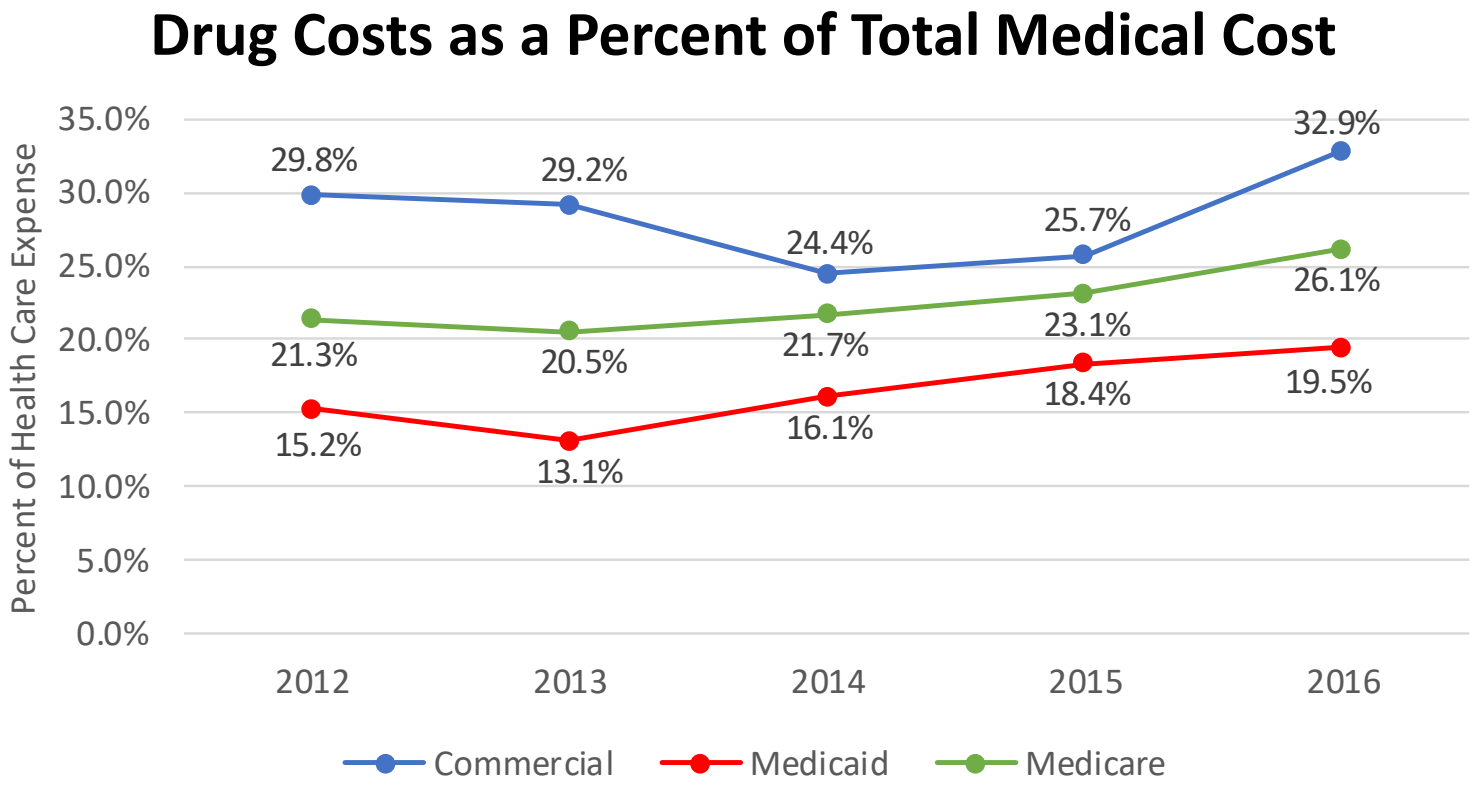
- Northwest-based health insurer and pharmacy benefit manager operating in Oregon, Washington and Alaska
- Administer medical and pharmacy programs across self-insured and fully insured groups
  - Commercial
  - Public sector
  - Medicare
  - Medicaid
  - Exchange
  - ASO
- Served as the Administration for the Northwest Prescription Drug Consortium (WPDP) since 2006
- Administered the pharmacy benefit for the Uniform Medical Plan since 2008

Moda Pharmacy Composition by Segment



Source: Moda Health Data Analytics: 2012 – 2016

Overall Drug Cost as a Percent of Total Medical Costs



While new medications may help offset healthcare costs, they consume a larger percentage of overall healthcare spending.

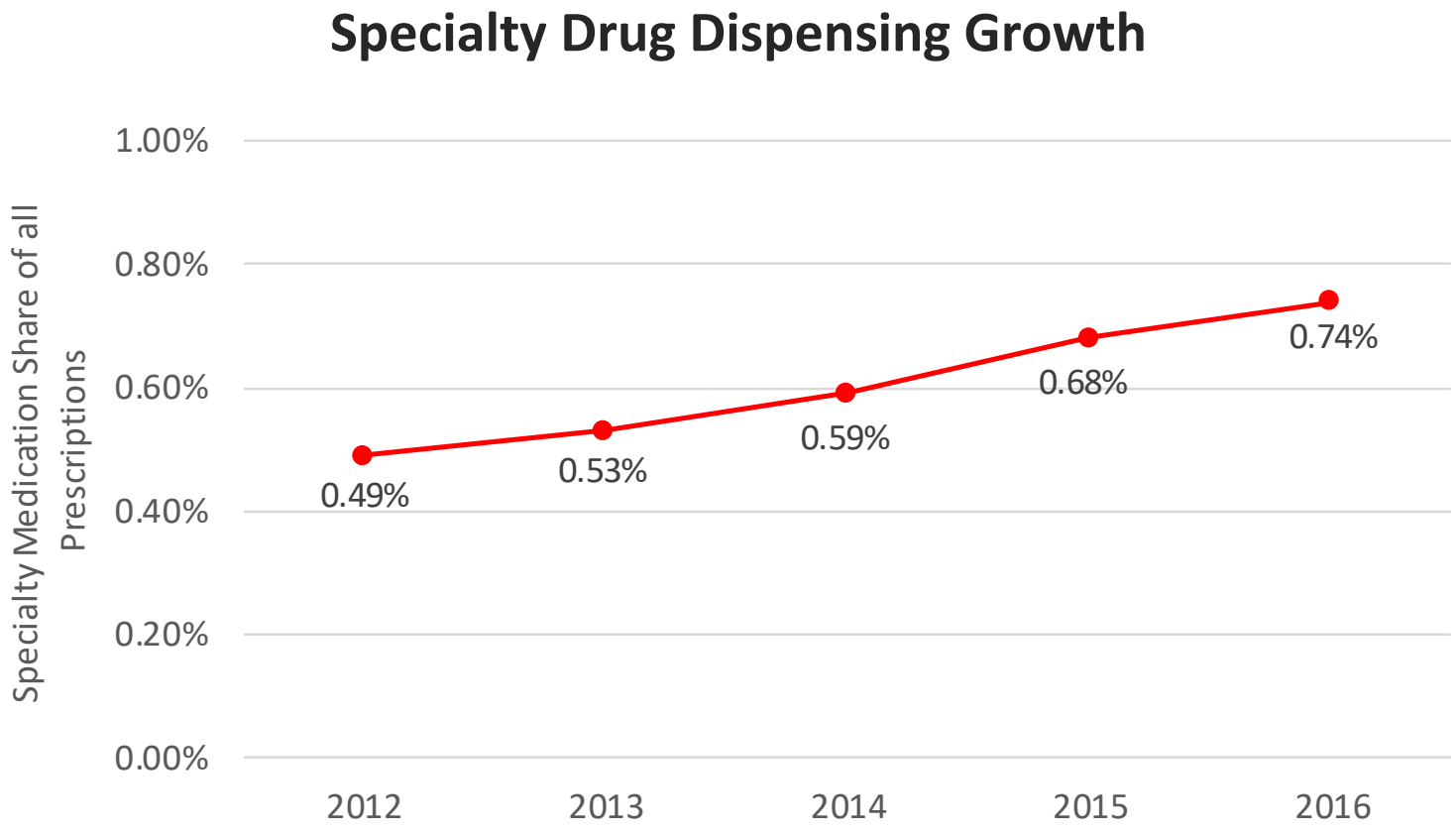
Source: Moda Health Data Analytics: 2012 – 2016

What are Specialty Medications?

High cost	Complex admin	Unique monitoring	Specific climate needs	Require additional patient education	Require 24/7 clinical support	Drugs not available in retail pharmacies
$1,000-$40,000 per Rx	Injection, infusion, complex oral regimen	Efficacy concerns, side-effect, REMS*	Specific storage or shipment protocol	"High touch" disease states, adherence	High side-effects, adherence assistance	LDD±

* REMS – Risk Evaluation and Mitigation Strategies
± LDD – Limited Distribution Drugs

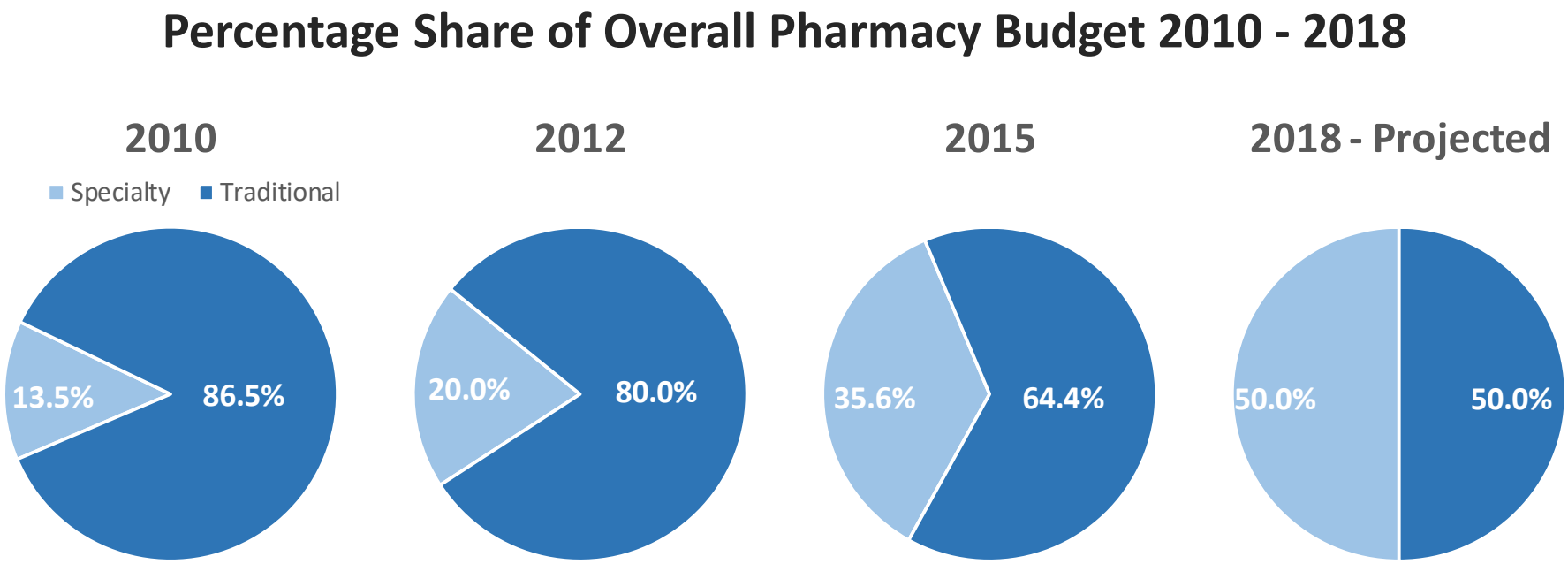
Specialty Drugs as a Percent of Total Dispensed



Specialty drugs represent <u>less than 1%</u> of all prescription drugs that are dispensed.

Source: Moda Health Data Analytics: 2012 – 2016

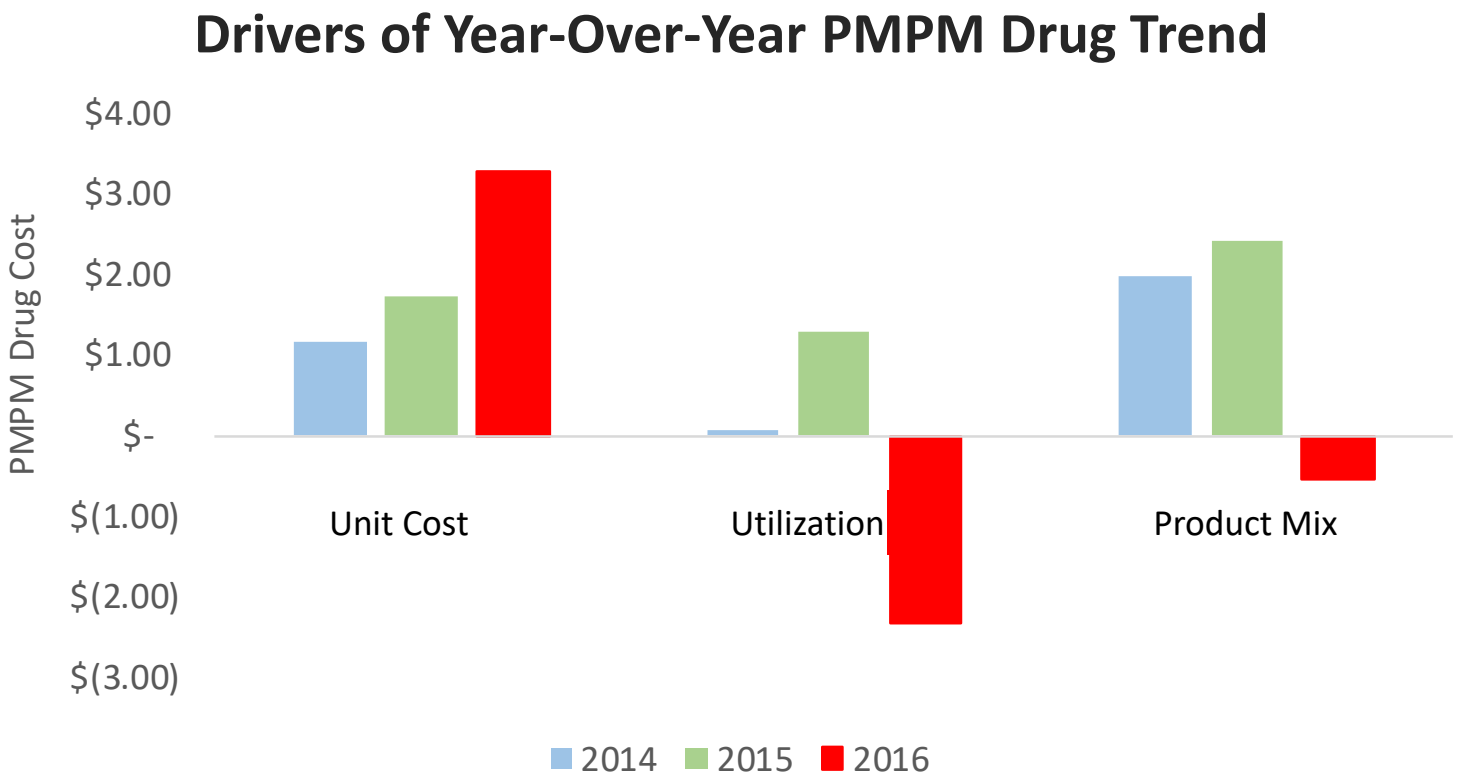
Specialty Drug Spend Growth



Specialty drug costs are projected to account for 50% of entire outpatient pharmacy budget by 2018.

Source: Moda Health Data Analytics: 2010 – 2015
Artemetrx, Specialty Drug Trend Report, 2013 (http://www.artemetrx.com/wp-content/uploads/2014/08/artemetrx-specialty-drug-trends.pdf)

Drivers of Increased Drug Costs



Year over year increases in unit cost continues to be major driver of increased PMPM drug trend.

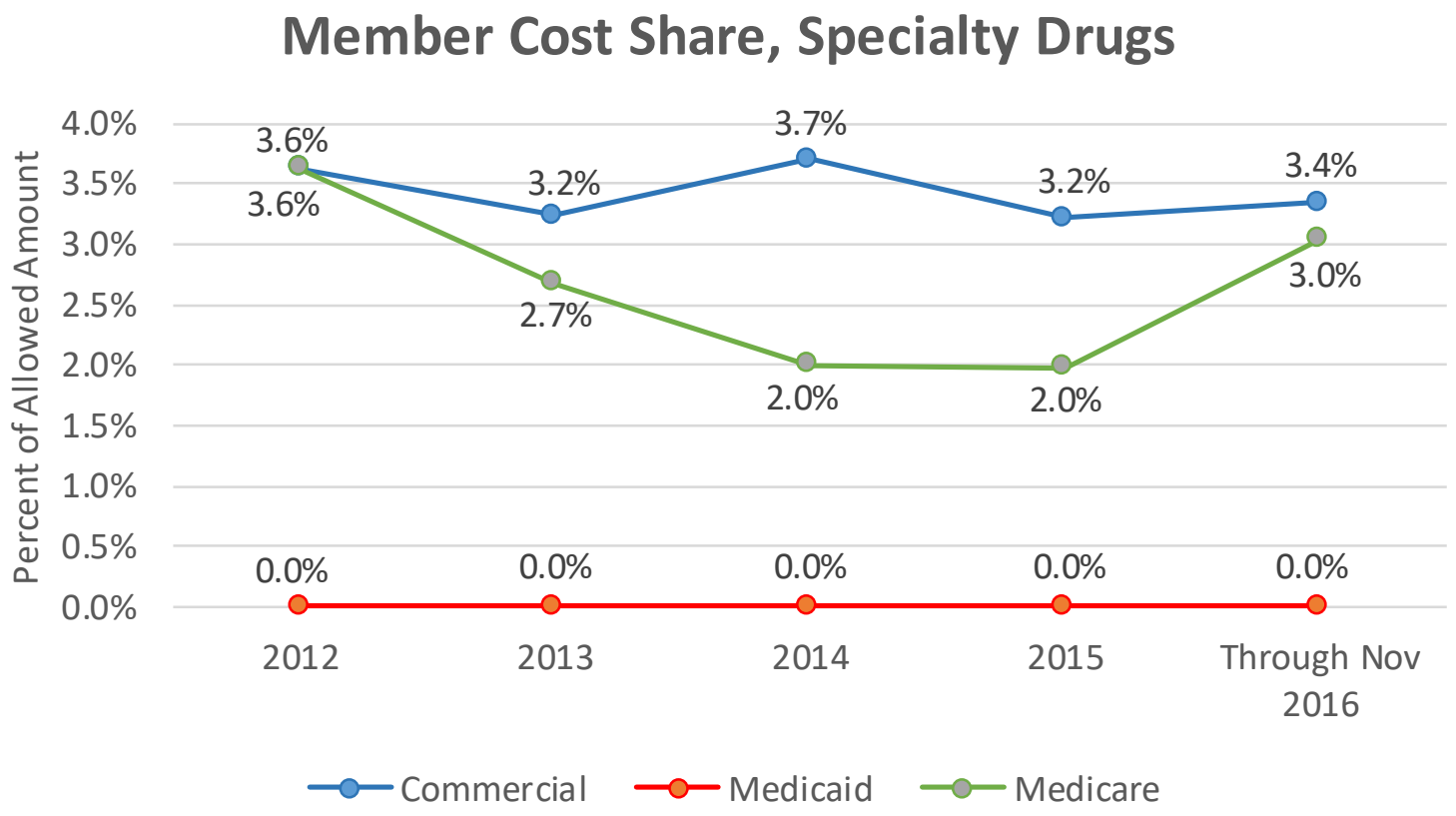
Manufacturer Prices Have Increased Faster Than Rate of Inflation

Specialty Therapeutic Class	Mfg Unit Price Increase (2013-2016)	CPI (2013 – 2016)
Analgesics / Anti-Inflammatory Agents (drugs used to treat rheumatoid arthritis, psoriatic arthritis, etc.)	193.3%	**2.97%**
Psychotherapeutic / Neurological Agents (drugs used to treat multiple sclerosis, etc.)	41.4%	
Dermatological Agents (drugs used to treat Psoriasis)	29.8%	
Endocrine / Metabolic Agents (drugs used to treat growth hormone deficiency)	38.9%	
Gastrointestinal Agents (drugs used to treat Crohn's disease)	49.7%	
Antineoplastic Agents (drugs used to treat cancer)	28.4%	

Manufacturer price increases for products already available increases the financial burden for patients, families, businesses, tax payers, and insurers.

Source: Moda Health Data Analytics: 2013 – 2016
U.S. Bureau of Labor Statistics, CPI Inflation Calculator, http://cpiinflationcalculator.com/

Member Cost Share for Specialty Drugs



Source: Moda Health Data Analytics: 2012 – 2016

Looking to the Future – Drug Pipeline

Therapeutic class	Treated conditions	Number of medications in specialty pipeline*
Anti-inflammatory disease	Rheumatoid arthritis, ulcerative colitis, Crohn's disease	54
Neurological agents	Multiple sclerosis	19
Dermatologic agent	Plaque psoriasis, dermatitis	38
Oncology	Breast cancer, non-small cell lung cancer, pancreatic cancer	186
Anti-viral	Chronic hepatitis C virus	11
Others	Endocrine gland disorders, cystic fibrosis, hemophilia	37

* Includes PDUFA dates in 2017 as well as Phase III trials expected 2018-2020. Final drug approvals subject to change.

Future Challenges

- Orphan drugs[1]
  - Treat conditions affecting less than 200,000 people in the United States
  - 30% of orphan drugs become blockbusters due to expanded indications
  - 30% increase in orphan drug approvals over past few years
  - Nearly 40% of the specialty pipeline consists of orphan drugs

- 21st Century Cures Act
  - Funding provided to fight the opioid dependency epidemic
  - Supports research for treatments based on genetics and applications to produce behavior changes
  - Allows expedited drug approval process for certain conditions (e.g., orphan disease states)
    - ✓ Drugs with minimal clinical data may be FDA approved
    - ✓ Example: Exondys 51 for Duchenne Muscular Dystrophy

Source: Tharaldson, A. (2016). *Specialty Pharmaceuticals in Development*. Presentation, AMCP Nexus.

Management Tools & Techniques

- Continue application of utilization management edits
  - Prior authorization
  - Step therapy
  - Quantity limits
  - Split fill
- Sites of service
  - Preferred specialty pharmacy
  - Preferred infusion providers
  - Directing care towards cost-effective sites
- Biosimilar strategy
  - Product preference
  - Rebate optimization

Management Tools & Techniques

- Dose optimization
  - Continue strategies on pharmacy benefit
  - Implement new strategies on medical benefit
    - ✓ Vial size
    - ✓ Optimal dosing strategies
- Provider contracts
  - Renegotiate contracts to eliminate misaligned incentives
- Closed formulary
  - Drive toward best value drugs
  - Eliminate low value drugs