

**Public Employees Benefits Board**  
**Meeting Minutes**

May 12, 2021  
Health Care Authority  
Sue Crystal Rooms A & B  
Olympia, Washington  
12:00 p.m. – 3:00 p.m.

The Briefing Book with the complete presentations can be found at:  
<https://www.hca.wa.gov/about-hca/public-employees-benefits-board-pebb-program/meetings-and-materials>

**Members Present via Phone**

Sue Birch, Chair  
Elyette Weinstein  
Tom MacRobert  
Leanne Kunze  
Yvonne Tate  
John Comerford  
Scott Nicholson  
Harry Bossi

**PEB Board Counsel**

Michael Tunick

**Call to Order**

**Sue Birch, Chair**, called the meeting to order at 12:05 p.m. Sufficient members were present to allow a quorum. Board introductions followed. Due to COVID-19 and the Governor's Proclamation 20-28, today's meeting is via Zoom only.

**Meeting Overview**

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

For today's Board Meeting, we're highlighting Southwest Washington, both Cowlitz and Clark Counties. Demographically, about seven percent of the population of Cowlitz County and Clark County each are in the PEBB and SEBB Programs. In the Medicaid program is an additional 33% of the Cowlitz County population enrolled in Medicaid and an additional 24% in Clark County in Medicaid. Between Medicaid, PEBB Program, and SEBB Program, we serve 40% of the Cowlitz County population and 30% of Clark County's population.

Unemployment rates are higher in Cowlitz County and lower in Clark County relative to the state. Same for the uninsured rates. Cowlitz County is hovering around 8%, Clark County is a little under 5%, and the statewide uninsured rate is about 6.8%. Median household incomes in that region are higher than national averages but lower than statewide averages. Housing costs are higher than the national averages but generally tracking within the state. It's important to highlight that Clark County essentially is a commuter population or suburb of Portland. There's more accessibility in that region because of access to the Metropolitan health care infrastructure. Between availability within the Vancouver Clinic, Peace Health Southwest, Legacy Salmon Creek, as well as Oregon Health System University, and other parts of the Portland infrastructure, there's a lot of accessibility within the region of where to access services.

The last thing I want to highlight that's unique to the PEBB Program is political subdivisions of the state can contract with the Health Care Authority for access to PEBB benefits. Currently over 300 political subdivisions participate in the PEBB Program. Other entities can also contract with HCA for benefits, like tribal governments, several of which are in the Cowlitz County Region. That includes the Cowlitz Tribe and the Cowlitz Tribal Housing Authority. They're around our 10th largest political subdivision, out of roughly 300 to 325 subdivisions.

This leads me to the land acknowledgement statement I share at the beginning of each meeting. I want to acknowledge that our meeting is supported physically in Olympia at the Health Care Authority on the traditional territories of the Coast Salish people. This area was a primary portage to and from the Puget Sound. The lands were shared by several tribes, including some we know today as the Squaxin Island Tribe and the Nisqually Tribe. HCA wants to honor and thank their ancestors and leaders who have been stewards of these lands and waters since time immemorial.

**Sue Birch:** The Board will now go into Executive Session. Pursuant to RCW 42.30.110(1)(l), the Board will now meet in Executive Session to consider proprietary or confidential nonpublished information related to the development, acquisition, or implementation of state purchased health care services, as provided in RCW 41.05.026.

**Executive Session Concluded at 1:13 p.m.**

### **2021-23 Biennial Budget Update**

**Tanya Deuel**, ERB Finance Manager, Financial Services Division. Slide 2 – Final Funding Rates shows the funding rates for FY 2022 and FY 2023. In the next legislative session, HCA will possibly update the FY 2023 funding rate. Both amounts match the House and the Senate that I presented to you last month. We believe the underlying assumptions are adequate to maintain our current level of benefits and have no concerns with these funding rates.

Slide 3 – Medicare Explicit Subsidy. This is the state's contribution towards our Medicare retirees' health care premiums. The amount remains the same at \$183 or 50% of the premium, whichever is less. This amount has not changed since calendar year 2020.

Slide 4 – Collective Bargaining Agreement. The amounts on this slide remain the same since our last discussion. The employer and employee split will remain at 85% for the employer and 15% for the employee. A \$25 collective bargaining agreement wellness incentive gift card has been eliminated in bargaining, which was valued at approximately \$1.1 million per calendar year.

**Dave Iseminger:** There are dozens of collective bargaining agreements negotiated by the Governor's Office. A few of those agreements did not result in a successor agreement or a new contract. When that happens, the existing contract evergreens for a year and negotiations continue. There are a few instances where a successor agreement was not reached and the old or existing agreement evergreens over. Under those narrow situations, HCA will continue to honor that collective bargaining provision related to the gift cards. Although the gift cards are being eliminated and retired for most of the program, there are a few vestige agreements and a couple of isolated scenarios where gift cards will remain for a brief period into 2022.

**John Comerford:** I mentioned this to Dave earlier or a couple months ago. The concern I have is some folks probably receive Medicare. I only pay \$169 a month for my supplement. I'm just wondering, that seems high, \$183 or 50%, whichever is lower. Do we negotiate Medicare rates on a regular basis, every year?

**Tanya Deuel:** Yes, annually. In January, we start the Request for Renewal (RFR) process, where we ask carriers to start the negotiation process to identify proposed benefit design changes or anything they need to change for legislation that passed. HCA is in the first round now working through rate negotiations. We receive proposals from each Medicare carrier - Kaiser and Premera for the supplement plans. We get bid rate proposals and then develop those rates ourselves for the Uniform Medical Plan. Over the next couple months, there will be multiple rounds of reviewing underlying assumptions, looking at trends and impacts to those rates for each of our carriers. HCA goes back and forth negotiating to get the lowest possible premium for the member. The bid rates received from the carriers are then reduced by the Medicare explicit subsidy. The amount the member pays is less, that \$183 or 50% of the premium.

**John Comerford:** Do we ever have a more open and competitive process where we invite other carriers to submit bids?

**Tanya Deuel:** We just did. This last calendar year was the first year when we did an open procurement for a Medicare Advantage product. We solicited a national PPO network for a Medicare Advantage product plus Part D. That's where we were able to identify UnitedHealthcare as the winning bidder of that procurement, providing two new plans.

**Sue Birch:** John, it's important to clarify that, without looking at the specifics of a supplemental product, it's not a fair comparison to think about price solely. Those are very different products is my very broad statement. I think we'd have to understand a lot more about your concern there.

**Tanya Deuel:** We definitely have supplemental products. We have coordination of benefit products that have coordination of benefits with original Medicare, as well as Medicare Advantage products, one with Part D and one without Part D.

**John Comerford:** I'll follow it up over the next year. Thank you very much.

**Tanya Deuel:** No problem. John, we will be getting into our Medicare rate presentations over the next month or two where we will walk through specifics of plan design and rate recommendations to the Board, both in Executive Session and publicly.

**John Comerford:** Great. Thank you very much.

**Elyette Weinstein:** Tanya, I'm assuming when you talk about employee plans, you're referring to active employees. You would say retiree if you meant retiree benefits or retiree plans, am I correct?

**Tanya Deuel:** Typically, unless I just had a slip up that you're pointing out.

**Elyette Weinstein:** Okay. Secondly, on Slide 5, what does TPA stand for?

**Tanya Deuel:** That's my next slide. Slide 5 – Final Conference Budget Funding, refers to the decision packages funded through the conference budget. I've walked through these both at the retreat and our last Board meeting. This is the final funding we received. Elyette, to answer your question on my first bullet, TPA spending authority is our Third-Party Administrators. These are who HCA contracts with to administer our self-insured medical and dental plans, primarily Regence and Delta Dental. Each year we get increased enrollment in those self-insured products, so HCA needs to request spending authority from the Legislature to be able to spend those funds from those accounts. \$5.9 million is a typical decision package you will see mentioned year after year as our enrollment increases in those self-insured products. Typically, this amount is already included in our funding rate projections, and this is to catch up with that spending authority.

The scheduling tool replacement decision package is the tool used by our Customer Service Unit for staff scheduling. The decision package was a total of \$300,000 split between the PEBB and the SEBB Programs, with the majority attributable to PEBB with 95%.

Benefits Administrator Customer Support received half an FTE in our Outreach and Training Unit to support agencies. This was also part of a larger decision package between the two Programs. The SEBB Program received 2.5 FTEs.

PEBB My Account received \$1.2 million, which includes two FTEs to support enhancements for a more robust maintenance and operations of our PEBB My Account system.

**Dave Iseminger:** We will bring a presentation later this Board season on PEBB My Account about launching that product and its use. The \$1.2 million is for maintenance and operations staff going forward once the platform launches.

**Sue Birch:** I want to punctuate what Dave's saying about PEBB My Account because we as Board Members will receive a lot of feedback. Dave will bring back more but we are modernizing for the first time in 20-some years. We will go from a paper enrollment

system to a fully automated account enrollment system. It's a big deal and Dave's done this successfully with SEBB My Account, so we're pulling those features over to the PEBB Program. This is a significant mile marker for the work of the ERB Division.

**Dave Iseminger:** Two pieces of context: 40 years, not 25 years. Paper isn't going away in its entirety. It will continue to be an option, but we're moving from a world where paper is the only option to electronic self service, which we know members will take advantage of.

**Sue Birch:** I knew it was a very long time!

**Tanya Deuel:** Slide 6 – Final Conference Budget Provision. This is new for the Board, so I wanted to include it in this presentation. In the final conference budget, we did receive a proviso where HCA will provide a legislative report by next January to estimate the financial impacts of providing a one-time open enrollment window for our retirees. Currently, that does not allow the Board to make changes in retiree eligibility criteria regarding PEBB benefits. House Bill 1040 was introduced this session regarding that retiree eligibility window. HCA produced a fiscal note regarding allowing that one-time enrollment window for school retirees and their dependents. This legislative report will somewhat mirror that fiscal note from January 2021.

**Dave Iseminger:** Over various bienniums, there have been retiree enrollment window bills. HB 1040 is the most recent in the current biennium, but prior bienniums have had different versions. Some included caps on the number of people who can enroll, some only included retirees from certain pension systems, some included all pension systems. There's a variety of ways this fiscal analysis can be done to show the broad impacts. There's a historical reason and a modern reason why I think this report has come up in the final conference budget. The historical reason is there are a variety of school employees who may not have understood or known to come towards the Health Care Authority as a potential benefit option when they entered retirement decades ago. They missed their eligibility window when they were transitioning from their employment status. With SEBB, the bridge to PEBB retiree coverage is much clearer. I think we've begun to see increased enrollment of K-12 retirees in the short period since SEBB launched.

The modern reason is with the establishment and offering of the MA-PD plans, there are now additional affordable options that were not in the portfolio when retirees were making their original eligibility and enrollment choices with regards to accessing PEBB benefits. With this increased diversity of plan availability and cost, the portfolio may be, again, a more attractive option than other options those former state and school employees are seeing elsewhere. I think it's the potential leveraging of the new plans that might be desirable to some former employees.

**Elyette Weinstein:** Am I correct in understanding that this study will focus on both PEBB and SEBB covered employees?

**Dave Iseminger:** Correct, Elyette. It will involve former school employees, former state agency employees, former higher education employees, the full smorgasbord of individuals who could be eligible under the existing retiree framework.

**Tom MacRobert:** I believe, Dave, you were contacted by some people about the inability at the time they retired to afford the health care benefits they would have been required to pay under the UMP plan so they chose another option or to go uninsured until they reached Medicare eligibility, at which time they felt they would be able to afford. Of course, then they found out they could no longer enroll in the HCA. I'm assuming this study is going to address the desire on the part of some people to get back into the Health Care Authority and it will address specifically what the costs would be to the state were they to have that option made available to them. Is that correct?

**Dave Iseminger:** Yes. The beginning of your question was that modern reason why I think this report is coming up, leveraging an opportunity for those lower cost plans that weren't there when the individual is entering retirement and having to make a choice as to accessing the portfolio or not. They may have chosen not to access the portfolio because there wasn't an option they felt met both their health care needs and their budget. But now with the MA-PD plans, that calculus can be very different. The report will focus a lot on what the potential obligations of the state would be for the explicit subsidy with increased enrollment under the various pension plans from the various sources of retirees in the system, whether it's K-12 or state agencies.

**Tom MacRobert:** Do we have an idea how many people might be affected by that?

**Dave Iseminger:** This is where the devil gets in the details, Tom. Tanya mentioned House Bill 1040. I believe that bill didn't hit all the pension plans, only the one set of plans.

**Tanya Deuel:** House Bill 1040, the most recent bill, only addressed the Teachers' Retirement System (TERS). When we looked at eligibility, it's hard to know who's drawing a pension. At the time we did the fiscal note, there were about 15,000 drawing a pension under TERS because you still must be withdrawing a state pension. We had to make assumptions for the purpose of the fiscal note, how many were already enrolled, who would come in, and who would add dependents, then it's simple on the financial piece as to remember the state only contributes the Medicare explicit subsidy. However, the Medicare explicit subsidy is funded by all three groups that participate in the retiree benefits. The funding rate must cover a portion of it, the K-12 remittance must cover a portion of it, and then our local government, through our employer groups, must pay a portion of retiree costs. The total cost is divided by the three groups.

**Dave Iseminger:** Tom, in the recent fiscal note, which was just TERS, we were looking at a range of 8,000 to 10,000 individuals that could be impacted, but that's a subset of the entire population. When we do this report, we'll describe the potential cause related to the full range of pension plans that could be open for eligibility. That gives you a snapshot at least. It's not a small number, we're talking five digits.

**Tanya Deuel:** Right because it would allow for dependents and spouses also.

### **2021 Legislative Session**

**Cade Walker**, Executive Special Assistant, Employees and Retirees Benefits Division. Slide 2 – Number of 2021 Bills Analyzed by ERB Division, recaps the number of bills done by the Division.

Slide 3 – 2021 Legislative Session – ERB High Lead Bills, is our progress funnel. Two of the bills we were tracking made it to the Governor's desk for signature, Senate Bill 5322, Prohibiting Enrollment Between SEBB and PEBB Programs and Senate Bill 5195, Opioid Overdose Medication. SB 5169, Provider Reimbursement for Personal Protective Equipment also passed.

Slide 4 – Upcoming Session – Agency Request Legislation. SB 5322 Prohibiting Enrollment Between SEBB and PEBB Programs passed and was signed by the Governor. HCA is implementing this legislation for the 2022 plan year.

Slide 5 – HB 1052 – Group Insurance Contracts. This bill did not make it out of session. It was caught up in the Senate due to other legislation ahead of its consideration. HCA is in conversations with the Office of the Insurance Commissioner (OIC) to determine HCA's next steps. This bill will continue to be introduced by rule next year. We fully anticipate another full court press in supporting its passage, working again with the OIC.

Slide 6 – Topical Areas of Introduced Legislation. Two pieces of legislation passed related to the Paid Family & Medical Leave Program. One has been signed by the Governor and the other is waiting for his signature. HCA was tracking these bills to stay attuned to potential impacts to our long-term disability product, but neither piece would impact our LTD product.

Senate Bill 5195, Opioid Overdose Medication expands the requirement for providers to give an overdose medication prescription to individuals who presented to an ER or other facility with an opioid overdose. No significant impacts to HCA because of the availability of overdose medication currently paid for by our Programs.

Slide 7 - Topical Areas of Introduced Legislation (*cont.*). Senate Bill 5018 – Acupuncture and Eastern Medicine passed with no significant impact on our plans as these services were already covered.

House Bill 1196 – Audio-only Telemedicine also passed. 2SSB 5313 – Health Insurance Discrimination also passed, pertaining to expanding the accessibility for gender affirming services. No significant impact to our program because of our compliance and services already covered.

**Elyette Weinstein:** I have a question about SB 5020. Given your expertise, why do you think it wasn't passed? And secondly, what do you think might help it get passed next session? As you know, it's still alive for purposes of the Legislature.

**Cade Walker:** In my quick review of the bill [SB 5020-RX Drug Price Increases], it didn't get to committee. I appreciate you feel I have an expertise on this. I would suggest there are other folks more politically involved in the actual process outside of the agency, possibly Dave or maybe Ryan Pistoresi.

**Dave Iseminger:** Elyette, the legislative process is inherently a political process. Sometimes you never know why a bill does or doesn't pass. For House Bill 1052, it was a timing problem. It was in the queue and scheduled for a vote, but debate on other bills took longer and it didn't make the cut off. Sometimes it's as simple as that. During

this legislative session, I feel confident that the inherent nature of the tele-legislative process that bills got lost in the shuffle. When you are working remotely, the nature of lobbying and stakeholder engagement is very different. It's very easy for something to get lost in the shuffle.

Then there's policy differences. Maybe you don't have enough people who agree with your policy position to have majority support to pass a bill. Some of that is based on a misunderstanding of a bill or the words don't quite get there in some people's minds. It can be a host of reasons. I don't know that we have any real specific insights as to where it falls on that spectrum. It's hard to give specific guidance on the why and the how. There are bills that take decades to pass for a policy reason and others fly through on the first attempt.

Sometimes there are bills that the leadership of a party just don't want that bill to pass. I'm not saying in this instance, but they can set the calendar so it doesn't pass. It could be anything, and again, I'm not ascribing any of those reasons. I'm describing generally why a bill might not pass.

**John Comerford:** Cade, I've talked to Sue about this I think at the last meeting. The state passed the Washington Cares Long-Term Care trust bill and it impacts state employees. There are very tight windows in that. For instance, an exemption must be filed between November 1 to the end of the year. Has the state got any plans to help employees either get a long-term care insurance policy or figure out how to opt out?

**Cade Walker:** I think it's a great question. It wasn't brought up in this legislative session. I have some understanding about the new Long-Term Care trust and those issues as I've been working on them with the SEBB Program. But I will turn to Dave to see what he can share related to that for the opt out window at the end of the year.

**Dave Iseminger:** What I can add, John, is first a reminder that this new product benefit isn't something managed or administered by the Health Care Authority, but we are involved in it. I believe Chair Birch is a member of that body for that new product line, that again isn't administered at HCA. My understanding at this point is that as a state produced benefit, we're not headed in a direction of opting out state employees. That's often the case when there's a new program brought up for employers. Even if there are opt out provisions for other employers, the state generally participates in the benefits established by the state. I don't believe there's any strong intent or movement to proceed in an opt out direction for state employees.

**Cade Walker:** John, the opt out is on an individual basis so the state wouldn't be opting out anything.

**John Comerford:** Oh, no, I understand that. My concern is I'm on the private side and I'm doing a lot of work in this area with private companies. It's a fiduciary issue to make sure they educate their employees in knowing that they can opt out. If they don't, then they'll be tied in this forever when they work with Washington State. I was wondering if there was any kind of a plan to educate public employees about the exemption.

**Sue Birch:** At this point, that has not been the topic at the trust board discussions. But as that matures, John, we can talk about this offline since it's separate.

**John Comerford:** I had Cade here and I thought since he was captive, I'd ask him about it.

**Ryan Pistori:** In response to the question on Senate Bill 5020, I was the lead bill analyst for HCA. I echo what Dave said. I wanted to reiterate that other states also introduced this legislation. It was being sponsored by national organizations and it also faces challenges in other states. One of the areas where they're going to take this feedback and help develop a new version in the future is addressing some of the concerns patient advocacy groups brought up during the public hearings. Not only in our state, but in Hawaii and a few in New England also saw a similar process. I think there's ongoing work to resolve those issues. I wouldn't be surprised to see something similar come back in future sessions.

**Elyette Weinstein:** Thank you. That was very helpful.

**Sue Birch:** Cade, on behalf of the Board, huge kudos to you for shepherding all this through with Dave and doing such a fine job in a very awkward legislative period. That quarantine threw everybody for some challenges, but thank you, Cade, for all you've done.

### **COBRA Subsidy Support for Benefits Administrators & Members**

**Jesse Paulsboe**, Manager, Employer Outreach & Training Unit and **Stacy Grof-Tisza**, Manager, Customer Service Operations Unit, ERB Division. Slide 2 – Overview of the American Rescue Plan Act of 2021. For purposes of this presentation, Benefits Administrator is an umbrella term for personnel, payroll, and benefits office staff within the various PEBB Program employer groups and institutions. The American Rescue Plan Act of 2021 provides almost \$2 trillion in COVID-19 relief funding and includes provisions that affect health care coverage, including a 100% subsidy of the COBRA monthly premium for assistance eligible individuals (AEIs) from April 1 through September 30, 2021. For these individuals, the federal government will pay their monthly premiums and applicable premium surcharges for up to six months of COBRA coverage. AEIs are employees and dependents who lose or already lost health care coverage due to involuntary termination or reduction in hours, voluntarily or involuntarily, and are federally eligible for COBRA. Additionally, they cannot be eligible for Medicare or group health care coverage.

Slide 3 – Outreach & Training Unit (O&T). This team serves the PEBB Program as the primary support resource for Benefits Administrators (BAs). It consists of a reactive customer service element which helps educate BAs by responding to employer questions and concerns. The staff also develop and deliver program training, webinars, materials, and guidance to BAs. Together these two efforts ensure the employers achieve accurate eligibility and enrollment decisions for their employees' accounts.

Slide 4 – Implementation of the COBRA Subsidy shows the process required to satisfy the federal requirements of this act. O&T staff partnered with employers to obtain the required information.

Slide 5 – COBRA subsidy Implementation Timeline shows the short timeline HCA had to complete the required task. As of this morning, about 20% (154) of the total organizations have returned their spreadsheets.

**Stacy Grof-Tisza:** Slide 6 – COBRA Subsidy Readiness. Once the O&T Unit received the information from the Benefits Administrators identifying assistant eligible individuals (AEI), the Customer Service team will use that information to determine the AEI eligibility. At that point, the Benefits Administrator’s work is complete. If individuals have further questions about their COBRA eligibility, they can reach out to our Customer Service team on our 1-800 line.

Slide 7 – COBRA Subsidy Customer Service Implementation. This team is responsible for the administration and processing of the COBRA and continuation coverage forms. Work is underway to prepare for this new initiative which includes training staff on new eligibility and processes, prioritizing COBRA subsidy forms for staff to process, reviewing forms for eligibility once they are received, enrolling eligible AEIs, and sending approval letters or denial letters with appeal rights to ineligible applicants.

Slide 8 – COBRA Subsidy Eligibility identifies three different scenarios of continuation coverage where individuals would be eligible for the subsidy. Those who are currently eligible, still eligible but not currently enrolled, and newly eligible.

Slides 9 – 12 – COBRA Subsidy Eligibility Scenarios. These slides discuss the three different scenarios of who is eligible for this subsidy.

Slide 13 – Deadlines. For those eligible and wanting to enroll in the COBRA subsidy, HCA must receive the required forms no later than 60 days from the date of the initial subsidy eligibility letter. Members currently enrolled must submit a Request for Treatment as an AEI form. Even though members are currently enrolled in COBRA, HCA still needs this form completed due to additional information needed to determine eligibility that HCA and former employers may not have. For those still eligible but not currently enrolled and those who are newly eligible, they must submit the 2021 COBRA Subsidy Election Form for PEBB Continuation Coverage (COBRA) and the Request for Treatment as an AEI form.

### **Agenda Item**

**Ryan Pistorosi**, Assistant Chief Pharmacy Officer, Clinical Quality and Care Transformation (CQCT) Division. Today’s presentation is an update on the 2020 Uniform Medical Plan (UMP) Preferred Drug List (PDL). The Board voted to transition to a value formulary in 2019.

Slide 2 – What is the Value Formulary? This slide defines the value formulary which is aimed at directing members and their health care providers to the highest value, most affordable prescription drugs on the UMP PDL. We took Tier 3 drugs that were previously at a much higher cost share and made them nonformulary in consultation with MODA because these were drugs with no additional benefit, safety, or efficacy when compared to the preferred alternatives. These are drugs in drug classes that have a lot of alternatives and drugs similar in terms of their safety and efficacy. To direct members towards the most value-based drugs, we’re moving these drugs to be

nonformulary because they often are significantly higher in cost than the preferred alternative. An example is using a brand name drug when generics are available. The generics are interchangeable, and the FDA has reviewed and approved them to be the same efficacy and safety. Brand name drugs cost more.

There is an exception process for the member when a formulary drug is deemed ineffective or not appropriate for an individual member.

Slide 3 – Why the Value Formulary? In 2018 HCA identified a member equity issue where some members were using Tier 3 drugs and knew about the tier exception process and were paying a lower cost share and other members didn't know about the process. HCA also wanted to address Board concerns that members would be protected and ensure they were getting therapeutic alternatives with a pathway that would allow them to receive the nonformulary drugs if they were the most appropriate for them.

Slide 4 – What We Did to Prepare. HCA worked with Washington State RX Services, or MODA, on training their customer service and getting them ready to handle member questions on the changes to their pharmacy benefit. We did a staggered approach, sending different letters in different stages so the Customer Service Team at MODA was not overloaded and the members who were calling did not have exceedingly long wait times to get a customer service representative. This same approach was implemented for the Oregon Educators Benefits Board (OEBB) health plans in 2018.

Slide 5 – Refill Protected Classes. The left column has the refill protected drug classes originally proposed in 2019 to the PEBB Board, as these are the drug classes refill protected on the Washington preferred drug list, which UMP participates in. MODA experienced in their transition with OEBB, they added in the additional drug classes as shown in the right column. HCA used that experience to help members using drugs in these drug classes.

Slide 6 – Communications lists the different resources HCA used to communicate to its members. Letters were sent to specific members.

Slides 7 & 8 - Member Experience. These slides show the members affected, requests, denial rates, etc. 40% of the denials were due to not meeting FDA approved criteria. For example, if they did not meet the FDA approved indications, if they did not meet the required age requirements for the drug, or if there were certain additional criteria, like with Xifaxan, which is approved by the FDA for a total of three courses per lifetime for irritable bowel syndrome for diarrhea. In case you were requesting it for a fourth time or greater, it is not considered FDA approved. HCA uses MODA's standard prior authorization criteria and that will continue to apply for these drug reviews.

**Sue Birch:** I think this is critically important and I want to make sure I fully get this. Of those denials, 9% were due to not meeting clinical policy criteria, but the rest were things we caught because these are denials, and in essence, medical sloppiness. Is that correct?

**Ryan Pistorosi:** Yes, I would say a lot of the drugs impacted were in that 40% we do not have a lot of utilization management on, given that they are not like the highest cost

or highest utilized drugs. These were certain older drugs and not necessarily used for, the high-cost disease states that we typically are reviewing like diabetes, rheumatoid arthritis, cholesterol medications, the ones that we spend a lot of time on. These were catching up to drugs that had not been reviewed recently and members would have been on and did not know there were preferred alternatives.

**Sue Birch:** Being a nurse in the system, I think this validates why we needed the value-based formulary. What you implemented caught sloppiness. This, in my opinion, helped people avoid possible negative outcomes. In hospitals, we worry about the infections we give people if they stay too long, seven- or ten-day admissions usually lead to what we call nosocomial infection. We induce more problems. In my opinion, this is the equivalent. You've just helped strain out of these denials, virtually 91% of sloppiness, or where harm could have come to people by doing a better job. I just want the Board to really note that this is a big deal. It's great.

**Ryan Pistori:** I think it's a great deal, too. Being able to catch these upon the review and applying the medical necessity criteria we think is very valuable to ensuring members are receiving the appropriate medications.

Slide 9 – Member Appeals and Complaints. Of the medications denied, appeal rights were given. These two graphs show member experience in 2020 around the appeals and complaints. The graph on the left side shows the total Tier 3 exception appeals in 2019 and the total formulary exceptions in 2020. The Tier 3 exception process wasn't being utilized well in 2019, and going through 2020, there were more denials, so subsequently more member appeals. There were 287 first level appeals and about 6.5% of those drugs that were denied through the formulary exception process generated appeals. Of those 287, 132 (46%) were overturned because they were able to present new medication to MODA for their clinical reviews or the members tried one of the other preferred alternatives. It may not have worked or there may have been safety concerns, and they went through the request again and were approved. Of the remaining 155 upheld denials, 15 moved to second level, and of those 15, three moved to an Independent Review Organization (IRO). There was an increase in the appeals for the formulary exception process.

The graph on the right side of Slice 9 looks at the total number of appeals on the clinical side for UMP with the yellow bars showing prior authorization step therapy or quantity level limits. These would have been the utilization management strategies in place for 2019 for those Tier 3 drugs. Between 2019 and 2020, there were fewer total appeals due to prior authorization step therapy and quantity level limits, which is restricted to the Value Tier, Tier 1, and Tier 2 drugs. We also saw a similar number of complaints in the not covered drugs and a decrease in others. Other types of clinical or administrative appeals were also seen. Overall, the total number of appeals between 2019 and 2020 was similar, although it was a shift from the standard utilization management to the formulary exception process.

**Dave Iseminger:** Ryan, I want to ask a question to drive it home. Normally when we see a jump in appeals, we have a concern because we think something happened. Here we know what happened, there were hundreds or even thousands of individuals who might have been eligible for the Tier 3 exception process, but never pursued it. Very likely, they didn't understand it or know it was available. So, this jump in appeals is

really because of the way the value formulary is implemented. Again, that member equity issue of people paying hundreds of dollars when they could have been paying a \$75 copay, but didn't, for whatever reason, go through the process. We now put them through that process. As a collateral piece, we see a jump in appeals. Is that a way to frame things and understand this?

**Ryan Pistorosi:** I think you said it better than me. This is something we would have expected given all these members were required to go through the process. You think about how many members we sent these letters to, how many authorization reviews were approved on the initial request, how many denials we saw, and then of those, how many members were maybe one drug away? They could appeal and provide new information and ask to get it approved. 46% of these first level appeals were overturned with new information or maybe trial of another drug. We would have expected this in requiring these numbers to go through this process.

**Dave Iseminger:** Those individuals for whom it was overturned are now paying a lower rate than they were before or getting coverage for a drug that was formerly not covered. It's interesting to think about it that way because normally when there's an appeal, we think what's the problem we're trying to address? We addressed the problem, which resulted in more appeals, a subset of appeals, but it was all with the goal of getting people to the most efficacious drug at a better out-of-pocket experience than what they were experiencing under the former formulary process.

**Ryan Pistorosi:** I agree.

**Elyette Weinstein:** I didn't catch what some of the acronyms stand for.

**Ryan Pistorosi:** Good point. PA stands for prior authorization and ST stands for step therapy, which requires a patient to use a specific drug before another one. It's like prior authorization but it doesn't have the clinical criteria. QLL is quantity level limits, putting utilization limits on drugs. For example, if you wanted to make sure no one was taking too many of a certain drug per month, you could put a quantity level limit. If a drug is sold in 10 milligram tablets and 20 milligram tablets, and if someone took two of the 10 milligram tablets, effectively a 20-milligram dose, they would be spending twice as much on the drug, if the 10 milligram and 20 milligram tablets cost the same. You put a quantity level limit on the 10 milligrams to say you can only get 30 of these per month. If you did need to use 20 milligrams, you'd have to use the 20-milligram version.

**Sue Birch:** I want to check on Board Members because I see heads and eyes spinning. Is this how the US health care system works? I am grateful to our pharmacy team that brought this forward because again, the medical errors, the gaming, and the capitalistic nature, you can see how our members can get rolled with this. I see Elyette, thumbs up. I want to applaud this analysis, Ryan. This is an important gatekeeping thing. It makes me very sad to think I have spent four decades being involved in a system, the health care macro system, that delivers this kind of unnecessary tool. This is really important for the protection of our members, not just financially but with the quality of their health care because you can imagine with those 10-milligram tablets and these limits, it gets dizzying. Can you imagine when it's a senior? Yes, I see heads shaking.

**Ryan Pistorosi:** That was an additional benefit of this that we had the opportunity to go through and do additional clinical reviews on all these drugs. Not only does it address the equity issue, or the member's cost, but we had pharmacists at MODA doing these reviews to make sure these were the right medications for the members.

Slides 10 & 11 will confirm members transitioning for these drugs were able to continue to take drugs and use drug classes, which we know was one of the Board's main concerns in 2019.

Slide 10 – Preferred Use (2019 to 2020), has a graph looking at three different subclasses of diabetes medications selected because diabetes had the highest number of impacted members, the highest number of drug classes impacted, and the highest amount of the formulary exception requests. It's a good illustration of the member experience. The columns show the number of members using preferred and non-preferred drugs in these drug classes. There are two columns for GLP-1 agonists, 2019 and 2020; two middle columns for DPP-4 inhibitors, 2019 and 2020, which are a slightly older class of anti-diabetes drugs; and two columns on the right for SGLT-2, inhibitors, 2019 and 2020, which are a newer diabetes drug class.

The GLP-1 agonist, went from about 73% preferred drug use in that class, to 93% in 2020. The number of members using this drug class rose. This number of preferred drugs in this drug class was expanded so members could continue to use more in this class. This illustrates why we saw more preferred drug use and an increase in utilization overall in 2020. This is one of the more popular drug classes and one we may even see expanded in 2021 for non-diabetes related indication. We're watching closely.

The DPP-4 number of preferred drugs also increased from 77% to almost 99%, but utilization dropped primarily because members using nonpreferred drugs may have opted to switch from this older drug class to one of the newer drug classes. We are not necessarily seeing members go without their drugs. We've seen a steady decline in this drug class the last few years with the rise of the GLP-1s and the SGLT-2s. Although the DPP-4s continue to decrease, this highlights the amount of preferred drug use is remaining flat, which means they continue to use the preferred drugs in this drug class.

The SGLT-2 inhibitors almost reached 100% for preferred drug use. There was increased utilization as well as members focusing on the preferred drugs in this class.

**Dave Iseminger:** Ryan, to double check my understanding, those non-preferred drug users who ultimately became a preferred drug user in 2020 are an example of someone who now pays less out of pocket every month for their diabetes drug. Is that right?

**Ryan Pistorosi:** That is correct.

**Dave Iseminger:** When you add up all those differences, it's easily over 1,000 people who, every month, have more disposable income today than they did before, and they're taking an equally efficacious drug today compared to what they were before. Correct? Everything I just said true statements?

**Ryan Pistorosi:** Right. If you think about these patients with diabetes, they likely have other chronic medical conditions. This is not the only drug they're taking. In fact, they may be taking multiple drugs for diabetes, even multiple of these drug classes. They may be taking medications for hypertension, for hyperlipidemia. They may have COPD or asthma. This is not looking at just a single person taking a single drug. These are members who are among our highest cost members that are spending the most on prescription drugs. Not only will it help them pay for this drug, but it could be helping them pay for other prescription drugs as well.

**Dave Iseminger:** For a finer point, you had an example of a diabetes drug where somebody was shifting and spending \$300 or more less every month by moving from non-preferred to preferred drug status. This can be a significant amount of money, especially as you said, when you have comorbidities and you're doing this across multiple medications, to the kind of kitchen table economics we often hear from our retiree community about their concerns. This is a direct infusion of kitchen table dollars because of this change by the Board.

**Ryan Pistorosi:** In fact, that drug that you were referencing from an earlier slide is in column number two. Those members using the green drug went through the formulary exception process and demonstrated they can't use any of the preferred drugs, so they are getting that drug at that Tier 2 cost share. All the drugs you see in the 2020 columns, are all at the Tier 2 cost share.

**Elyette Weinstein:** Am I correct in understanding that the slide we're looking at, Slide 10, these are all diabetes related drugs, are they not?

**Ryan Pistorosi:** Yes, all three of these are different subclasses of diabetes medications. You may be saying to yourself, if someone were taking a non-preferred drug in 2019 and switched to a preferred drug in 2019, wouldn't they be counted in both? That's technically correct. On Slide 11 – Scripts/1000 (2019 to 2020) shows a breakdown by the number of scripts per 1,000 members. The graphs are very, very similar to Slide 10. There are slight differences. In the GLP-1s, through the different metrics we used internally to evaluate the member experience and the utilization of these drugs, it tells a similar story that they continued to have access to drugs in these drug classes, and ultimately, these members were shifting to preferred drugs, which as Dave mentioned, is saving them money and helps the plan because they're paying for drugs that cost less for the plan and the agency overall.

**Tom MacRobert:** When you do your prescription drug analysis, is a lot of that work done with artificial intelligence or is it all human involvement?

**Ryan Pistorosi:** That's a great question. I would have to check with our actuarial analyses and our data team at MODA. I do know they have been looking at different ways of analyzing the prescription drug data, but all the information you see in the slides today is done internally. These are reports HCA developed, that we helped design with MODA.

Slide 12 – Member Experience, highlights why we went to the 2020 UMP Preferred Drug List.

**Scott Nicholson:** I want to say thank you very much for this presentation. I thought it was amazing to see and echo what the Chair's comments were about how amazing this is to see what you're doing for members in this area. It's very complicated as seen in this presentation. And the fact you're able to guide people through this process and get to a great result is uplifting. I appreciate that.

**Ryan Pistorosi:** Great, thank you.

**Sue Birch:** Ryan and Dave, I think this really should be a case study to think about how we could introduce more of this value-based purchasing alignment with other large purchasers. To me, this is really showing the importance of being on top of how we manage things with our members. I would really encourage you to think about if we were to do a press statement on something like this, how in the heck would we help people understand the benefits and what this has done. I look forward to when we get real solid estimates on the total savings rolled up to a high level.

**Dave Iseminger:** We're doing our best to get there.

**Sue Birch:** And really, just beyond the finances, just the safety. I mean, did you know you're using a drug not approved by the FDA for purposes other than what you should? It's just staggering to think about how, again, our US health system runs.

**John Comerford:** Can I just take a moment to thank Dave and the staff for all the great work they do here? This is phenomenal information to have. More so than I see in any business that I work with, the kind of things you've done here with the state.

**Elyette Weinstein:** Well done.

**Dave Iseminger:** Thank you. I kind of joke, it's just another day at the Health Care Authority. There's always a lot to do and more to change, a lot to keep moving on, but I said this before with the value formulary when I came in and became the acting director in 2017 right as rate setting season was happening. I knew there were things that needed to be on my personal to do list as goals for the Division. I look back over the past couple of years, the value formulary is on that list. The introduction of MA-PD plans is on that list, both of those things directly expanding the disposable income for retirees, which I heard loud and clear during the summer 2017 rate increase conversation as I took over leadership of the PEBB Program. I look at the long-standing LTD design enrollment issues, which are now heavily underway. Then I look at the SEBB Program and we're talking about possible additional plans within the PEBB portfolio for choice. It's a lot of hard work by a lot of people. I appreciate the Board's support on various initiatives over the past couple of years. You're now starting to see some of our reporting back on how we've done and what it means for our members in their everyday lives. That's what drives us. Thank you for your support.

### **Public Comment**

No public comment.

### **Next Meeting**

June 9, 2021

12:00 p.m. – 3:00 p.m.

**Preview of June 9, 2021 PEB Board Meeting**

**Dave Iseminger**, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the June 9, 2021 Board Meeting.

Meeting adjourned at 2:50 p.m.