Washington State Health Care Authority

Public Employees Benefits Board Meeting

April 25, 2018

Washington State Health Care Authority

Public Employees Benefits Board

April 25, 2018
1:30 p.m. – 4:00 p.m.

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

Table of Contents

TAB 1

Washington State Health Care Authority

AGENDA

Public Employees Benefits Board
April 25, 2018
1:30 p.m. – 4:00 p.m.

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

Call-in Number: 1-888-407-5039 **Participant PIN Code: 95587891**

1:30 p.m.*	**Welcome and Introductions**		Sue Birch, Chair	
1:40 p.m.	**Meeting Overview**		Dave Iseminger, Director Employees & Retirees Benefits (ERB) Division	Information
1:45 p.m.	**Follow-up Responses to Questions from March 21, 2018 Meeting**		Dave Iseminger, Director ERB Division	Information
1:50 p.m.	**CHAMPVA Follow-Up (Civilian Health and Medical Program of the Department of Veterans Affairs)**	TAB 3	Barb Scott, Manager Policy & Rules Section ERB Division	Information
2:05 p.m.	**SEBB Procurement Update**	TAB 4	Lauren Johnston, Procurement Manager ERB Division	Information
2:15 p.m.	**PEBB Procurement Update**	TAB 5	Beth Heston, Procurement Manager ERB Division	Information
2:25 p.m.	**Centers of Excellence Program Update**	TAB 6	Marty Thies, Account Mgr. Marcia Peterson, Manager Benefit Strategy & Design Section ERB Division	Information
2:35 p.m.	**SmartHealth Update**	TAB 7	Justin Hahn, Program Mgr. WA Wellness ERB Division	Information
2:50 p.m.	**UMP Value Formulary Options**	TAB 8	Donna Sullivan, Chief Pharmacy Officer Clinical Quality and Care Transformation Division	Information

3:45 p.m.	**Public Comment**			
4:00 p.m.	**Adjourn**			

***All Times Approximate**

The Public Employees Benefits Board will meet Wednesday, April 25, 2018, at the Washington State Health Care Authority, Sue Crystal Rooms A & B, 626 8th Avenue SE, Olympia, WA. The Board will consider all matters on the agenda plus any items that may normally come before them.

This notice is pursuant to the requirements of the Open Public Meeting Act, Chapter 42.30 RCW.

Direct e-mail to: board@hca.wa.gov. Materials posted at: http://www.pebb.hca.wa.gov/board/ no later than close of business on April 23, 2018.

Washington State Health Care Authority

PEB Board Members

Name	Representing
Sue Birch, Director Health Care Authority 626 8th Ave SE PO Box 42713 Olympia WA 98504-2713 V 360-725-2104 sue.birch@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
Carol Dotlich 8312 198th Street E Spanaway WA 98387 V 253-846-6371 wfsecarol@comcast.net	State Retirees
Tom MacRobert 4527 Waldrick RD SE Olympia WA 98501 V 360-264-4450 zapmac@hotmail.com	K-12 Retirees

PEB Board Members

Name	Representing
Tim Barclay 9624 NE 182nd CT, D Bothell WA 98011 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
Vacant	Benefits Management/Cost Containment
Harry Bossi* 19619 23rd DR SE Bothell WA 98012 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

4/18/18

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

2018 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 31, 2018 (Board Retreat) 9:00 a.m. – 4:00 p.m.

March 21, 2018

April 25, 2018

May 21, 2018

June 7, 2018

June 20, 2018

July 11, 2018

July 17, 2018

July 25, 2018

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

Updated 7/21/17

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

Washington State Health Care Authority

CHAMPVA Follow-up

Barb Scott, Manager
Policy and Rules Section
Employees and Retirees Benefits Division
April 25, 2018

Topics to discuss

- Timeline for PEB Board policy resolutions
- Information on current PEB Board deferral policy
- Effective date of eligibility policy changes

Timeline for PEB Board eligibility policy resolutions

- Introduce policy resolutions in June
- Board action on policy resolutions in July

PEB Board Retiree Deferral Policy

Current policy allows deferral while enrolled in:

- Employer-based group medical as an employee or the dependent of an employee *(2001)*
- Federal retiree medical plan *(2001)*
- Medicare/Medicaid dual-eligible *(2006)*
- Health Benefit Exchange coverage *(2014)*

Effective date of eligibility changes

- January 1 of next plan year
- Mid-year or retroactive when legislatively required

Questions?

Barbara Scott

Policy and Rules Section Manager

Employees and Retirees Benefits Division

barbara.scott@hca.wa.gov

360-725-0830

TAB 4

Washington State Health Care Authority

SEBB Procurement Update

Lauren Johnston
SEBB Procurement Manager
Employees and Retirees Benefits Division
April 25, 2018

Approved Resolutions

On March 15, 2018 the SEB Board voted to procure for:

- Fully-insured group medical plan
- Stand-alone vision (as a group vision plan)
- Long- and short-term disability

All benefits will start January 1, 2020

Procurement Process

Fully-insured medical and group vision

- Request for Information (RFI)
  - Objectives of RFI: inform collective bargaining and the creation of a future competitive solicitation; learn geographic coverage areas, plan designs, and projected costs
- Request for Proposal (RFP)

Disability

- Request for Proposal

Washington State Health Care Authority

SEBB Procurement Timeline

Benefit	RFP Release Date*	RFP Reponses Due*	Provision to later add PEBB?
Fully-insured medical	Early June 2018	Early August 2018	Yes
Group vision	Mid-June 2018	Late July 2018	Yes
Disability	Early May 2018	Early June 2018	Maybe

***Subject to change.**

Washington State Health Care Authority

Questions?

Lauren Johnston

SEBB Procurement Manager

Employees and Retires Benefits Division

lauren.johnston@hca.wa.gov

Tel: 360-725-1117

TAB 5

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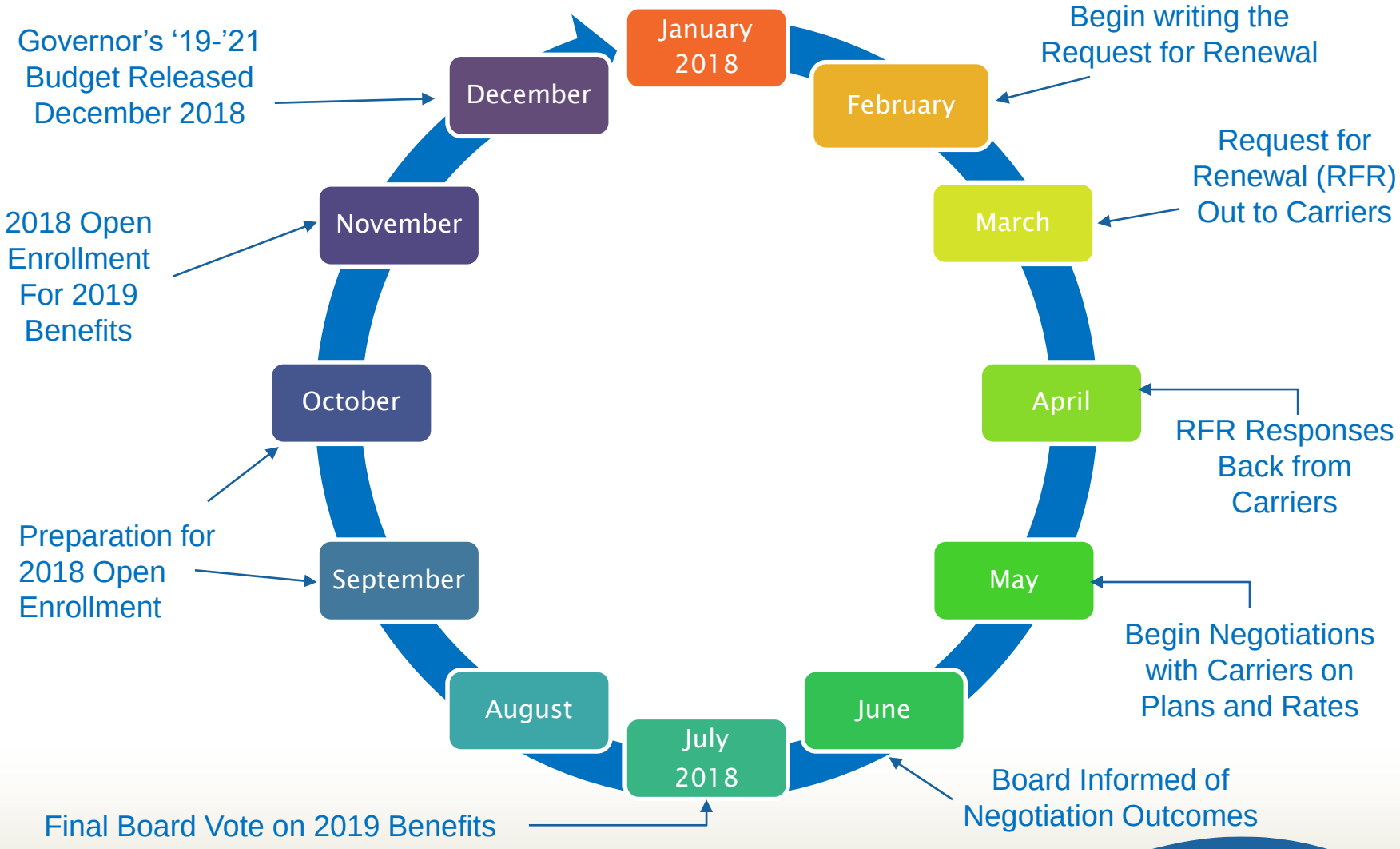
PEBB Procurement Update

Beth Heston
PEBB Procurement Manager
Employees and Retirees Benefits Division
April 25, 2018

Washington State Health Care Authority

2019 PEBB Procurement Cycle



Questions?

Beth Heston, PEB Procurement Manager
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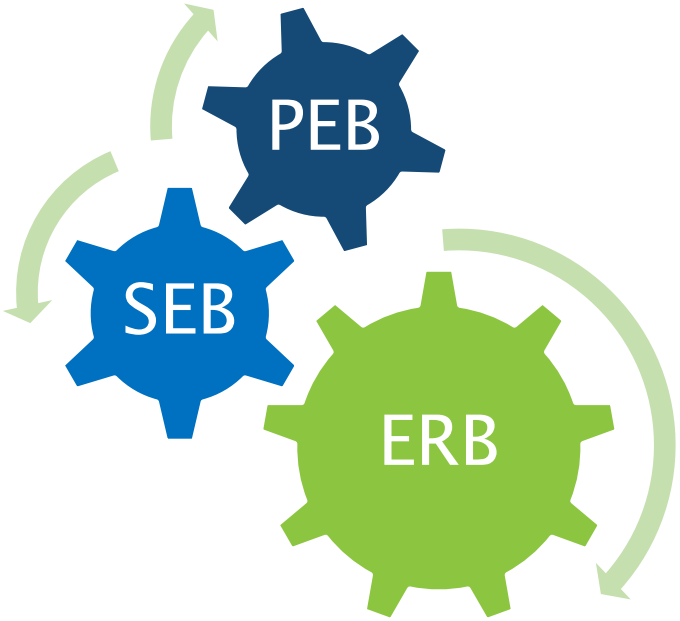
beth.heston@hca.wa.gov
Tel: 360-725-0865



TAB 6

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Centers of Excellence Program Update

Marty Thies, Program Manager
Marcia Peterson, Section Manager
Employees and Retirees Benefits Division
April 25, 2018

Centers of Excellence Program Total Joint Replacements (COE-TJR)

Washington State Health Care Authority

Background

- Clinical Standards: The Bree Collaborative (2011)
- A national movement away from Fee for Service (FFS) toward quality and coordinated care
- Legislature directs HCA to increase value-based purchasing and payment in pursuit of increasing access to high-quality and high-value care (2014)
- PEBB approves resolution for the Centers of Excellence Program (COE) (2016)

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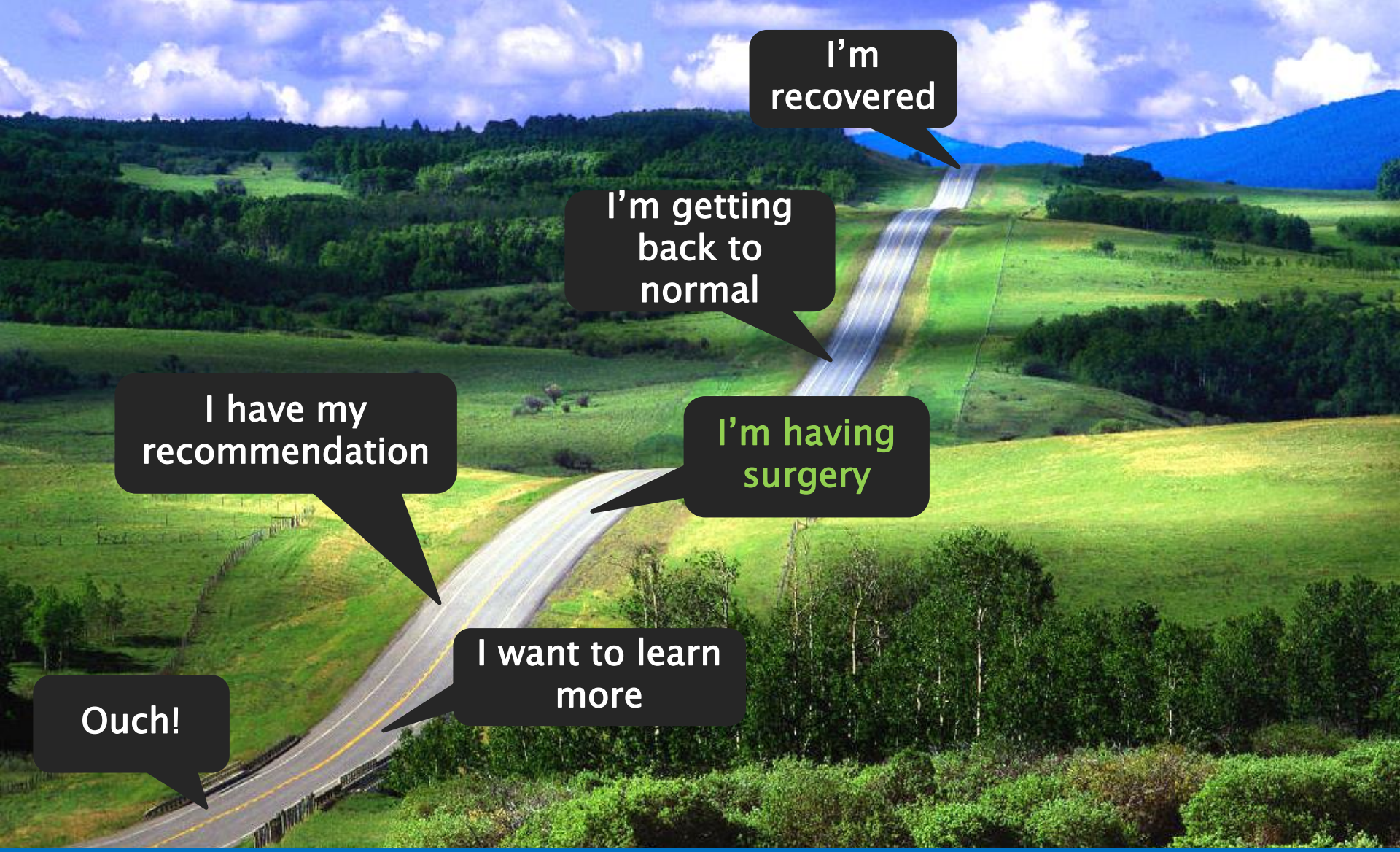
TJR: Benefit Design

Why Total Joint Replacement?

- High utilization (650/year in UMP)
- High variability in cost & outcomes

For members: Incentivizing toward quality

- Low to no out-of-pocket costs, including:
  - Surgery & associated inpatient services
  - Implant and Durable Medical Equipment (DME)
  - Case Management
  - Transportation and accommodations
- 90-day warranty for specific complications



Patient Journey

Washington State Health Care Authority

The COE-TJR Team

Center of Excellence: Virginia Mason

- Experience in Total Joint Replacement (TJR) bundling
- Comprehensive, patient-focused approach to providing care
- History of high quality, low complication rate
- Established best practices using Bree criteria

Third-Party Administrator: Premera

- Intake, customer service, referrals, travel, logistics
- Patient Experience Surveys
- End-to-end member-focused concierge facilitation

Program Implementation

- Contracts signed Fall 2016
- Publicized before and during Open Enrollment
- Benefit go-live: January 1, 2017
- HCA-Virginia Mason-Premera partnership
  - Building business processes
  - Establishing reports
  - Enhancing communications
  - Troubleshooting issues

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Calendar 2017 Traffic

- 122 Referrals to Virginia Mason thru Dec. 31
- 95 Completed Surgeries
- <2 nights Average Length-of-Stay

<u>Regarding the Data here presented</u>:

- **Costs** are based on 2017 bundled surgeries invoiced and paid (**95**)
- **Demographics** are based on total number of participants Premera referred to Virginia Mason in 2017 (**122**)

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Clinical Outcomes

Post-Operative Events	Description	2017 Non-COE-TJR		2017 COE-TJR	
		COUNT	COST	COUNT	COST
7-Day Complications	Infection	1	$9,619.22	0	$0.00
30-Day Complications	Pulmonary Embolism	2	$76,800.94	0	$0.00
90-Day Complications	None Found	0	$0.00	0	$0.00
182-Day TJR Revisions	NA	5	$220,968.43	0	$0.00

Member Surveys

Premera: **69% Response Rate, Scored 1-10**

- My Case Manager was courteous and helpful **9.8**
- Travel benefits coordinated by Premera **9.7**
- I felt ready for my surgery **9.5**

Virginia Mason as Center of Excellence:

- I understood my recovery plan **9.1**
- If I have another TJR, I'd use the COE again **9.7**
- I'd recommend the program to family, friends **9.7**

- **Overall satisfaction with total experience: 9.5**

Comments from UMP Members

- *" I thought the whole organizing from Premera to VM was well handled, **they did a wonderful job**. It's been a good experience."*
- *"It was **second to none**; [the program] was awesome!"*
- *"**One of the most positive medical experiences I've ever had!**"*
- *"I was very **impressed with the entire process**. The people at Virginia Mason were awesome and [Premera] did a great job setting everything up for me. **You guys made it as easy as possible for me.**"*
- *"Everything about it was amazing: everyone was super helpful and knowledgeable. **Everything about it was great.** I would definitely recommend to friends."*
- *"My recovery went well because **I was taken care of so well that I recovered well from start until end.** They called to see if I had any questions. The staff, the hospital, the facility was excellent. I could not say anything better. My experience there was great!"*

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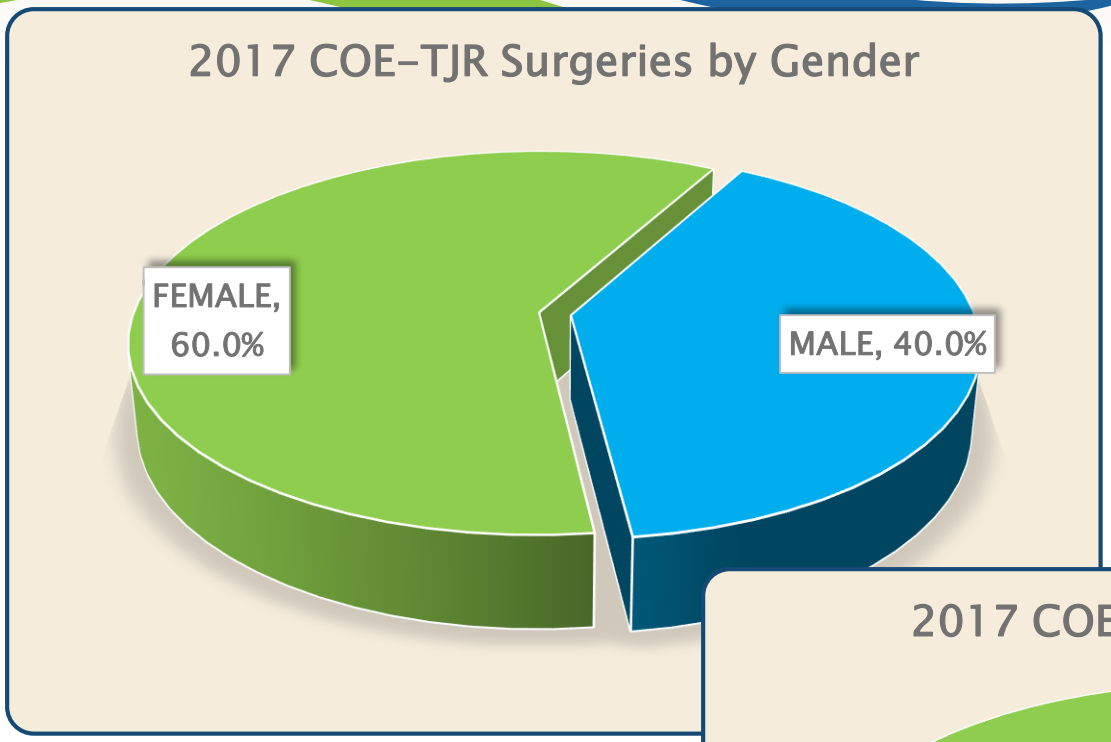
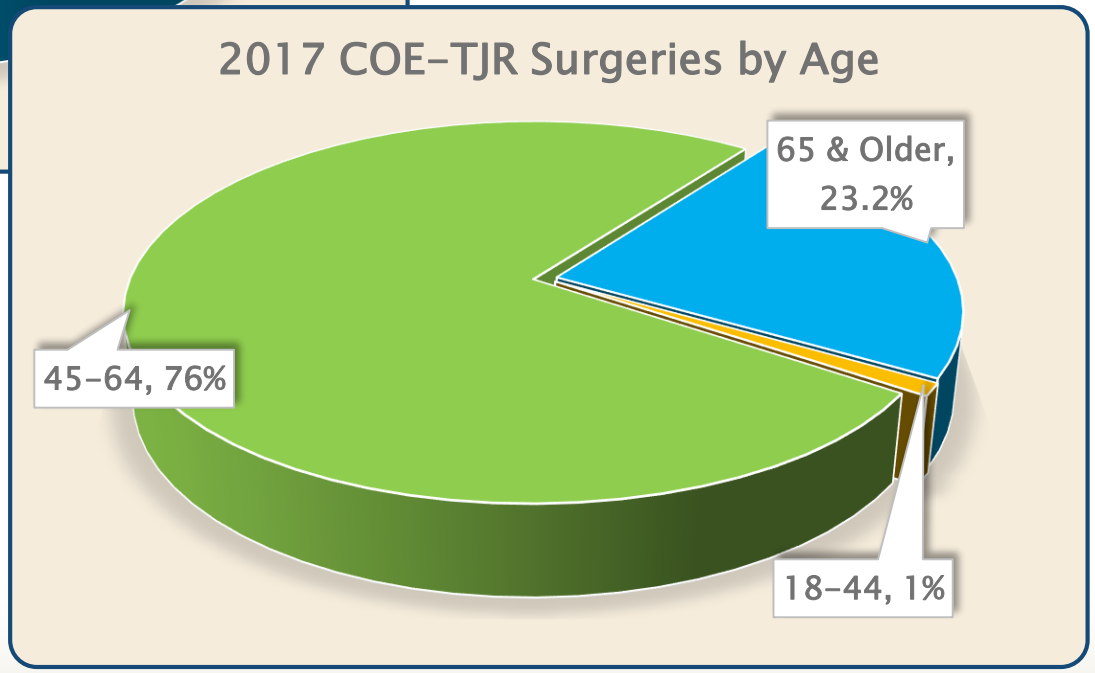
Age & Gender





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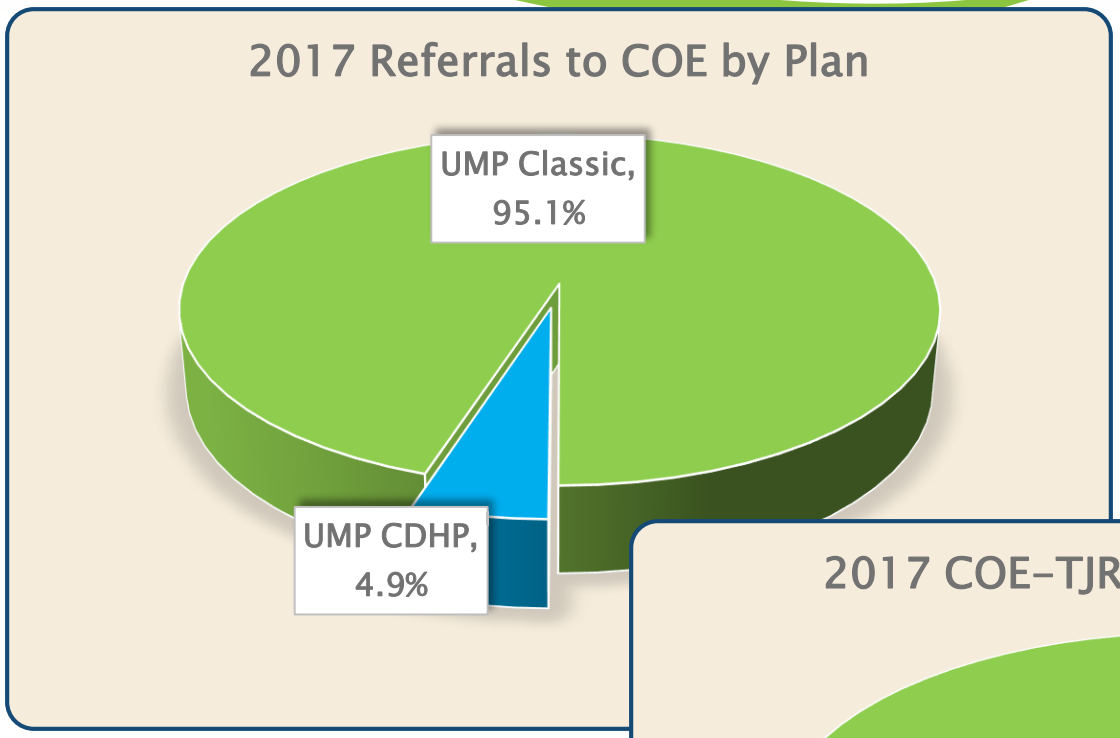
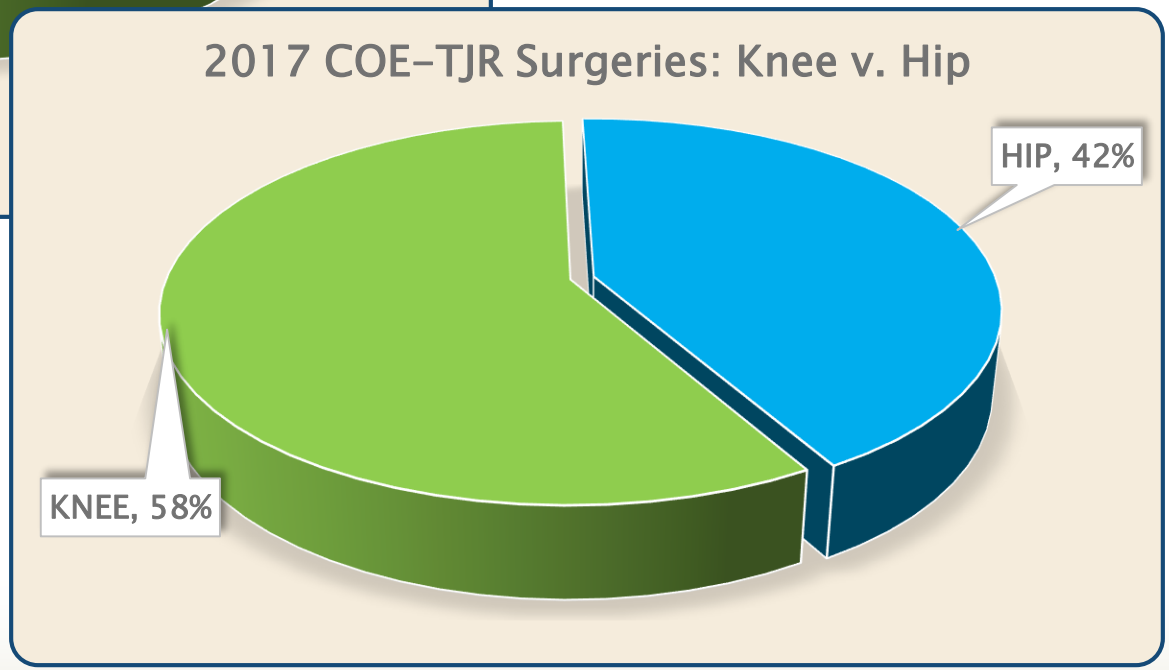
Plan & Surgical Site





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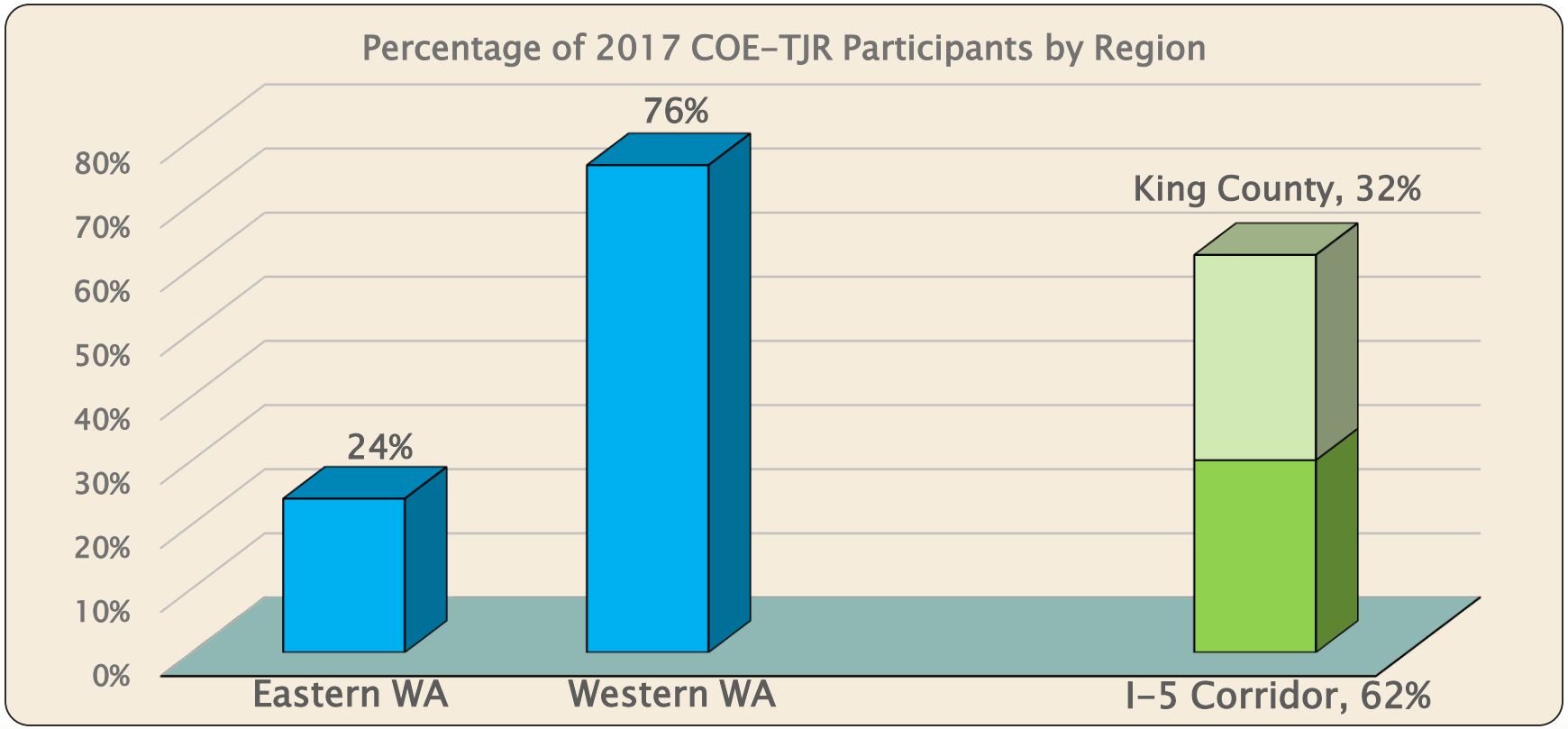
2017 COE-TJR Participants by Region



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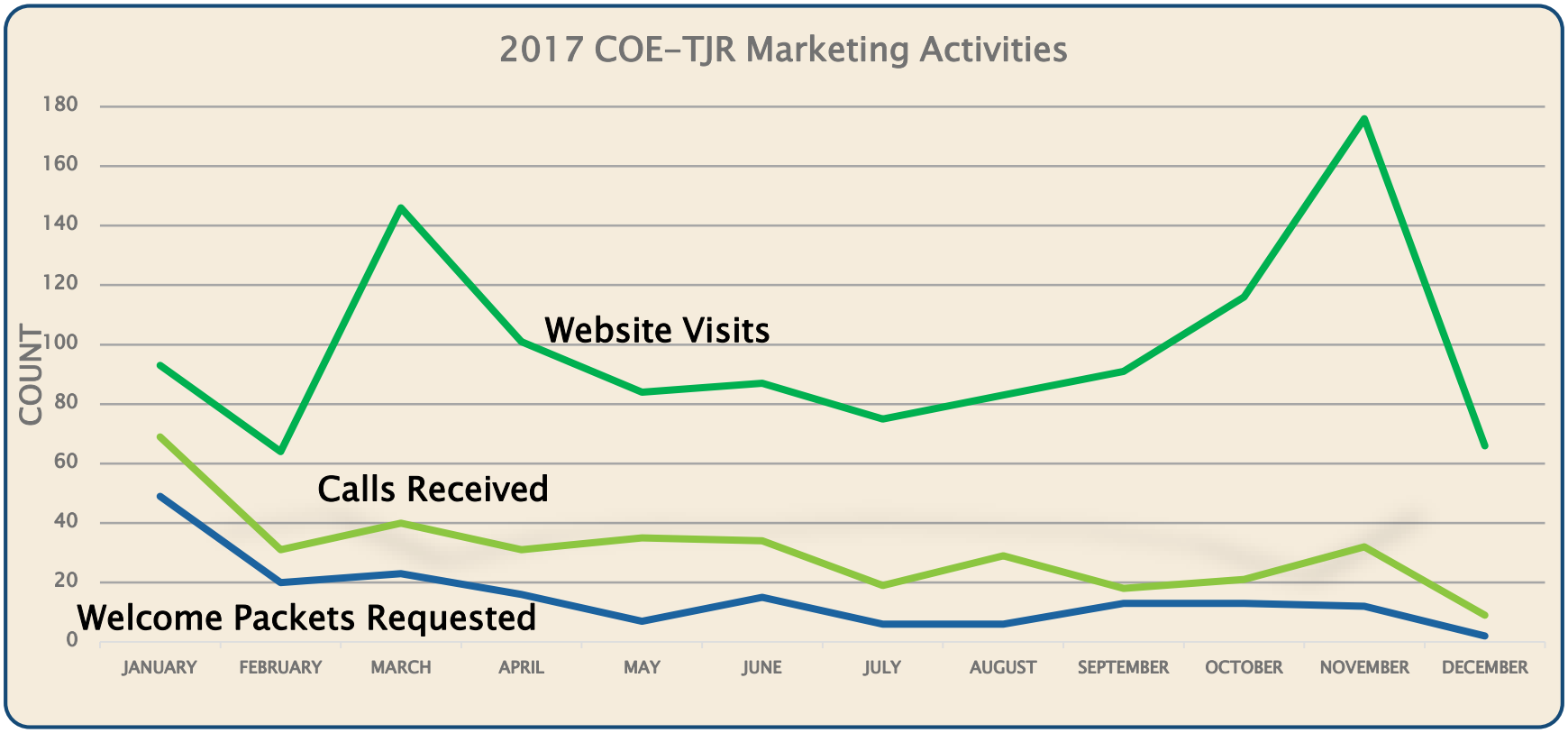
2017 COE-TJR Marketing & Outreach Activity



- Premera TJR Website Visits
- Incoming Calls to Premera Customer Service
- Welcome Packets Requested & Sent

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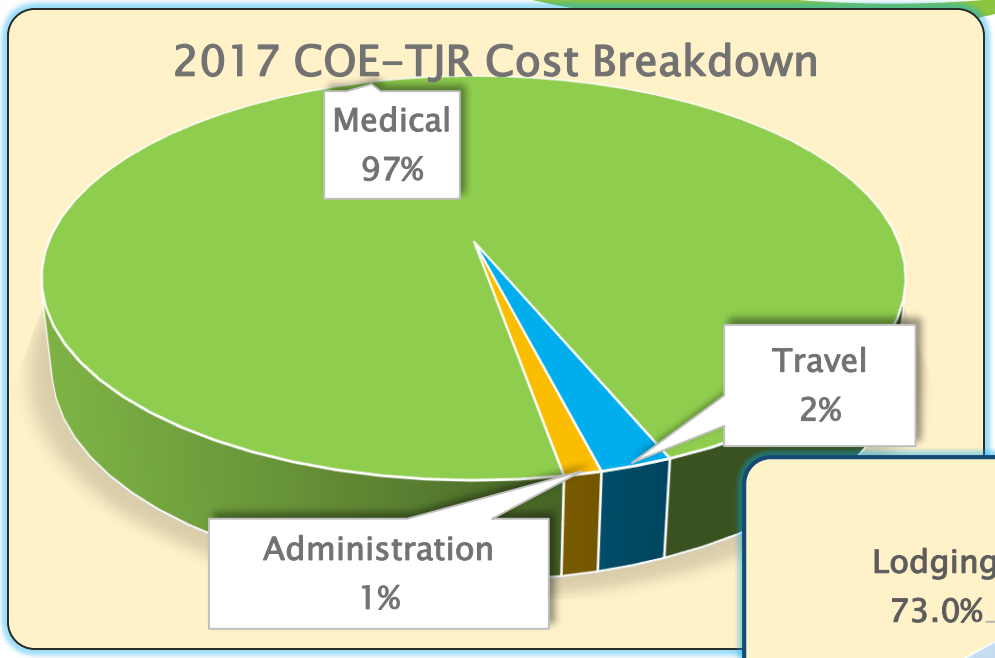
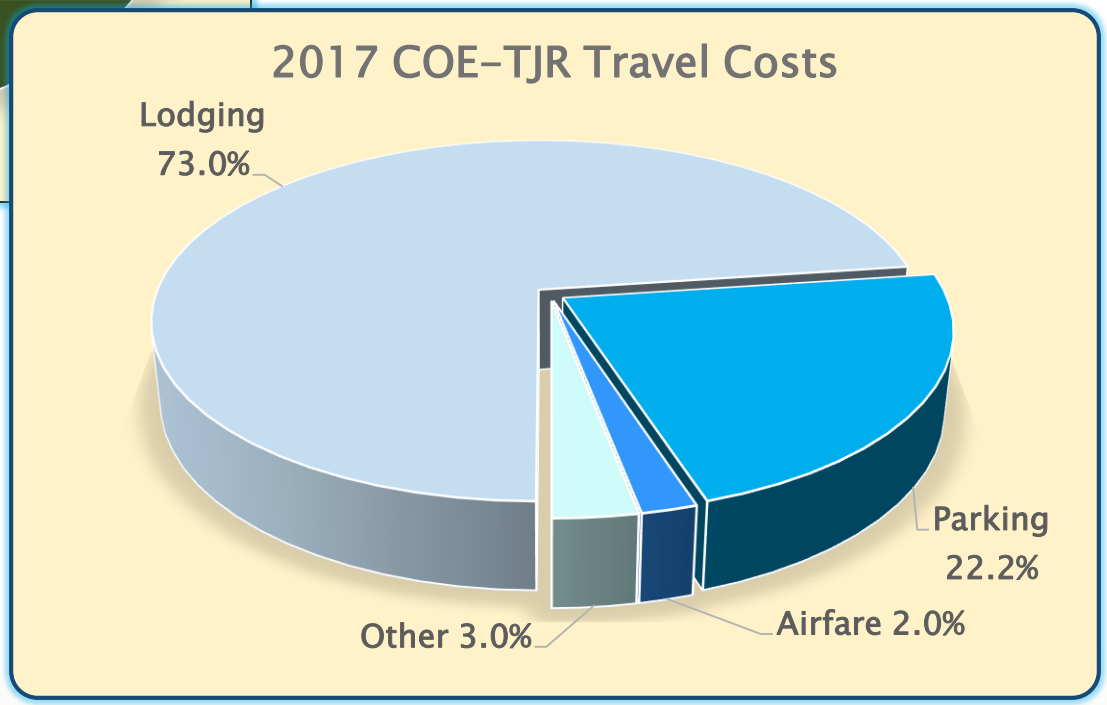
Cost Overview





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2017 Member Savings
(95 COE Surgeries)

- Average TJR Out-of-Pocket, 2014 to 2016: $855.41
- Average TJR Out-of-Pocket, 2017: $988.46
- Out-of-Pocket, most COE-TJR Participants: $ 0.00

- **Approximate Member Savings: $94,000.00**

Cost Comparison with non-COE TJRs (after 95 COE Surgeries, Billed and Paid)

Plan Claim Savings:

- In 2017, UMP saved more than 15% per COE surgery compared to joint replacements performed elsewhere

Centers of Excellence Program
Spinal Fusion

Washington State Health Care Authority

Bree Collaborative

Bundled Episodes of Care

Total Hip & Knee Replacement	Bariatric Surgery	Spinal Fusion	Coronary Artery Bypass Graft

ANNALS OF HEALTH CARE MAY 11, 2015 ISSUE

OVERKILL

An avalanche of unnecessary medical care is harming patients physically and financially. What can we do about it?

By Atul Gawande

"Nationwide, we spend more money on spinal fusions, for instance, than on any other operation—thirteen billion dollars in 2011. And if there are complications the costs of the procedure go up further. The medical and disability costs can be enormous, especially if an employee is left permanently unable to return to work."

- Atul Gawande, *The New Yorker*, May 11, 2015

"I can tell you if you're listening out there, stay away from back surgery. I can say that from the bottom of my heart. Rehab, rehab, rehab. Don't let anyone get in there."

Steve Kerr
Head Coach, Golden State Warriors

Variation in Care

WASHINGTON HEALTH ALLIANCE
Leading health system improvement

SPINE FUSION IN WESTERN WASHINGTON
Olympia residents were more likely to have spine fusion procedures and Seattle residents less likely.

Among women 45-54, those living in Olympia were 192% more prone to have this procedure than their counterparts in Seattle.

-Different Regions, Different Health Care: Where You Live Matters: A Report on Variation in Procedure Rates in Puget Sound - 2015

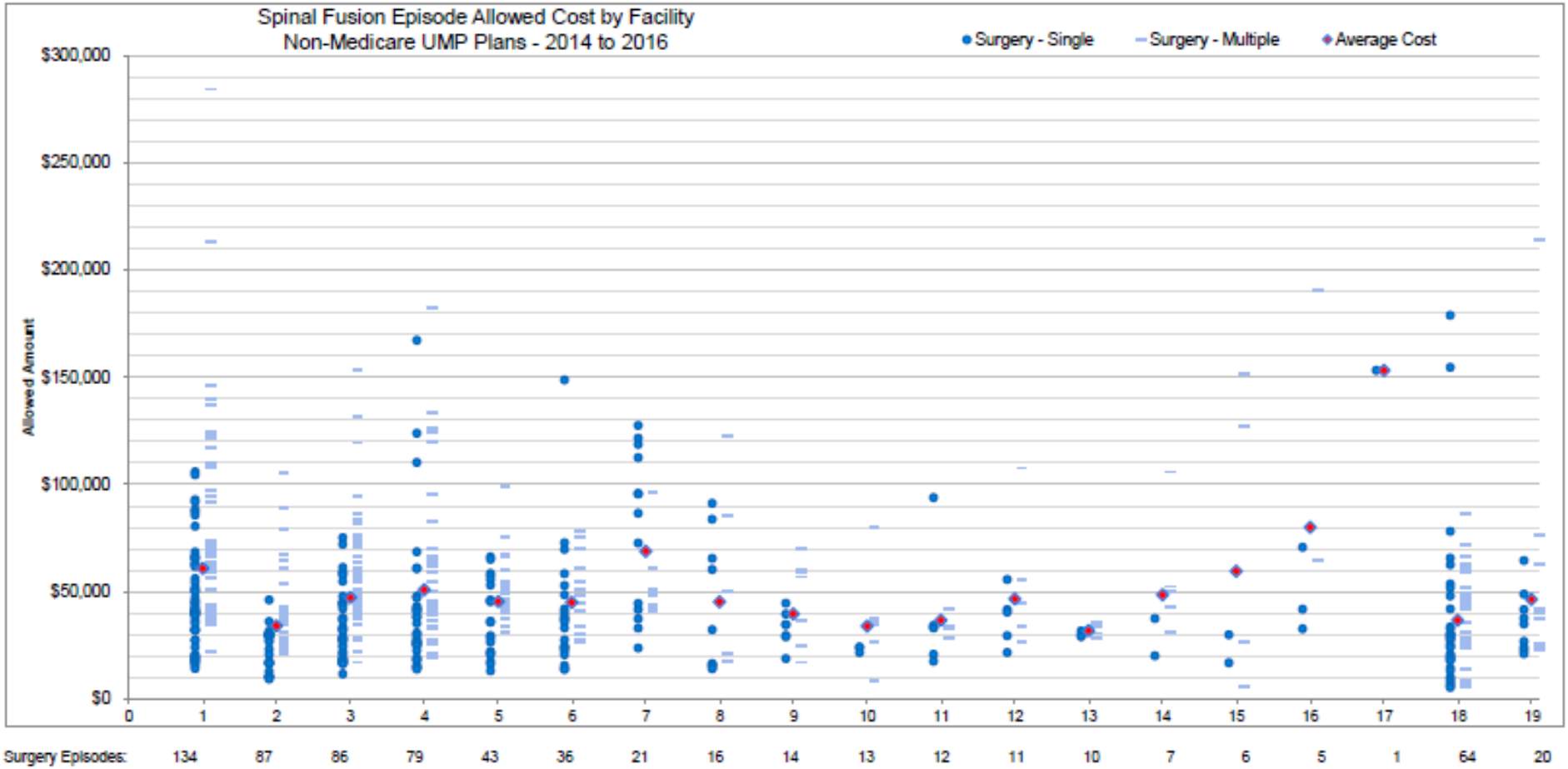
Variation in Cost

Volumes and claims costs for UMP members having spinal fusion

2014: 226 surgeries
2015: 196 surgeries
2016: 211 surgeries

3 year total: 633 – Allowed cost amount: $30,389,098
Average allowed costs $49,010 *

* Does not include allowed costs over $100,000


Spinal Fusion Episode Allowed Cost by Facility
Non-Medicare UMP Plans - 2014 to 2016
Surgery - Single
Surgery - Multiple
Average Cost
Allowed Amount
$300,000
$250,000
$200,000
$150,000
$100,000
$50,000
$0
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19
Surgery Episodes: 134 87 86 79 43 36 21 16 14 13 12 11 10 7 6 5 1 64 20

Spinal Fusion Centers of Excellence Procurement

- Timeline
  - RFP released 2/1/2018
  - Responses due 4/20/18
  - Benefit launch to members 1/2019

- Similar to Total Joint Centers of Excellence Program
  - Voluntary program
  - Members using the COE will have little to no out-of-pocket costs
  - Travel (if appropriate) will be covered
  - Requires a care companion
  - Meet Bree criteria for Appropriateness and Fitness for Surgery

Questions?

Martin Thies
Account Manager
martin.thies@hca.wa.gov
360-725-1043

Marcia Peterson
Section Manager, Benefit Strategy & Design
marcia.peterson@hca.wa.gov
360-725-1327

TAB 7

Washington State Health Care Authority

Smart Health

Justin Hahn, CWPC
Washington Wellness
Employees and Retirees Benefits Division
April 25, 2018

Washington State Health Care Authority

Topics for Discussion

- SmartHealth Overview
- 2018 SmartHealth Program
- SmartHealth Participation: 2016, 2017, and 2018

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SmartHealth Overview

Washington State Health Care Authority

"To help us **be our best** for work and with the **family**, **friends**, and **community** we care about."

– Governor Jay Inslee

Washington State Health Care Authority

Whole-Person Approach

Washington State Health Care Authority

Secure. Private. Confidential.

- Stringent HIPAA privacy standards followed.
- Federal law prohibits disclosing identifiable information to the employer.
- Personally identifiable health data is not shared with employer or Washington Wellness staff. ***Only*** anonymized and aggregate data is shared.
- Data from groups with fewer than 20 people is not revealed.

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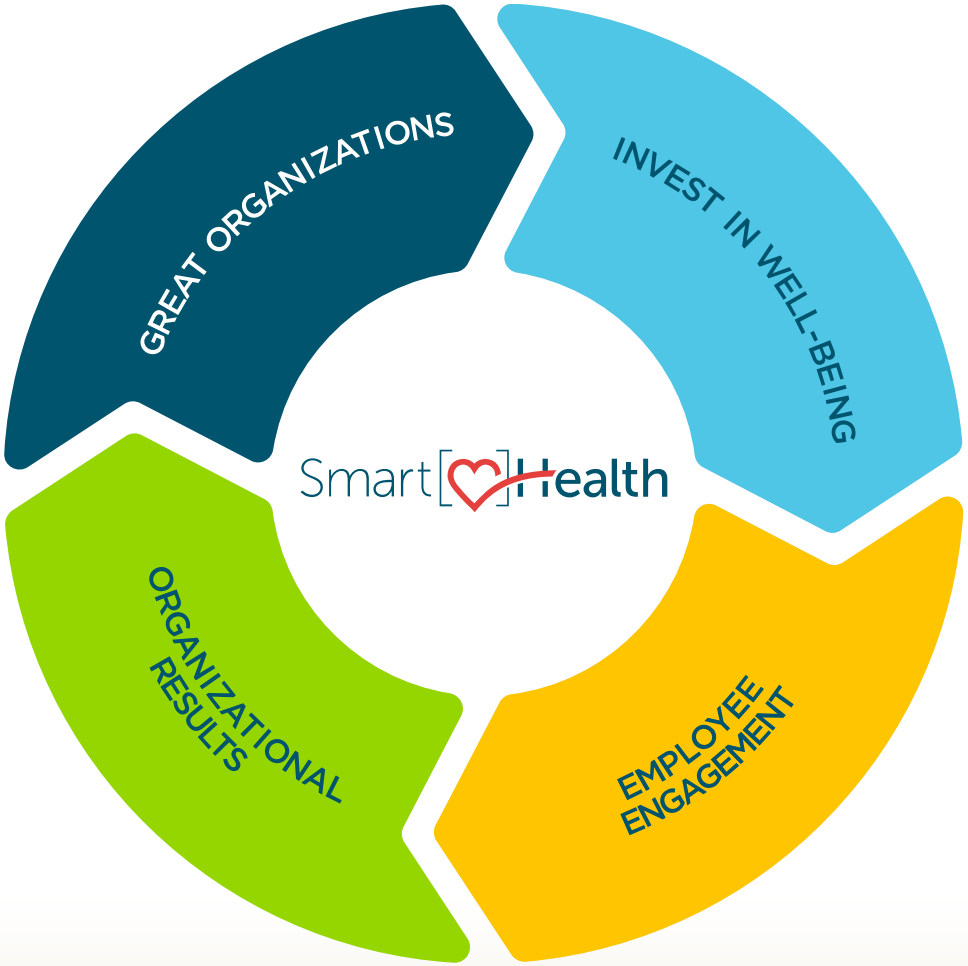
Good for Employees and Organizations



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SmartHealth Increases Well-being!

2015 to 2017

12,000 employees

with low well-being scores

Improved in EVERY

well-being dimension

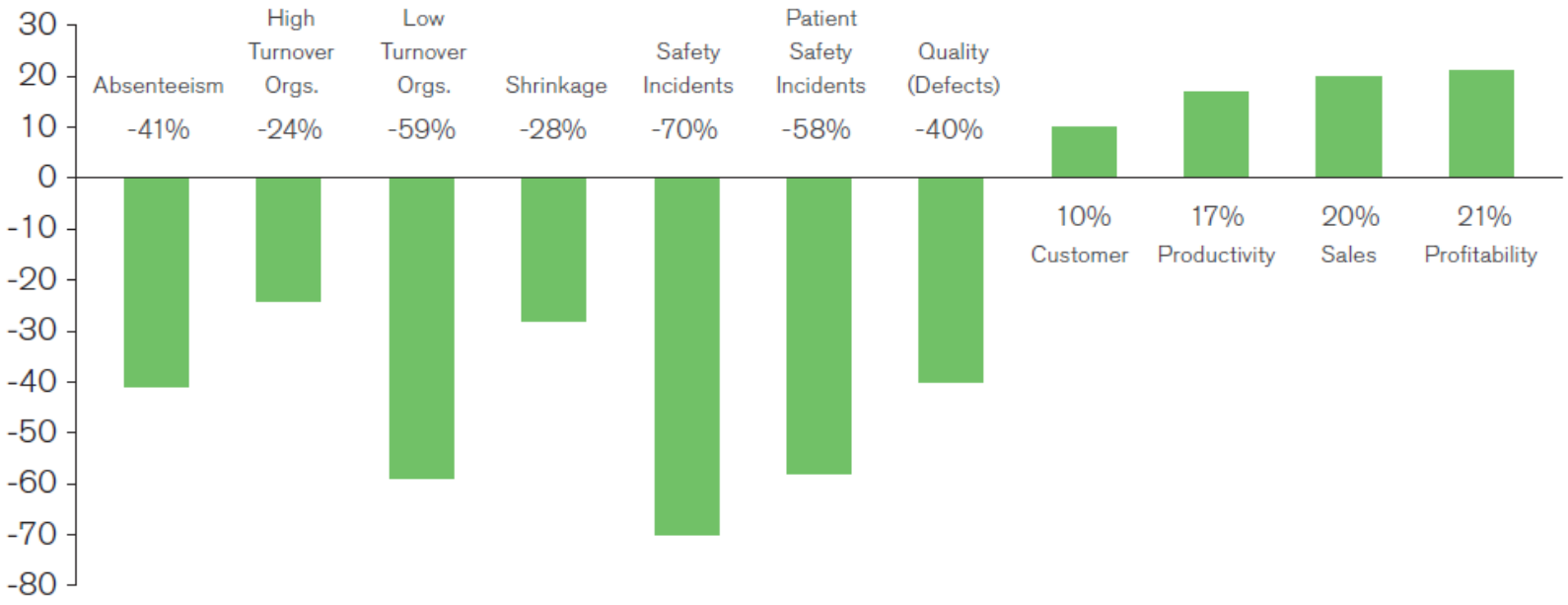
34 out of 34!

Washington State Health Care Authority

Higher Engagement Equals Better Organizational Results

Q¹²® Meta-Analysis: Outcomes

Difference between top and bottom engagement quartiles



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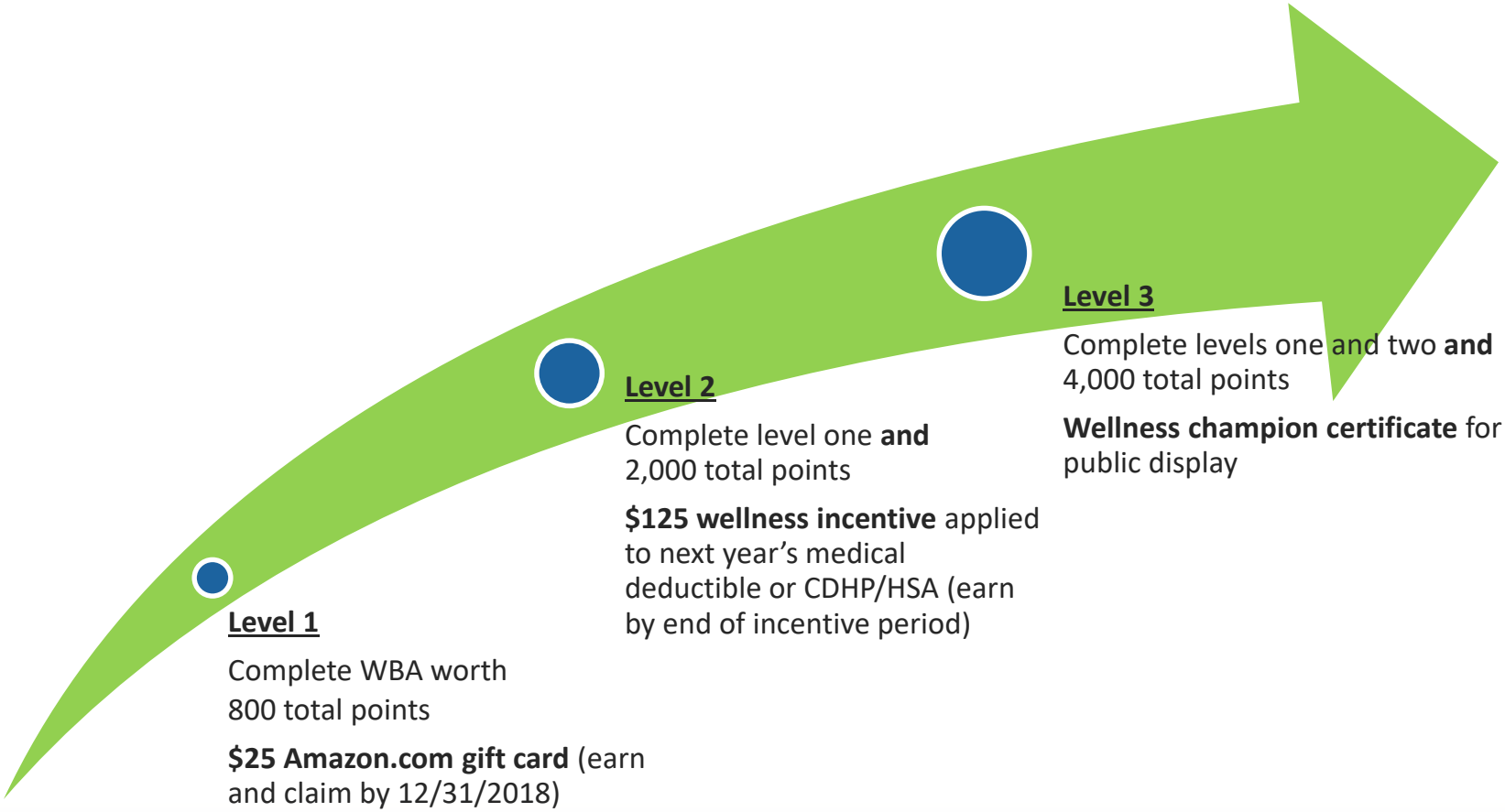
Source: How Employee Engagement Drives Growth (Gallup, 2013)
http://www.gallup.com/businessjournal/163130/employee-engagement-drives-growth.aspx

2018 SmartHealth Program

2018 SmartHealth Strategy

- "What's your why?" theme
- $25 Amazon.com Well-being Assessment gift card *New!*
- $125 wellness incentive
- Communications: Strategic, frequent, varied, and branded
- SmartHealth portal enhancements
- Training, resources, technical assistance, and outreach strategy to **larger** agencies, higher education, and political subdivisions
- Direct outreach at SmartHealth events, Healthy Worksite Summit, health fairs, and PEBB Program open enrollment

2018 SmartHealth Levels



Level 1

Complete WBA worth 800 total points

$25 Amazon.com gift card (earn and claim by 12/31/2018)

Level 2

Complete level one **and** 2,000 total points

$125 wellness incentive applied to next year's medical deductible or CDHP/HSA (earn by end of incentive period)

Level 3

Complete levels one and two **and** 4,000 total points

Wellness champion certificate for public display

2018 Ready-to-use Resources

Key resources to promote SmartHealth

- Flyers
- Video
- Team activities
- Turnkey toolkit
- Activity calendar
- Health observances
- Custom activity examples
- Custom activity request
- Presentation

2018 SmartHealth Events

SmartHealth Well-being Assessment Week

February 26 to March 2, 2018

Encourage staff to celebrate their well-being by completing the Well-being Assessment during this week to earn a $25 Amazon.com gift card.

SmartHealth Week

June 4 to 10, 2018

A weeklong celebration of SmartHealth to help us all be our best.

Governor Walks for SmartHealth

July 2018

A fun walking event led by Governor Jay Inslee.

Leader Walks for SmartHealth

August 2018

Plan a walking event with your leadership team to highlight wellness at your worksite.

SmartHealth Participation: 2016, 2017, and 2018

SmartHealth Registrations

- 2017 new registrations totaled 6,746 for the entire year (2,538 registered through April 18, 2017)

- 2018 new registrations total 6,554 through April 15, 2018
  - 2018 SmartHealth level breakdown (5,919):
    - Level 1: 5,069
    - Level 2: 758
    - Level 3: 92

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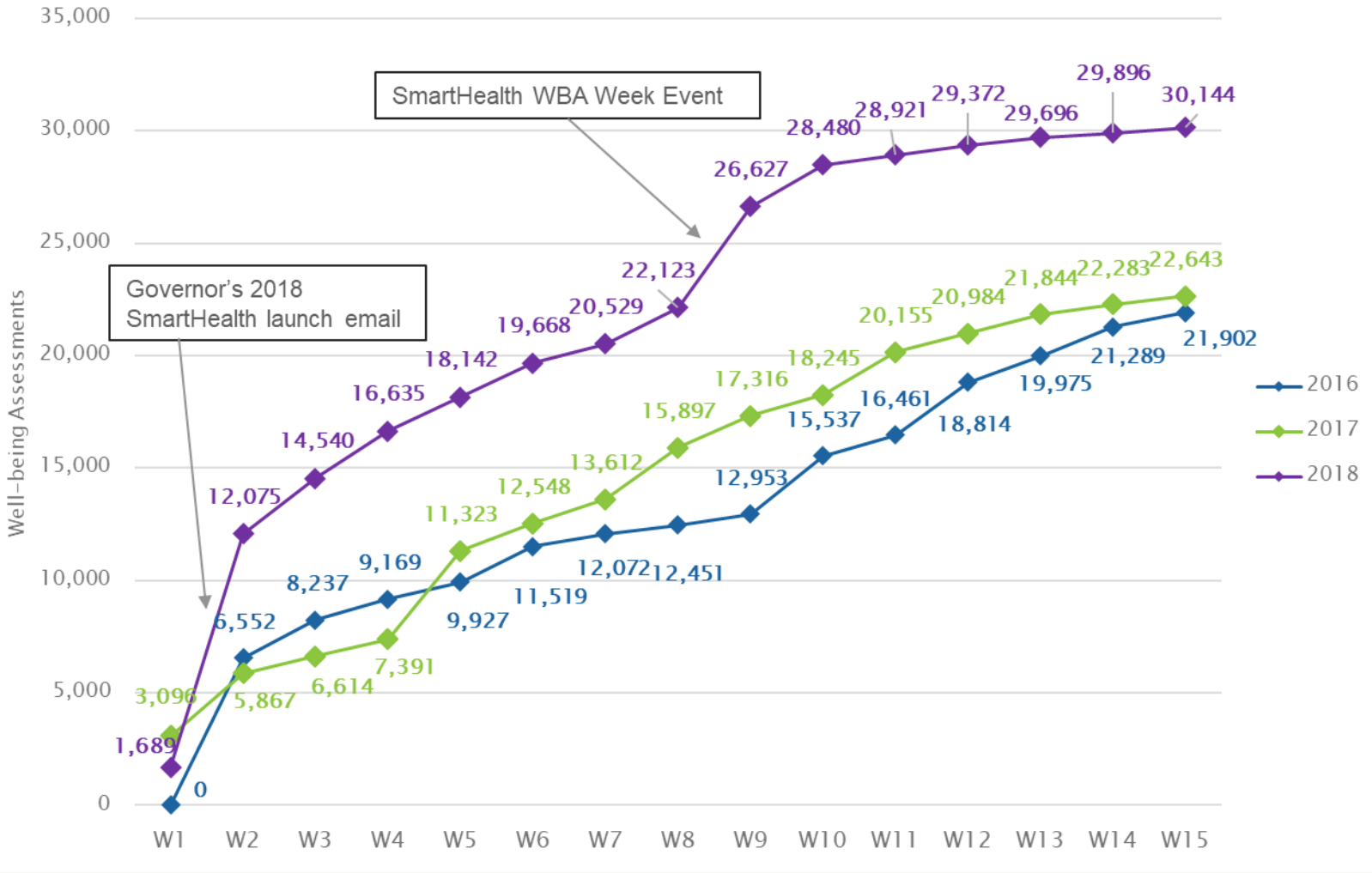
Well-being Assessment Completions: 2016, 2017, and 2018



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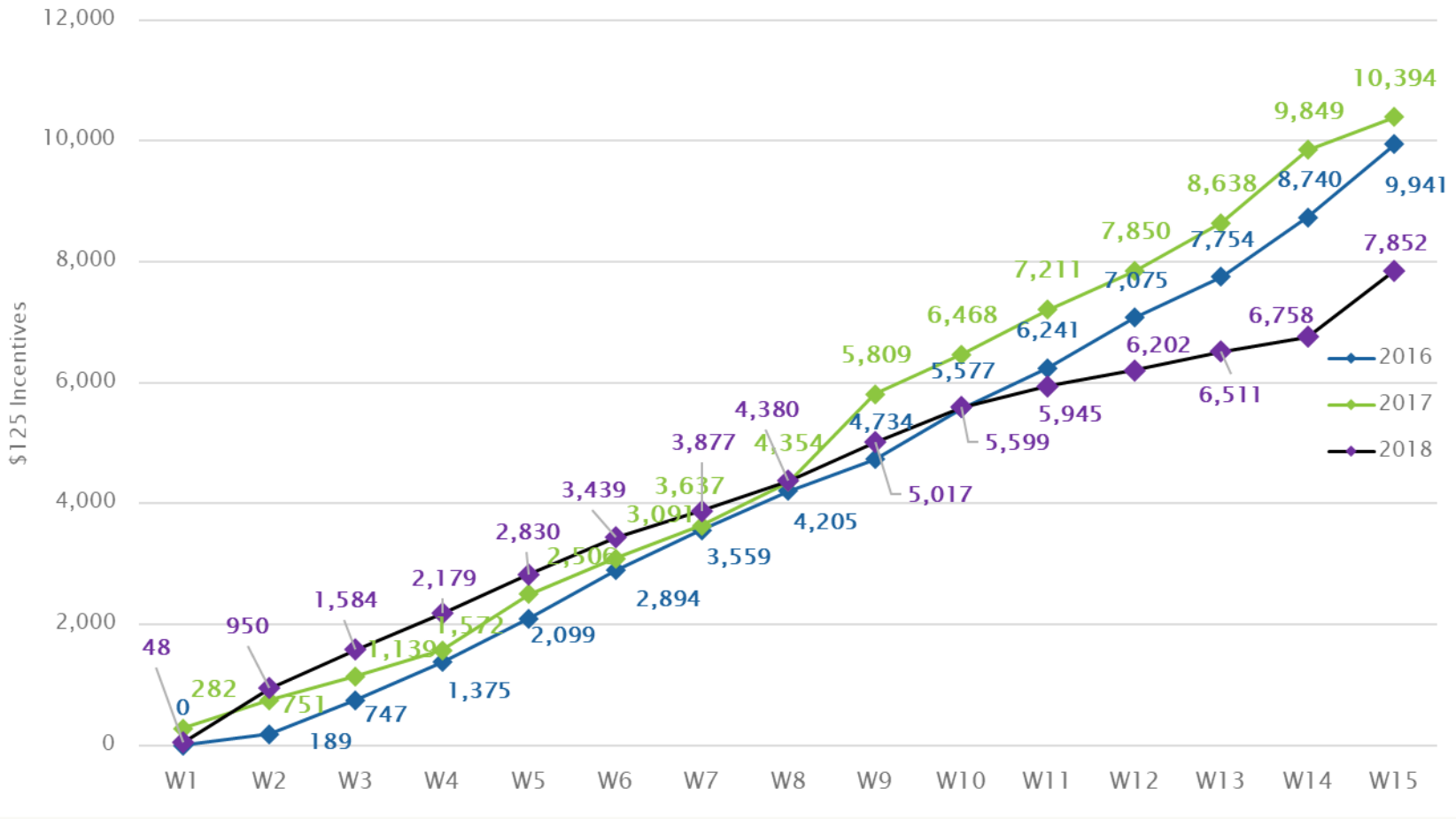
Incentive Qualifications: 2016, 2017, and 2018



Questions?

Justin Hahn, CWPC

Washington Wellness Program Manager

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TAB 8

Washington State Health Care Authority

UMP Value Formulary Options

Donna L. Sullivan, PharmD, MS
Chief Pharmacy Officer
Clinical Quality and Care Transformation
April 25, 2018

Washington State Health Care Authority

Overview

- Our Journey
- Review of Options to Reduce Drug Trend
- Background
- Value Formulary Options
- Recommendation

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Our Journey

- Mail order pharmacy cost sharing changed in 2012 from flat copays to percentage coinsurance to align retail and mail order benefits
  - Increased reports of members unable to afford their medication and unable to change to a preferred or generic drug
- Options considered
  - Implement a closed formulary and cover non-formulary drugs at Tier 2 only when medically necessary
  - Place per claim maximum on Tier 3 drugs
  - Allow exceptions to Tier 3 coinsurance based on medical necessity (implemented 2015)
- Outcome
  - This did provide relief to some members who were granted the exception
  - Different members pay different amounts for the same drugs
  - Could be considered inequitable as it requires members to be well informed on their UMP benefit

Overview of Options To Reduce Drug Trend

- Current strategies being used by the NW Prescription Drug Consortium to manage drug spend:
  - Demanding more transparency from pharmacy benefit managers (PBMs) including 100% return of drug manufacturer rebates,
  - Tighter performance guarantees,
  - Requiring “pass-through pricing” to avoid PBMs from keeping the “spread” between what the pharmacy is paid and what the purchaser is charged,
  - Independent third-party market checks of local retail pharmacy market rates, and more routine third-party audits in general.

- In 2016, HCA convened the Washington prescription drug price and purchasing summit series.

Long-Term Options to Reduce Drug Trend

- Options for State Legislature:
  - Increasing drug price transparency to create public visibility and accountability;
  - Creating a public utility model to oversee in-state drug prices;
  - Bulk purchasing and distribution of high-priced, broadly-indicated drugs that protect public health;
  - Utilizing state unfair trade and consumer protection laws to address high drug prices;
  - Protecting consumers against misleading marketing; and
  - Using shareholder activism through state pension funds to influence pharmaceutical company actions.
- Options for Federal Government:
  - Seeking the ability to re-import drugs from Canada on a state-by-state basis;
  - Enabling states to operate as pharmacy benefit managers to broaden their purchasing and negotiating powers, including expanding purchasing pools that unify around a single preferred drug list;
  - Pursuing return on investment pricing strategies to allow flexible financing based on long-term, avoided costs.

Short-term Options to Reduce Drug Trend

- **No changes for 2019**
  - Drug trend anticipated to increase 10.4% for non-Medicare and 12.5% for Medicare
- **Change member cost-share**
  - Changing deductible, coinsurance, or maximum out-of-pocket would reduce plan spend but shift costs to members
  - May be an option to address specialty drugs
- **Guide member utilization**
  - Directing members to higher-value, lower-cost therapeutic alternatives in drug classes with highest trend

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Formulary Models

Formulary Type	Description
Open	Non-formulary drugs still available at a higher member cost share.
Closed	No coverage for non-formulary drugs unless it is medically necessary after review of the individual clinical circumstances.
Hybrid	Partially closed, with a select mix of drugs identified as warranting exclusion for clinical or financial reasons.
Value-based	Emphasizes the clinical effectiveness of a drug rather than cost.

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Other Terms

- **Grandfathering:** A member will continue to receive the same benefit for a drug even after new policies are effective

- **Multi-Source Brand (MSB):** The originator drug that originally held a drug patent that has expired and now has generic alternatives

- **Copay Coupon:** A remuneration to patients for specific brand-name drugs applied after a drug has been billed to a health plan and used in place of member cost-share

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National Background on Formulary Use

- Closed formularies were common in the late 1980s and early 1990s
- In the late 1990s to early 2000s, a push for member access and choice drove most health plans to an open formulary model, managing utilization through higher cost sharing
- Now plans are trending to the hybrid formulary with “exclusion” lists, or closed formularies, but adding additional tiers with higher cost sharing

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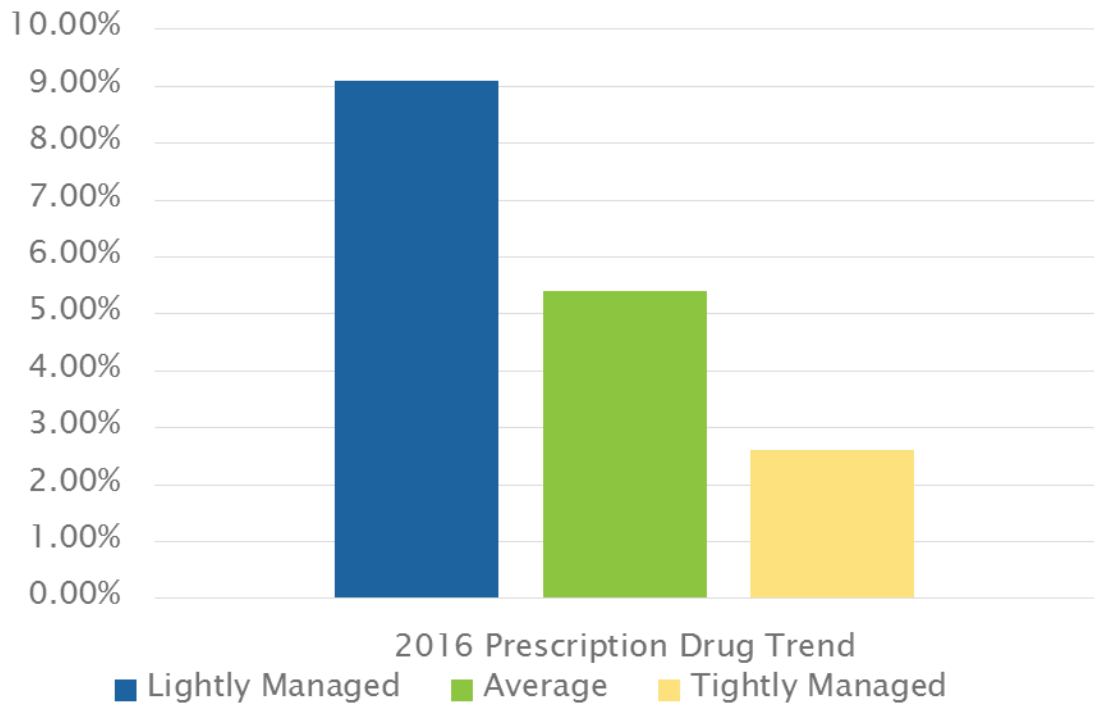
Challenges to Formulary Management

- Manufacturer programs take away members' incentive to choose an equally effective lower cost alternative by offering
  - Copay coupons
  - Patient assistance programs
- Use of copay coupons for 23 of 85 multi-source brand name drugs accounted for $700 million in drug expenditure nationally in 2007 and increased to $2.3 billion in 2010[1]

[1]Lyles. PharmacoEconomics. February 16, 2017

Trend for Managed Formularies



Total drug spend for tightly managed plans at Express Scripts had a significantly lower trend than lesser managed plans

Express Scripts 2016 Drug Trend Report

Information on Value Formulary Model

- The Value Formulary model examines what could occur when:
  - Certain drugs are only covered when medically necessary
  - Members are grandfathered
  - Based on the number of appeal requests and approvals

- The Value Formulary model uses claims data from 2015-2017 and projects member impact, cost avoidance, and administrative costs from 2019 through 2022.

Information on Value Formulary Model, (*cont.*)

- To reduce the projected **Medicare** trend for 2019 by 1%, UMP would need to save approximately $2.0 million in claims
  - To reduce the projected **Medicare** trend for 2020, 2021, or 2022 by 1%, UMP would need to save approximately $2.4 million in claims

- To reduce the projected **non-Medicare** trend for 2019 by 1%, UMP would need to save approximately $2.7 million in claims
  - To reduce the projected **non-Medicare** trend for 2020, 2021, or 2022 by 1%, UMP would need to save approximately $3.1 million in claims

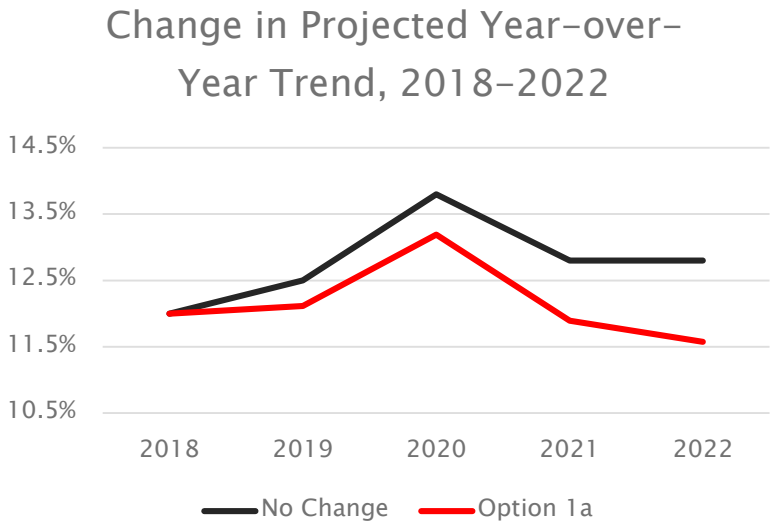
Option 1:
Multi-source Brands

Option 1a: Multi-source Brands

Who is affected?	**Medicare Only** (Non-Medicare to have current formulary)
What changes?	All multi-source brands (currently non-preferred) will only be covered when medically necessary
Current users?	Current users would not be grandfathered
Grandfather or Exception Tier	Members who demonstrate that the non-covered drug is medically necessary would pay a Tier 2 cost share

Option 1a: Multi-source Brands, (*cont.*)

- Approximately 7,500 Medicare members would be impacted (13.4% of entire UMP Medicare population [56,051]).
- Projected cost avoidance is approximately $770K in 2019.
- Projected cost avoidance for 2020 to 2022 averages about $2.19M per year.



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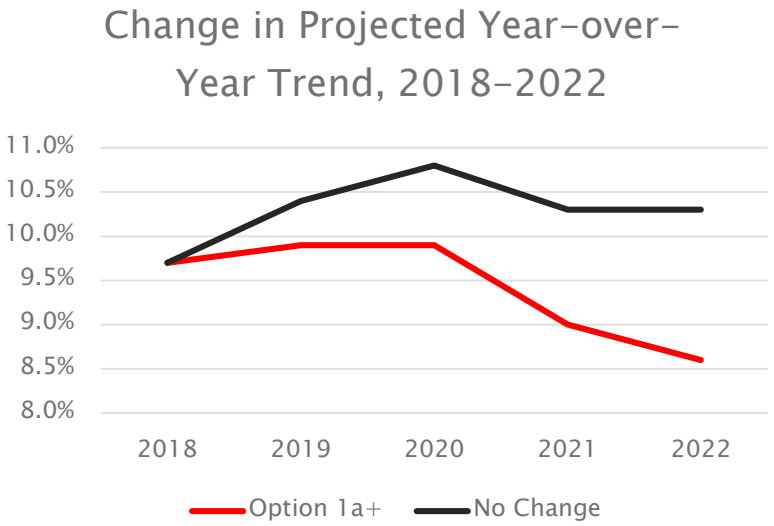
Option 1a+: Multi-source Brands

Who is affected?	**All UMP**
What changes?	All multi-source brands (currently non-preferred) will only be covered when medically necessary
Current users?	Current users would not be grandfathered
Grandfather or Exception Tier	Members who demonstrate that the non-covered drug is medically necessary would pay a Tier 2 cost share

Option 1a+: Multi-source Brands, (*cont.*)

- Approximately 12,000 non-Medicare UMP members would be impacted (5.7% of entire UMP population [211,835]).
- Projected cost avoidance is approximately $1.41M in 2019.
- Projected cost avoidance for 2020 to 2022 averages about $4.02M per year.



Option 2:
Diabetes Drug Classes

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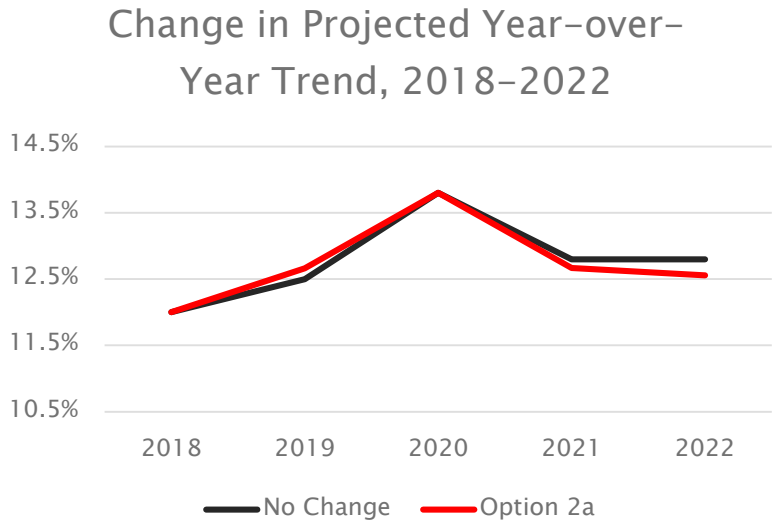
Option 2a: Diabetes Drug Class

Who is affected?	**Medicare Only** (Non-Medicare to have current formulary)
What changes?	All non-preferred drugs used for diabetes will only be covered when medically necessary
Current users?	Current users would be grandfathered if on a single-source brand and would not be grandfathered if on a multi-source brand
Grandfather or Exception Tier	Patients who are grandfathered or who demonstrate medical necessity would pay Tier 2 cost share

Option 2a: Diabetes

- Approximately 850 Medicare members would be impacted.
  - 700 members would see reduced cost-share
  - 150 members would need to switch or appeal for multi-source brand
- Projected claim cost **increase** is ~$315K in 2019.
  - Overall grandfathered members have a ~$480K reduction in out of pocket costs.
- Projected cost avoidance for 2020 to 2022 averages about $319K per year.



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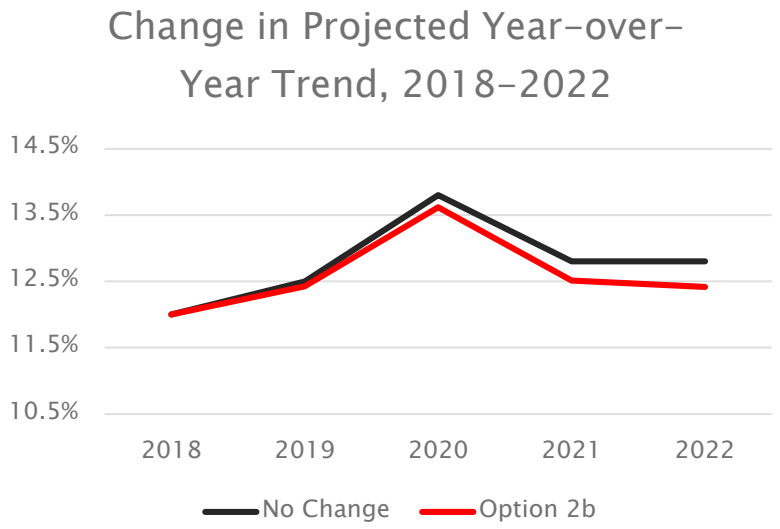
Option 2b: Diabetes Drug Class

Who is affected?	**Medicare Only** (Non-Medicare to have current formulary)
What changes?	All non-preferred drugs used for diabetes will only be covered when medically necessary
Current users?	Current users would be grandfathered if on a single-source brand and would not be grandfathered if on a multi-source brand
Grandfather or Exception Tier	Patients who are grandfathered would pay **Tier 3** cost share**, but can request an exemption to pay Tier 2 cost share.**

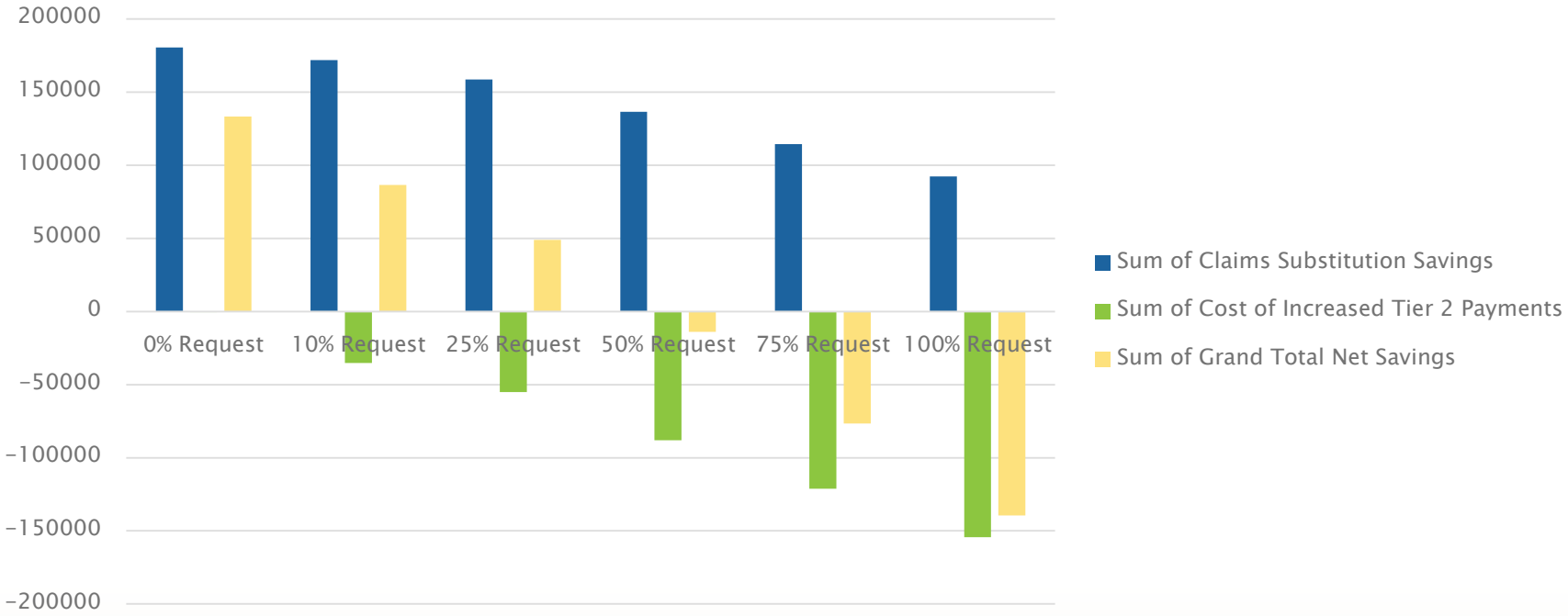
Option 2b: Diabetes

- Approximately 850 Medicare members would be impacted.
  - 700 members would see no change in cost-share
  - 150 members would need to switch or appeal for multi-source brand
- Projected cost avoidance is $49K in 2019 (with est. 25% request rate).
- Projected cost avoidance for 2020 to 2022 averages about $686K per year.



Option 2b: Diabetes

- Cost avoidance for Scenario 2b is dependent upon the number of members requesting exceptions.
  - Range goes from $133,000 (at 0% requests) to $-139,000 (at 100% requests) for 2019.

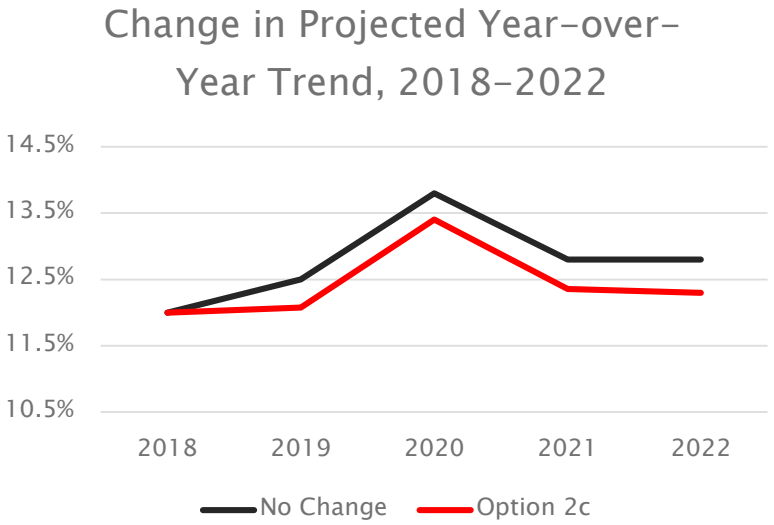


Option 2c: Diabetes Drug Class

Who is affected?	**Medicare Only** (Non-Medicare to have current formulary)
What changes?	All non-preferred drugs used for diabetes will only be covered when medically necessary
Current users?	**Current users would not be grandfathered**
Grandfather or Exception Tier	Members who demonstrate that the non-covered drug is medically necessary would pay a Tier 2 cost share

Option 2c: Diabetes

- Approximately 850 Medicare members would be impacted.
  - All 850 need to switch or appeal
- Projected cost avoidance is $1.03MK in 2019.
- Projected cost avoidance for 2020 to 2022 averages about $1.08M per year.

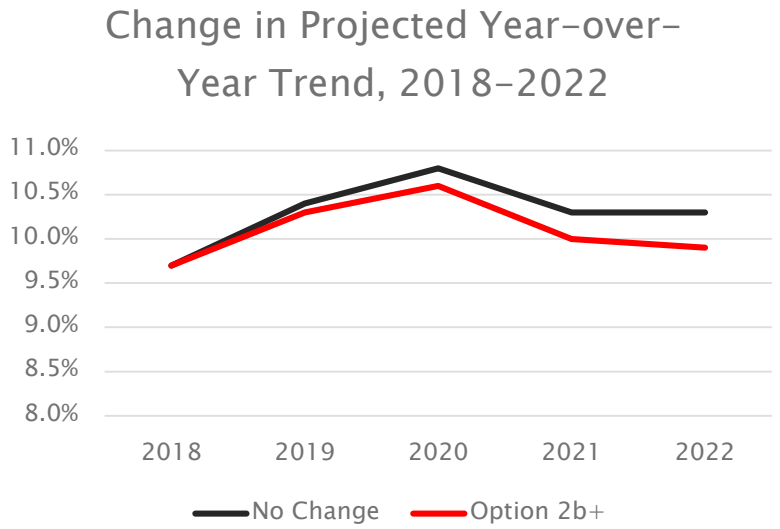


Option 2b+: Diabetes Drug Class

Who is affected?	**All UMP**
What changes?	All non-preferred drugs used for diabetes will only be covered when medically necessary
Current users?	Current users would be grandfathered if on a single-source brand and would not be grandfathered if on a multi-source brand
Grandfather or Exception Tier	Patients who are grandfathered would pay **Tier 3** cost share**, but can request an exemption to pay Tier 2 cost share**

Option 2b+: Diabetes

- Approximately 1,000 non-Medicare members would be impacted.
  - 600 members would see no change in cost share
  - 400 members would need to switch or appeal for multi-source brand
- Projected cost avoidance is $238K in 2019.
- Projected cost avoidance for 2020 to 2022 averages about $1.05M per year.



Member Example

- Paula and Edward are UMP members who both use Trulicity (dulaglutide) for their Type 2 diabetes mellitus.
  - Each month, each member pays $310.29 for Trulicity. UMP pays the remainder for each member, $310.29. The total cost is $620.58 per month for each member.
- Under Scenario 2b Trulicity could be grandfathered for members who have used the medication for over 1 year.
  - Paula has used Trulicity for 2 years, so she would be grandfathered and continue to be eligible to receive Trulicity. Paula would continue to pay $310.29 and UMP would pay $310.29 each month, or request an exception.
  - Edward has only used Trulicity for 3 months, so it would be excluded for him. Ed could switch to another diabetes medication or appeal the exclusion. If approved, Ed would pay $75 each month for Trulicity.

Member Example, (*cont.*)

- Paula and Edward are UMP members who both use Trulicity (dulaglutide) for their Type 2 diabetes mellitus.
  - Each month, each member pays $310.29 for Trulicity. UMP pays the remainder for each member, $310.29. The total cost is $620.58 per month for each member.

- Under Scenario 2c, Trulicity would not be grandfathered for members who have used the medication.
  - Paula and Ed could switch to another diabetes medication or appeal the exclusion. If approved, Paula or Ed would pay $75.00 each month for Trulicity.

Washington State Health Care Authority

Summary of Drug Classes

Therapeutic Class	Scenario	Non-GF Members	2019 Est. Cost Avoid. (1000s)	2020 Est. Cost Avoid. (1000s)
Ophthalmologic	GF, Tier 2	1076	-$225	-$106
	GF, Tier 3	1076	$35	$186
	No GF, Tier 2	2715	$410	$467
Diabetes	GF, Tier 2	150	-$330	$31
	GF, Tier 3	150	$49	$442
	No GF, Tier 2	850	$845	$951
Cholesterol	GF, Tier 2	273	$18	$50
	GF, Tier 3	273	$71	$107
	No GF, Tier 2	351	$138	$154
Dermatologic	GF, Tier 2	148	-$140	-$90
	GF, Tier 3	148	$30	$63
	No GF, Tier 2	332	$24	$35

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Summary of Drug Classes

Therapeutic Class	Scenario	Non-GF Members	2019 Est. Cost Avoid. (1000s)	2020 Est. Cost Avoid. (1000s)
Overactive Bladder	GF, Tier 2	103	-$133	-$126
	GF, Tier 3	103	$12	$27
	No GF, Tier 2	269	$29	$29
Beta Blockers	GF, Tier 2	90	$5	$20
	GF, Tier 3	90	$34	$54
	No GF, Tier 2	254	$94	$104
Antianginal	GF, Tier 2	137	-$36	$2
	GF, Tier 3	137	$4	$43
	No GF, Tier 2	197	$110	$121
Androgens	GF, Tier 2	74	-$24	$72
	GF, Tier 3	74	$34	$128
	No GF, Tier 2	183	$211	$234

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Summary of Drug Classes

Therapeutic Class	Scenario	Non-GF Members	2019 Est. Cost Avoid. (1000s)	2020 Est. Cost Avoid. (1000s)
Blood Pressure	GF, Tier 2	143	$90	$102
	GF, Tier 3	143	$96	$110
	No GF, Tier 2	159	$110	$120
Antidepressants	GF, Tier 2	90	$72	$97
	GF, Tier 3	90	$80	$104
	No GF, Tier 2	134	$107	$117
Pyschotherapeutic/ Neurological	GF, Tier 2	80	$37	$107
	GF, Tier 3	80	$71	$157
	No GF, Tier 2	133	$526	$668
Parkinson's Disease	GF, Tier 2	33	$29	$80
	GF, Tier 3	33	$60	$111
	No GF, Tier 2	82	$250	$272

Recommendation

- Pursue a value formulary option for drug classes diabetes, cholesterol, beta blockers, androgens, blood pressure, antidepressants, psychotherapeutic/neurological, and Parkinson's
  - Affects 1,083 Medicare members, 1,213 could also request an exception
  - Cost avoidance of $495K in 2019 (trend down by 0.2%)
  - Cost avoidance of $1.21M in 2020 (trend down by 0.5%)

- Pursue an option of changing non-preferred multi-source brands to become non-covered
  - Affects 7,500 Medicare members
  - Cost avoidance of $770K in 2019 (trend down by 0.4%)
  - Cost avoidance of $1.46M in 2020 (trend down by 0.6%)

Draft Policy Resolution PEBB 2018 – xx Proposal for Value Formulary

Require the use of a value based formulary, with a select mix of drugs that are only covered when medically necessary and all preferred products have been ineffective or are not clinically appropriate.

When a drug class is added to the value-based formulary, members who have been taking a drug at the same dose for at least one year must be grandfathered with the same cost share tier as other similar (e.g., brand or generic) preferred drugs in that class.

Washington State Health Care Authority

Questions?

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