

Public Employees Benefits Board Meeting

May 21, 2018

Public Employees Benefits Board

May 21, 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

Meeting Agenda	1-1
Member List.....	1-2
2018 Meeting Schedule	1-3
Board By-Laws	2-1
Medicare Retiree Premium Review	3-1
UMP Value Formulary	4-1

TAB 1

AGENDA

Public Employees Benefits Board
May 21, 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		Lou McDermott, Deputy Director Health Care Authority	Information
1:50 p.m.	Medicare Retiree Premium Preview	TAB 3	Tanya Deuel, PEBB Finance Manager Unit Manager Finance Division	Information
2:00 p.m.	UMP Value Formulary Options	TAB 4	Ryan Pistoressi, Assistant Chief Pharmacy Officer Clinical Quality and Care Transformation Division	Information
3:40 p.m.	Public Comment			
4:00 p.m.	Adjourn			

***All Times Approximate**

The Public Employees Benefits Board will meet Wednesday, May 21, 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 May 18, 2018.

PEB Board Members

Name	Representing
Sue Birch, Director Health Care Authority 626 8 th 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 198 th 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 182 nd CT, D Bothell WA 98011 V 206-819-5588 timbarclay51@gmail.com	Benefits Management/Cost Containment
Yvonne Tate 1407 169 th PL NE Bellevue WA 98008 V 425-417-4416 ytate@comcast.net	Benefits Management/Cost Containment
Vacant	Benefits Management/Cost Containment
Harry Bossi* 19619 23 rd 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

TAB 2

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



Medicare Retiree Premium Preview

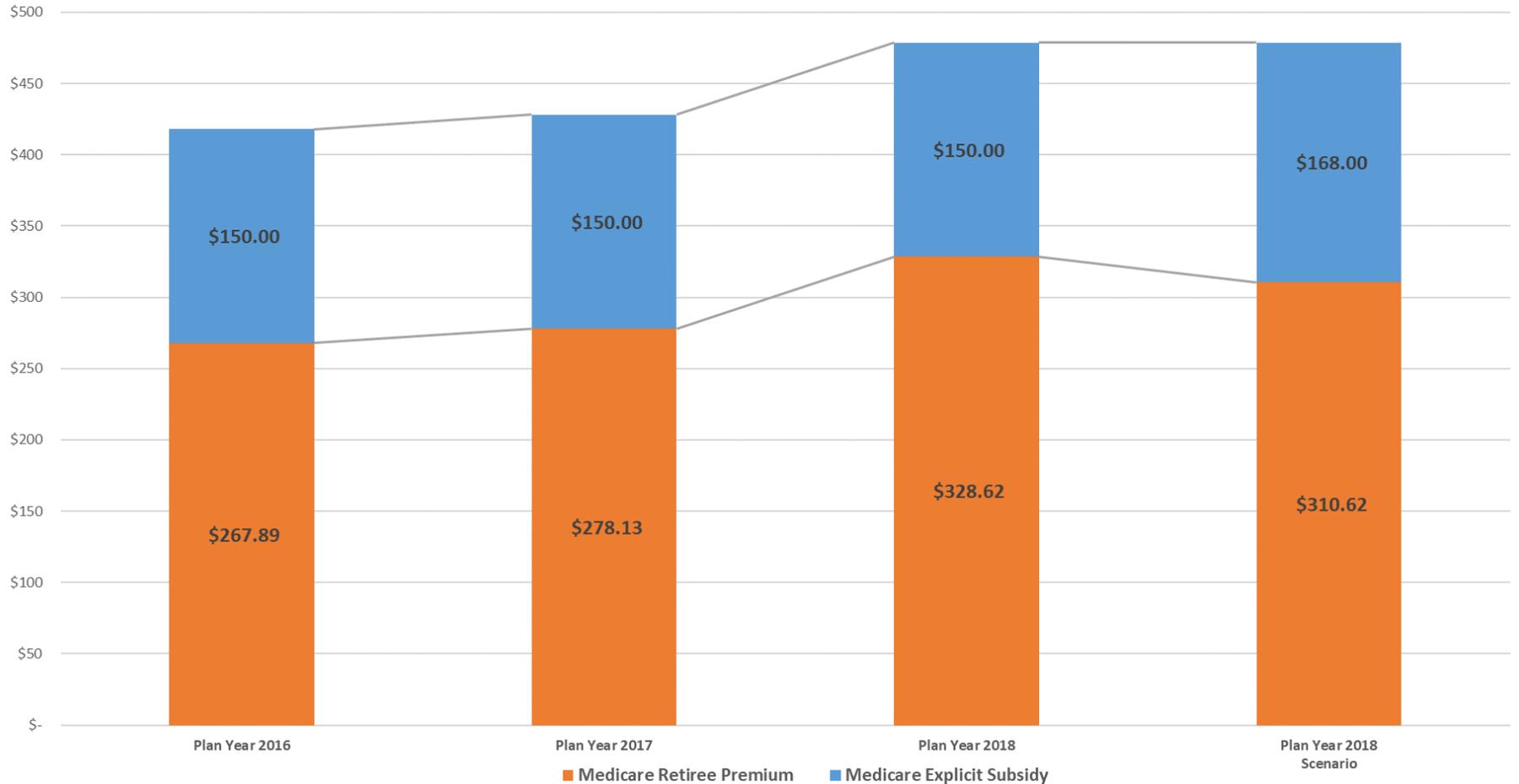
Tanya Deuel
PEBB Finance Unit Manager
Financial Services
May 21, 2018

Medicare Retiree Premium Preview

- Medicare Rate Development
 - Developed an early estimate of premiums to assist with key decision making
 - Legislature established the Medicare Explicit Subsidy earlier than previous years
- Anticipating relatively flat retiree premium contributions
 - Legislature increased the Medicare Explicit Subsidy from \$150 to \$168
 - Medicare Explicit Subsidy has been \$150 since 2012
 - No indication of future Medicare explicit subsidy amounts
 - Improved pharmacy trends

*Estimates do not include formulary changes

UMP Classic Medicare Retiree Premium Example \$150 vs \$168 Medicare Explicit Subsidy



Questions?

Tanya Deuel

PEBB Finance Unit Manager

Financial Services Division

Tanya.Deuel@hca.wa.gov

Tel: 360-725-0908

TAB 4



UMP Value Formulary

Ryan Pistoresi, PharmD, MS
Assistant Chief Pharmacy Officer
Clinical Quality and Care Transformation
May 21, 2018

Overview

- Our Journey
- Options to Reduce Drug Trend
- Value Formulary
- Policy Resolution

Formulary Models

Formulary Type	Description
Open	Non-preferred drugs still available at a higher member cost share.
Closed	No coverage for non-formulary drugs. Drugs are blocked for rebate purposes. A smaller, limited formulary.
Hybrid	A formulary where a select mix of drugs in drug classes are identified as warranting exclusion for clinical or financial reasons.
Value-based	Emphasizes the clinical effectiveness of a drug rather than cost. Non-preferred are covered only when medically necessary and clinically appropriate after review of the individual clinical circumstances.

Other Terms

- **Grandfathering:** A member will continue to receive the same benefit for a drug even after a new policy is effective
- **Multi-Source Brand (MSB):** The originator drug that originally held the patent for the drug but the patent 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
 - Manufacturer programs take away members' incentive to choose an equally effective lower cost alternative by offering copay coupons and patient assistance programs

Our Journey

- In 2012, mail order pharmacy cost-sharing changed from flat copays to percentage coinsurance to align retail and mail order benefits
- In 2013, a member equity issue was identified
 - Increased reports of members unable to afford their medication and unable to change to a preferred or generic drug
- In 2015, UMP allows exceptions to Tier 3 coinsurance based on medical necessity
 - This provided 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

The Equity Issue Explained

Lou and Dave are UMP members who both use Victoza (liraglutide) to manage their diabetes. Both members have tried all the preferred medications in this class (GLP-1 agonists) and they are either ineffective or are not clinically appropriate. Both pay 50% for their medication, about \$370 per month.

Lou knows about the Tier 3 exception policy, and his provider submits a request. Because Lou meets the criteria and is approved, Lou now pays the Tier 2 cost-share for the Tier 3 medication, \$75 per month.

Dave also meets the criteria for the Tier 3 exception, but he does not know about the policy and does not request it.

Now, both Lou and Dave are using the same drug, but Lou pays \$75 per month while Dave pays \$370. Even though they are both UMP members they are now paying different amounts for the same medication.

Other Ways to Address Equity Issue

- Implement a closed formulary: making all non-preferred drugs become non-formulary and then cover all non-formulary drugs at Tier 2 only when medically necessary
 - This would address the equity issue but increase administrative costs, plan costs, and increase member premiums
- Place per claim maximum on Tier 3 drugs
- Implement a value formulary: identifying drug classes that demonstrate value and non-preferred drugs are covered only when medically necessary and clinically appropriate
 - This will direct members to the most cost-effective drugs in certain drug classes
 - This would still allow members to access to non-preferred drugs when they are medically necessary and clinically appropriate (for example, when preferred drugs are unsafe or not effective)

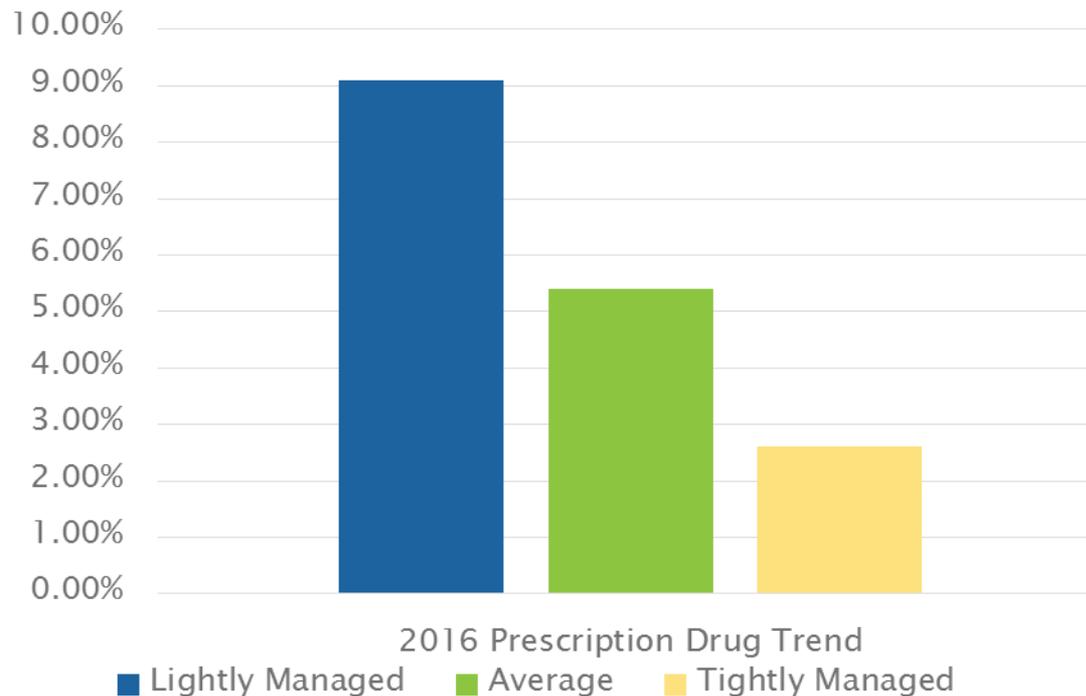
Implemented Strategies

- In 2016, HCA convened the Washington prescription drug price and purchasing summit series
- Several long-term strategies were identified
- Strategies currently implemented by the NW Prescription Drug Consortium to manage drug spend for UMP:
 - 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.

Current Board Options for 2019

- **No formulary changes**
 - Drug trend would remain unchanged from current projections
 - Does not address member equity issue
- **Change member cost-share**
 - Changing deductible, coinsurance, or maximum out-of-pocket would reduce plan spend but shift costs to members
 - Does not address member equity issue
 - May be an option to address rising specialty drug trend
- **Guide member utilization**
 - Directing members to higher-value, lower-cost therapeutic alternatives in drug classes, but allow use of non-preferred drugs when medically necessary and clinically appropriate

Trend for Managed Formularies



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

Information on Value Formulary Model

- The Value Formulary model examines what happens when:
 - Non-preferred drugs are only covered when preferred drugs are contraindicated, intolerable, or ineffective
 - Members are grandfathered
 - The number of appeals requested and approved changes
- The Value Formulary model uses claims data from 2016-2017 and projects member impact, cost avoidance, and administrative costs from 2019 through 2022

Changes between January and April Presentation

- Updated prescription claims data in the model
 - Data for January 2018 presentation used data from 6/2016–5/2017 (Data for April 2018 presentation used data from 1/2017–12/2017)
 - Tier 2 drugs in 2016 may have new generic versions in 2017 or 2018
- Updated baseline assumptions for other parameters in the model
 - Updated drug trend for Medicare and non-Medicare
 - Increased the predicted number of exception requests and appeals
 - Updated drug substitution assumptions to better reflect clinically appropriate alternatives and observed market share

Information on Value Formulary Model

- To reduce the projected **Medicare** trend for 2019 by 1%, UMP would need to save approximately \$1.7 million in claims
 - This would reduce the member premium by ~\$2.50 per month
 - To reduce the projected **Medicare** trend for 2020 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 \$2.0 million in claims
 - This would reduce the member premium by ~\$1.00 per month (Classic)
 - To reduce the projected **non-Medicare** trend for 2020 by 1%, UMP would need to save approximately \$3.1 million in claims

The Equity Issue Resolved

Lou and Dave are UMP members who both use Victoza (liraglutide) to manage their diabetes. Both members have tried all the preferred medications in this class (GLP-1 agonists) and they are either ineffective or are not clinically appropriate. Both pay 50% for their medication, about \$370 per month.

If the diabetes drug class is part of the UMP Value Formulary, then members who have used Victoza are eligible to be grandfathered. This will allow the members to continue receiving the medication and pay at a Tier 2 member cost-share.

Now, both Lou and Dave are using the same drug and paying the same amount, \$75 per month. This resolves the equity issue since now members are paying the same amount for the same drug.

Principles for Designing the Value Formulary

- Focus on drug classes with cost savings without reducing quality of care to members
- Make a difference to premium without sacrificing care
- Grandfather members who have used these medications for a long time or who are in refill-protected drug classes

Things to Consider with the Value Formulary

Options	Impact to Members	# of Members	Impact to Costs	Overall Impact
Multi-source Brands	Minimal; generic alternatives available	Low	Low	Lowest disruption, lowest savings
Individual Drug Classes	Medium	Low to Medium	Low to Medium	Can tailor the value formulary to increase value
All Drug Classes	High	High	Medium	Biggest disruption, may not be highest savings

Designing the Value Formulary

- A value formulary for some drug classes, such as diabetes, cholesterol, beta blockers, androgens, blood pressure, antidepressants, psychotherapeutic/neurological, and Parkinson's disease
 - Some drug classes would remain the same as current formulary
 - Resolves equity issue for some classes, but remains for others
 - Grandfathering allows members to continue on their medications
 - New users would be directed to preferred or be grandfathered if stable on non-preferred medication
- A value formulary for multi-source brands
 - All MSB in all drug classes would be covered only when medically necessary and clinically appropriate
 - Resolved equity issue around MSB, but remains for all single-source brands

Grandfathering Examples

- Scott is a long-time UMP member who uses the antipsychotic, Abilify, for bipolar disorder. Since antipsychotics are a refill-protected class, Abilify would be grandfathered for Scott, and he would pay \$75 per month for his prescription.
- Lou is new to UMP in July 2019, but he was diagnosed with bipolar disorder years ago and has been stable on Abilify for 5 years. Lou's provider can request Abilify, and Lou would pay \$75 per month for his prescription.
- Dave is new to UMP in July 2019 and was recently diagnosed with bipolar disorder. Dave would be directed to preferred antipsychotics first. If the preferred drugs are not effective for Dave he can then try non-preferred drugs.

Recommendation and Crosswalk Help

- The recommendation to the Board is “Option 2a” as presented at the January 2018 PEBB retreat with one modification:
 - Apply the value formulary to all UMP members instead of only Medicare UMP members.
- At the April 2018 meeting “Option 2a” provided examples of individual drug classes applying the principles described for “Option 2a” in January 2018, to help the Board better understand more granular aspects of the option.
 - *In April, “Option 2a” did not address MSB drugs as stated in January. But the recommendation is to include MSB drugs in the value formulary.*
 - *The MSB drug options “1a” and “1a+” presented in April described the impacts separately for Medicare and Non-Medicare UMP members for the recommended MSB drug aspects of the value formulary.*

Policy Resolution PEBB 2018 – xx *Draft* Proposal for Value Formulary

Beginning January 1, 2019, all UMP plans require the use of a value based formulary with:

- a select mix of drugs within a drug class that are covered only when medically necessary and all preferred products have been ineffective or are not clinically appropriate, and
- multi-source brand drugs being covered only when medically necessary and clinically appropriate, and

Policy Resolution PEBB 2018 – xx

Draft Proposal for Value Formulary, (*cont.*)

- members who have been taking a non-preferred drug at the same dose for at least one year being grandfathered with the same cost share tier as other similar preferred drugs in that class, and
- the grandfather period for brand name drugs ends when a generic equivalent or interchangeable biologic becomes available, unless the grandfathered multi-source brand name drug is medically necessary and clinically appropriate.

Questions?

Ryan Pistorresi, PharmD, MS
Assistant Chief Pharmacy Officer
Clinical Quality and Care Transformation

Appendix

Other Long-term Options for Drug Trend

- Other policy recommendations to be considered to manage drug spend:
 - 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.

Full January and April 2018 Option Crosswalk

- January “Option 1” is the April “Option 1a”
- January “Options 2a/b/c” are April “Options 2a/b/c”
 - Except April’s presentation provided examples of individual drug classes applying the principles of the options and did not describe MSBs
- January “Options 3a/b/c” were not presented in April because they were explained as “not recommended in January,” but were originally presented for thoroughness
- January “Option 4” is the combination of April “Options 1a/1a+”
 - Put another way, April “Option 1a+” is the Non-Medicare only member impact that is a subset of January “Option 4”

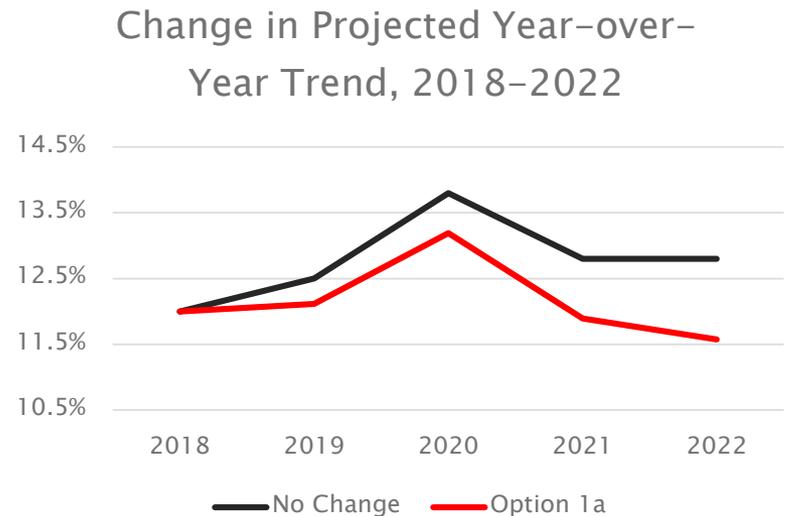
Medicare Only Multi-source Brands Only (Option 1a from April 2018)

Option 1a: Multi-source Brands

Who is affected?	Medicare Only
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

- 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.



**Non-Medicare Only
Multi-source Brands Only
(Option 1a+ from April 2018)**

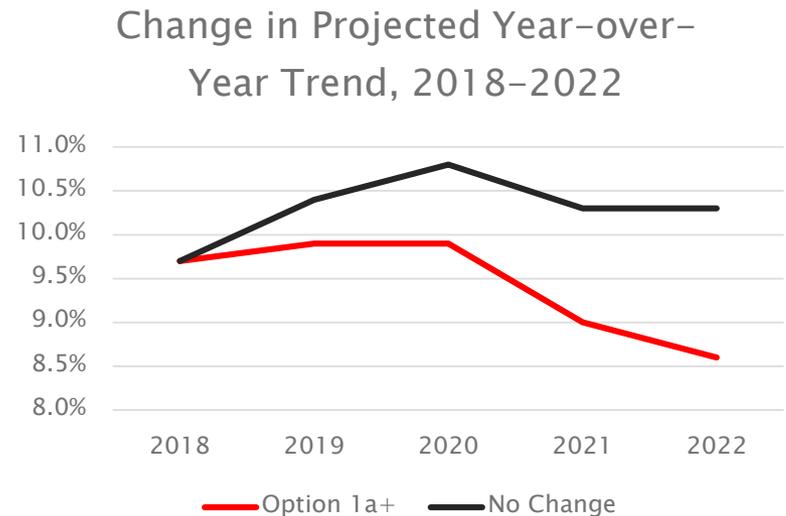
Option 1a+: Multi-source Brands

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

*Incorrectly labeled ALL UMP in the April 25, 2018 meeting materials.

Option 1a+: Multi-source Brands

- 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.



Medicare Only Diabetes Drug Classes (Option 2 from April 2018)

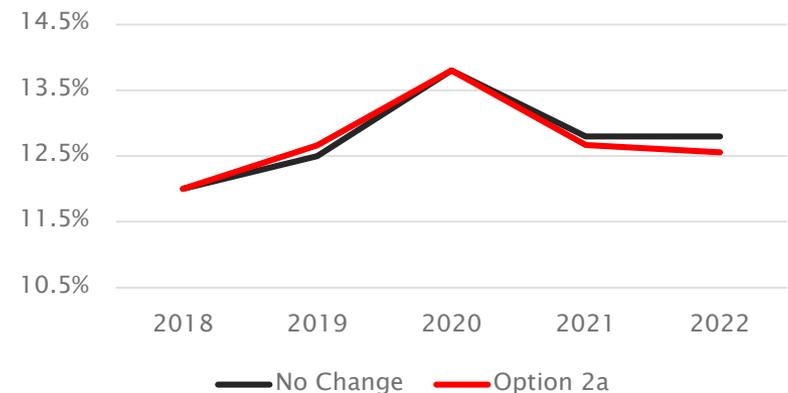
Option 2a: Diabetes Drug Class

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

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 MSB
- Projected claim cost **increase** is \$330K 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.

Change in Projected Year-over-Year Trend, 2018-2022



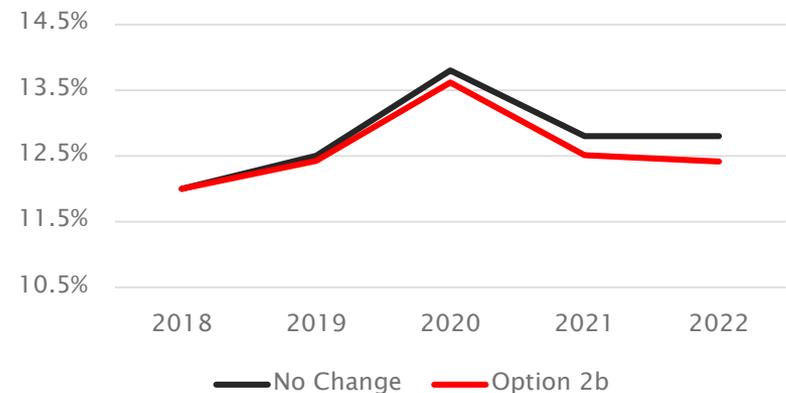
Option 2b: Diabetes Drug Class

Who is affected?	Medicare Only
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 multisource 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

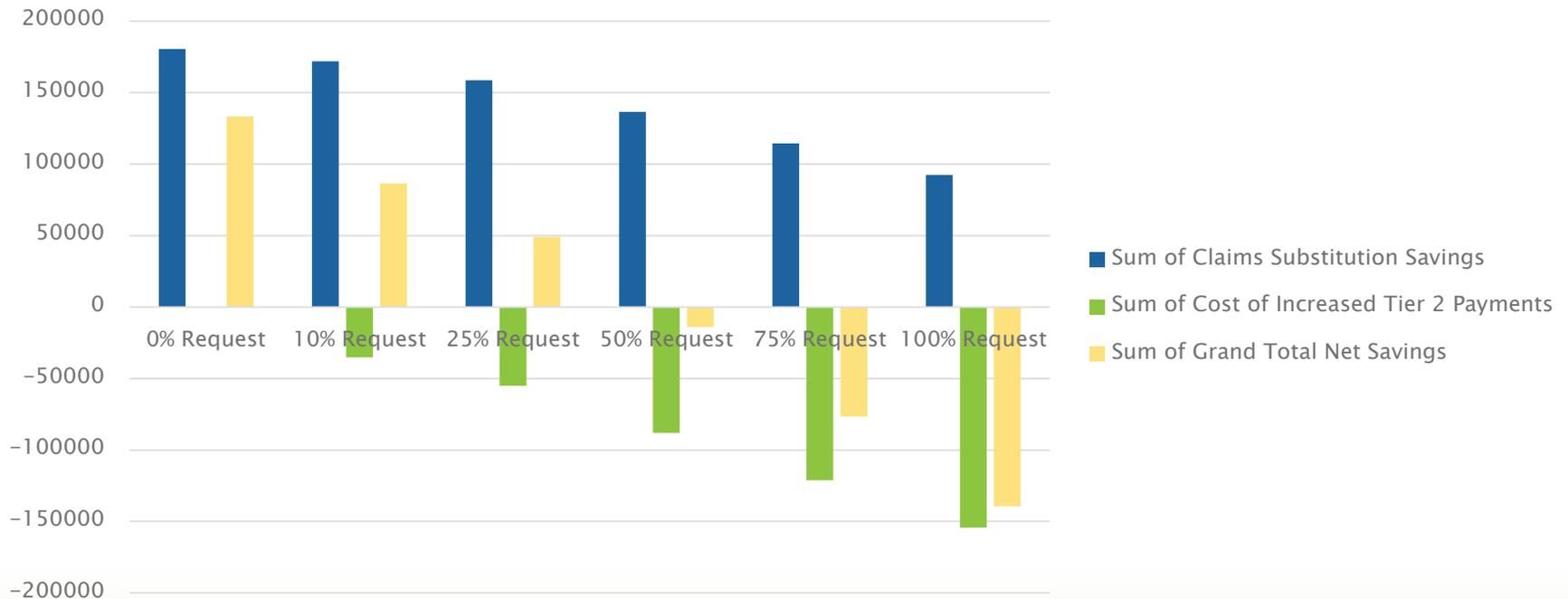
- Approximately 850 Medicare members would be impacted.
 - 700 members would see no change in cost-share
 - 150 members would need to switch or appeal for MSB
- Projected cost avoidance is \$49K in 2019 (with est. 25% request rate).
- Projected cost avoidance for 2020 to 2022 averages about \$686K per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

Change in Projected Year-over-Year Trend, 2018–2022



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.



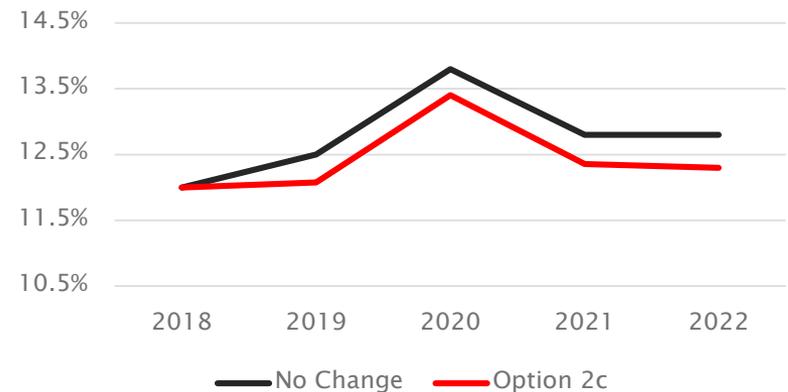
Option 2c: Diabetes Drug Class

Who is affected?	Medicare Only
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 \$845K in 2019.
- Projected cost avoidance for 2020 to 2022 averages about \$1.08M per year.

Change in Projected Year-over-Year Trend, 2018–2022



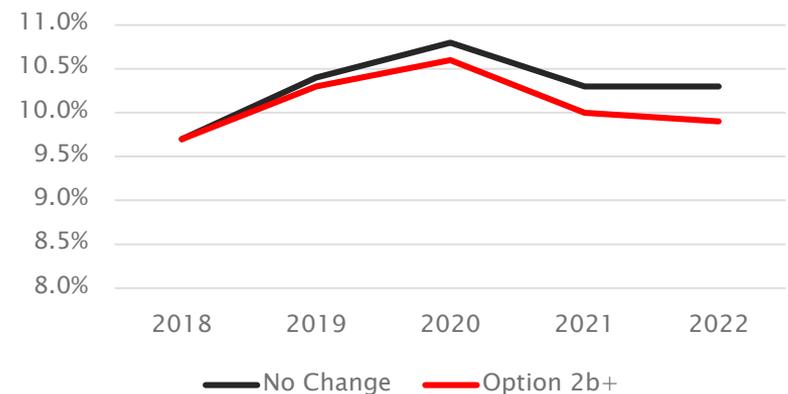
Option 2b+: Diabetes Drug Class

Who is affected?	Non-Medicare 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 MSB
- Projected cost avoidance is \$238K in 2019.
- Projected cost avoidance for 2020 to 2022 averages about \$1.05M per year.

Change in Projected Year-over-Year Trend, 2018–2022



Summary of Drug Classes

Therapeutic Class	Scenario	Non-Grandfathered 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*, T2	2715	\$410	\$467
Diabetes	GF*, Tier 2	150	-\$330	\$31
	GF*, Tier 3	150	\$49	\$442
	No GF*, T2	850	\$845	\$951
Cholesterol	GF*, Tier 2	273	\$18	\$50
	GF*, Tier 3	273	\$71	\$107
	No GF*, T2	351	\$138	\$154
Dermatologic	GF*, Tier 2	148	-\$140	-\$90
	GF*, Tier 3	148	\$30	\$63
	No GF*, T2	332	\$24	\$35

* Grandfathered

Summary of Drug Classes

Therapeutic Class	Scenario	Non-Grandfathered 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*, T2	269	\$29	\$29
Beta Blockers	GF*, Tier 2	90	\$5	\$20
	GF*, Tier 3	90	\$34	\$54
	No GF*, T2	254	\$94	\$104
Antianginal	GF*, Tier 2	137	-\$36	\$2
	GF*, Tier 3	137	\$4	\$43
	No GF*, T2	197	\$110	\$121
Androgens	GF*, Tier 2	74	-\$24	\$72
	GF*, Tier 3	74	\$34	\$128
	No GF*, T2	183	\$211	\$234

* Grandfathered

Summary of Drug Classes

Therapeutic Class	Scenario	Non-Grandfathered 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*, T2	159	\$110	\$120
Antidepressants	GF*, Tier 2	90	\$72	\$97
	GF*, Tier 3	90	\$80	\$104
	No GF*, T2	134	\$107	\$117
Psychotherapeutic /Neurological	GF*, Tier 2	80	\$37	\$107
	GF*, Tier 3	80	\$71	\$157
	No GF*, T2	133	\$526	\$668
Parkinson's Disease	GF*, Tier 2	33	\$29	\$80
	GF*, Tier 3	33	\$60	\$111
	No GF*, T2	82	\$250	\$272

* Grandfathered