

Public Employees Benefits Board Meeting

June 7, 2018

Public Employees Benefits Board

June 7, 2018

1:30 p.m. – 4:00 p.m.

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

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TAB 1

AGENDA

Public Employees Benefits Board
June 7, 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 Questions from Prior Meetings		Dave Iseminger, Director Employees & Retirees Benefits (ERB) Division	Information / Discussion
1:55 p.m.	UMP Value Formulary Follow-up and Proposed Resolution	TAB 3	Ryan Pistoresi, Assistant Chief Pharmacy Officer Clinical Quality and Care Transformation Division	Information / Discussion
3:05 p.m.	Emerging Medications Update	TAB 4	Ryan Pistoresi, Assistant Chief Pharmacy Officer Clinical Quality and Care Transformation Division	Information / Discussion
3:20 p.m.	Proposed Annual Procurement Plan Changes	TAB 5	Beth Heston, PEB Procurement Manager ERB Division	Information / Discussion
3:35 p.m.	Public Comment			
3:45 p.m.	Adjourn			

***All Times Approximate**

The Public Employees Benefits Board will meet Thursday, June 7, 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.

Prior to the meeting, pursuant to RCW 42.30.110(l), the Board will meet in Executive Session to "consider proprietary or confidential non-published information related to the development, acquisition, or implementation of state purchased health care services as provided in RCW 41.05.026," and for the purpose of discussing current litigation against the governing body with legal counsel when public knowledge regarding the discussion is likely to

result in an adverse legal or financial consequence to the agency. The Executive Session will begin at noon on June 7, 2018, and be concluded no later 1:30 p.m.

No "action," as defined in RCW 42.30.020(3), will be taken at the Executive Session.

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 June 5, 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

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*non-voting members

4/18/18



Washington State Health Care Authority
Public Employees Benefits Board

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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

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: August 01, 2017

TIME: 1:51 PM

WSR 17-16-148

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



UMP Value Formulary Follow-up and Proposed Resolution

Ryan Pistoresi, PharmD, MS
Assistant Chief Pharmacy Officer
Clinical Quality and Care Transformation
June 7, 2018

Board Questions

Define Medically Necessary

Medically necessary or **medical necessity** means health care services, drugs, supplies, or interventions that a treating licensed health care provider recommends and all of the following conditions are met:

1. The purpose of the service, supply, intervention, or drug is to treat or diagnose a medical condition.
2. It is the appropriate level of service, supply, intervention, or drug dose considering the potential benefits and harm to the patient.
3. The level of service, supply, intervention, or drug dose is known to be effective in improving health outcomes.
4. The level of service, supply, intervention, or drug recommended for this condition is cost-effective compared to alternative interventions, including no intervention.

The fact that a physician or other provider prescribes, orders, recommends, or approves a service or supply, drug, or drug dose does not, in itself, make it medically necessary.

Define Clinically Appropriate

Clinically appropriate means at least one of the following:

A. Confirmation and documentation from your prescribing provider that all preferred therapeutic alternatives (Value Tier, Tier 1, and Tier 2) have been tried for a clinically appropriate duration of treatment and failed to produce a therapeutic response.

OR

B. Confirmation and documentation from your prescribing provider that all preferred therapeutic alternatives (Value Tier, Tier 1, and Tier 2), including the required number of manufacturers of the same generic drug, caused an adverse drug reaction that prevents the patient from taking the medication as directed.

Why are so many Tier 3 exception requests denied?

- Most of the denials for Tier 3 exception requests are because members have not tried preferred products.
- Another reason for denials are because there is no clinical documentation that the preferred medications fails to produce a therapeutic response.

Does a physician or a pharmacist review pharmacy cases for UMP?

- A doctor of pharmacy (PharmD) reviews cases, including prior authorizations, Tier 3 exceptions, and appeals.
- These licensed pharmacists work in collaboration with physicians, who are either medical directors or specialists, on cases.

How many UMP members are affected by the inequity issue?

- The exact number of members is unknown as this would require a review of the electronic medical record (EMR) of UMP members.
- There are approximately 47,000 UMP members utilizing Tier 3 drugs. If we apply the Tier 3 exception approval rate (31%) to this population, then an estimated 14,500 members may be impacted. There are 529 members who have been approved for a Tier 3 Exception out of the 1,700 who applied.

What are the anticipated member impacts and cost avoidance for the non-Medicare population?

Drug Class	Scenario (April 2018)	Medicare			Non-Medicare			Total		
		Members Impacted	Cost Avoidance 2019 (thousands)	Cost Avoidance 2020 (thousands)	Members Impacted	Cost Avoidance 2019 (thousands)	Cost Avoidance 2020 (thousands)	Members Impacted	Cost Avoidance 2019 (thousands)	Cost Avoidance 2020 (thousands)
Ophthalmologic	2A	1,076	(\$225)	(\$106)	744	(\$87)	(\$30)	1,820	(\$312)	(\$136)
	2B	1,076	\$35	\$186	744	\$22	\$61	1,820	\$57	\$247
	2C	2,715	\$410	\$467	1,464	\$98	\$118	4,179	\$508	\$585
Diabetes	2A	150	(\$330)	\$31	396	(\$393)	\$175	546	(\$723)	\$206
	2B	150	\$49	\$442	396	\$237	\$690	546	\$286	\$1,132
	2C	850	\$845	\$951	3127	\$1,203	\$1,343	3,977	\$2,048	\$2,294
Cholesterol	2A	273	\$18	\$50	164	(\$7)	\$14	437	\$11	\$64
	2B	273	\$71	\$107	164	\$27	\$42	437	\$98	\$149
	2C	351	\$138	\$154	222	\$50	\$56	573	\$188	\$210
Dermatologic	2A	148	(\$140)	(\$90)	488	(\$643)	(\$401)	636	(\$783)	(\$491)
	2B	148	\$30	\$63	488	\$7	\$144	636	\$37	\$207
	2C	332	\$24	\$35	1,046	(\$42)	(\$6)	1,378	(\$18)	\$29

What are the anticipated member impacts and cost avoidance for the non-Medicare population? (*cont.*)

Drug Class	Scenario (April 2018)	Medicare			Non-Medicare			Total		
		Members Impacted	Cost Avoidance 2019 (thousands)	Cost Avoidance 2020 (thousands)	Members Impacted	Cost Avoidance 2019 (thousands)	Cost Avoidance 2020 (thousands)	Members Impacted	Cost Avoidance 2019 (thousands)	Cost Avoidance 2020 (thousands)
Overactive Bladder	2A	103	(\$133)	(\$126)	14	(\$38)	(\$32)	117	(\$171)	(\$158)
	2B	103	\$12	\$27	14	\$6	\$12	117	\$18	\$39
	2C	269	\$29	\$29	82	\$16	\$17	351	\$45	\$46
Beta Blockers	2A	90	\$5	\$20	44	(\$8)	\$1	134	(\$3)	\$21
	2B	90	\$34	\$54	44	\$23	\$33	134	\$57	\$87
	2C	254	\$94	\$104	180	\$68	\$75	434	\$162	\$179
Antianginal	2A	137	(\$36)	\$2	52	(\$11)	\$0	189	(\$47)	\$2
	2B	137	\$4	\$43	52	\$1	\$10	189	\$5	\$53
	2C	197	\$110	\$121	72	\$23	\$26	269	\$133	\$147
Androgens	2A	74	(\$24)	\$72	148	(\$60)	\$77	222	(\$84)	\$149
	2B	74	\$34	\$128	148	\$63	\$177	222	\$97	\$305
	2C	183	\$211	\$234	341	\$329	\$368	524	\$540	\$602

What are the anticipated member impacts and cost avoidance for the non-Medicare population? (*cont.*)

Drug Class	Scenario (April 2018)	Medicare			Non-Medicare			Total		
		Members Impacted	Cost Avoidance 2019 (thousands)	Cost Avoidance 2020 (thousands)	Members Impacted	Cost Avoidance 2019 (thousands)	Cost Avoidance 2020 (thousands)	Members Impacted	Cost Avoidance 2019 (thousands)	Cost Avoidance 2020 (thousands)
Blood Pressure	2A	143	\$90	\$102	86	\$38	\$44	229	\$128	\$146
	2B	143	\$96	\$110	86	\$47	\$53	229	\$143	\$163
	2C	159	\$110	\$120	115	\$57	\$63	274	\$167	\$183
Antidepressants	2A	90	\$72	\$97	249	\$156	\$223	339	\$228	\$320
	2B	90	\$80	\$104	249	\$196	\$253	339	\$276	\$357
	2C	134	\$107	\$117	413	\$267	\$292	547	\$374	\$409
Psychotherapeutic / Neurological	2A	80	\$37	\$107	109	(\$3)	\$161	189	\$34	\$268
	2B	80	\$71	\$157	109	\$71	\$246	189	\$142	\$403
	2C	133	\$526	\$668	197	\$467	\$595	330	\$993	\$1,263
Parkinson's Disease	2A	33	\$29	\$80	15	\$6	\$33	48	\$35	\$113
	2B	33	\$60	\$111	15	\$28	\$54	48	\$88	\$165
	2C	82	\$250	\$272	40	\$111	\$121	122	\$361	\$393

What drug classes would be included in the Value Formulary?

- HCA is gathering data on the drug spend and utilization in 2018 in order to make a determination for drug classes in 2019.
- New drugs and new generics are regularly approved to market that affect existing drug classes. Drug prices change mid-year that impact which drugs are the most cost-effective for UMP.
- HCA would manage the formulary and direct members to preferred products. Each year during July, HCA would make final decisions on the drug classes in the value formulary for the next plan year.
- Likely drug classes for the value formulary in 2019 are diabetes, cholesterol, beta blockers, androgens, blood pressure, antidepressants, psychotherapeutic/neurological, and Parkinson's disease.

Has HCA performed an analysis on what happens to the member's cost-share?

- The value formulary has the potential to reduce the member cost-share for medications.
 - Members who are currently paying for Tier 3 drugs may be grandfathered on their existing medication and pay Tier 2 cost-share; they could also switch to a preferred medication (either Value Tier, Tier 1, or Tier 2).
 - New members who are granted appeals would pay a Tier 2 cost-share.
- In all these situations, the member would pay a 30% cost-share with a maximum of \$75 per month supply compared to the existing 50% cost-share (with no maximum).

What were the results of the 2013 analysis on capping the Tier 3 cost-share for members?

- An analysis on placing a \$150 cap on Tier 3 drugs showed that the costs would shift from members to the plan, thereby increasing premiums for all members.
- The only members who would benefit from the Tier 3 cost-share cap would be the members who use Tier 3 drugs but do not reach the out-of-pocket maximum (\$2000 per year).

What drug classes have copay coupons?

- Classes with brand-name drugs (either single-source brands or multi-source brands) have copay coupons or other patient assistance programs.

The Consortium recently went into automatic negotiations as a result of the third-party audit showing that the rates were outperforming the contract. When did the new consortium rates for specialty drugs go into effect?

- The new rates went into effect on January 1, 2018.

Value Formulary Final Recommendation

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

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.*

Proposed Policy Resolution PEBB 2018 – 01 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

Proposed Policy Resolution PEBB 2018 – 01 Value Formulary, (*cont.*)

- members who have been taking a non-preferred drug will be grandfathered or be able to receive their current medications during a transition period, and
- the grandfathering or transition period for brand name drugs ends when a generic equivalent or interchangeable biologic becomes available (the drug then becomes a multi-source brand and is subject to medical necessity).

Questions?

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

Appendix

Full January and April 2018 Option Crosswalk

- January “Option 1” is 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”

TAB 4



Emerging Medications Update

Ryan Pistoresi, PharmD, MS
Assistant Chief Pharmacy Officer
Clinical Quality and Care Transformation
June 7, 2018

Decorative wavy lines in blue and green at the bottom right corner of the slide.

Purpose

- There is widespread concern about rising drug spend and how new drugs and new drug classes may impact UMP.
 - New drugs approved by the FDA after rates are set can have an impact on how much the plan spends on prescription drugs.
 - Forecasting new drug impacts can be difficult because there is a lack of cost information until a drug is approved by the FDA.
- The Legislature placed a provision in the 2017-2019 Operating Budget requiring HCA perform a comprehensive cost impact analysis of any new drug placed into a new drug class. The cost impact will be presented to the PEB Board to promote transparency about emerging drug classes and their fiscal impact to UMP costs.
- HCA plans to present basic clinical information with the cost impact analyses to the PEB Board.

Background

- New drugs are reviewed and approved by the FDA throughout the year
 - In 2017, the FDA approved 46 new drugs and 80 first-time generics.
 - The FDA also had many other supplemental reviews and approvals for new drug combinations, indications, formulations, strengths, and other generic products.
- New drugs have the ability to impact plan spend by shifting current drug utilization and creating new drug utilization
 - New drug *classes* have the greatest potential impact for changing utilization and spend.

Process

- Each week, HCA receives a report (weekly drug file) of every new medication that is loaded into the pharmacy claims systems.
 - An HCA pharmacist reviews the new drugs to determine whether they will create a new drug class.
- Upon identifying drugs that create new drug classes, the HCA pharmacist will perform a comprehensive review of the evidence to present to HCA leadership. The analysis will include:
 - A review of the safety, efficacy, and comparative effectiveness.
 - A cost analysis of projected UMP budget impacts.
- HCA will present a summary of these new drug classes, including projected UMP budget impacts, to the PEB Board.

Ibalizumab-uiyk (Trogarzo)

- Trogarzo was approved by the FDA on March 6, 2018.
- Trogarzo is indicated for the treatment of HIV-1 in adults with multidrug resistant HIV-1 who have failed multiple courses of therapy.
- It is anticipated there are 2 to 4 UMP members who may be appropriate for this treatment based on a review of the available safety and efficacy data from clinical trials.
- Treating 2 to 4 members may cost UMP between \$200,000 to \$400,000 in 2018.

Questions?

Ryan Pistoiresi, PharmD, MS
Assistant Chief Pharmacy Officer
Clinical Quality and Care Transformation
Ryan.Pistoiresi@hca.wa.gov

TAB 5



Proposed Annual Procurement Plan Changes

Beth Heston
PEB Procurement Manager
Employees and Retirees Benefits Division (ERB)
June 7, 2018

Kaiser Permanente of Washington (formerly Group Health)

Network Changes

SoundChoice Plan

- Add network coverage in Kitsap and Spokane Counties

Plan Design Changes

SoundChoice Plan

- Lower deductible from \$250 to \$125 per person and from \$750 to \$375 per family
- Lower Primary Care visit co-insurance from 15% to \$0 co-pay
- Change Inpatient Hospital Services from \$200 per day up to \$1,000 max to \$500 per admission with no maximum
- Unlimited massage therapy visits

Plan Design Changes

Classic

- Increase the MRI/CT/PET co-pay from \$30 to \$50

All Plans

- Add Virtual Diabetes Prevention Program (Omada)

Kaiser Permanente of the Northwest (Cowlitz and Clark Counties)

Network Changes

All Plans

- Add network coverage in Lane County, Oregon

Plan Design Changes

All Plans

- Add a fitting fee of \$30 to all contact lens exams
- Add prescription drug tier and cost share (up to a maximum of 15% after deductible on CDHP) for self-administered chemotherapy, per new legislation

Plan Design Changes

- Add a group durable medical equipment (DME) 20% co-insurance to selected DME items:
 - Enteral pump, formulas, and supplies
 - CADD (continuous ambulatory drug delivery) pumps
 - Osteogenic bone stimulators
 - Osteogenic spine stimulators
 - Ventilators

Uniform Medical Plan

Plan Design Changes

- Add a Virtual Diabetes Prevention Program

Uniform Dental Plan

Plan Design Changes

- Reduce the limit on Class III Restorations (Crowns) from 7 years to 5 years

Questions?

Beth Heston, PEB Procurement Manager
Employees and Retirees Benefits Division (ERB)

Beth.Heston@hca.wa.gov

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