Public Employees Benefits Board
Meeting Minutes

May 21, 2018
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 3:30 p.m.

Members Present:
Sue Birch
Harry Bossi
Greg Devereux
Tim Barclay
Carol Dotlich
Yvonne Tate
Tom MacRobert

Members via Phone:
Myra Johnson

PEB Board Counsel:
Katy Hatfield

Call to Order
Sue Birch, Chair, called the meeting to order at 1:33 p.m. Sufficient members were present to allow a quorum. Board and audience self-introductions followed.

Meeting Overview
Lou McDermott, Deputy Director of the Health Care Authority, provided an overview of the agenda on Dave Iseminger's behalf. Dave is on vacation.

Sue Birch: At recent meetings, Dave has tried to follow up on questions from prior meetings. The pharmacy-related questions will be covered during today's presentation. Dave will bring back insights on the non-pharmacy questions at our next meeting. Today is all about pharmacy and drugs. We want to make sure there's time for Board Members to ask questions.

Medicare Retiree Premium Preview
Tanya Deuel, PEBB Finance Manager, Financial Services Division. Today's presentation is a preview on the preliminary development of the Medicare retiree rates for plan year 2019. One of the key reasons we're able to accelerate the timeline slightly is that the Legislature established the Medicare explicit subsidy earlier than it has in previous years.

Last year's legislative session was a short session, which adjourned on time and gave us the value of the Medicare explicit subsidy. Next year is a long session and we don't anticipate that we can accelerate the timeline as quickly next year.

For the upcoming plan year 2019, we are anticipating relatively flat retiree premium contributions. One of the key reasons is that the Legislature increased the Medicare explicit subsidy from $150 to $168. There are also slightly improved pharmacy trends for plan year 2019. The Legislature has not changed the value of the Medicare explicit subsidy since 2012.

Slide 3 is a quick refresher of the relationship between the Medicare explicit subsidy and its impact on the Medicare retiree contributions. This is a visualization of the UMP Classic Medicare retiree premiums from plan year 2016 to plan year 2018. The bar on the far left is Plan Year 2016, next is Plan Year 2017, followed by Plan Year 2018, and the far right bar is titled Plan Year 2018 Scenario. This is titled "Scenario" because it's the exact total rate of the UMP Classic Medicare retiree rate for 2018, but modeled with both the $150 Medicare explicit subsidy and the $168 Medicare explicit subsidy.

The top blue part of the bar is the Medicare explicit subsidy. That is the state's contribution towards the Medicare retiree rates. As the total bar increases, the amount of blue has remained the same, meaning the amount on the orange part has increased. That portion is paid by the Medicare retiree. In the two bars on the right, if we look at the orange portion, as the blue section increased from $150 to $168, the amount in orange actually decreased.

Megan Atkinson: I want to emphasize the point of this presentation, and the reason we're coming to you with very preliminary numbers is because we are not yet finished with procurement. We're in the midst of going back and forth with conversations around rate development, but to Tanya's point, the rates are looking relatively flat. When you were having these conversations last year, they were not looking flat as you can see on this chart. The difference between 2017 and 2018 was a significant increase. We are not expecting that same trend to continue into the second year. The reason we are illustrating this bar chart with you using 2018 rates is not that we literally believe 2019 will numerically be exactly equal to 2018. We're trying to illustrate for you the difference, the significant impact of the legislative decision to go from $150 to $168 and how that impact, dollar for dollar, is playing out on the member premium.

The Legislature made the decision to go from $150 to $168. Those are year-by-year decisions by the Legislature. There is no guarantee the Legislature will stay at $168 in 2020, 2021, etc., but that's what we have right now.

Sue Birch: I'd be remiss in not formally thanking the Legislature and staff. Thank you for bringing this information to us. We hope you can keep holding things flat or moving in a different direction since we're all about making things as efficient as possible.

UMP Value Formulary Options

Ryan Pistoresi, Assistant Chief Pharmacy Officer, Health Care Authority. Today we'll be presenting on the UMP Value formulary. Previously, when presenting the value formulary, we've presented different scenarios and options. Today we're going to focus on the core values, principles of the value formulary, and how it can address two current issues facing UMP. We have a recommendation at the end prior to a draft policy resolution, but we will not be reviewing the scenarios in depth like we have at previous meetings.

Slide 3 – Formulary Models: First, we'll start with terms we'll be using throughout today's presentation. We'll go over different types of formularies. The first one is the open formulary in which all drugs are covered under a plan formulary. The non-preferred drugs are available at a higher member cost-share.

There is a closed formulary which has no coverage for the non-formulary drugs. This is a much stricter formulary. These drugs are often blocked for rebate purposes. If a Pharmacy Benefits Manager (PBM) has a preferred drug and they're getting a very good rebate on it, they will try to drive as much of their utilization to that drug in order to save them money. By blocking the competitor drugs, they're able to maximize the amount of utilization they have for those drugs.

A hybrid formulary is seen more in the commercial marketplace. This formulary has a select mix of drugs and classes identified as warranting an exclusion, either for clinical or financial reasons.

The value-based formulary, which we will be talking about today, emphasizes the clinical effectiveness of the drug, rather than just the cost. Non-preferred drugs are covered only when they are medically necessary and clinically appropriate after reviewing the individual clinical circumstances by looking at the members and determining how these drugs can be used for them.

Tom MacRobert: I have some questions just to make sure everybody understands clearly the terminology. When you refer to the formulary, you're talking about a list of preferred drugs. Is that correct?

Ryan Pistoresi: Yes. When I'm talking about a formulary, it's a list of preferred and non-preferred drugs.

Tom MacRobert: You also used the term non-formulary. I'm assuming when you do that you mean those are drugs not on the preferred drug list.

Ryan Pistoresi: Yes. When a drug is non-formulary, it is not covered by the plan. When talking about a formulary in general, we're talking about all the types of drugs that could be covered. Then when a drug is non-formulary, it is not covered by the plan. When we're talking about a formulary, the terms could be preferred, non-preferred, and non-formulary.

Tom MacRobert: Okay. You also have Tier 1, Tier 2, and Tier 3 drugs. Those are all typically on the preferred drug list but at a different cost basis?

Ryan Pistoresi: Yes, that is correct. The Tier 1, Tier 2, and Tier 3 drugs are all on the preferred drug list.

Tom MacRobert: Okay, thank you.

Ryan Pistoresi: Slide 4 – Other Terms: Grandfathering means a member would continue to receive the same benefit for a drug even after the new policies are effective. I want to emphasize that as we talk about some of the options later today, we do want to make it clear that we can grandfather members who join UMP after the January 1, 2019 date if they meet the qualifications. If they joined UMP at the start of the plan year and met the criteria, they could be grandfathered. That is a possibility.

Multi-source Brand (MSB) means the originator drug that originally held the patent, but the patent expired, and now there are generic equivalents. This is opposite of a single-source brand drug, which is an originator drug that still holds the patent and does not have any generic competition.

Copay coupons is a remuneration to patients for specific brand name drugs applied after the drug has been built in the health plan and used in place of the member cost-share. What these programs do is take away the member's incentive to choose an equally effective lower cost alternative by offering copay coupons and patient assistant programs. To follow up to Tim's question from the last presentation about grandfathering, what grandfathering can do is allow patients who are stable on their medications to continue on it without going through an administrative process. This helps reduce the amount of administrative costs while not interrupting patient care. Did that adequately address your question?

Carol Dotlich: My question is about grandfathering. If I'm new to the plan in 2019, how do I know I am grandfathered or not? In other words, since I haven't been in the program before, you wouldn't necessarily know what drugs I've been on over time, right? What is the process for becoming a grandfathered person in 2019 if you haven't been in the plan before?

Ryan Pistoresi: We'll go into some of the scenarios of grandfathering later on, but what I can tell you is there is a process for your provider to submit a request and provide documentation that you have been using a drug and you've been stable on it. If those meet the criteria for grandfathering a patient on their specific drug, then that would qualify for them. Just like if you were a UMP patient and we had that information previously.

Carol Dotlich: How would I find out that I could have that drug? Would I go to the pharmacy and be told, "No, you can't have that drug. You have to get a statement from your doctor and send it to your insurance." Or is there some advanced way of providing documentation or whatever before the plan takes effect? I'm looking for a process.

Ryan Pistoresi: We haven't necessarily looked at a communication process yet, but I do think that would be a good idea to be proactive and to let members know that if we are going to be changing to the value formulary to provide them with the information so we don't interrupt their care. That way they can continue on the medications even with this transition in 2019.

Donna Sullivan: This is Donna Sullivan, Chief Pharmacy Officer with the Health Care Authority. We do notify members at least 30 days in advance if their medication is going to change tiers. Any member affected by the value formulary would be notified well in advance at the end of 2018. We would also make sure to include in the open enrollment materials that we pass out at the benefit fairs information about the formulary and the value formulary, what we're doing and why we're doing it. We would make sure that all members are well aware of what the changes are and what they need to do to if they are impacted by the value formulary.

Harry Bossi: Ryan, regarding grandfathering. Carol was suggesting or referring to, wouldn't it be the same process as showing medical necessity? Why would we need to use the term grandfathering? It would just be medical necessity like it would be someone who had been in the plan for years who was prescribed a new drug that wasn't part of the plan.

Ryan Pistoresi: Yes, the grandfathering is similar to determining medical necessity for that drug, but throughout the presentation we'll be using this grandfathering term for those types of situations.

Greg Devereux: I actually see a distinction between those two. I thought what Carol was trying to get at is if given the 30-day notification, I'm told that my drug may change, I then go to my physician and say, "Can you write me a note?" I don't know whether the Health Care Authority has a form or whatever. Then, you bring that to the pharmacy and they're allowed to honor it. I think that's different. Medical necessity to me means you might have to try several different things and then prove that the specific drug is the one you need. That's different than just simply saying, "I need to continue on this specific drug." To me it's a distinction.

Ryan Pistoresi: Let me see if I can clarify your point. The medical necessity is determining whether the drug is appropriate to use, whereas the grandfathering is to continue a patient on that drug. So, yes, grandfathering is more about someone who is established on a drug or a drug regimen, can demonstrate they are on it for a medically necessary reason, and that it is clinically appropriate. Whereas the medical necessity is you have a specific diagnosis for that drug and can you take that drug for that reason. Is that your point?

Donna Sullivan: I think you have it almost right but not quite. Greg, yes, to your point, grandfathering means that the person who's already established on that drug gets to continue on that drug and they don't have to justify medical necessity. We verify that you've been on it and you can continue. Where medical necessity comes in would be if you're on the drug, it's not being grandfathered, and you're being asked

to quit. If you're unable to switch, you would have to demonstrate medical necessity to remain on the drug.

Greg Devereux: That was the distinction I was trying to draw.

Tim Barclay: If we were to not grandfather, getting back to Greg's point, would we require the person to actually use alternative drugs and prove they don't work in order to get back to where they were? Or would a simple conversation and a form submitted by their physician to say, "No, we absolutely don't want this person to try any alternatives. We need to stick with this." Is that sufficient? If we don't grandfather, are we going to make people try alternatives or is there a way around that?

Ryan Pistoresi: If we do not grandfather members on their drugs, they will either need to switch to alternative drugs, or if they have tried those alternative drugs in the past, or there are contraindications, say, drug-drug interactions, or other issues with those drugs, the provider would need to send a form requesting that they do not need to go through that process.

Tim Barclay: Just to clarify then, so let's suppose I'm a person who is taking a drug since its inception. There were no alternatives. I've been on this drug for many years. It's working. I don't know if the alternatives work or not. We pass a policy that does not include grandfathering. Just to be real clear, do I or don't I have to try the alternatives or can my physician allow me to stay on the current drug without having to go experiment with the alternatives first?

Ryan Pistoresi: In that situation your provider could submit a request and say, "My patient has not taken the alternatives but for these reasons needs to continue on this drug." Then, after a review of the clinical circumstances, they may either approve it and allow you to then continue, or not approve it and require you to take the alternatives.

Lou McDermott: Tim, basically, if there's no other medical reason, you just haven't tried anything else, and you've always been on it, then you would have to switch drugs. You would have to try the other drugs.

Tim Barclay: I'll just lay my point out now. I don't necessarily want to debate it now. I want you to be able to go through your presentation, but I guess that's my concern with grandfathering is my assumption is we have many, many people who started taking a drug when it was the only option. Now we have generic equivalents, which in theory could work just fine for a given patient, but they just don't ever change. It kind of defeats the purpose a little bit in my mind if we just blanket grandfather everyone and say, "Keep doing what you're doing." It seems like we haven't done a whole lot. That's my concern with it. Given that there's a way around it without a person who truly needs to be on that drug to have to switch and suffer the consequences of an alternative if their physician can come in and say, "Yeah, this is what they have to have." For me, I'm not, at this point, not convinced that grandfathering is the right thing to do. I just wanted to throw that out there.

Ryan Pistoresi: Tim, when we get into our draft policy resolution we do have a slight nuance between the multi-source brand drugs that do have generic equivalents versus the single-source brand drugs that do not have generic equivalents. When we get to that, I'll see if that addresses your concern. If not, then we can discuss further.

Tim Barclay: Thank you.

Ryan Pistoresi: We have a follow up question about the copay coupons. The question is, "Are the copay coupons income-based?" After doing some research, I found that, no, the copay coupons are available to anyone with commercial insurance. They are not based on income. Patients who have federal insurance or who do not have any insurance do not qualify for the copay coupon cards. Patients with federal assistance are not allowed to use these because they count as kickbacks under the Federal Anti-Kickback Statute.

Slide 5 – Our Journey. We'll begin with why we're discussing the value formulary today. In 2012, we changed our mail order pharmacy cost-sharing from a flat copay to a percentage co-insurance. This was done to align the mail order pharmacy with the retail benefit. Soon after, we identified a member equity issue. We were getting reports from members who were unable to afford their medications and unable to change to preferred or generic drugs. These members were using non-preferred drugs through the mail order pharmacy and had a medically necessary reason to use these drugs because the preferred drugs or the generic drugs were not appropriate for them. We began studying different ways to address this member equity issue. In 2015, we allowed a tier exception process in which members using Tier 3 drugs could submit a request to change their cost-share to a Tier 2 cost-share. What this process did is provide relief to some members who were granted the exception, but then this led to another issue in which different members were paying different amounts for the same drug. This process required the members to know about this policy in order to get this specific UMP benefit.

So let's take a look at a case to help explain this in more detail. We have two UMP members, Lou and Dave, who are both using Victoza to manage their diabetes. Both members have tried all the preferred medications in this class and they are either ineffective or non-clinically appropriate. Both are currently paying 50% for this medication, which is about $370 per month. Lou, knows about the Tier 3 exception process and his provider submits a request. Because Lou meets the criteria and is approved, Lou will now pay the Tier 2 cost-share for his Tier 3 medication, which is $75 per month.

Dave, however, also meets the criteria for this Tier 3 exception process but does not know about it and is not able to request it. Now we have two UMP members using the same drug and who both meet the criteria for this policy, but one is paying $75 per month and the other is paying $370 per month. This is the equity issue explained.

Harry Bossi: Is there not a maximum out-of-pocket for the plan year for the member on the drugs?

Ryan Pistoresi: Yes, so there is a maximum out-of-pocket cost for the members. For the Classic population it's $2,000 per year. But the main takeaway from this slide is that there is a difference between the UMP members and what they're paying for that same medication.

Slide 7 – Other Ways to Address Equity Issues. This slide shows other options we considered back in 2013 and 2014 to address this issue. One option was to implement a closed formulary, which would make all the currently non-preferred drugs become non-formulary drugs and cover them only when medically necessary. This would require all members currently using Tier 3 drugs to request an exception similar to the Tier 3 exception process I just mentioned. When reviewing this option, we did see that it would address the equity issue but it would increase the administrative costs of the plan as well as plan costs and could potentially increase member premiums.

Another option we looked at is to place a claim maximum on Tier 3 drugs similar to how we have a maximum on Tier 3 specialty drugs. This was done because many specialty drugs cost thousands of dollars per month, even tens of thousands of dollars per month. If we had a 50% cost-share for the members, they would be spending $2,000 out of pocket at the first month every year.

The last option considered was to implement a value formulary, where we would identify drug classes that demonstrate value, and non-preferred drugs would only be covered when medically necessary and clinically appropriate. This directs members to the most cost effective drugs in these classes. It still allows the members with individual circumstances that need to use non-preferred drugs to do that. In addition to the equity issue we discussed, we're also looking at addressing member premiums, especially for our Medicare population.

Slide 8 – Implemented Strategies. The value formulary may help with member premiums. In the January meeting when we presented on the value formulary, one of the Board Members requested information about other strategies that we were looking at besides changing the formulary that could help address our drug trend. In 2016, the Health Care Authority convened the Washington Prescription Drug Price and Purchasing Summit Series, in which we gathered several key stakeholders from around the region to talk about different strategies to address drug price and drug utilization. We identified several long-term strategies. Some of the strategies currently implemented by the Northwest Prescription Drug Consortium are on this slide, including demanding more transparency from pharmacy benefit managers (PBMs), including a 100% return of rebates. That way, if a drug manufacturer has rebates on a drug, that entire rebate amount is passed on to the plan. Another strategy is tighter performance guarantees, insuring that the PBM is at a market competitive rate for purchasing of medications. Requiring pass-through pricing prevents the PBM from keeping the spread from what we pay the PBM to what the PBM pays the pharmacy and allowing us to see that what we are paying the PBM is going directly to the pharmacy and that they're not keeping any of the margin in between. Also, we require third party market checks of the local retail pharmacy

market rates, which would allow us to see where we are in comparison to other plans.

Carol Dotlich: I have a question back on the first slide, Slide 7. When you talked about the per claim maximum on Tier 3 drugs, I need more information about that.

Ryan Pistoresi: A per claim maximum on Tier 3 drugs would be similar to what we have for Tier 1 and Tier 2 drugs where we have a percentage coinsurance up to a dollar threshold. For Tier 1 drugs, members will pay a 10% cost-share but no more than $25 per drug. If a drug costs $300 per month, that 10% cost-share would be $30 but because we have a maximum on it of $25, the member would pay $25. However, if it's below that threshold, if the drug costs $1 a month, the member would pay ten cents.

Carol Dotlich: Can you apply that to the Tier 3 drugs?

Ryan Pistoresi: Yes, we could. That is an option we considered in 2013 and 2014 to address this.

Carol Dotlich: What were the dollar figures looking like?

Ryan Pistoresi: Unfortunately, I was not at HCA at this time and I don't have that.

Donna Sullivan: We were looking at $150 and $225 per month for the maximum out-of-pocket towards that month, for that prescription.

Carol Dotlich: Thank you.

Sue Birch: Ryan, on the independent third party market checks of local retail pharmacy market rates, what did the audits show? What did they tell?

Ryan Pistoresi: Burchfield did perform an audit within the last year, assessing our rates, but I don't have the exact numbers for you today.

Donna Sullivan: I can answer that question. What Burchfield does is they compare what we're reimbursing pharmacies to what other large employers are reimbursing pharmacies in the same region. I think it’s a market difference of a half a percentage point between what we're paying and what the average market is bearing. Our reimbursement rates will automatically adjust to those center rates. This time we did have a rate adjustment. It’s automatic and happens behind the scenes for the plan.

Sue Birch: Was it a nominal savings to us, Donna?

Donna Sullivan: Yes, it was. I don't have that number. It was a million or more dollars.

Ryan Pistoresi: Slide 9 – Current Board Options for 2019. These are options available to the Board that could address pharmacy spends for 2019. The first option

is making no changes. It would be unchanged from the current projections. What Tanya and Megan had presented, it would continue to be what we're developing. This would also not address the member equity issue.

Another option would change the member cost-share. It would be changing the deductible, the coinsurance, or the maximum out-of-pocket, which would reduce the amount the plan spends. This would likely shift the cost over to the UMP members. This option does not address the equity issue but may be an option to address the rising specialty drug trend.

The last option, one of the core values of the value formulary, is to guide member utilization. It would direct members to higher value, lower costs, therapeutic alternatives in drug classes, but allow the use of non-preferred drugs when medically necessary and clinically appropriate. Guiding member utilization has been an effective strategy for reducing drug trend. For example, Express Scripts, a national PBM, shows different formulary management strategies can have a different result on drug trend.

Slide 10 shows the drug trend for three different management styles for different plans. Plan design and management can have a good impact on a drug trend. The value formulary would direct members to the highest value drugs and could help reduce the drug trends for UMP.

Slide 11 – Information on Value Formulary Model. Now that we've discussed some of the current issues regarding the equity issue for members and the drug trend, we can move into the value formulary which will help show how it can address these issues. The value formulary was developed from our pharmacy third party administrator, Moda Health. They took our drug claims data and allowed us to create different scenarios where we could examine what happens when non-covered drugs are covered only when the preferred drugs are not medically necessary or clinically appropriate. What happens when we grandfather members or don't grandfather members? What happens when we change or adjust the amount of appeals requested or the approval rate for those appeals? This is using our own UMP claims data from 2016 to 2017. It projects what we would see for the member impact cost avoidance and the administrative costs from the plan years of 2019 to 2022. As some of the Board Members noticed in our April presentation, there were some differences between the January model and the April model.

Slide 12 shows what changed between January and April. The main difference is that we updated claims data. In the January presentation, we were using claims data from June 2016 to May 2017. When we had Moda work on the model, they were able to update it to calendar year 2017. This changes the shift of the utilization for the drugs. Members previously on a preferred Tier 2 drug in the old claims data may have shifted to a new generic in the new claims data, which would reduce the amount they're spending on a drug because they shifted from a brand to a generic. This is the one factor that influenced the updated model.

We also had Moda update a few other areas, including the drug trend for the Medicare and non-Medicare populations. We increased a number of exception requests and appeals we may receive. We also updated our drug substitution assumptions to better reflect clinically appropriate alternatives and what we currently see as the market share for these drugs.

To Tom's question from the last meeting, there is a crosswalk from the January to the April presentation on Slide 19, and in the Appendix. The different scenarios are also included in the Appendix.

Slide 13 is more updated information about what the value formulary may do in terms of member premiums. For the Medicare population, in order to reduce the trend by 1%, the plan would need to save about $1.7 million in claims. This would reduce the projected member premium by about $2.50 per month. If you had a target to reduce the premium by $5 with this value formulary, we would need to aim for about $3.4 million of claims savings for Medicare. For non-Medicare, it's slightly different. To reduce the trend by 1%, the plan would need to save about $2.0 million in claims. This would reduce the premium by about $1 per month for the Classic population. Also included on the slide is information for 2020 targets. We don't have a way to identify what that would do for member premiums, only on what we would see for drug trend. In addition to addressing the drug trend, the value formulary also addresses the member equity issue that we've discussed.

Slide 14 goes back to the example we had earlier with Lou and Dave, but this time it applies to the equity issue. If the diabetes drug class is part of the UMP value formulary, members on Victoza could be grandfathered in. Members don't need to know about this Tier 3 exception process because it would be applied to all members using this medication who had been stable on it. Now, both Lou and Dave are paying the same amount for the same medication, which would be $75 per month.

Slide 15 are some of the principles we are looking to focus on with the value formulary. First, focus on the drug classes that can achieve cost savings without reducing the quality of care to our members. We want to make a difference to the premiums without sacrificing care. We want to be able to grandfather members who have used these medications for a long time or who are in refill protected classes.

Sue Birch: Could you explain what a refill protected drug class is? We didn't study that terminology.

Ryan Pistoresi: Yes, I apologize for bringing up a new term without previously defining it. A refill-protected class is a class of medications with narrow therapeutic indexes, which means they have a narrow window in order to treat a patient without becoming either subtherapeutic or too toxic for the member. These drug classes are things like HIV, antipsychotics, immunotherapies, Hepatitis C treatments, antidepressants, and a few other classes.

Slide 16 lists things to consider with the value formulary. It shows different options, impact to members, the number of members who may be impacted, impact to costs, and the overall impact through the value formulary to the plan.

The top row looks at the multi-source brand drugs, which would have more of a minimal impact to members because there are generic alternatives available, but it would affect the lower number of members and have a low impact to cost. So a low disruption, also the lowest savings.

The bottom row is all drug classes, which would have the highest impact to members and impact the most amount of UMP members. Upon our review, we determined this would have a medium impact to cost. Not the highest impact to costs but this would have the highest member disruption.

The middle row is the menu of options that the Board Members talked about at the January meeting. Being able to customize the value formulary, pick and choose which drug classes, and to tailor the value formulary to have the highest amount of savings with the lowest member impact. This could have a medium amount of impact to members. Being able to tailor the value formulary and choose the individual drug classes could be a low to medium impact for the members and a low to medium impact for the cost. Allowing this would then increase the value that the value formulary has for the plan.

Slide 17 explains the options a little more. One of the options for a value formulary could be with the different drug classes. Drug classes could be diabetes, cholesterol, beta blockers, androgens, etc. Being able to pick and choose the different drug classes would allow us to help resolve the equity issue in those drug classes, but also acknowledge that for the other drug classes not part of the value formulary, the issue would remain. Grandfathering could allow members in these classes to continue on their current medications. Members new to UMP in 2019 or beyond could be directed to preferred drugs. Or if they had been stable on these non-preferred drugs and could demonstrate that they are medically necessary, they would be eligible to be grandfathered.

Carol Dotlich: It sounded like either/or when you were talking about grandfathering. You sounded like it had to be medically necessary. It wasn't just like you were stable for a long time.

Ryan Pistoresi: One of the things we'll talk about with the policy resolution later is that grandfathering can be applied for the members who are stable and have been on these drugs for a number of years, or could be for the members who have to demonstrate they're medically necessary and the alternatives don't work for them. We could look at that when we get to the policy resolution.

Value formulary for just the multi-source brand drugs would apply to drugs in all the multi-source brand drugs in all the drug classes. In this situation, they would only be covered when medically necessary and clinically appropriate. This would resolve the

equity issue around the multi-source brand drugs but still remain for members using single-source drugs.

Slide 18 are grandfathering examples. Scott is a long time UMP member using an antipsychotic Abilify for bipolar disorder. Since the antipsychotics are a refill protected class, Scott would be grandfathered and pay the $75 per month for the prescription. We have another member, Lou, who joined UMP in July 2019. Under this grandfathering scenario, Lou was diagnosed with bipolar years ago and was been stable on Abilify for five years. In this situation, Lou's provider could request Abilify and Lou would then pay the $75 per month on the prescription, allowing him to be grandfathered in, even though he joined in July 2019. The last example is Dave, new to UMP in July 2019 and recently diagnosed with bipolar disorder. Dave will be directed to the preferred antipsychotics first. If these medications are not effective, Dave could be allowed to try the non-preferred antipsychotics. This is an example of what it would look like under some of the different grandfathering scenarios, not necessarily that antipsychotics would be a part of the value formulary.

Slide 19 is our recommendation and crosswalk help. The recommendation to the Board is to look at Option 2a which was presented at the January 2018 PEB Board Retreat with one modification. That would be to apply the value formulary to all UMP members instead of only the Medicare UMP members. At the April 2018 meeting, Option 2a provided an example of what it would look like for an individual drug class while applying the principles described for Option 2a in the January 2018 meeting. This was to help the Board understand the granular aspects of this option, what it would look like at an individual drug class level. In April, Option 2a did not address the multi-source brand drugs like we did in the January meeting, but those were addressed in our Options 1a and 1a+, which were presented in April. Some of those options from the April meeting are included in the Appendix.

Slide 20 – Draft Policy Resolution PEBB 2018-xx. 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
- members how 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 or equivalent or interchangeable biologic becomes available, unless the grandfathered multi-source brand name drug is medically necessary and clinically appropriate.

The first bullet is a core concept of the value formulary and addresses the member equity issue.

The second bullet means that members who have been using the multi-source brand drugs that have generic equivalents will have the same ingredient at the same strength and same dosage form available to them.

The third bullet would apply to members taking the non-preferred single-source brand drugs. If a member was using a non-preferred multi-source brand drug, the second clause would apply to them.

The last bullet means the members were grandfathered on a specific ingredient, not a specific brand name drug. The member will always have that ingredient available to them at that same strength and same dosage form, but they may have to switch from the brand manufacturer to the generic manufacturer, similar to the current UMP pharmacy benefit when a single-source brand becomes a multi-source brand.

Tom MacRobert: When we met in January, your last slide specifically said that we would like to examine 2a, 2b, and 2c in more depth. Between that meeting and now, basically 2b and 2c were eliminated and only 2a is the focus. I'm curious as to how that decision came to be, to only focus on 2a.

Ryan Pistoresi: We're focusing more on 2a rather than 2b and 2c due to the member equity issue, allowing members to be grandfathered on these drugs when they are stable, and to reduce the amount we may see in terms of administrative costs. Examining 2b in detail, we realized that some of the assumptions in the value formulary may not have been accurate. If you look in your Appendix, Slide 37, this scenario shows the overall plan cost depending on the number of requests members could submit. Option 2b would be a scenario in which the members would be grandfathered at Tier 3, so the members would not see a change in their cost-share but could still go through the tier exception process. Again, this one does not address the equity issue. Depending on the number of requests members submit, and depending on the amount of approvals, the plan could potentially see $133,000 in terms of savings if no one submitted a request to actually increasing the plan cost to $139,000 if every one of those members submitted a request. Depending on how many members submitted a request in the B scenarios, it would increase the plan costs. That's one of the things we learned between the January and April meetings.

Harry Bossi: Can you can give us a sense for what percent of overrides or medical necessities have been approved in the last few years. Do you have that information? Not necessarily how many but on average. 50%? 70%? 90%? Just a sense for how likely, in the past, overrides have been granted, if "override" is the correct term.

Ryan Pistoresi: I don't have an exact number available to you today, but from my review of our Tier 3 exception process, it looks like about a third of them are approved for the members who request them. I don't see any differences between different drug classes. The diabetes drug class is about 33% and other classes are similar.

Tim Barclay: If we can look at Slide 42 of the Appendix, I want to make sure I'm reading this correctly. I believe what you're recommending is the first scenario under each of the drug classes, the grandfather with the Tier 2.

Ryan Pistoresi: Yes. If Option 2a was pursued, it would be the top row of each of the different therapeutic classes.

Tim Barclay: So we headed down this path before with the primary goal of savings. We wanted to do it in a responsible way that wouldn't negatively impact people and their care. Yet, I look at this page and three of the four drug classes actually increase costs with the recommended solution. I'm reading this correctly, right?

Ryan Pistoresi: Yes. For the April meeting we prepared 12 different drug classes; but as you'll note from one of the earlier slides, I did not mention some of the classes, so the ophthalmologic drugs, the dermatologic drugs, those ones may not necessarily be recommended for the value formulary because they do increase the plan cost. One of the principles we're looking at with the value formulary is selecting drug classes that can demonstrate drug savings.

Tim Barclay: I think, furthermore, what this exhibit shows is the cost of the grandfathering clause. If you take the first drug class there, it's a difference in 2019 of costing $225,000 versus saving $410,000 by throwing on the broad grandfather clause. If I understand correctly, the purpose of grandfathering, if I'm hearing the presentation correctly, is the equity issue. That's what's driving this grandfather decision, which, again, is curious to me because we created the inequity by trying to do the right thing by allowing people a process by which they could avoid the higher cost-share in a situation where they have no choice but to take the more expensive drug. Now, because we've done a less than adequate job of communicating that to our population to use that exception, we're going to lower the cost for everybody to make it fair. That seems like a curious route that we got to a place where we're now allowing the cost-share on all Tier 3 drugs down to a Tier 2 level.

I guess my question would be, are there better ways to address the equity issue other than cutting cost-share? For example, it seems like we have the ability to analyze data because one of the requirements is that people have tried all these other drugs first. Is there a way to use data to look and see if people are eligible for the exception and notifying them? Can we do a better job of communicating somehow to address the equity issue rather than increasing plan costs in a fairly dramatic way? For me, I'm struggling because we're getting a convergence here of multiple ideas; the value based formulary, the equity issue. These things are all coming together and I feel like we're twisting things up and not necessarily getting to the best place.

Donna Sullivan: I want to address Slide 42. You can look at it by saying Tier 2 would be worst-case scenario. Tier 1 is grandfathering, Tier 2 is the worst-case scenario. No grandfathering at Tier 2 is potentially the best-case scenario. We have to be very cautious when you look at these slides in the model because this model is very sensitive to the number of patients that request an exception. I believe the savings in the third column, there's a huge potential that this could be overstating the savings, dependent on how accurate we were in requests for estimating the number of patients that would request an exception and it be granted. I understand your

plight but it's something that is very difficult to estimate and it differs from drug class to drug class. We have seen certain drug classes where patients will switch their medications and others won't. This model is not set up to go in and individually account for that inelasticity.

The other thing is there are often times where there's a clinical reason to grandfather the patient. I don't want to lose sight of that by saying we're not going to grandfather anybody because if there is someone on an anticonvulsant or antidepressant and they have been on it and doing well, there's a clinical reason why we don't want to ask them to switch their medication and essentially stop their care. There are many different aspects and nuances to grandfathering, when it's a good time to do it and when it's not a good. There are also times when drugs are not preferred but they have a similar cost to the preferred drug. Grandfathering those patients actually increases costs because we are now paying a bigger portion of that drug. There are other times where not grandfathering the number of patients that would request an exception would outweigh the savings we would get by not grandfathering. It's a difficult thing to establish.

Tim Barclay: I appreciate that, Donna. Let me ask you another question because you said something that concerns me. I thought we chose these classes and we're talking about a process of a value based formulary and categorizing drugs in such a way that we really believed that equivalent therapeutic sources were available. You just made the comment that you rattled off several different classes where you'd be very concerned about asking people to switch categories because it could disrupt their care. I would have assumed that those categories you just named weren't even part of this conversation as being part of the value based formulary where we try to push people into an alternative source. I thought that's where we started in this value based formulary conversation - specifically choosing drugs and drug classes where reasonable therapeutic alternatives were readily available.

Donna Sullivan: That is an option. I think what we didn't make clear is that grandfathering can be drug class specific. We don't have to say everybody's grandfathered or nobody's grandfathered. We can make a decision based on each drug class and do that in order to tailor our savings. I wouldn't say let's not put the antipsychotic on the value formulary because we're concerned about people having to switch medications. We will grandfather them, but we have an array of medications, many of them generic. If the provider doesn't know which drug is going to work first, why not start with the least expensive drug and work towards the other medications. Start with the generic drug. If that's not working then switch to the next preferred drug and so on, instead of just going right to the non-preferred drug, which may not work anyway. It's how we're guiding the prescribing utilization.

Sue Birch: Donna, is it fair to say that antidepressants, the psychotherapeutics, and the Parkinson drugs are the three most sensitive? Those three classes?

Donna Sullivan: I would say that antipsychotics and antidepressants. There is not a wide range of drugs for Parkinson’s Disease. Most have brands that are also

generic. I think almost all have generic. There wouldn't be much switching in that particular class.

Tom MacRobert: It seems a lot of this is being driven by this equity issue. Do we have any idea how many people are affected by this?

Ryan Pistoresi: I don't think we have a good idea of the actual number of members who could be eligible for this Tier 3 exception process. We can look and see how many of our members are using Tier 3 drugs who have used the preferred products before compared to the number of members who have not stepped through the preferred products and have stepped to Tier 3 drugs.

Carol Dotlich: My question is about page 42. Are these actual numbers of people affected by these particular conditions or drugs or just an example?

Ryan Pistoresi: These numbers are based on what we have in our model and the number of members are the UMP Medicare only at this point. I did not have the non-Medicare numbers ready for this table. The costs are also Medicare only. The number of members listed are currently utilizing the non-preferred drugs that would be part of the value formulary.

Carol Dotlich: So these numbers are all for non-preferred? And these are all real people?

Ryan Pistoresi: Yes.

Tim Barclay: Just one more minor issue, I think on the draft proposal. On your first bullet point, just a wording thing. You say they'd be covered when medically necessary and all preferred products have been ineffective. Do we really want to put the word "all" in there? I mean it could be of a drug class where there are many, many preferred products and do they really have to try them all before they can move on? You don't have to answer it now. Just a concern about the wording there that, is that what we really mean?

Donna Sullivan: Sorry to interrupt, Ryan, but going back to my point, if you don't have a good reason of why that non-preferred drug is going to work, why wouldn't you try all of the preferred products first? I think it depends on if there a clinical reason where the doctor, instead of having to try all the preferred products, submits a request and says, "Based on these clinical parameters of my patient and this drug, I think this drug's going to work and these others are not." If they don't have that clinical reasoning, I don't see a reason not to try all of the preferred products. Sometimes it's just one or two anyway.

Yvonne Tate: I can give you an example of that. In my particular situation, my nemesis are these doggone statin drugs for cholesterol. I've probably been through four of them and they all give me the same problem: muscle cramps and things like that. I'm finally on my fifth one that isn't giving me that problem, but I had to go

through a bunch of them before I could find one that works. I don't think that's an unusual thing to ask.

Tom MacRobert: On the second page of the policy draft, at the bottom it says "medically necessary and clinically appropriate." It seems to me in a lot of the discussions we've had in different scenarios, at a certain point, there's this appeal process that comes into effect. I'm curious to know who gets to make the decision. The patient and the doctor work together to make a determination as to which drug is most effective and then they write an appeal. Who does that appeal go to and who makes the decision? Is it a doctor? Is it a group of doctors? How is that decision made?

Ryan Pistoresi: Appeals are submitted to Moda Health, our pharmacy third party administrator. They have clinicians review. It is often sent to a pharmacist who then does the review of the patient charts and submitted documentation. They do a review of the medical literature to see what evidence there is to back up this decision, makes a decision, and informs the member.

Tom MacRobert: Was that the one third get approved that you were referring to? Is that about the percentage? So two thirds are not approved and one third are approved?

Ryan Pistoresi: Yes. For the tier exception process, it goes to a pharmacist. From my recollection, about one third of the Tier 3 exceptions are approved about two thirds are not.

Harry Bossi: I asked a similar question last meeting or the one before. My recall was I was told it was a physician that made the determination not a pharmacist. Could we get a clarification on that?

Donna Sullivan: I probably made that answer. I might have misspoken. I'll clarify. I believe it's either a physician or his delegate, which might be a pharmacist. We'll clarify that and bring it back to you.

Carol Dotlich: I just want to be very clear. It's my understanding that under this draft proposal, people who have been taking a drug for a year are grandfathered in on that drug and don't have a higher cost-share.

Ryan Pistoresi: Yes. As the draft proposal is currently written, the members who had been using the drugs under clause three, would be grandfathered at the same cost-share tier as other similar preferred drugs in that class. To that point, if a member is currently using a multi-source brand drug, they would not be grandfathered unless they had tried the generic equivalent and it was ineffective for them, which is to the second clause for the multi-source brand. Or you could look at the fourth clause, which says the grandfather period for brand name drugs ends when a generic equivalent or interchangeable biologic becomes available.

Carol Dotlich: My concern with the older population is change is hard for them and compliance is an issue. If you have someone who's stable on a drug for a long period of time, I would prefer to see them grandfathered no matter what the drug is because if they're out of compliance with their treatment plan, it's a serious issue very quickly for them.

Ryan Pistoresi: Under our proposal, we would always allow that same ingredient to be available to the patient. If the patient was taking a brand name drug, the generic, the same copy of that medication, the only difference being the manufacturer, that same ingredient will always be available to that patient.

Donna Sullivan: I just wanted to let you know, currently our benefit design is when drugs, those off patent and a generic becomes available, it gets moved to Tier 3. We also have mandatory generic substitution rules in our state. Pharmacists are automatically starting to switch to each of these generics once they come out onto the market. That's been going on for decades. The multi-source brand issue is not something new. It's our current policy and we're just saying now that we're not going to cover them as opposed to allowing them to be covered under Tier 3 if the patient chooses to pay the 50%.

Carol Dotlich: I guess I would say to you that for some people, additives, what is mixed in the pill is an issue. It's not just the basic drug but there are other considerations. I'm wondering why if the patient doesn't object to the change, if the patient is given a choice, I think most of the time the patient would choose the less expensive option. I think people should have a choice. In other words, if somebody's been on Abilify, for example, for a long time for a serious condition, I don't think they should be made to change based on somebody's idea that something else will work the same. I think that patient should have a choice in that, a voice in that. I guess what I'm saying to you is, I prefer that people that have been on a drug for a long time be grandfathered. If they're offered options to use a generic and they choose to do that, I think that's great. I think a lot of people would do that. I think there are people, however, who will not do that and will be out of compliance with their treatment as a result of a change like that.

Lou McDermott: Donna, can I throw in two cents? I haven't been a part of all these discussions. Obviously, you've been working with Dave and Sue and going through this process. But one of the things, when I was PEB Director that we were taking into consideration was, to your point about choice and members having that ability. The more choice you have is usually associated with cost. What some of our members are experiencing is because of that choice, because of that open formulary, their costs are going up in terms of premium. The older generation who usually are the retired population, they're the ones who are feeling the pharmaceutical impacts more acutely because it's a larger portion of their premium.

In the younger population, the active population, pharmacy is only one component of the whole mix of expenses. Even if we have an increase trend in pharmacy, it has a more of a minimal impact on the member, but for the retirees, it's more acutely felt. So, yes, it's true that going through some of these processes and changing the

benefit is going to limit some of the choices, but it'll also take some of the pressure off the premium, which we've heard many members say was affecting their ability to take the drugs anyway. They were going every other month. They were skipping medications.

I totally hear you and I do wish that it wasn't so acutely felt in that population, but because the subsidy's been locked in for a long time and we're maximizing the subsidy right now at $168, that's one of the only reasons why we're not going to have another increase. The Legislature, the last time they changed it was 2012, so counting on them to continually increase the subsidy is probably not going to happen. I think folks are trying to pick the sweet spot that allows change to occur with compassion, with understanding that if you really do need to take it, you have tried other things, there's an avenue for you. But at the same time, moving that population over to the most cost effective drug as easily as possible, with good communication and with good science. That's just my two cents, my perspective on why we're trying to recommend this change.

Carol Dotlich: It's interesting to me that since Medicare picks up a lot of the cost for the elder population that our insurance premiums are so high.

Lou McDermott: They don't pick up drugs.

Carol Dotlich: I understand that. I'm talking about, it's interesting to me that our premiums are so high anyway when Medicare picks up a lot of things.

Lou McDermott: Because these premiums are paying for the bulk of the pharmaceuticals. The pharmaceuticals, when you look at cost trends throughout the country, the different sectors, when you look at in-patient, out-patient, all these different areas within medical, you see one trend. When you look at pharmacy, you see another trend. I think, and now I'm reaching a little because I'm trying to remember back, but I believe one of our increases in the specialty pharmacy was in the high 20%. You're having a 20% increase in costs in specialty pharmacy, which was driving the overall pharmacy costs. Less than 1% of all the pills being doled out was specialty. We're seeing massive increases in pharmacy expenditures throughout the country.

Greg Devereux: Ryan, did I take away from the conversation when we were discussing 42 through 44, I think, that some of these therapeutic classes would not be considered? Like the antidepressants and --

Sue Birch: Antipsychotics.

Greg Devereux: Yes, they might come off?

Ryan Pistoresi: Yes, we just wanted to present to you a different mix of drug classes to show you that there is a lot of variation between the number of members impacted and the amount of cost avoidance we would see over the years, depending on these different scenarios.

In our January meeting, we shared a set of ten drug classes. The Board Members were curious about what individual drug classes look like? We created this table to show you what some of the differences could be for these different drug classes. For example, the ophthalmologic drug class, you can see it has a very high, in fact, of these drug classes, it has the highest amount of members impacted. The cost avoidance may not necessarily be the highest. We would not necessarily pursue this one for the value formulary for 2019. This shows there is diversity within the different drug classes.

Sue Birch: That was my question. Of the classes we're looking at, which one is there the most sensitivity to?

Greg Devereux: No, I remember that, but I guess what makes me nervous is are we voting at the next meeting on a recommendation?

Lou McDermott: No. I think the next meeting a proposal will come before the Board, but I believe the vote for the pharmacy benefit is scheduled for June 20.

Greg Devereux: Okay because I would really want to know what therapeutic classes we're talking about. I believe, Ryan, you said these charts covered Medicare only currently.

Ryan Pistoresi: That is correct.

Greg Devereux: And if there's any way to get non-Medicare by the next meeting, that would be great. I'd love to see the impact.

Sue Birch: Again, the point was to have these ongoing tutorial sessions because it's a lot for us to take in and to be able to ask questions so staff could go back and refine the information. We're coming along, but great questions.

Greg Devereux: I appreciate that tremendously.

Tim Barclay: One other request for information, if you could. We talked earlier about copay coupons. I would be interested to know what drug classes are where that's a prevalent issue; and in particular, which drugs are doing that and how you are thinking of classifying those drugs. That may play a role in how we respond and what we do in terms of how that behavior is taking place.

Ryan Pistoresi: Unfortunately, we aren't able to quantify the copay coupon issue within our population because what we see in our pharmacy claims data is the first amount that we bill. We don't see whether the members are paying out of pocket for these drugs or using copay coupons. We are unable to capture that information. If we are able to quantify that issue for UMP, we'd probably be looking at what we see nationally in terms of copay coupon use.

Lou McDermott: I think what Tim's getting at is understanding which drugs have the copay opportunity, not necessarily who's taking it or not because we don't have access to that.

Donna Sullivan: Lou, I think you can assume that any brand name drug has a copay coupon. It's pretty much our experience from Arden that they've told us almost all of the brand name drugs have copay coupons, even a multi-source brand.

Public Comment

Fred Yancey: I represent Washington State School of Retirees Association. First of all, let me tell you, this is all new to me and not easily understood. If I say something that is incorrect then it's out of ignorance not fake news.

The rate sheet you were presented with at the very first, showing the subsidy, I didn't understand because the figures don't add up to what the rates retirees pay for insurance for Medicare. I'm not sure what the point of that is. As an example, if you're a subscriber and a spouse, and you have one Medicare eligible person and you're in UMP Classic, you pay $986 a month for insurance. Now, you can subtract $168 from that and you're still out of pocket a lot. I'm not sure that chart kind of implies you're only paying $300-something. I'm just not sure what the chart was trying to show.

Sue Birch: It's for a single subscriber, so one person only.

Fred Yancey: Well, see, that rate would be $333, which is in a $400 figure on the far right. So I'm still -- you understand my confusion? I just don't understand the connection.

Yvonne Tate: I was going to say, now, you know, Medicare is an actual variable rate. How much Medicare charges you depends on your income. So different people pay different amounts for Medicare.

Fred Yancey: Right. No question. I was just looking at the amount you pay for the UMP Classic through the PEBB Program.

Tanya Deuel: The $333 for UMP Classic is before the subsidy. So this amount plus $150 is the 2018 total rate. So $483. Yes.

Fred Yancey: Gotcha. Yet this would be $428. This would be $278, $378, $420. So, you understand what I'm saying? If you add these two, they should --

Tanya Deuel: This is only 2018. So this, $328 plus $150 --

Fred Yancey: Right. Is $478.

Tanya Deuel: Correct and that's the total amount.

Fred Yancey: But do you understand my confusion? I understand that this chart says $478, this one says $333.

Tanya Deuel: Because this is the portion published on this chart.

Fred Yancey: So this should be $333.

Tanya Deuel: There's approximately a $5 admin fee.

Fred Yancey: Okay, that's the difference. So the difference in that cost would be admin. Thank you.

I'm not sure what “medical necessity and clinically appropriate” means. When I go to my doctor, my doctor gives me a prescription. I'm not sure he knows what's medically -- what those terms would mean. He knows I could be cynical, he knows what salesman has been in to see him. He knows what is the general prescription, sort of, that is given for various diseases. But everything depends on a determination on what medical necessity is and clinical appropriate. If I understood it correctly, it's unclear that determination, should you appeal it, is either by a doctor, a pharmacist, or a delegate. I think it was by a nurse in my case, you know, that made a determination once, and I appealed and I requested a physician examine it. What I found is when you appeal, squeaky wheel gets the grease, basically, is what I've found. A physician did review it and approved it because what I keep going in my mind is, you know, these people need these medications because they're ill. While you're ill, we want you to try a variety of medications or we want you to do the paperwork and the appeal process and the note gathering, if you will, to get the medication you need. I don't have an answer for it but I just keep the picture in my mind that I'm not seeing. We're talking rates and savings and so forth but I'm not seeing the sick person here.

When you save a premium, you save a $2.00 premium a month by shifting my out-of-pocket cost in excess of that $2.50, that may be a savings to PEBB but it's not a savings to the consumer or the retiree.

A third, I would really like to see more research done as to why people are turned down. If I was told that I only stood a 33% chance of winning a court case, I'd never go to court. So why is that and why are 66%, roughly, turned down? That's really all I have. I'm here only as a number of you are to speak for retirees, who had a 50-some odd dollar increase in their Uniform rates that barely got -- didn't even cover the inflation since it was frozen in 2011 at $150. Thank you for your time.

Yvonne Tate: I just wanted to say on this issue of what's medically necessary. I think we can all agree we don't want administrators making that decision because they're not providers. What they've done is contracted with this pharmacy benefit company that uses providers to make that decision. But I think the very difficult decision to make, and I think you rightly pointed out, maybe the physician is making that representation based on being influenced by something else. It's kind of an interplay between the member's physician and the medical staff that we've contracted

with to try to make that decision. To me, it's always going to be a difficult decision to make, unfortunately.

Tom MacRobert: Yes, that brings up a question that I would like to see answered. We've determined that approximately 67% of these appeals are rejected. I'd like to know, if we get information as to why these appeals are rejected, what is the basis of the rejections? Do we have any knowledge of that or does only the individual consumer who makes the appeal find out? Do we have a way of knowing that? I'd like to know.

Sue Birch: So we will task staff to come back with that information at our future meetings. I'm certain there'll be some information available.

Carol Dotlich: I would like to comment that I hear what our person who testified said. I just wanted to add that I have a real concern for all the members that I represent that would not begin to appeal anything because they simply can't. I don't know how you address those people because I know people who are in my group who are very caring people who cannot see. They don't file appeals. They ask the neighbor to read stuff to them. They don't write anything and there are a number of people like that, people who are in a nursing home. They're not able. To change their meds, to require them to appeal things to stay on meds they've already been on, at their age, I think is cruel. I'm just very concerned about the impact on those real people who are living at the end of their lives. I have real heart for that and I hope our Board will too.

Sue Birch: Carol, thank you for your comments. I do just want to comment as a nurse that oftentimes, the team of health providers that are involved will work with the client to get through an appeal process, especially like, Yvonne, if we can use your example, when they are really trying to get the best response from the drugs, they work with the clients. It's not just a go figure this out on your own. I do just want to represent that there's a lot of caring health professionals that assist with the appeal processes, but thank you for your comments and I think we all take that to heart.

The next meeting is June 7, from 1:30 p.m. to 4 p.m. We will meet in Executive Session at noon.

Preview of June 7, 2018 SEB Board Meeting

Lou McDermott: We will answer non-pharmacy related questions asked by the Board. We'll continue to refine the resolution on the value based pharmacy formulary and present other benefit changes for Board review that are being proposed by our fully insured products.

Sue Birch: Meeting adjourned 3:15 p.m.