

Public Employees Benefits Board
Meeting Minutes

March 20, 2019
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 3:30 p.m.

Members Present:

Sue Birch
Tom MacRobert
Yvonne Tate
Greg Devereux

Members via Phone:

Tim Barclay
Harry Bossi

Members Absent:

Carol Dotlich
Myra Johnson

PEB Board Counsel:

Michael Tunick, Assistant Attorney General

Call to Order

Sue Birch, Chair, called the meeting to order at 1:34 p.m. Sufficient members were present to allow a quorum. Audience and board self-introductions followed.

Meeting Overview

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

Approval of July 25, 2018 PEB Board Minutes

Sue Birch: Greg Devereux moved and Tom MacRobert seconded a motion to approve the July 25, 2018 PEB Board Meeting Minutes. Minutes approved by unanimous vote as written.

Approval of September 17, 2018 Combined PEBB/SEBB Minutes

Sue Birch: Greg Devereux moved and Tom MacRobert seconded a motion to approve the September 17, 2018 Combined PEBB/SEBB Minutes. Minutes approved by unanimous vote as written.

Approval of September 17, 2018 PEB Board Meeting Minutes

Sue Birch: Tom MacRobert moved and Greg Devereux seconded a motion to approve the September 17, 2018 PEB Board Meeting Minutes. Minutes approved by unanimous vote as written.

Approval of January 31, 2019 PEB Board Retreat Minutes

Dave Iseminger: Typically, we haven't prepared minutes for the retreat because it's more educational. But at the advice of PEB Board Counsel, we put together a very high overview, which we believe would meet the requirements of the Open Public Meetings Act. There is also a link to the Briefing Book on the PEBB website.

For most meeting minutes, we do a full verbatim recording, pare them down, and bring those to you. That's above and beyond what's required under the OPMA. We think it's good for the record but we wanted to thread the needle between the more informal nature of the Retreat that's held, while still limiting risk related to the OPMA. That's why the minutes for the Retreat are a little different than you've had in the past.

Sue Birch: Yvonne Tate moved and Greg Devereux seconded a motion to approve the January 31, 2019 PEB Board Retreat Minutes. Minutes approved by unanimous vote as written.

Legislative Update

Cade Walker, Executive Special Assistant for Employees and Retirees Benefits Division. Slide 2 – Number of Bills Analyzed by ERB Division. As of today, we have performed analyses on 256 bills, which includes their substitutes, engrossed substitutes, second engrossed substitutes, and all the variations on those particular topics. We have conducted approximately 100 lead analyses where our Division took the lead responsibility for analyzing the bill, collecting input from other divisions that may have impacts, and providing the consolidated review for our legislative staff and liaisons within the agency. We've also done approximately 140 support analyses where we provide input. The grand total, as of last week was 241, and 256 analyses have been performed as of this morning.

For clarification, the HCA designates bills as either having high impact or low impact. It's high impact if it has a monetary impact over \$50,000, or if it has an impact on our rules that would require us to undergo the rule-writing process. A low impact designation doesn't have either of those.

Slide 3 – Legislative Update – ERB High Lead Bills, is a snapshot of where these bills are in the legislative process. Approximately 33 of the high priority bills that we've reviewed as the lead analyst are still in their original chamber, 17 are in the fiscal chamber, and 9 are in the rules or on the floor. There are approximately 7 bills in the opposite chamber of where the bill was introduced in a committee. As of this morning, two bills were in the opposite chamber related to fiscal. We're tracking those closer than the remainder of the bills we're following.

Slide 4 – PEBB Program Impact Bills. The bills identified here are the ones we wanted to call out for your specific attention today. Starting with House Bill 1085 and its companion bill, Senate Bill 5469, is concerning the premium reduction for Medicare-eligible retiree participants in the Public Employees Benefits Board Program.

Similar bills are House Bill 1414 and Senate Bill 5335, paying state retirement benefits until the end of the month in which the retiree or beneficiary dies. These are both stalled in the committee and their original house of origin. That doesn't mean they're completely dead for the session, but that's where they are currently.

House Bill 1220 and Senate Bill 5275 add a non-voting representative from the Office of the Insurance Commissioner to the PEB Board. House Bill 1220 has moved to the Senate and is being heard in the Senate State Government Tribal Relations and Elections Committee.

Greg Devereux: Is that the first committee it's been heard in, in the Senate?

Cade Walker: Yes, in the Senate.

Dave Iseminger: Just to clarify, the Senate companion had its hearings and went through policy and fiscal committees. It just didn't make it to a floor vote. The companion bill had hearings, but this is the first hearing on the house version.

Cade Walker: Correct. My comments were in regards to House Bill 1220. The Senate bill had not moved out of the Senate. The House bill has moved to the Senate now.

Slide 5 – SEBB Program Impact Bills. We are tracking House Bill 1547 and other bills related to educational funding for the SEBB Program. House Bill 1547 relates to the levy lid, but it has stalled in committee, although we do anticipate there may be additional legislation that comes related to educational funding, and levies, etc. during this session.

House Bill 2096 concerns educational service district health benefits. It would allow a delay in the participation of non-represented employees of the educational service districts, while the represented employees would remain in the SEBB Program. That bill has stalled in committee.

Dave Iseminger: There are about five ESDs who contract with the Health Care Authority and participate in PEBB benefits. The way HB 2096 was written, those people would not have been able to continue in the PEBB Program either. We believe that was not the intent of the legislation and we've provided technical assistance about how to ensure continued access to PEBB benefits. But, before any amendments or anything were introduced, the cutoff period happened and the bill is still sitting in committee. We have given the Legislature and sponsor advice and technical assistance about how to reestablish the ability to continue on the PEBB Program if this idea gains further traction.

Tom MacRobert: I do have one question about HB 1547. Is that an attempt to address the shortfall that school districts are experiencing for next year? Is that the intent?

Cade Walker: I'd say that's a fair generalization of what the bill was attempting to do.

Greg Devereux: Going back to Senate Bill 5275, what you and Dave said earlier, does that mean they're using HB 1220 as the vehicle and they're not moving SB 5275?

Cade Walker: From best I can tell, that appears to be the case, yes.

Slide 6 – ERB Impact Bills. These bills seem to have impacts on both the PEBB and SEBB Programs, starting with House Bill 1065 and its companion Senate Bill 5031, protecting consumers from charges for out-of-network health care services. This topic that has been brought up in the Legislature for the last several years and it does seem to have legs with it as the nomenclature goes. HB 1065 has moved from the House and is being heard in the Senate Health and Long-Term Care Committee today. This bill is related to out-of-network billing, balance billing. It's a consumer protection bill largely.

House Bill 1074 and its companion Senate Bill 5057, is protecting youth from tobacco products and vapor products by increasing the minimum legal age of sale of tobacco and vapor products. This bill raises the age to purchase tobacco products from 18 years of age to 21 years of age. HCA supports this bill. House Bill 1873 and Senate Bill 5986 also relate to vapor products, vapor tobacco products, or vapor nicotine products. We're also tracking those as it may have implications on the tobacco surcharge. You may be hearing more about these bills should they continue to move in their respective houses.

Dave Iseminger: As a reminder, for the tobacco surcharge, the definition of tobacco products passed by the Board and the implemented several years ago does not include vapor products or e-cigarettes. We've been monitoring developments from the FDA and regulatory authority to how the state is treating vapor and e-cigarettes. We constantly watch these bills to determine if we've reached the point we need to discuss with the Board about amending the definition of tobacco products.

Cade Walker: House Bill 1523 and Senate Bill 5526, increase the availability of quality affordable health coverage in the individual market. This is the Cascade Care Bill sponsored, or pushed for, by the Governor's Office, as well as Representative Cody. It has a hearing today in the Senate. We're watching it closely as HCA has a significant role in that bill. Related to that is Senate Bill 5882, which requires HCA to form a work group to study establishing a universal health care system for the state.

Senate Bill 5889 concerns insurance communications confidentiality. This bill will provide additional protections and requirements on carriers related to communications with the dependents covered by a plan, making sure communications are made directly with those individuals over the age of 13, including up to the age of 26, for children who are on their parents' insurance plans. Just clarifying and providing additional protections and privacy for those individuals.

House Bill 1099, requires carriers to post their contracted mental health and substance use disorder providers, whether they're accepting new patients, and to report on their network access on their website. We're watching this bill closely.

Side 7 – ERB Topical Bills. Topical areas of bills pop up every year and we continue to watch. Senate Bill 5602 relates to reproductive health, which is currently in the opposite house committee, related to eliminating barriers to reproductive health for all. There is a slate of pharmacy bills we're tracking, listed here with brief descriptions.

Dave Iseminger: When we come back in April, the list of bills will be much less. We'll make sure for any of these bills that have made it through the process by our April meeting, we'll go into their detail. But the names generally speak for themselves.

That was the policy piece. There aren't any slides about funding. I didn't ask finance to come because there's not much to talk about. The proposed budgets from the Senate and the House don't come out until next week. At the April meeting, we will bring the Board information about what the funding rate is and what we believe are the implications of that funding rate. We'll tee up and compare what was in the Governor's budget versus what was in the House budget and Senate budget. We will be able to describe the financial impacts of it.

UMP Pharmacy Update

Marcia Peterson, Manager, Benefits Strategy and Design Section.

Ryan Pistorosi, HCA Assistant Chief Pharmacy Officer.

Marcia Peterson: Today I'll follow up from the discussion we had at the PEB Board Retreat about the pharmacy benefit and reintroduce the value formulary proposal from last year. We made a few changes based Board feedback. We feel the revised version offers a simplified, member friendly benefit, addresses the equity issue where two members could end up paying different out-of-pocket costs for the same drug depending on their understanding of the exception process. We'll hopefully provide premium protection should we continue to see the extreme volatility in drug pricing that we've seen in recent years.

Slide 2 – Themes from the Retreat. We discussed waste in health care, which was defined as non-evidence-based practices; we learned when you include both medical and pharmacy benefits based on this methodology, there is estimated to be \$236 million in waste in commercial plans in Washington State, and that's just the tip of the iceberg.

One example given of non-evidence-based care categorized as waste from Nancy Giunto's presentation was for routine eye imaging in the absence of significant eye disease. It turns out less than 4% of patients who received routine eye imaging had a diagnosis of diabetes per Nancy's *First, Do No Harm* Report. It is available on the Washington Health Alliance website and I'd encourage you to take a look at it. It goes into great detail on this topic.

Dave Iseminger: We will follow up with a message from Connie that gives you a copy of the report or the link.

Marcia Peterson: Secondly, the Board had a lively interaction with our panel of physicians. There were a lot of questions last year about the role of the physician and the pharmacist related to the value formulary. We brought in practicing physicians to talk about how they deal with drug formularies. There were a couple of themes that came out of that discussion, including the use of generics. And we learned that, it turns out, situations where the patient feels like they need to be on the non-formulary drug are actually very rare. Also, if there's a generic drug, the provider will normally prescribe it. Providers are interested in helping their patients save money. It helps with medication adherence. And, finally, patients are almost always willing to try shifting to generics. It

was interesting to me, the physicians said they rarely have a patient come in and insist on being able to use a non-formulary drug just because they've seen it advertised on TV, which makes me wonder if the pharmacy companies know what they're doing in terms of all that advertising if it's not actually working.

Slide 3. The third theme had to do with the formulary transparency. We learned that physicians are frustrated by what they call the "fax wars" that can happen when a patient is prescribed a drug that's not on their formulary, they show up at the pharmacy, and there can be confusion as the pharmacist faxes the doctor the request for the different drug and the physician faxes back. We learned it would be helpful if patients and doctors had easy access to the formulary, like a tool to view the preferred drug lists. The link on this slide is to that tool that exists on the UMP website.

Finally, one of the takeaways was very interesting. It was considerably less complicated for those physicians in the Kaiser plans, at least the staff model, to deal with formularies since they've had them forever and tend to have the same formulary overall.

Slide 4 shows the web page where you can find the UMP preferred drug list. It's easy to find if you Google it. I Googled UMP preferred drug list. Nevertheless, we do realize that it can be a bit buried so we're working on where it's located and on communicating it more widely. When you click on UMP preferred drug list, it takes you to a page where you can type in the name of the drug, it brings up results on the drug, including if it's covered by the plan, the tier, if it requires a preauthorization, and if there's a less expensive drug alternative available. You can also print the entire drug list. Changes to the list are posted online at least once a month. Circled at the bottom of Slide 4 is the link to the prescription price-check tool if you want to know how much your drug will cost and where you can get it the cheapest, for instance.

I actually spent a fair amount of time on this site as I researched examples for this presentation and I actually found it pretty easy to use. I do agree it would be very cool if it could be accessible for my phone in an easy way while I'm sitting in my doctor's office discussing what drug she's going to prescribe for me. We've given that feedback to MODA and hopefully that will be on their roadmap for the future.

Slide 5 – UMP Exceptions for Tier 3 Drugs. We wanted to follow up on questions the Board had about the exceptions for Tier 3 drugs and what's included in that 70% denial of requests. As you recall, the members can request an exception to pay at the Tier 2 copay for a Tier 3 drug. In the last quarter of 2018, we said 70% of those requests were denied. That 70% includes people who haven't gone through the exception process. They were denied for that reason. It also includes people currently in the process of trying those drugs. That's how it's counted. Is that helpful?

Greg Devereux: Do we know how many have tried the lower cost alternatives and then been denied, what percentage?

Ryan Pistorosi: There should not be anyone who tries the lower cost alternatives, finds out it doesn't work for them, and not get approved. That's what this process is for. These 70% are people requesting it too early in the process. We tell them, "If you do

need this medication, we need you to try this other lower cost alternative first. If that medication doesn't work for you, then you can come back and the exception request should be approved." We do have that communication in there and that's why that 70% is so high. People are coming in maybe one or two steps too early in that process.

Dave Iseminger: Ryan, I think I heard you say, essentially, if an individual tries the lower alternative, it doesn't work, and asks for the exception, you're not aware of any denials in that scenario.

Ryan Pistori: Yes. We do get a report from MODA each quarter that shows us documentation of how drugs are approved. We use that as feedback to move drugs off of prior authorization or change the tier if there's a lot of requests for these drugs. But, to my knowledge, I have not seen anywhere they've tried the lower cost alternative and then it was denied.

Marcia Peterson: Slide 6 – UMP Exceptions for Tier 3 Drugs. In 2018, 469 members requested the Tier 2 cost share. 126 of those went through the exception process, were approved, and they paid the lower cost share. 337 requested the lower cost share but haven't actually gone through the process, so they haven't tried the lower cost alternatives, which is why they received the denial.

MODA believes this percentage will go down further since one or two of the main drugs that were in the exception process, in Tier 3, have been moved to Tier 2. On the other hand, there are other drugs coming along all the time.

Sue Birch: Marcia, do we have an approximate cost for what these exceptions range from? By denying these and referring down to the lower cost drug, what does that save the client, us? Do we have a range of that?

Ryan Pistori: There is not a number off the top of my head. We could do an analysis to see what the behavior was of the members who did request this change. Did they continue to take the Tier 3 drug and pay the Tier 3 copay or did they actually switch and try a lower cost alternative, and then follow them from there.

Marcia Peterson: I don't know the overall cost but one of the examples used later in this presentation may shed some light. I looked at Lyrica, which is used for nerve pain, particularly around fibromyalgia. If I'm remembering correctly, that cost for our members is \$242 out of pocket. It's a Tier 3 drug. The generic alternative is Gabapentin at \$1.83 out of pocket. Both for a 30-day supply. That gives you an example of the magnitude of cost for a very common drug. A lot of those exceptions I noted were for Lyrica. Is that right?

Ryan Pistori: Yes.

Marcia Peterson: Slide 7 – Uniform Medical Plan Proposed Value Formulary. With UMP, we currently have an open formulary under which all drugs, including low value, high-cost drugs are covered at different cost shares. I want to revisit the value aspect of that. When we use the term "value," we are referring to the fact drugs that have the same or similar level of effectiveness as lower cost drugs that are higher cost are not

included in the formulary. It's a very basic concept. Access to medicines equally effective but more costly than therapeutic alternatives are not covered in the value formulary.

For our members, it means access to medicines in every covered therapeutic class, the possibility for lower out-of-pocket costs at the pharmacy, and an exception process for non-formulary that is non-covered drugs, if they're determined to be medically necessary by the member's physician and the plan. What we're talking about is no longer covering Tier 3 drugs. Those would no longer be on the formulary. Members could still get them if they want to pay full price or they can go through the exception process for medically necessary. They would be covered at that lower out-of-pocket cost.

Ryan Pistorresi: To describe it similar to what we just talked about with the Tier 3 exception process, there is a process in place for these patients to access Tier 3 drugs. They have to try the lower cost alternatives. If they don't work, they can then request the Tier 3 drug, have it approved, and see if that drug works.

Greg Devereux: I guess I'm confused. I just heard there won't be Tier 3 anymore.

Marcia Peterson: Correct. Off-formulary. Tier 3 is just off-formulary, not included in the formulary. There's a process to go through should the alternatives not work for you.

Greg Devereux: So, we won't be referring to Tier 3 at all. It'll just be something else that's not covered.

Marcia Peterson: Exactly.

Dave Iseminger: It's an exception that's now covered. From the member perspective right now, we describe Preventive, Value, Tier 1, Tier 2, Tier 3. In the future state, it would be Preventive, Value, Tier 1, Tier 2. If a Tier 2 drug doesn't work for you, here's a process by which you might get another, otherwise, not covered drug. From that standpoint, it's simplifying the formulary to describe only four tiers, and then you go into the exception process rather than five tiers and how you go through the exception process to step down to Tier 2.

Greg Devereux: If you applied for the exception, you would get it at the Tier 2 level price, if you met the exception.

Ryan Pistorresi: Correct. Since we are taking away Tier 3, whenever they get an approval, they'll pay it at the Tier 2 cost share similar to that Tier 3 exception process.

Greg Devereux: Has any other state done this?

Ryan Pistorresi: Oregon's Public Employees Program and their school employees program, OEBC, moved to these value formularies in the last couple years. They have some experience; and MODA, who is our pharmacy services administrator, services those communities as well. We've been able to work with MODA and learn about the experience, learn about the transition process. We received a lot of feedback from

them about how we may want to apply this process to our state. We do have some examples. MODA, in a recent call with them earlier this week, told us about some of the exception processes as we're trying to detail in today's presentation and give us some ideas about how that transition could occur for both our PEBB and potentially SEBB populations.

Greg Devereux: I'm not asking for it today, but I would like to know some of the lessons learned that MODA passes on from the Oregon experience.

Marcia Peterson: Slide 8 walks through what the member experience is, should the Board approve this formulary approach. We went through this at the retreat. In the first example, we're starting with a member who has been notified the drug she's already using, which was previously covered, is no longer on the formulary. She's been using Lyrica. It's now a non-covered drug.

Tom MacRobert: Is Lyrica a good example of a drug that that could apply to? It is? Okay.

Ryan Pistorresi: Yes. The reason we're using Lyrica is because it's one we've noticed has the most amount of Tier 3 exceptions. We thought this would be a good example to walk through today because that's one where a lot of members who might qualify for it would appreciate the Tier 2 cost share.

Tom MacRobert: Just so I'm clear in my understanding, so I've been taking Lyrica now for ten years and I'm now suddenly receiving notification that it's no longer going to be covered from there?

Dave Iseminger: Tom, that's this exact scenario. A member who's previously covered drug is now non-formulary. Somebody who's on the drug right now, this resolution is passed, and in a future state, they're told non-formulary.

Marcia Peterson: That member would need to use the generic alternative, Gabapentin. Remember the difference in price: Gabapentin, \$1.83; Lyrica, around \$238. This is not one of the refill projected drug classes. Unless this member has already gone through the exception process and been approved, she has three choices. She can either continue using Lyrica, pay out-of-pocket 100%, it's non-covered. Or she can go through the exception process, which involves using Gabapentin, the covered drug. Gabapentin is a generic alternative.

Ryan Pistorresi: A generic alternative is not necessarily a generic version of the same drug, but it is a generic version within the same drug class. Both Lyrica and Gabapentin can treat neuropathic pain conditions. It's just they have slightly different chemical formulations, but they both work on the same proteins and in the same pathways in the body. For this example, Gabapentin is a generic alternative and one of the lower tier drugs required prior to getting the tier exception approval. Currently, when these members are requesting Tier 3 exceptions for Lyrica, we check to see if they tried Gabapentin, have they tried Duloxetine. And if they've had both, great. We approve them for a Tier 2 cost share and they don't necessarily have to go through this process with the value formulary. But, for example, if the member has not used either the

Gabapentin or the Duloxetine, then we request, "There are these lower cost alternatives. Would you be able to try these and see if they manage your neuropathic pain?"

Sue Birch: I'm going to take that one step further. The client chooses to try the lower cost ones. If it was a drug that wasn't successfully treating their condition, and the doctor made the decision to put them back to Lyrica, it's fair to represent they would likely be approved.

Marcia Peterson: Yes. That's the box on the left, "Approved. They can continue using the non-formulary drug and pay that Tier 2 copay."

Ryan Pistori: Yes. They previously were paying Tier 3 prior to the value formulary. Now they go through this process and they automatically get put into Tier 2. It helps solve the equity issue where we have some members who know about the Tier 3 process and do qualify and some members that don't know about the Tier 3 process and could qualify and save on the out-of-pocket expense every month.

Tom MacRobert: Lyrica is no longer approved. You go to the generics. How many generics are there? That's question number one.

Ryan Pistori: For Lyrica, there are two generic alternatives that treat neuropathic pain. One of them is Gabapentin and the other is Duloxetine.

Tom MacRobert: Okay, and when you were talking about Gabapentin, you said that it is not exactly the same as Lyrica, that there are some differences in it. And I'm assuming that those differences could produce some side effects that might not be the same as the Lyrica side effects. Is that correct?

Ryan Pistori: That is correct. If someone goes from Pregabalin to Gabapentin and they have some drowsiness or some other symptoms, that would then qualify for the drug not working. You don't necessarily have to take it for a month or two months or three months. Once you start getting that adverse event or realize that drug is no longer tolerable, that drug is no longer an option. They may switch to Duloxetine next. It works on a different mechanism than the Lyrica or the Gabapentin. If that is able to treat the neuropathic pain, go forward with that. But if neither of those work, they meet the criteria that Lyrica is the only one of the medications that could treat that neuropathic pain. We do want to provide access to that medication and at an affordable cost share and not at the Tier 3 cost share, which is 50% of the drug.

Dave Iseminger: Ryan, would a member have to try one or both in order to essentially go through and receive the Tier 2 exception?

Ryan Pistori: For this example, yes.

Dave Iseminger: Those two drugs on the formulary are because they are shown to be clinically effective to most people. And that's partly why it's balancing that interest of what's clinically effective also with cost.

Ryan Pistorresi: Correct. Those two drugs have been around longer. In fact, they're both generics. They do have extensive studies to show they are able to treat neuropathic pain. But some patients may respond, some patients may not. Some patients may have side effects, others may not. But these drugs, to Marcia's point, are a couple dollars versus several hundred dollars. If they both can treat the neuropathic pain for the patients, we would prefer they take the one that is less expensive, both for the member and for the plan. But if it doesn't work, we do want to continue to provide access to these drugs that do work and we do have this process in place that would allow them to get it while also reducing that cost share to them, instead of that Tier 3 cost share, to that Tier 2 cost share.

Dave Iseminger: It's safe to say that with the pharmacy cost containment issue that everyone is grappling with all over the country, it's in everyone's interest for many reasons, if it's a clinically effective drug that's low cost, for a member to be on that drug. That helps the plan payments but it also helps drive the premium costs, which directly impacts the members themselves, too. There are two points, two financial considerations from the member perspective. There's the point of sale, a \$1.82 versus \$240-ish dollars. But there's also the overall cost to the plan, which then bears into the employee premium contributions as well. It's a fair representation in all the conversations I've had with most people that, if it's a clinically effective drug that also happens to be cheap, why wouldn't we want somebody on that drug?

Marcia Peterson: Slide 9 is another example. Now, we have a member who goes to see his doctor and he's newly prescribed Lyrica for the first time. He gets to the pharmacy and the pharmacist says that, "Lyrica is not on your formulary. It's not covered but Gabapentin, the generic alternative, is." This is where you remember the physician panel says this doesn't happen very often because normally, the physician won't prescribe you something that's not on your formulary. But, it happens. Maybe the member has some reason why he wants to use Lyrica, decides to go through the exception process.

Now his physician is working with his plan and the pharmacist to determine if there is medical necessity for him to use this non-formulary drug. It's likely that he'll need to try those lower cost alternatives first to see if they work. There's a good chance they will. If he's approved, he can use Lyrica, the non-formulary drug, if there's medical necessity, pay that lower copay. If he's not approved, he can use the non-formulary drug, but pay 100% of the cost. It's not that he can't use it at all, but it's cost prohibitive for some people.

Slide 10 – Refill Protected Drug Classes. This slide lists the refill protected drug classes. If a formulary changed to exclude a drug in one of these classes, like the first example where the woman is already on it, she would not be required to switch to the formulary drug unless it's a generic drug. That's by state law, correct?

Ryan Pistorresi: For clarification, this is written into the Washington Pharmacy & Therapeutics (P&T) Committee process. When the Washington P&T Committee reviews these drug classes, they're not subject to therapeutic interchange, which means the pharmacist can't automatically substitute someone who's been on these drugs to a preferred drug on the Washington preferred drug list. We're trying to capture if

someone is on an anti-retroviral, we won't necessarily direct them to switch to another anti-retroviral. We'll allow them to continue on therapy. Or if they're on an anti-psychotic, we're not necessarily going to change their anti-psychotic.

Tom MacRobert: I'm making sure I'm understanding correctly. They are on a Tier 3 drug and they get to remain on that drug. Anyone that's in this list of seven categories, if they are on that drug to begin with, they will not be asked to switch to a Tier 2 drug.

Ryan Pistorosi: We will talk more about how this is applied in the value formulary once we get to the draft proposal, which is next. But, yes, if these patients are on the Tier 3 version of a drug in these drug classes, which are now non-formulary, they can continue on it and pay at the Tier 2 cost share.

Dave Iseminger: Not only would they not be required to try an alternative, if they were paying the Tier 3 copay now be reduced to Tier 2. They would not have to change drugs and they would get the lower cost share.

There is this nuance I want to hammer home. If at some point a generic drug, which has a definition of the exact same dosage, the exact same intended use, the same side effects, is chemically the same, is truly a generic and not an alternative, has a different mechanism, state law already requires a conversion to the generic drug. In that instance, the person would be moved from their drug that's in one of these seven classifications to the true generic identical equivalent that is cheaper because state law requires that. Where there's not a generic, we're saying the therapeutic alternative that's slightly the same, but not really the same, and it works a little bit differently, those people would not be forced to try a therapeutic alternative. Instead, they would remain on their drug at the Tier 2 copay.

Greg Devereux: Ryan, a moment ago, you said not necessarily have to change. I assume the only instance is what Dave just said.

Ryan Pistorosi: Yes. There is no other requirement. If they are in a refill protected drug class, the only time that they would change is if a generic version of that drug becomes available.

Marcia Peterson: Slide 11 – Proposed Policy Resolution PEBB 2019-01 Value Formulary. The language in this resolution has changed slightly. The original resolution from last year is in the Appendix if you want to compare.

We tried to align the language to the proposed resolution with those flow diagrams that you just saw. Beginning January 1, 2020, contingent upon approval of a the value formulary resolution by both the PEB Board and SEB Board, all UMP plans require the use of a value-based formulary, and:

- Non-formulary drugs are covered only when medically necessary and all formulary drugs were ineffective or are not clinically appropriate for the member, and
- Multi-source brand-name drugs, including those in refill protected classes, are covered only when medically necessary and all formulary drugs have been ineffective or are clinically inappropriate for that member, and

- Members who have been taking a non-formulary drug are required to switch to the formulary drug, unless:
 - they receive or have already gone through the exception process and been approved, or
 - their drug is within one of the refill protected drug classes which includes: antipsychotics, antidepressants, antiepileptics, chemotherapy, antiretrovirals, immunosuppressives, and immunomodulatory/antiviral treatment for Hepatitis C.

Slide 13. If you're comfortable and there are no substantial changes you want to make to the proposed resolution, you can take action in April, in May, but no later than the June 5 Board Meeting if it's going to go into effect January 1, 2020.

Dave Iseminger: Briefly, I want to describe the process that we're going through with the SEB Board. We have a meeting between both Boards every two-ish weeks. The PEB Board has had a year or two-year of conversation about the value formulary. We started the journey. We've been doing pharmacy 101 education with the SEB Board for the last several months and moving onto presenting a similar value formulary presentation to the SEB Board in early April. Ideally, the PEB Board would act first because it's had the longer multi-year conversations. This PEB Board would inform the SEB Board as to what this Board's view is on this policy proposal and that might help inform their decision.

We initially presented the value formulary to them last year. They were interested in hearing what this Board thought because this Board has been talking about pharmacy much longer than they had. We've teed it up so their resolution Slide 13 says that the SEB Board will need to take action no later than June 12, the very next week. That way it's staggered so you both are getting information along the way and learning what the other one's asking. Any questions that one Board asks, we'll give that insight to the other Board at its next subsequent meeting.

Marcia Peterson: We feel this approach will be much clearer and simpler for members to understand. We also believe having a formulary may serve to protect our member premiums from the extreme volatility in drug pricing that we've seen in the past few years as more expensive drugs are released and there's very little we can do about that.

As you consider your vote in the next month or two, keep in mind our earlier discussion of non-evidence based care and waste in health care. Ask yourself if there's really no evidence that one drug is better than the other in terms of the member and the member's need, but it costs substantially more, why would the plan want to, or be willing to pay for it? Are there any changes to the resolution, any clarification you would like us to bring back for the next Board Meeting?

Tom MacRobert: I do have some questions, but, Ryan I'm going to probably contact you via email because I need to formulate how I'm going to present that.

Ryan Pistorresi: Okay.

Dave Iseminger: We'll share the information with the entire Board after we've answered the questions of one Board Member in email.

Tom MacRobert: That's okay.

Sue Birch: Thank you, Dave, for that clarification. I want to commend the staff on this work and the improved language because I do believe, from what was initially proposed and reflected on page 19, streamlined the language and it's clearer. I think with the visual diagrams that will be helpful to our members as well if we do choose to proceed with this. I want to commend you on the improvements and taking people through a very complex topic.

I personally support this. I did last time. I think Tim proposed some good amendments. I think we have a duty to help people navigate these very complicated areas and you have sufficient protections for exemptions and whatnot. As a nurse, I have been in this business far too long to see the latest freshly colored pill with the exact same ingredients, and priced at an outrageously, and I think people don't really plow into that and oftentimes get tricked. I do believe there's some very good research. And with MODA and our team watching and maintaining the formulary lists and the processes that are in place, we have a duty to save money wherever we can and push towards value. So, thank you and those are just comments. No clarifications needed on your presentation.

Yvonne Tate: I was basically going to say the same thing. I think this new proposal is a lot clearer and easier to understand and I think will be helpful to the members.

Greg Devereux: At first blush, the only thing that gives me pause is in the first two bullets, the word "all."

Marcia Peterson: Let's go to that. "All formulary drugs were ineffective."

Greg Devereux: Yes. I have visions of having to try nine drugs. I don't know whether there's a way to limit that, but it just seems like "all," I have no idea how many formulary, how many drugs there are.

Marcia Peterson: I know where you're going with that, but I think that's based on an assumption that a lot of us have that "the non-formulary drug is the one that's going to work for me and I'm going to try all these other things to get to that." When in fact, one of those formulary drugs is probably going to work for you. That's the assumption. It's just lower cost but it's similarly effective.

Greg Devereux: That's one assumption. I have used drugs before in the same class and they did nothing for me.

Marcia Peterson: That can happen.

Greg Devereux: I think that's another assumption. I'm thinking about the member who, I don't think anybody wants to expend outrageous amounts of money for some sexy new drug. At the same time, there are reasons why certain drugs work, and if you have to go through an unlimited number of other drugs to get to the one that works, that's not fair, either.

Dave Iseminger: Greg, I'll ask Ryan if our team can pull together what might help give more context to this of how many drug classes there are that have one formulary drug, how many have two, and see if there's ranges. Can we come up with a percentage of drugs that have only one or two alternatives? Or try to give you a sense as to how many drugs have a dozen, or nine, tons of drugs that one might feel they need to go through. If there's a way to quantify that and give the Board a range of how many formulary drugs there are for the Tier 3 drugs.

Ryan Pistorosi: I can see what we can. Off the top of my head, there are a lot of drug classes that we've been looking at in these reports that only have one or two options. A lot of the diabetes drug classes are specific for that mechanism of action or that specific drug class. If you're trying to get to a Tier 3 diabetes drug, you don't need to try every single generic alternative from all the different drug classes.

For example, with the GLP-1s that Marcia mentioned, we removed that one because we noticed there are a lot of Tier 3 exceptions. Previously, you had to step through one of those products before you could get that Tier 3 exception. Physicians were prescribing that Tier 3 one without having patients go through the Tier 2 alternative because other commercial plans may have that as their preferred and they don't necessarily know what our preferred is, similar to what they mentioned at the Retreat in January. We moved that one down, now we have two alternatives. Since there are other drugs in that class, now they have to step through those too before they can step into the other preferred ones.

We can look and see how we can quantify this and help answer your question.

Marcia Peterson: We don't want to see months and months of trying drugs that don't work. Ryan, if there are five generic drugs, they don't have to try more than one do they?

Ryan Pistorosi: You wouldn't necessarily have to use the same ingredients. If you've tried, you know one drug, you don't have to use that same ingredient like an extended release formulation or if it's paired with another drug. You know, if these drugs aren't working for people, we don't want to have them continue. We want to help find a drug that is appropriate and can treat their condition and not give them side effects where they can't tolerate the drug.

Sue Birch: That will be great additional information to bring back so we can look at that.

Greg Devereux: Ryan and Dave, if you could follow through on those, I would feel a lot more comfortable.

Harry Bossi: To Greg's comment, I think he might have a good point there. I don't think it would do any damage to remove the word "all" to formulary drugs. From what I heard from Ryan, there were five generics and they were all close to the same. The first one you tried didn't work, you try the second, third, fourth, or fifth. It seems to me that the approval authority probably already has that discretion and doesn't make everybody go through each and every one. I guess I would opine that maybe we don't need to have the word "all" in either of those first two bullets. Thank you.

Sue Birch: Harry, I appreciate your comments and we'll wait until staff bring the data back that we've asked for so we can look at what the variation is before we take action on that, okay? That's something to consider.

Tom MacRobert: I'd like to follow up with what Harry said. I have a 96-year-old aunt. She currently takes six medications. If you even throw one curveball at her in terms of, "Oh, you've got to try this," it really messes her up. If you were to say, "Well, you've got to try this," and then it doesn't work and you have to go two or three weeks and then you have to try another and another, that would not be good. When we have these conversations, we're talking about the extreme elderly, the most vulnerable people in our constituency. We have to be very thoughtful about what we do with that vulnerable group. I do like the idea of removing the word "all." That at least pares that down a bit. Thank you.

Ryan Pistori: To put some context to this, for Tier 3, not a lot of members are currently using these Tier 3 drugs. They usually step through a lot of these alternatives so we're not asking these members to go back and try drugs that they've previously tried before and didn't work. A lot of these patients have a history of using these generic alternatives or using these lower cost alternatives. They don't know that they can request that Tier 3 exception, or they may be requesting the Tier 3 exception too early, like the Lyrica example.

A lot of the patients who use Lyrica have tried Gabapentin before but they may not have tried Duloxetine or they may have started with Duloxetine and may not have tried Gabapentin. There's not necessarily a lot of these members on Tier 3 who start on Tier 3. A lot of them have history of using some of the other lower cost alternatives because to their point, when they get to the pharmacy and they see a \$250 copay, they ask if there is anything else they can do. Their pharmacist and their provider/their prescriber will try to help navigate the formulary. We do have the tools online that can help them find lower cost alternatives and their provider can decide whether it is an appropriate option.

Sue Birch: Tom, I want to share my professional insight into that because oftentimes, seniors on a high number of drugs are already in a classification having things tightly balanced. I see this being an area an exception would be granted. In the industry side, where geriatric patients have absolutely a lot going on, a lot of complexity that's almost always a flag where people grant that exception. I see Ryan shaking his head.

Marcia Peterson: Because that would be medical necessity.

Sue Birch: Correct. The geriatricians and insurance are careful about changing those protocols.

Tim Barclay: I'm actually comfortable with the language and the words we've got in here. The physician panel we brought here at the end of January added a lot of comfort for me in this process and expecting people to go through the formulary routes that are available before getting to the non-formulary drugs. I thought their discussion on the situation added a lot of comfort for me in implementing the process as described in this proposal.

I understand Greg's point that you start to use the term "all the formulary drugs" and then you fear there might be two dozen of them. If the information you've talked about bringing forward is helpful at making people comfortable with the word "all," I think it's an important classification to be clear with people that those who are our three formulary drugs, you need to try all three first. That's just the way it works. Again, based on what the physicians said, I'm comfortable with this as is.

Sue Birch: Tim, thank you for those comments. I think we've heard from all Board Members. Marcia, thank you for your work on this.

Emerging Medications

Ryan Pistori, HCA Assistant Chief Pharmacy Officer. Today is the latest installment of the emerging medications update. With today's presentation, we finish all of the drugs that were approved by the FDA in 2018 and also include the first drug approved in 2019. Slide 2 lists eleven drugs we'll be reviewing today.

Slide 3 – Tibsovo (ivosidenib) is a medication used in relapsed or refractory acute myeloid leukemia with an IDH1 mutation. One of the recent trends we're seeing with industry and with these new drug approvals is that they're looking at different proteins in different mutations to treat these cancers.

They identify these proteins that either help the cancer proliferate or to survive. If they can target these proteins and suppress or eliminate them, it'll reduce the cancer and help the patient, and potentially cure it. You'll start to see some of these specific mutations or proteins in some of these other drugs. For Tibsovo, it targets the IDH1 mutation. This is the first medication that targets this. AML is a common cancer and there are a lot of different treatment regimens for that. The first line treatment is still chemotherapy, but if this mutation is identified, patients as early as second line could potentially use this.

This mutation is not very frequent. It's only found in about 6% to 10% of all patients with AML. There is approximately 700 to 1,100 patients living in the US with this disease and with this specific mutation. Putting that into a perspective for UMP, we might see one patient with this every two to three years. If they don't respond to more conventional treatment, we may see a request. It looks to be a pretty rare disease for us.

Sue Birch: Do we have cost estimates on these drugs?

Dave Iseminger: Ryan's going through each drugs. The theme is these are all very rare instances. It is fairly rare so Ryan will do a roll-up of costs at the end.

Sue Birch: Great. Thank you.

Ryan Pistori: Slide 4 – Azedra (iobenguane I-131) is approved for metastatic pheochromocytoma, which is a cancer of the adrenal glands or a paraganglioma, which is a neuron tumor that talks to the endocrine system. This is the first medication approved specifically for these metastatic diseases.

This drug is designed to be absorbed specifically within these cells and then emit radiation, which then kills the cancer cells. Current treatment options are limited for these diseases. This is a very rare disease. For pheochromocytomas, there's about 50 cases per year in the US. For paragangliomas, about 1,600 cases per year in the US. A fraction of these develop to metastatic disease. We're looking at a smaller population of that per year in the US. We anticipate this to be very rare. We may not see this in the UMP population.

Slide 5 – Galafold (migalastat) is for the treatment of Fabry disease. Patients have a specific type of gene mutation known as the amenable galactosidase alpha gene. This disease is a deficient protein that doesn't necessarily cleave off lipids from molecules and it allows it to build up in cells. This lipid build up then causes inflammation, fibrosis, and eventually will kill the cells. It impacts the entire body. Different organs like the heart, the brain, the lungs, the kidney can be effected. It's a hard disease.

This medication helps stabilize this defective protein so it can continue to cleave that lipid and prevent it from building up in these cells. Fabrazyme is a medication available as an enzyme replacement therapy. This is an alternative for patients who may not necessarily need an enzyme replacement therapy. They may have somewhat functioning proteins this new drug may help. There are about 3,000 patients living with this disease in the US. We have history of Fabrazyme use in the past in UMP. To date, we have not seen any requests for Galafold yet.

Slide 6 – Libtayo (cemiplimab-rwic) is approved for metastatic or locally advanced cutaneous squamous cell carcinoma, a type of skin cancer. This is the first medication approved by the FDA for this advanced disease, but there are a couple other treatments that haven't gone through the FDA review, but there's enough clinical research that oncologists in cancer centers would use. Herbidoxe and Vectibix are types of chemotherapy. This is not necessarily the first one, but is the first one approved by the FDA. Although this is rare, cutaneous squamous cell carcinoma is the second most common type of skin cancer. There's about 700,000 cases diagnosed and most are cured by surgical resections. Once skin cancer is detected, they'll usually remove the area to take the cancer away. Some that aren't able to remove the area in time, the disease may progress, metastasize in the body, and spread to other areas. This drug is for those unable to be cured by surgery and may not have been candidates for other types of chemotherapy. We expect this to be a very rare drug for the UMP population.

Slide 7 – Oxervate (cenegermin-bkbj) is for the treatment of neurotrophic keratitis, a disease where the nerves that lead to the eye are damaged and are not able to function. With impaired neural function to the eye, it can lead to impaired healing, damage, like the development of ulcers. This can eventually lead to blindness. There is no genetic cause but can be caused by a number of different diseases. People with diabetes, exposure to chemicals, multiple sclerosis can develop this type of disease. It's not like others where there's a genetic mutation or it's a specific type of cancer. This is the secondary result of another disease or another incident. There's really no other therapy to treat it. Most common ways of treating it are supportive therapy, artificial tears, or antibiotics. It is rare with about 65,000 people in the US. We might see this in the UMP population, depending on how it is diagnosed.

Slide 8 – Vitraki (larotrectinib) is a medication used for advanced central nervous system or solid tumors that have a specific type of fusion known as the neurotrophic receptor tyrosine kinase fusion. This cancer has a very specific target where the drug looks at either inhibiting it or reducing its ability to allow the cancer to continue to proliferate.

This medication is reserved for patients who have progressed beyond all standard therapies. It is truly the last line. There are different cancer types for this that have solid tumors that could arise in the bone, the breast, or in the brain. There are different treatments for different cancers. Treatments for bone cancer will be different than for breast cancer than for renal cell carcinoma. They want to use those specific tissue cancer's treatments first before using this one that is specifically targeted to that mutation. This is a new approach to cancer treatment. Its place in therapy is unique. We don't anticipate many members will use this, given it's a rare cancer and there are a lot of alternatives that would be used prior to this one. It's an interesting approach that the manufacturers and the FDA took in approving this drug.

Slide 9 – Gamifant (emapalumab-lzsg) is approved for primary hemophagocytic lymphohistiocytosis (HLH) with refractory, recurrent, or progressive disease, or intolerance with conventional HLH therapy. This is a very rare disease. Less than 100 diagnosed with it this year. A number of therapies can help support these patients. This is the first medication that targets the root cause of this disease. We do anticipate this to be rare, given there are alternatives, but this one has a new place in therapy for people who aren't able to respond to this, especially in this kind of emergency situation. If someone has this, they need to be rushed to the ER and treated at an in-patient facility.

Slide 10 - Lumoxiti (moxetumomab pasudotox-tdfk) is approved for relapsed or refractory hairy cell leukemia. It targets a specific protein, CD22, that sits on the outside of these cells. It finds the cells that are expressing this and is able to kill the cancer by selectively targeting the specific protein on those cells. This is reserved for people who have tried two prior systemic treatments. Hairy cell leukemia is a rare type of cancer. There's approximately three cases per one million people in the US. We anticipate this to be rare for UMP.

Slide 11 – Firdapse (amifampridine) is approved for Lambert-Eaton Myasthenic Syndrome or LEMS, which is a progressive degenerative neuromuscular disease when the nerves begin to lose function because some of the proteins don't regulate the ion exchange well. They get progressive muscle weakness. If they try to move their arm, they may not be able to. It's a rare autoimmune neuromuscular disease. About 1,000 people in the US are diagnosed with this each year. We anticipate there may be one to two patients with UMP that may need this medication. There aren't many alternatives. There used to be compounding pharmacies that would make this compound on their own and ship to members. A manufacturer was able to go through the FDA approval process and gained patent authority over this and compounding pharmacies are no longer making this drug. We anticipate some utilization of this drug.

Slide 12 – Elzonris (tagraxofusp-erzs) is approved for blastic plasmacytoid dendritic cell neoplasms, which are rare, aggressive cancers characterized by skin lesions. The current treatment options for this are similar to other more common cancers because

they treat a similar type of cancer. The estimates of incidents and prevalence are challenging because this drug's name and definition has evolved over the years. As scientists have better tools to understand, characterize, and categorize these, the expected incidents of this has changed several times since 2008. There wasn't a good definition for this drug. It was grouped with other cancers and has since been split out. The treatment options for these two types of cancers both work, but now they're starting to understand this type of cancer is unique, relative to the other cancers. We did find a paper that was published last year that anticipates there may be four cases per 10,000,000 people in the US. Rates appear to be higher in males aged 80 and older, but is anticipated to be rare for the UMP population.

Slide 13 – Cablivi (caplacizumab-yhdp) is the first drug approved in 2019. It is approved for acquired thrombotic thrombocytopenic purpura, a condition in which blood clots manifest in the small blood vessels which then blocks blood flow to different tissues to the brain, the heart, the kidneys. It can lead to internal bleeding, low platelet count, and hemolytic anemia. It's very rare but serious condition in which the blood flow is blocked in the arteries. There are about three cases per one million adults and about one case per ten million in children. We anticipate this to be very rare for the UMP.

Slide 15 – UMP Budget Impact. Of the eleven new drugs, we anticipate the impact to UMP to be about \$800,000 per year. We didn't go into the list price for what we would pay for them, but they're usually in the tens of thousands, to hundreds of thousands, to close to a million. Looking at how these drugs may be used in the UMP population and looking at prior history of who may have these diseases in this population, we're figuring these eleven drugs may collectively have about \$800,000 per year. The cost of these drugs are \$300,000 to about \$600,000 per year. Some may be higher than what we are estimating, given they also require use of other drugs on top of it. The estimated UMP budget impact is based on plan size and estimated per-member-per-month estimates from third-party analyses.

At the last PEB Board Meeting where we talked about this, we had eight drugs and anticipated that to be \$877,000 per year. In total for the 19 drugs reviewed to date, we estimate an impact of about \$1.68 million. We'll continue to monitor these drugs and see how they're being used. Some of the drugs that we originally presented like Trogarzo or the CGRP inhibitors like Aimovig have actually seen lower cost than what we were originally anticipated.

Dave Iseminger: I've started seeing Aimovig commercials on TV so maybe that'll go up. Slide 14 really is the reason we do these presentations. You'll remember a couple of years ago there was a new drug called Harvoni. It caught people off guard regarding cost. As part of the legislative process, there was a budget provision that asks the agency to present this information and the total budget impacts anticipated to the PEB Board. Although it feels like we've done a lot of work on 19 drugs, and apparently the drug companies and FDA are really good if you're working on rare diseases, it's good news these numbers are small. You can't control the volatility that exists. The point of these presentations over the last year or two are a result of wanting to monitor that potential volatility.

Ryan Pistori: Slide 15 – Recent Generic Entries. Based on feedback from the PEB Board at the last presentation, you wanted to hear some good news about drugs that

may actually be reducing plan costs. There have been recent generic entries with drug names you may recognize, because they are on TV. One of the trends we've noticed in the industry since the start of the year are authorized generics, which are the same drugs made by the same manufacturer as a brand name, but labeled and marketed as a generic. The industry is starting to promote the use of authorized generics because their drug prices have risen so much, and with all this news and intention about wanting to lower drug prices, they don't necessarily want to lower the drug price of the brand-name drug because there are ramifications to federal programs like Medicaid, Medicare, the Department of Defense. But, if they release these new products as generics, they don't necessarily have to touch the brand-name price. Authorized generics are essentially the exact same drug with a different package and maybe sold under a different name. The outcome to the commercial world, or the self-paid plan for UMP, is that we now have the option to choose between the very high cost brand-name drug or the lower cost authorized generic. We are evaluating these trying to determine the type of impacts. It looks favorable for UMP, not so much for a Medicare or a Medicaid plan.

Hepatitis C now has an authorized generic for Harvoni and Epclusa which was launched in January 2019.

Asthma rescue inhalers, rescue medications people with asthma carry with them to help them breathe when they have an asthma attack, now have generics. for these. They're both authorized generics but they're the first generics. There's one for Proair and one for Ventolin authorized in January 2019 and on the market in February.

For asthma/COPD, so this is for actually controlling and reducing the symptoms of asthma and COPD, there is the generic Advair Diskus, a true generic Advair. The main manufacturer of Advair Diskus also launched an authorized generic at the same time. There are now two lower price options available to members.

Last week, Eli Lilly, who makes Humalog, a rapid acting insulin, announced an authorized generic. We're starting to see these authorized generics for other brand-name products in a host of disease states. We will continue to monitor these authorized generics to see how this impacts UMP costs.

Sue Birch: Ryan, thank you. This is always really informative. I appreciated the balance of good news/bad news. Let's just hope our members stay as healthy as possible.

SmartHealth

Marcia Peterson, Manager, Benefits Strategy and Design Section, ERB Division. Today I am providing an update on the SmartHealth Program and introducing a resolution to change the incentive deadlines for next year.

Slide 3 – 2019 SmartHealth Portal. For those of you who are able to use SmartHealth, this is how it looks now. There are some new features. This slide is a screenshot of the portal when you log on. There is a banner that goes across and spotlights promoted activities. The red circle around the word "feed" highlights the SmartHealth community, which is referred to as the "Facebook of SmartHealth." It's a virtual social community dedicated to celebrating and supporting wellness where members can talk to each other, they can post and like pictures of events, they can make virtual friends. There's a

hashtag feature where you can post a picture with a specific hashtag and get points. There are interactive features including videos which helps retain information.

There are team activities to challenge each other. We recently had a challenge with the well-being assessment week. That's a new feature.

Slide 4 – 2019 SmartHealth Updates. This is the fifth year for the SmartHealth Program. There are some tried and true activities to continue to encourage excitement and participation in the Program. 2019 activities are Well-being Assessment Week, SmartHealth Week in June, the Governor's Walk in July, and Leader Walks In August and September. There are fun activities in addition to those. Like last year, members can earn a \$25 Amazon gift card through the end of December and the \$125 wellness incentive that goes through September 30 for most of those eligible.

Slide 5 – 2019 SmartHealth Levels. These levels have not changed. There are three levels. Level 1 is what you achieve when you complete your well-being assessment. You get 800 points and are eligible for the \$25 Amazon.com gift card. Level 2 is still 2,000 points and makes you eligible for a \$125 wellness incentive next year. Level 3 is completing Levels 1 and 2 and earning 4,000 total points. If you reach that number, you get a Wellness Champion badge.

Slide 6 is the 2019 Incentive Flyer. It's a postcard we are sending out this year. It informs the SmartHealth eligible why to use SmartHealth, what they can earn for participating, and where to get more information. We encourage people to find their purpose.

Slide 8 – New SmartHealth Registrations. These numbers focus on 2018. In 2017 there were 6,745 new registrations. As of December 31, 2018, we doubled that number. There were 12,082 new registrations. Of that 12,000, approximately 11,000 continued and participated in some way, whether they reached Level 1, completed their well-being assessment, or continued through Levels 2 and 3. Currently, we have around 67,000 people in the Program currently registered, about 47% of those eligible.

Slide 9 – Well-being Assessment Completions: 2016, 2017, and 2018. This chart shows the history of the Program. It shows, year over year, well-being assessment completions from 2016, 2017, and 2018. We don't show 2015 information even though it was the first year because the incentive deadline was different. It isn't comparable, but there are trends. There is a similar pattern every year with a notable change in the purple line, which was 2018, the well-being assessment completion numbers jumped up and stayed high. Completing the well-being assessment makes you eligible for the \$25 Amazon gift card, which is an immediate reward.

Slide 10 - \$125 Incentive Qualifications: 2016, 2017, and 2018. The \$125 incentive qualifications last year were actually below previous years. It was right with the others in terms of participation, but dropped a bit below. We attribute that to immediate rewards versus the award you might earn next year, but a similar pattern with people participating. For 2019, the well-being assessment numbers are slightly lower than last year, but I don't have the numbers yet. The incentive qualifications are similar. We'll bring you numbers as we get them.

Slide 11 – SmartHealth Cohort Analysis. We're always being asked, "Does this work? What is the return on investment? Are people actually improving their health?" There are different ways to look at that. We analyze the well-being assessment, the self-reported scores on the well-being assessments for that cohort who has been in it from the beginning and stayed. We've seen the same thing every year, which we've reported to you.

Of those people who take the SmartHealth well-being assessment, there's 34 dimensions and 200 questions, a scale of one to five that they score themselves. We see from year to year, an increase in scores across all but two of the 34 SmartHealth dimensions for the cohort overall. The group that reported themselves "at risk" scored themselves lower, 3.5 or lower on that 5-point scale, theoretically, at risk. Year after year, we've seen the same thing. They increase their scores across every one of the 34 SmartHealth dimensions, including well-being productivity and health. We think it's exciting. It's one way of looking at how the Program is impacting people's lives.

Slide 13 – SmartHealth Incentive Deadline. This slide shows how incentive deadlines have changed since the Program started. When we debuted the Program in 2015, the deadline was June 30, which was midway through the year. We weren't sure how people were going to respond or how many participants there would be. We didn't know what the cost would be or how the carriers would manage the operations of it all. We wanted to give everybody from June 30 to the end of the year to manage issues. After the first year, everything was fine and we brought you a resolution to move the deadline to September 30, which it has been from 2016 to 2019. Starting January 2020, we'd like to move the incentive deadline even further back to November 30 for most users.

The SEB Board has already approved the November 30 deadline. We wanted to use the latest possible date we could, given operations. School employees tend to start in September, which is the time our current incentive deadline ends. We looked at moving that further out.

This will also help PEBB Program members, as well. We've always had a challenge the way we promote the Program in higher education. They have the same thing, starting in September. They just get started and the deadline's over and they're starting a new year. It doesn't work with their cycle. We talked to the carriers and Limeade and came up with November 30 as the deadline. Today's proposed resolution reflects that and is the exact language passed by the SEB Board.

Proposed Policy Resolution PEBB 2019-02 – Deadline for Completing Wellness Activities. Effective January 1, 2020, to receive any Public Employees Benefits Board (PEBB) Wellness Incentive in the following plan year, eligible subscribers must complete PEBB Wellness Incentive Program requirements by the following deadline:

- For subscribers enrolling in PEBB medical with an effective date in January through September, the deadline is November 30.
- For subscribers enrolling in PEBB medical with an effective date in October through December, the deadline is December 31.

Dave Iseminger: This always puzzles people when they wonder why we need two clauses here. When we brought to the Board the resolution a couple of years ago to set the deadline at September 30, the closer you get to December 30, there are fewer days from when you start benefits. The shortest period someone has is 90 days to complete all Program requirements to get the incentive. Once you start October, there are fewer than 90 days as you get to December. You have to cut off Program eligibility at some point. The requirements, as you get into that group with the shorter time period, accommodate the ability to complete the Program and still earn an incentive as you enter the program for the first time late in the year.

Our plan is to bring this for Board action at the next Board Meeting unless there are questions you need answered. With so many moving parts between the two Programs as we gear up for a very busy fall, anything we can get Board agreement on early is helpful.

Greg Devereux: With the SmartHealth Program and Limeade, one of the concerns people have had over time is not enough tiles and not enough things to get points for. There's so many things to get points for and so many tiles this year, it's phenomenal. They really have listened and I think it's great. There's no excuse for not getting these things.

Dave Iseminger: And now you'll have more time.

Marcia Peterson: You definitely see the drop off after September 30 for whatever reason. As we head into the fall, Thanksgiving, etc., we don't want to send the message of we don't care about wellness anymore. We want to encourage people to continue to participate. For some reason, we do respond to points as human beings. We love those points.

Dave Iseminger: By having the incentive deadline at the end of November, we can describe it in context of open enrollment and other deadlines that people experience. There'll be the opportunity to promote things that might get more participation like the Great American Smoke-Out, and then describe the impacts of "don't forget to change your tobacco attestation and save money on the tobacco attestation you're paying." There are things we can continue to promote and dovetail with other parts of the Program by having this deadline at the end of November.

Sue Birch: Great, thank you for that, Marcia. Very thoughtful of you all. I think at this point, we're going to call for public comment and, Connie, I don't see that anybody has signed up, but I'll just call, if there's anybody else that came in or didn't sign up, anybody out there that wants to make public comment? No. All right.

Next Meeting

April 24, 2019
1:30 p.m. to 3:30 p.m.

Meeting adjourned at 3:29 p.m.