Chair Shaun Parkman will convene a public meeting of the PEBB Board on Tuesday, October 16, 2018, at 9:30 a.m. The meeting will be held in the boardroom of the Health Licensing Office at 1430 Tandem Ave., Ne, Suite 180, Salem, Oregon.

PEBB BOARD AGENDA

I.	9:30 a.m. – 9:35 a.m. Attachment 1	**Welcome & Approval of September 18, 2018 meeting synopsis** **(action)** *Shaun Parkman, Chair*
II.	9:35 a.m. – 9:40 a.m. Attachment 2	**State Employee Wellness Survey Funding** *Margaret Smith-Isa, PEBB Program Development Coordinator*
III.	9:40 a.m. – 10:10 a.m. Attachment 3	**Senate Bill 1067 Double Coverage & Opt-out Elimination Fiscal Analysis (information/discussion)** *Emery Chen and Robert Valdez, Mercer Health & Benefits, LLC*
IV.	10:10 a.m. – 10:35 a.m. Attachment 4	**Pharmacy Benefit Trends** *Virginia Rivas, West Market Pharmacy Lead, Mercer Health & Benefits, LLC*
V.	10:35 a.m. – 11:05 a.m. Attachment 5	**Oregon Prescription Drug Program (OPDP) Update** *Trevor Douglass, OPDP Director*
VI.	11:05 a.m. – 12:15 p.m. Attachments 6, 6a and 6b	**Pharmacy Services and Programs (Medical Carriers) (information/discussion)** *Dr. Keith Bachman, PEBB Medical Director and Sunshine Sommers, Manager, Clinical Pharmacy Services, Kaiser Permanente* *Carly Rodriguez, Director of Clinical Pharmacy, Moda Health Plans* *Helen Noonan-Harnsberger, PharmD, AVP and Aaron Masini, PharmD, Clinical Pharmacy Manager, Providence Health Plan*

Providence Health Plans

VII. 12:15 p.m. – 12:20 p.m. **Innovation Workgroup Update**

Shaun Parkman, Chair and Dana Hargunani, IWG Member

VIII. 12:20 p.m. – 12:25 p.m. **Other Business**

IX. 12:25 p.m. – 12:30 p.m. **Public Comment**

Adjourn

Public Employees' Benefit Board
Meeting Synopsis
September 18, 2018

The Public Employees' Benefit Board held a regular meeting on September 18, 2018, at the Health Licensing Office, 1430 Tandem Ave. NE, Suite 180, Salem, Oregon. Chair Shaun Parkman called the meeting to order at 9:30 a.m.

Attendees

Board Members:
Shaun Parkman, Chair
Kimberly Hendricks, Vic Chair
Bill Barr
Representative Mitch Greenlick
Dana Hargunani, MD
Kim Harman
Siobhan Martin
Mark Perlman (via phone)
Jeremy Vandehey

Board Members Excused/Absent:
Senator Betsy Johnson

OEBB Staff:
Ali Hassoun, Interim Director
Cindy Bowman, Director of Operations
Rose Mann, Executive Assistant
Linda Freeze, Benefits Manager

Consultants (WTW):
Emery Chen, Mercer Health and Benefits, LLC
Robert Valdez, Mercer Health and Benefits, LLC

View meeting agenda and attachments.
View the meeting recording

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I. Welcome and approval of August 21, 2018, Board Meeting Synopsis (Attachment 1) - ***Video Recording 0:02:39***

MOTION - *Video Recording 0:01:48*

Kim Harman moved to approve the Board meeting synopsis of the August 21, 2018 meeting. Kimberly Hendricks seconded the motion. The motion carried 7 – 0.

II. PEBB Opt-out and Double Coverage Elimination per SB 1067 (Attachment 3) - *Video Recording 00:02:13*

Cindy Bowman and Linda Freeze presented information regarding the potential impact of SB 1067 regarding opt-out and double coverage as it pertains to PEBB members.

III. PEBB Financial Update - *Video Recording 00:51:56*

Ali Hassoun, Interim OEBB/PEBB Director presented a PEBB Financial update for the 2017 – 19 biennium.

IV. Carrier Network/Access (Attachments 4, 4a and 4b) - *Video Recording 01:10:06*

Dr. Keith Bachman, PEBB Medical Director and Sophary Sturdevant, Executive Account Manager, Kaiser Permanente

Dr. Jim Rickards, Senior Medical Director and Jill Harland, Director Provider Relations, Moda Health Plans

Stephanie Dreyfus, Vice President of Network Development, Providence Health Plans

V. Strategic Planning continued - *Video Recording 02:54:38*

Emery Chen and Robert Valdez, Mercer Health & Benefits, LLC

VI. Other Business/Public Comment - *Video Recording 02:04:08*

There being no public comment nor further business to come before the Board, Chair Shaun Parkman adjourned the meeting at 12:30 p.m.

State Employee Wellness Survey Funding Request

October 16, 2018

Margaret Smith-Isa, Program Development Coordinator

Survey Overview

Since 2006 PEBB has collaborated with the Public Health Division's Health Promotion and Chronic Disease Prevention (HPCDP) section to conduct a biennial survey of state employees' health behaviors and health risks. Historically known as the Behavioral Risk Factor Surveillance System Survey of State Employees (BSSE), this survey is modeled after a long-standing population health survey designed by the Centers for Disease Control and Prevention (CDC). PEBB's version of this survey has been conducted though telephone interviews with randomly selected state employees and has captured responses from between 1,500 to 2,000 employees during each survey cycle. PEBB has relied on the survey results to provide population level information about behaviors and health risks of current employees and has used the information to help inform benefit design and program development.

PEBB and HPCDP are currently collaborating on plans to field the next cycle of this survey during the first half of 2019. Several changes are being incorporated to streamline the survey and ensure focus on capturing information not available through other data sources. Specific changes include:

- Transitioning the survey from a telephone survey to an online survey to allow for more efficient administration and the ability to capture responses from a larger number of employees
- Pruning the survey questionnaire to ensure reasonable length and a primary focus on health risk and behavior questions that are not captured in other data sources
- Aligning the survey to capture information on progress toward the goals outlined in state agency wellness plans
- Renaming the survey as the State Employee Wellness Survey to more closely reflect the survey's role in measuring progress toward health and wellness goals

Survey Funding

HPCDP has taken primary responsibility for identifying a vendor to administer the survey and coordinating the selected vendor's work. PEBB and HPCDP have a memorandum of understanding updated each survey cycle to specify roles and responsibilities under this collaborative effort. Under the most recent memorandum written for the 2016 survey PEBB committed to provide 75% of the total funds required to administer the survey, not to exceed $60,000. In 2016 the actual cost for administering the survey was approximately $68,000, with PEBB covering $51,000 of this cost.

In order to proceed with planning for the 2019 survey PEBB and HPCDP need to finalize updates to the memorandum. Staff is recommending a status quo commitment to PEBB's funding for the 2019 survey.

Action

Board action on the staff funding recommendation is requested.

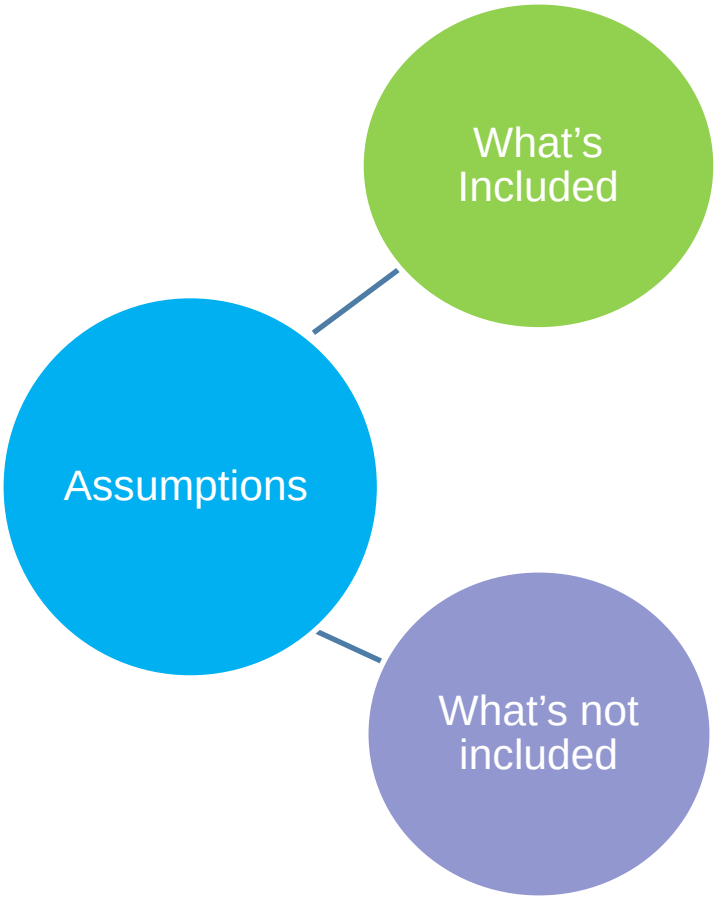
OREGON PUBLIC EMPLOYEES' BENEFITS BOARD

FINANCIAL IMPACTS OF ELIMINATING OPT OUTS AND DOUBLE COVERAGE

October 16, 2018

Emery Chen, ASA, MAAA

ASSUMPTIONS AND DEFINITIONS



- Impact on member's out-of-pocket costs
- Impact on member's contributions
- Opt out payments to employees and PEBB

- Impact on dental and vision enrollment and claims
- Assumptions on percentage of members selecting PEBB versus OEBB when forced to choose
  - Best case and worst case ranges are provided

BACKGROUND
DOUBLE COVERAGE AND OPT-OUT SCENARIOS

	Double Coverage	Opt-Out
#1	**PEBB / PEBB** Jack and Diane both work for different state agencies. Jack and Diane usually both take the PEBB Medical Plan and cover their entire family	**PEBB / PEBB** Jack and Diane both work for different state agencies. Jack usually takes the PEBB Medical Plan for the entire family and Diane usually Opts Out of medical and takes the $233 incentive
#2	**OEBB / PEBB** Jack works for DOC and Diane works for Astoria SD. Jack and Diane usually both take medical coverage via PEBB and OEBB and cover their entire family.	**OEBB / PEBB** Jack works for DOC and Diane works for Astoria SD. Either of them are currently eligible for an Opt Out incentive. But, this incentive now goes away effective 10/1/2019 for Diane and 1/1/2020 for Jack
#3	**PEBB / PGE** Jack works for DOC and Diane works for PGE. Jack and Diane usually both take medical coverage via PEBB and PGE and cover their entire family	**PEBB / PGE** Jack works for DOC and Diane works for PGE. Jack and Diane usually both take medical coverage via PEBB and PGE and cover their entire family

DOUBLE COVERAGE SCENARIOS
PEBB DOUBLE COVERED

DOUBLE COVERED SCENARIO: 1

Both PEBB Employees Enroll and Cover Dependents

Current: Both employees (and their dependents) are currently enrolled in PEBB plans
Future: Employees enroll themselves separately and dependents are with one parent

Current: All family members are double covered under medical
Future: All family members are single covered and lose the additional payments of out-of-pocket costs (coordination)

Current: Employees pay double the family contributions
Future: One employee pays EE+CH (EE only if no dependents), one pays EE only

Opt out payments: Not provided previously, no change
Health Care Costs (OOP): All member out-of-pocket costs (coordination) are now the members' responsibility (was provided as value of double coverage)
Additional Considerations: For those with no dependents, no real change by being covered separately versus as EE+SP; for families, those with four or more members would likely select family coverage due to 3x deductible and OOP

EXAMPLES OF FINANCIAL IMPACT

Double Covered PEBB Family	Statewide Family Coverage (Annual Costs)		Providence Choice Family Coverage (Annual Costs)	
	2019	2020	2019	2020
Employee Premium Share	$1,274	$1,274	$221	$221
Spouse Premium Share	$1,274	$0	$221	$0
Family Medical Deductible	$750	$750	$750	$750
Pharmacy Deductible	$150	$150	$150	$150
12 Generic Drug Copayments	$0	$120	$0	$120
12 Brand Copayments	$0	$360	$0	$360
12 Specialty Drug Copayments	$0	$1,200	$0	$1,200
12 Primary Care Copayments	$0	$300	$0	$120
Total	$3,448	$4,154	$1,342	$2,921

DOUBLE COVERAGE FINANCES #1: PEBB DOUBLE COVERED

DOUBLE COVERED SCENARIO: 1

Number Covered	Impact on Premium	Impact on Agencies and PEBB
• 1,963 employees	• Decrease in out-of-pocket costs of **$3.3 million** (coordination) • Total number of enrolled members decreases but cost per member (and premium rate) increases	• **Agencies**: A decrease of **$3.3M** in costs (loss of coordination) and a decrease of **$1.1M** in employee contributions for a net change of **$2.2M** without a decrease in employees • **PEBB**: Composite rate will decrease as total costs decrease **($3.3M)** and PEBB employees remains constant • If doubled covered employees leave PEBB due to elimination of coverage for OOP costs, new replacement employees will likely cost more on a per employee basis

DOUBLE COVERAGE SCENARIOS #2: PEBB AND OEBB DOUBLE COVERAGE

DOUBLE COVERED SCENARIO: 2

PEBB Employee Doubled Covered Under OEBB

Current: PEBB employee (and their dependents) are covered by PEBB and OEBB
Future: Employee elects to be covered in PEBB or OEBB. Lower contributions and higher benefit may result in OEBB members electing PEBB primary coverage

Current: PEBB employees receive coordination from OEBB, OEBB employees receive coordination from PEBB, dependents are based on birthday month rule
Future: Dependent on election of coverage; highest PEBB cost assumes PEBB as medical coverage

Current: Employees pay PEBB contributions for all enrolled dependents
Future: Employees electing PEBB would continue to pay contributions for all dependents

Opt out payments: Not provided previously, no change
Health Care Costs (OOP): All member out-of-pocket costs are now the members' responsibility (was provided as value of double coverage)
Additional Considerations: Potential higher coverage of OEBB employees and dependents if they enroll in PEBB.

DOUBLE COVERED SCENARIO: 2

DOUBLE COVERAGE FINANCES #2: DOUBLE COVERED IN PEBB AND OEBB

Number Covered

- 550 PEBB employees in OEBB
- 650 OEBB employees in PEBB

Impact on Premium

- Dependent upon whether the member elects to be covered in PEBB versus OEBB
- Based upon the higher benefit value and 1%/3%/5% contribution structure, it is likely that PEBB would pick up additional enrollees
- Current OEBB employees covered as secondary could become primary under PEBB (max of **$4.9M**)
  - Dependents would become primary under PEBB (about ½ of covered dependents included above)
- ½ of PEBB dependents double covered in OEBB could become primary (max of **$1.0M**)

Impact on Agencies and PEBB

- **Agencies**: Assuming members elect PEBB coverage, increase of up to **$5.9M** in cost due to move from secondary to primary for spouses and ½ of dependents
  - If all 550 OEBB employees drop PEBB coverage, savings to agencies of **$0.5M**
- **PEBB**: Max difference of up to **$0.9M** in savings from dropping PEBB coverage to **$5.9M** in additional cost if all OEBB employees elect PEBB

DOUBLE COVERAGE SCENARIOS
PEBB AND ANOTHER EMPLOYER DOUBLE COVERAGE

DOUBLE COVERED SCENARIO: 3

PEBB Employee Doubled Covered Under non-State Employer

Current: PEBB employee (and their dependents) are covered by PEBB and another employer
Future: Likely no change

Current: PEBB employees receive coordination from other employer, spouse receives coordination from PEBB, dependents are based on birthday month rule
Future: No change

Current: Employees pay PEBB contributions for all enrolled dependents
Future: Employees electing PEBB would continue to pay contributions for all dependents

Opt out payments: Not provided previously, no change
Health Care Costs (OOP): No change
Additional Considerations: None

DOUBLE COVERED SCENARIO: 3

DOUBLE COVERAGE FINANCES
PEBB AND ANOTHER EMPLOYER DOUBLE COVERAGE

Number Covered	Impact on Premium	Impact on Agencies and PEBB
• N/A	• None	• **Agencies**: No change • **PEBB**: No change

OPT OUT SCENARIOS
TWO PEBB EMPLOYEES

PEBB Employee Opts Out and is Covered Under PEBB

Current: PEBB employee opts out and covered under PEBB
Future: Employee may select coverage or continue to opt out without payment; likely based on impact of deductible/OOP (e.g. families would continue to enroll as families)

Current: Coverage as EE+SP or Family tiers
Future: Likely minimal change due to no real impact on employees

Current: One employee pays PEBB contributions for all dependents, other receives opt-out payment
Future: Loss of opt-out payment for one employee

Opt out payments: Loss of $233 per month opt-out payment (net dental/vision premiums)
Health Care Costs (OOP): No change
Additional Considerations: PEBB loses opt-out payment to reserves ($154 for full-time employee)

OPT OUT SCENARIO: 1

OPT OUT FINANCES TWO PEBB EMPLOYEES

Number Covered	Impact on Premium	Impact on Agencies and PEBB
• 833 opt outs	• Loss of **$2.3M** in opt out payments • Minimal impact to medical claims as employees are already in the plan • Only change in medical claims would be for employees impacted by deductible and out-of-pocket limit on families • Employees might not elect double coverage for dental and vision with minimal impact from loss of coordination of benefits	• **Agencies**: Elimination of opt-out payments to employees and PEBB resulting in a decrease of **$3.8M** in costs • **PEBB**: Elimination of opt-out payment to reserves (loss of **$1.5M**)

OPT OUT SCENARIOS
PEBB AND OEBB EMPLOYEES/PEBB OPT OUT

PEBB Employee and OEBB Employee/PEBB Opt Out

Current: PEBB employee opts out and is covered by OEBB
Future: Employee elects coverage in PEBB or OEBB. Loss of opt out payment may result in election of PEBB coverage due to plan value and low contributions

Current: PEBB employee opts out
Future: Dependent on election of coverage; largest impact on PEBB cost assumes PEBB is elected as medical coverage

Current: Employees receives opt out payment
Future: Employees electing PEBB would pay contributions and receive medical coverage

Opt out payments: Not provided previously, no change
Health Care Costs (OOP): All member out-of-pocket costs are now the members' responsibility (was provided as value of double coverage)
Additional Considerations: Potential higher coverage of OEBB employees and dependents if they enroll in PEBB.

OPT OUT SCENARIO:2

DOUBLE COVERAGE FINANCES
PEBB AND OEBB EMPLOYEES/PEBB OPT OUT

Number Covered	Impact on Premium	Impact on Agencies and PEBB
• 100 PEBB employees opting out for OEBB	• Based upon the higher benefit value and 1%/3%/5% contribution structure, it is likely that PEBB would pick up additional enrollees (max cost of **$1.1M**)	• **Agencies**: Assuming members elect PEBB coverage, increase in cost (max of **$1.1M**) due to new enrollees excluding contributions • Additional cost is offset by elimination of the opt out payment (**$0.5M**) • **PEBB**: Composite rate will increase as total costs increase (max of **$1.1M**); opt out payment to reserves are lost impacting stabilization fund reserve (loss of **$0.2M**)

OPT OUT SCENARIOS
PEBB AND OEBB EMPLOYEES/OEBB OPT OUT

PEBB Employee and OEBB Employee/OEBB Opt Out

Current: OEBB employee opts out and is covered by PEBB
Future: Employee elects coverage in PEBB or OEBB. Loss of opt out payment may result in election of spouse electing OEBB coverage

Current: PEBB employee covers OEBB employee (opt out)
Future: May result in no change to PEBB coverage as OEBB member may stay in the PEBB plan

Current: Employee pays contributions to cover OEBB spouse/partner
Future: Potentially no change although employee might not cover spouse/partner

Opt out payments: Not provided previously, no change
Health Care Costs (OOP): All member out-of-pocket costs are now the members' responsibility (was provided as value of double coverage)
Additional Considerations: Potential higher coverage of OEBB employees and dependents if they enroll in PEBB.

OPT OUT SCENARIO:2

OPT OUT SCENARIOS
PEBB AND OEBB EMPLOYEES/OEBB OPT OUT

Number Covered	Impact on Premium	Impact on Agencies and PEBB
• 600 employees covering OEBB opt outs	• Dependent upon whether the members elect to be covered in PEBB versus OEBB • Based upon the higher benefit value and 1%/3%/5% contribution structure, it is likely that PEBB would remain the health plan resulting in no change to plan costs or premiums	• **Agencies**: Assuming members elect PEBB coverage, no change to Agencies; if spouse/partner elects OEBB coverage, a decrease in cost is possible (max savings of **$5.2M**) • **PEBB**: Composite rate will remain unchanged unless spouse/partner elects OEBB coverage (max savings of **$5.5M**)

OPT OUT SCENARIOS
PEBB AND ANOTHER EMPLOYER OPT OUT

PEBB Employee Opts Out for Non-State Employer Coverage

Current: PEBB employee (and their dependents) are covered by PEBB and another employer
Future: Likely no change

Current: PEBB employees receive coordination from other employer, spouse receives coordination from PEBB, dependents are based on birthday month rule
Future: No change

Current: Employees pay PEBB contributions for all enrolled dependents
Future: Employees electing PEBB would continue to pay contributions for all dependents

Opt out payments: Not provided previously, no change
Health Care Costs (OOP): No change
Additional Considerations: None

OPT OUT SCENARIO:3

OPT OUT SCENARIOS
PEBB AND ANOTHER EMPLOYER DOUBLE COVERAGE

Number Covered	Impact on Premium	Impact on Agencies and PEBB
• 2,032 employees	• None	• **Agencies**: No change • **PEBB**: No change

TOTAL IMPACT OF OPT OUTS AND DOUBLE COVERAGE

Scenario	EEs	Impact on			
		Medical Cost	Employee Contributions	Agencies	PEBB
Double Covered in PEBB	1,963	($3.3M)	($1.1M)	($2.2M)	($3.3M)
In PEBB/ OEBB Double Covered	550 PEBB 650 OEBB	$0 to $1.0M ($0.9M) to $4.9M	None ($0.3M) to none	$0 to $1.0M ($0.5M) to $4.9M	$0 to $1.0M ($0.9M) to $4.9M
In PEBB/ Other Double Covered	N/A	None	None	None	None
In PEBB/ PEBB Opt Out	833	None	$2.3M in lost opt out payments	($3.8M)	$1.5M loss to PSR
In OEBB/ PEBB Opt Out	100	$0 to $1.1M	$280K to $320K	($0.5M) to $0.6M	$0 to $1.1M Plus $0.2M loss to PSR
In PEBB/ OEBB Opt Out	600 (OEBB)	($5.4M) to $0	($0.2M) to $0	($5.2M) to $0	($5.4M) to $0
PEBB Opt Out/ In Other	2,032	None	None	None	None
Total PEBB	**6,628**	**($9.6M) to $3.8M**	**$1.0M to $1.6M**	**($12.3M) to $0.5M**	**($7.9M) to $5.5M**

EXCLUDES IMPACT ON OEBB COSTS AND CONTRIBUTIONS


MERCER

HEALTH WEALTH CAREER

REVIEWING THE PHARMACY LANDSCAPE

OCTOBER 16, 2018

Virginia Rivas, Pharm.D.
West Market Pharmacy Lead

AGENDA

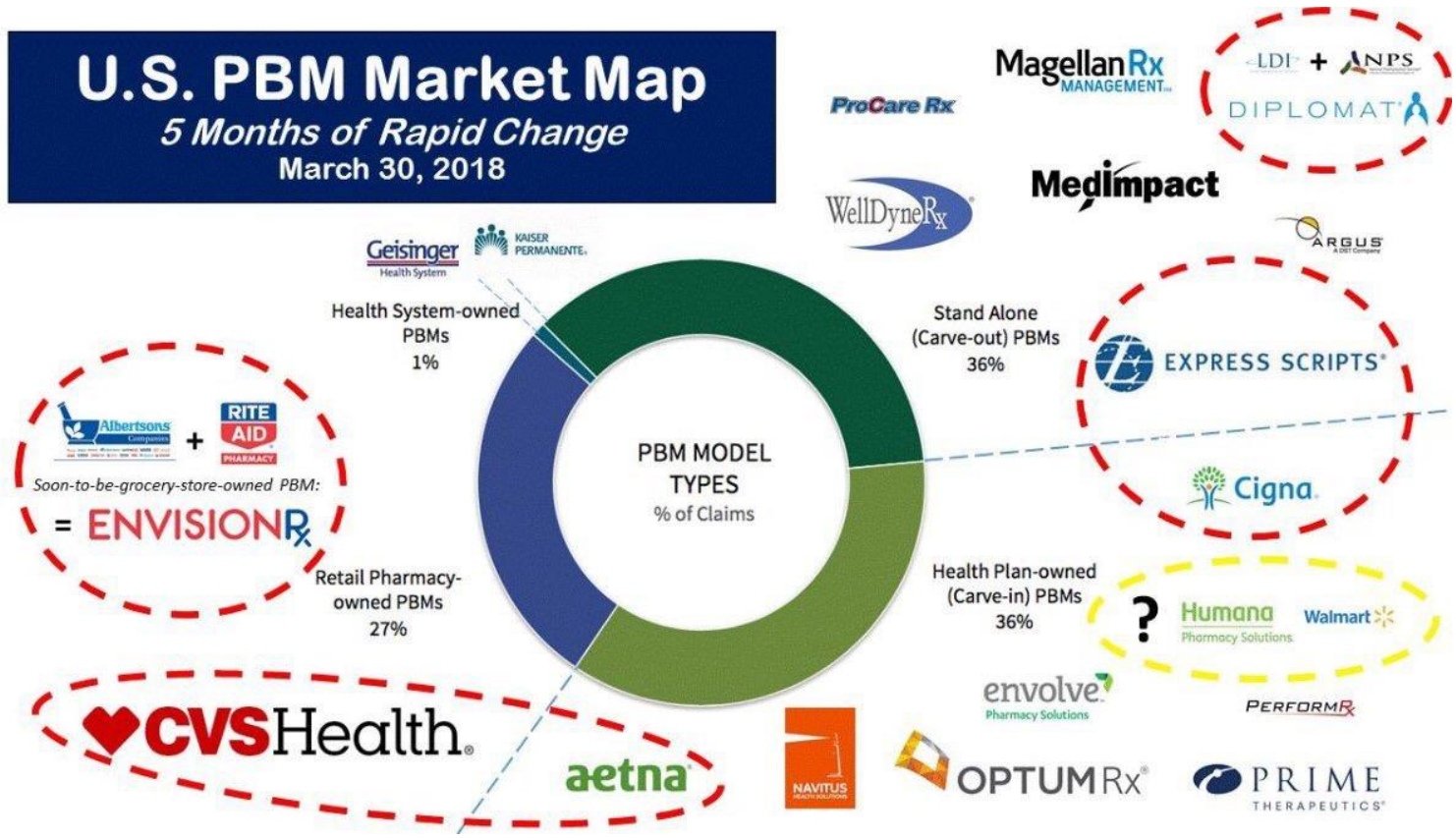
1 PBM MARKET AND INDUSTRY UPDATES

2 UPWARD PRESSURES ON DRUG PRICES

3 PHARMACY MANAGEMENT CONSIDERATIONS

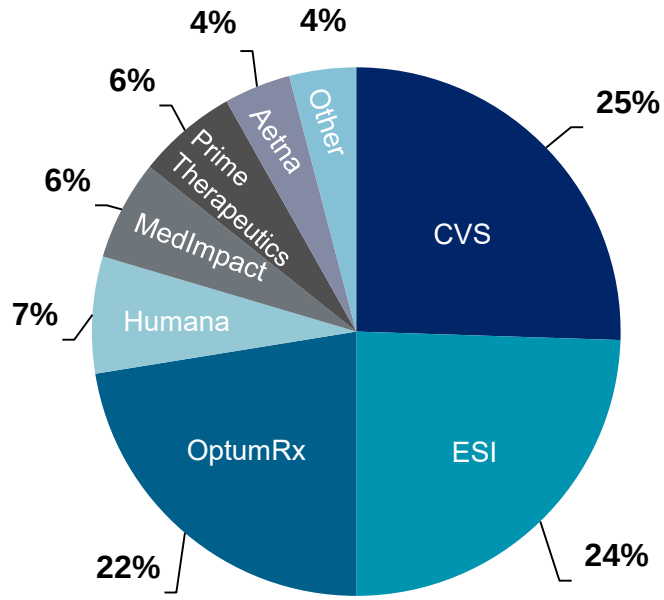
PBM MARKET AND INDUSTRY UPDATES

EVOLUTION OF THE PBM MODEL



- Three prevalent models have developed in Rx management—carve-out, retail based and health plan owned
- In general market share has shifted away from pure carve-out to carve-in and retail owned
- Aetna/CVS will blur these lines further but carve-in/integrated is gaining traction

2017 PBM MARKET SHARE
BY TOTAL EQUIVALENT RX CLAIMS MANAGED

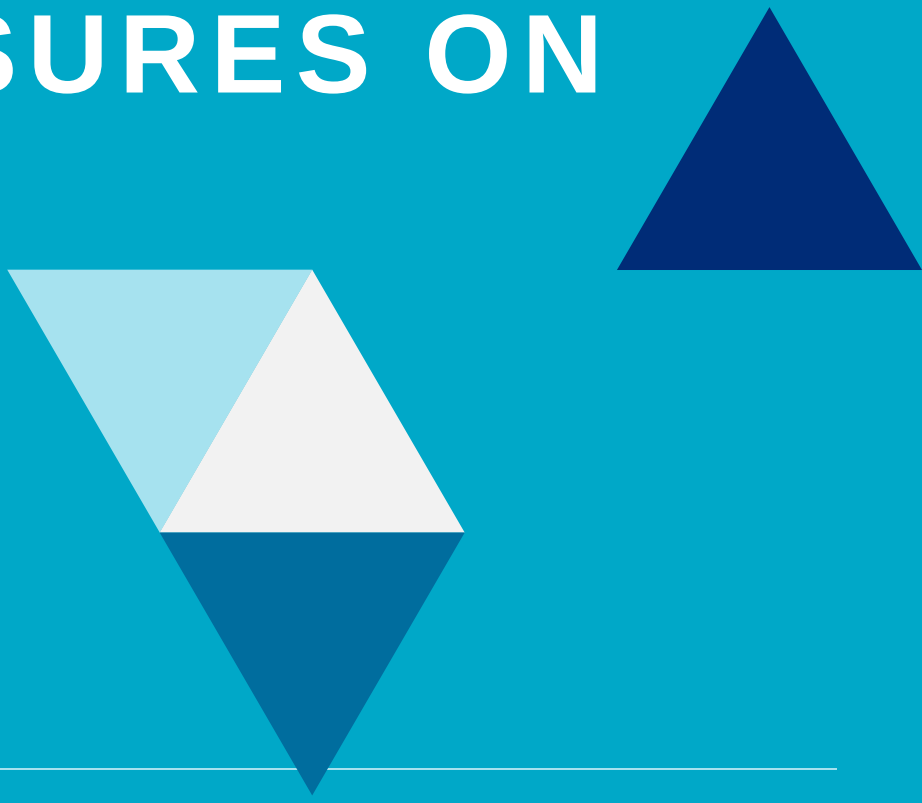


- **Express Scripts**
  - Expected to be acquired by Cigna by YE 2018
  - Formed joint venture with Walgreens on purchasing of specialty medications, ValoremRx
- **CVS/caremark:**
  - Acquisition of Aetna projected to close 2H 2018
  - Supporting Anthem's PBM (IngenioRx), effective 1/1/2020
- **EnvisionRx**
  - Albertson's in the process of acquiring Rite Aid (EnvisionRx' parent company)
- **MedImpact**
  - Large presence in the Health System vertical
- **Optum**
  - Currently supports many back-end fulfillment processes for Cigna
- **Prime Therapeutics**
  - Formed AllianceRx, a specialty and mail pharmacy joint venture with Walgreens
- **Walmart**
  - Rumors have been circulating that Walmart is looking to acquire Humana

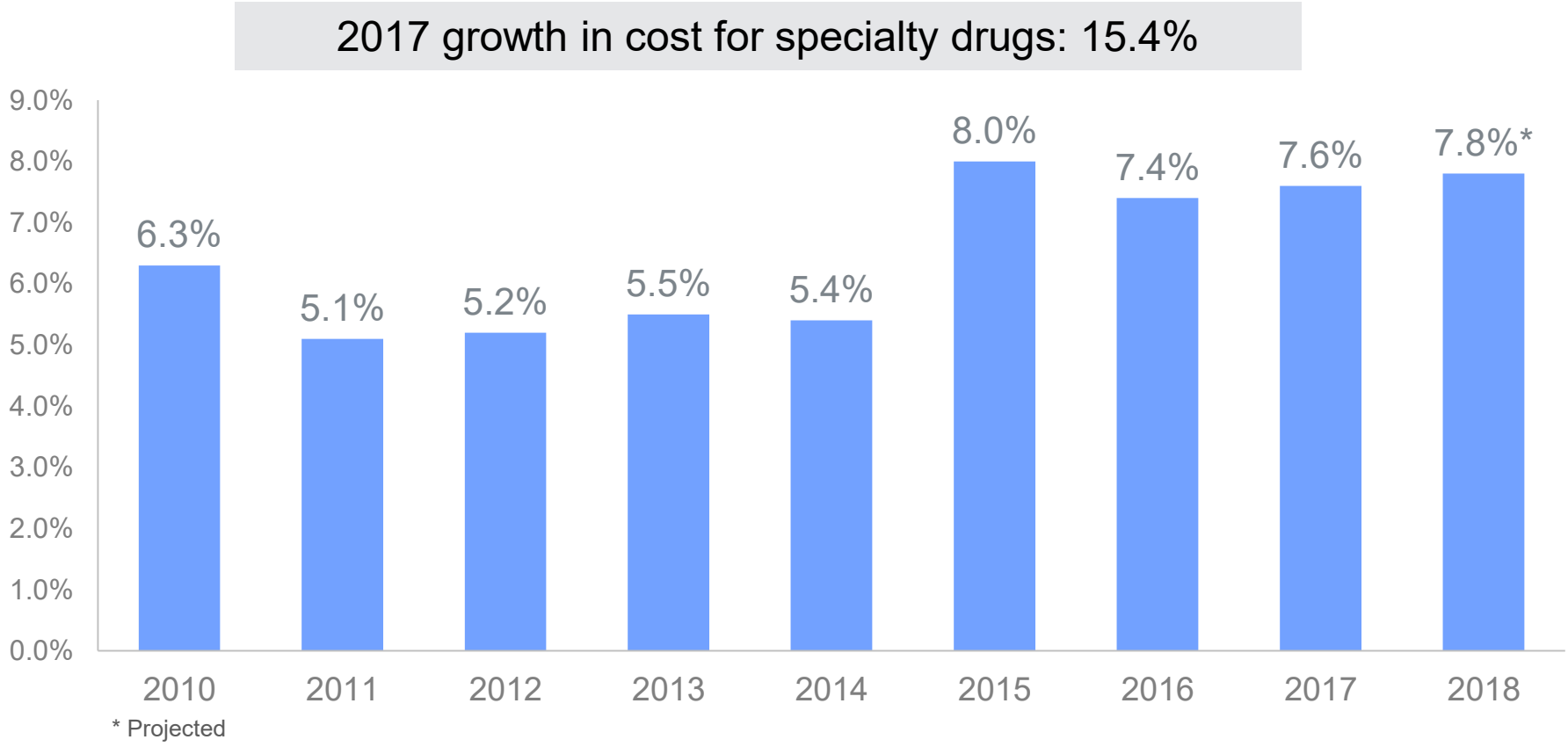
CVS market share excludes claims processed by Aetna

Source: Drug Channels Institute research and estimates

UPWARD PRESSURES ON DRUG PRICES



DRUG COSTS IN EMPLOYER HEALTH PLANS CONTINUE TO RISE NEARLY 8% PER YEAR



Avg. annual change in prescription drug benefit cost for large employers
Source: Mercer National Survey of Employer-Sponsored Health Plans

HOT PHARMACY TOPICS IN THE NEWS

February 2, 2018

"… [A] recently approved revolutionary gene therapy drug aimed at treating a rare type of inherited retinal dystrophy will come with an eye watering price tag."

New million-dollar eye treatment

April 25, 2018

"The price of just one of [her] drugs will be about $600,000 this year."

Mother, wife, million-dollar patient

May 11, 2018

"Drugs that can cost tens of thousands of dollars a month mostly treat rare conditions."

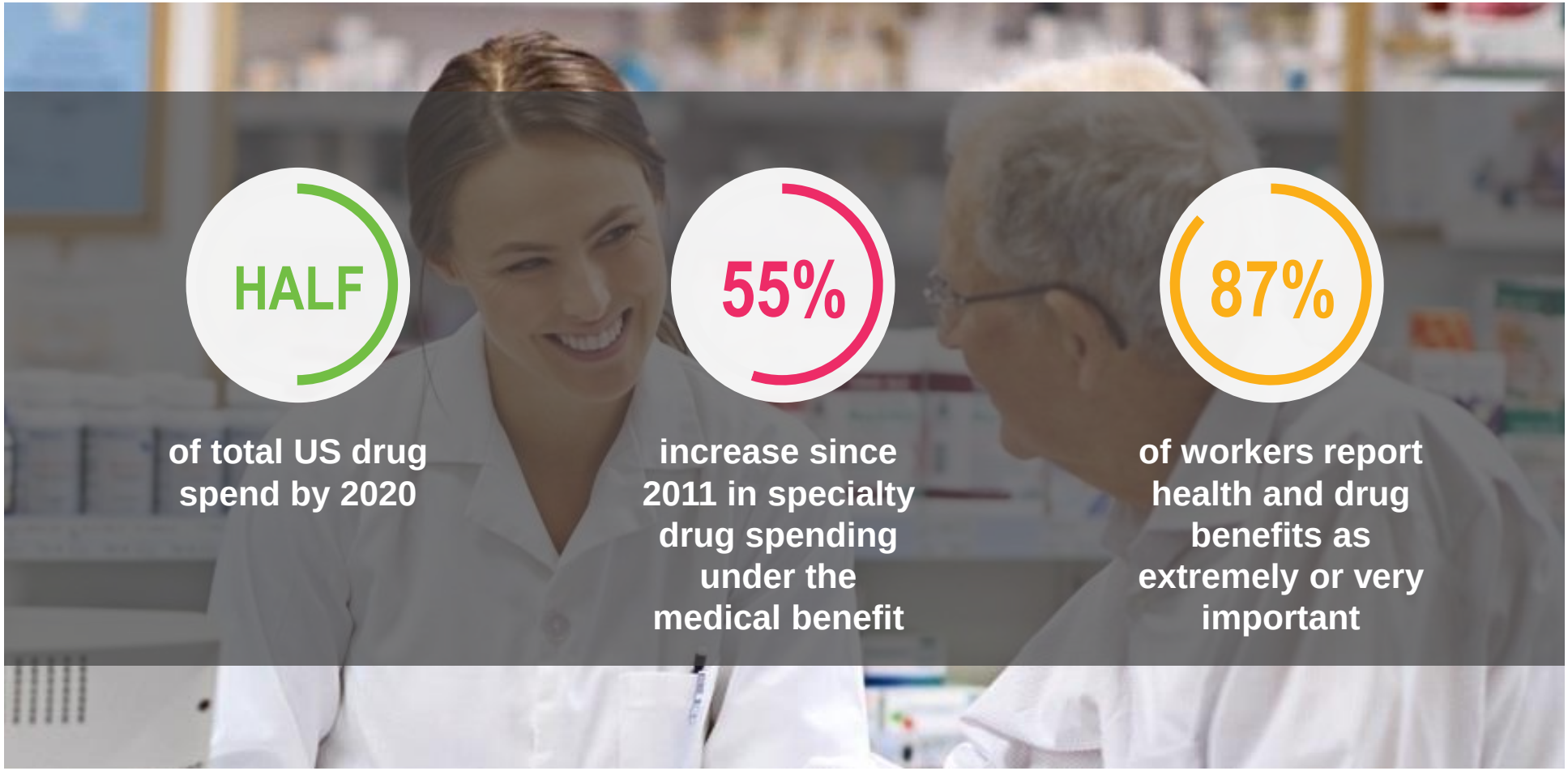
The 5 most expensive drugs in the United States

July 27,2018

"A growing chorus … is calling for a rethinking of after-the-fact drug discounts (rebates) that some say contribute to rising prices."

Meet the rebate, the new villain of high drug prices

THE GROWING IMPACT OF SPECIALTY DRUGS



Source: Pharmacy Benefit Management Institute: *Trends in Specialty Drug Benefits,* 2018.

PIPELINE OVER THE NEXT FIVE YEARS

75% Specialty drugs

30% Priority review by FDA

15% Breakthrough therapy

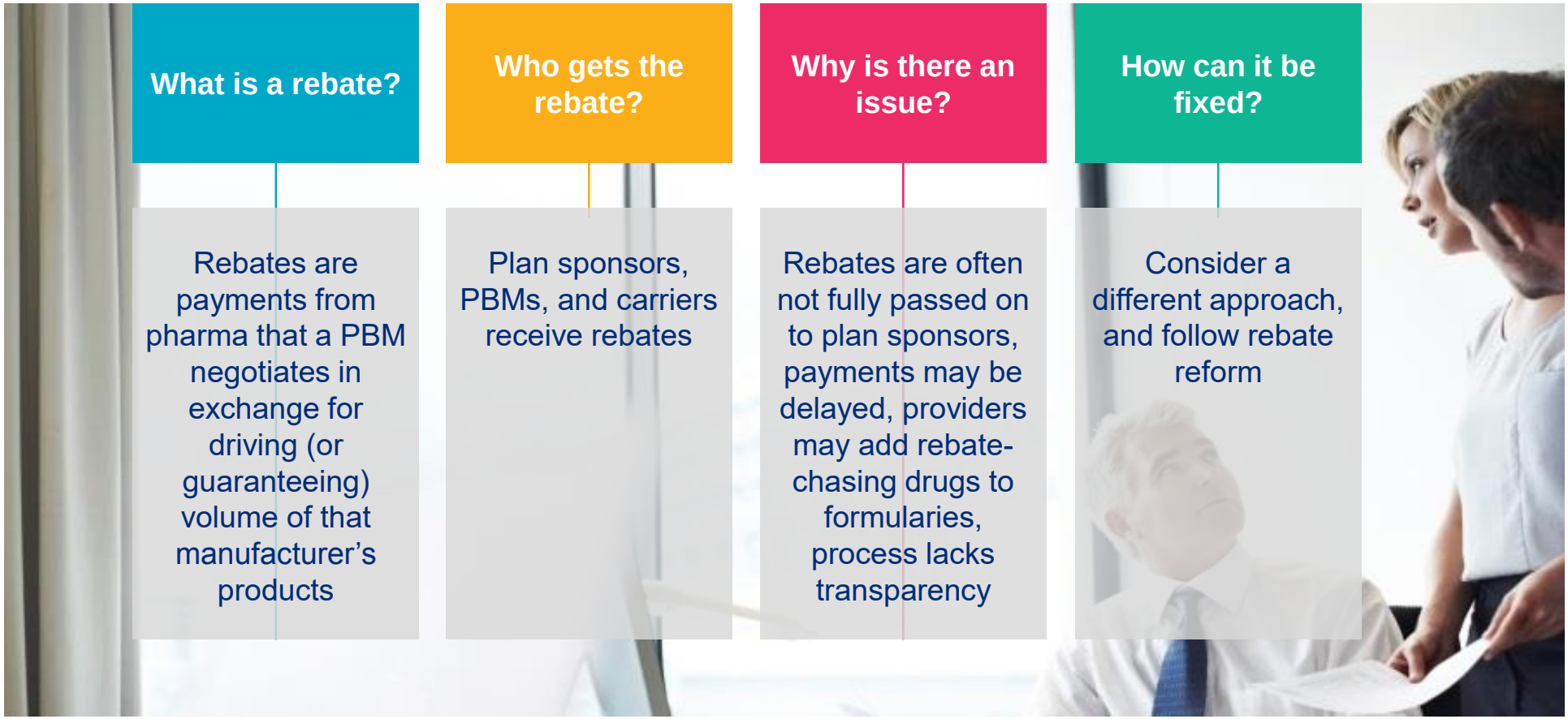
55% Biosimilar

30% Orphan drugs

Major areas of focus

- Cancer
- Hemophilia
- Alzheimer’s
- Migraine prophylaxis
- Liver
- Gene therapy

REBATE OVERVIEW



What is a rebate?

Rebates are payments from pharma that a PBM negotiates in exchange for driving (or guaranteeing) volume of that manufacturer's products

Who gets the rebate?

Plan sponsors, PBMs, and carriers receive rebates

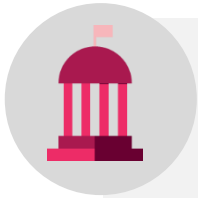
Why is there an issue?

Rebates are often not fully passed on to plan sponsors, payments may be delayed, providers may add rebate-chasing drugs to formularies, process lacks transparency

How can it be fixed?

Consider a different approach, and follow rebate reform

LEGAL RECAP: WATCH REGULATORY AND LITIGATION DEVELOPMENTS, BUT FOCUS ON CONTRACTING



- Few federal legal initiatives to address escalating drug costs in employer sponsored plans:
  - ERISA does not generally regulate what drugs are covered and not covered
  - Efforts to hold PBMs accountable as fiduciaries through the courts have not been successful
  - No action so far on ERISA Advisory Council recommendation from 2014
  - Trump administration focus has been on changes to the public programs with the goal to drive changes across the entire system

- More activity at the state level, but legal barriers could impede progress, and many laws won't apply to self-insured ERISA plans

- For now, plan sponsors should continue to focus on contracting and plan terms

PHARMACY MANAGEMENT CONSIDERATIONS

CONSIDERATIONS FOR PHARMACY MANAGEMENT

Determine where your biggest opportunities are to manage specialty trend – Rx and medical

Gauge your dependence on rebates, and consider alternatives

Monitor federal and state legislative initiatives and regulatory changes

Revisit current arrangements to address areas for improvement

OPDP
Oregon Prescription Drug Program

PEBB Board Meeting

10/16/2018

Oregon Health Authority

Trevor Douglass, DC, MPH

Outline

- Historical roadmap of OPDP
- Success and experience
- What we do!
- Discount card
- Transparency
- What has OPDP done for you lately?

History

2003

OPDP was established – Oregon's only prescription drug purchasing pool.

2006

OPDP joined with the Washington Prescription Drug Program (WPDP) to form the Northwest Prescription Drug Consortium to pool drug purchasing and bring the best price to participants.

2007-08

Moda Health selected to administer the Consortium program and expand participation. Consortium launches with Washington's Public employees and Oregon's Educator Benefits Board.

2010

Consortium expands scope of services with new RFP to include Medicaid, Medicare, GPO and 340B programs. Moda Health selected to administer program.

2013

OPDP launches GPO program to include Traditional and Non-Traditional non-profit entities.

2015

Through passage of Oregon House Bill 2638, Medicaid received authorization to join OPDP. Any Medicaid Health Plan can elect to use OPDP's programs and contracts to better manage their program costs.

2016

Consortium extends current agreement with Moda through 2021.

2017

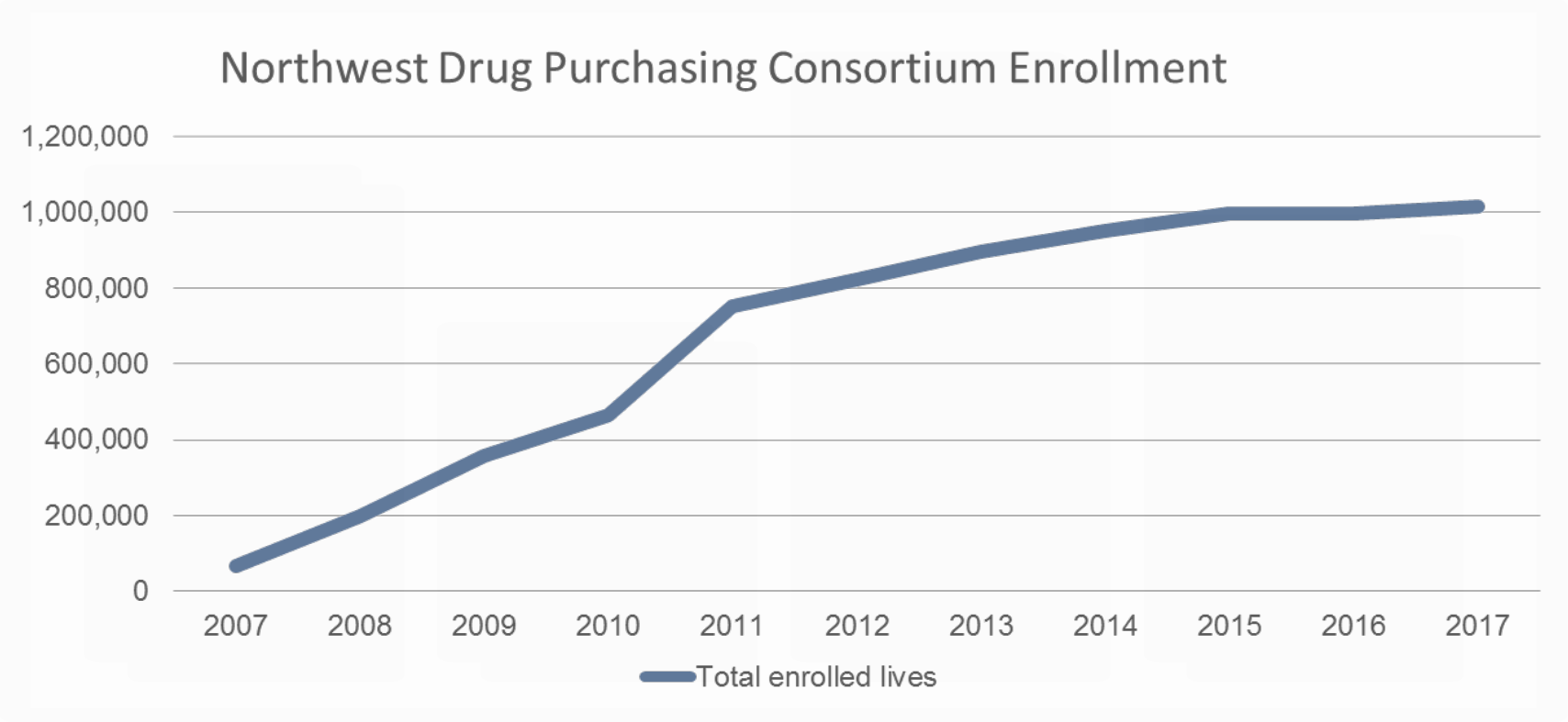
Eastern Oregon CCO joins Consortium, adding Managed Medicaid as a participant in program.

2018

Consortium facilitates more than $800 million in annual drug purchases for over 1 million people in participating groups and facilities.

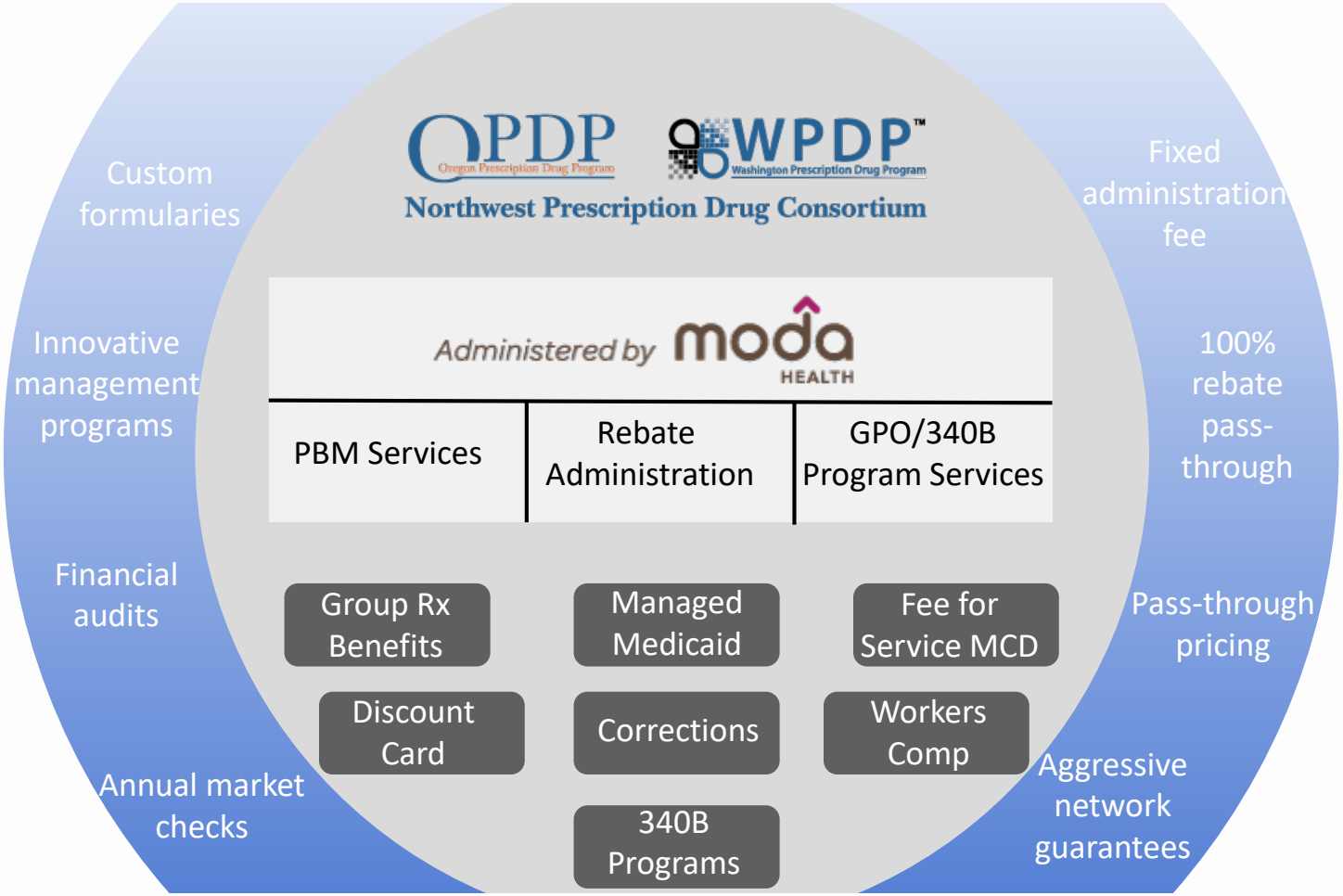
Success

More than a decade of continued and sustainable growth



Northwest Prescription Drug Consortium

1.2 million lives enrolled



OPDP Rx Discount Card Program

Total Members enrolled through

August 31, 2018: 307,645 Oregonians

- ✓ Member savings over past 12 months: $12,427,732
  - o Total member savings last month: $1,012,604
- ✓ A viable program to assist members with closed formularies.
  - o Program delivers discounts on brand and generic products at POS.
- ✓ Any resident of Oregon can enroll in OPDP.
  - o There are no age or income restrictions

Full Transparency

- Clarity in PBM Contracting
- Annual Market Check
- 100% Rebate Pass-through
- Fixed per claim fee
- Performance above guaranteed rates

Administrative Fee Savings

OPDP Oregon Prescription Drug Program WPDP Washington Prescription Drug Program

Northwest Prescription Drug Consortium

Integrating Solutions for Best Value

October 5, 2018

Ali Hassoun, OEBB-PEBB Interim Administrator
Public Employees' Benefit Board
500 Summer St NE
Salem, OR 97301-1097

Re: New Rx Claims Admin Fee Effective October 1, 2018

Dear Ali,

The Oregon Prescription Drug Program (OPDP) and Moda thank and greatly value you for being a participating member with us since 2015. As you may know, we initiate and conduct annual market checks to ensure we remain competitive. These market checks validate our network rates and administration fees are competitive.

We are writing to share good news. We are pleased to announce effective October 1st 2018, the following change in administrative fees will take place:

- The administrative fee will be lowered to $1.85 from $2.95 per claim. From January through June 2018, Public Employees' Benefit Board (PEBB) had 39,832 claims. With a similar number of claims during 2019, when PEBB is under an ASO arrangement, PEBB can expect to save approximately $87,600 annually ($1.10 per claim) due to this new, lower administrative fee.

$87,600 in additional savings for PEBB

$986,000 in additional savings for OEBB

Network Performance Summary[1]

Rx type	Overperformance 2017	Overperformance Jan.-Jun. 2018
Retail, Choice 90, Mail, and Specialty	$ 19.50 M	$ 13.70 M
Dispensing fees	$ 0.50 M	$ 0.32 M
Total Overperformance	**$20.40 M**	**$14.02 M**

[1] Consortium Network Performance reflects performance of all Participating Programs in Washington and Oregon in the aggregate across all distribution channels.

In Closing

OPDP continues to innovate and adapt to health system changes and seeks out opportunity to explore how we can synergistically deliver exceptional care at reduced costs while promoting the health and well-being of all Oregonians.

Questions?

OPDP
Oregon Prescription Drug Program

More information:

http://www.opdp.org

Trevor Douglass, OPDP and Pharmacy Purchasing Director
Oregon Prescription Drug Program (OPDP)
Trevor.Douglass@state.or.us
971-209-8491

Kaiser Permanente Pharmacy Program

October 16, 2018

Presented by:

Dr. Keith Bachman, PEBB Medical Director
Sunshine Sommers, Manager, Clinical Pharmacy Services

PEBB Board Attachment #6

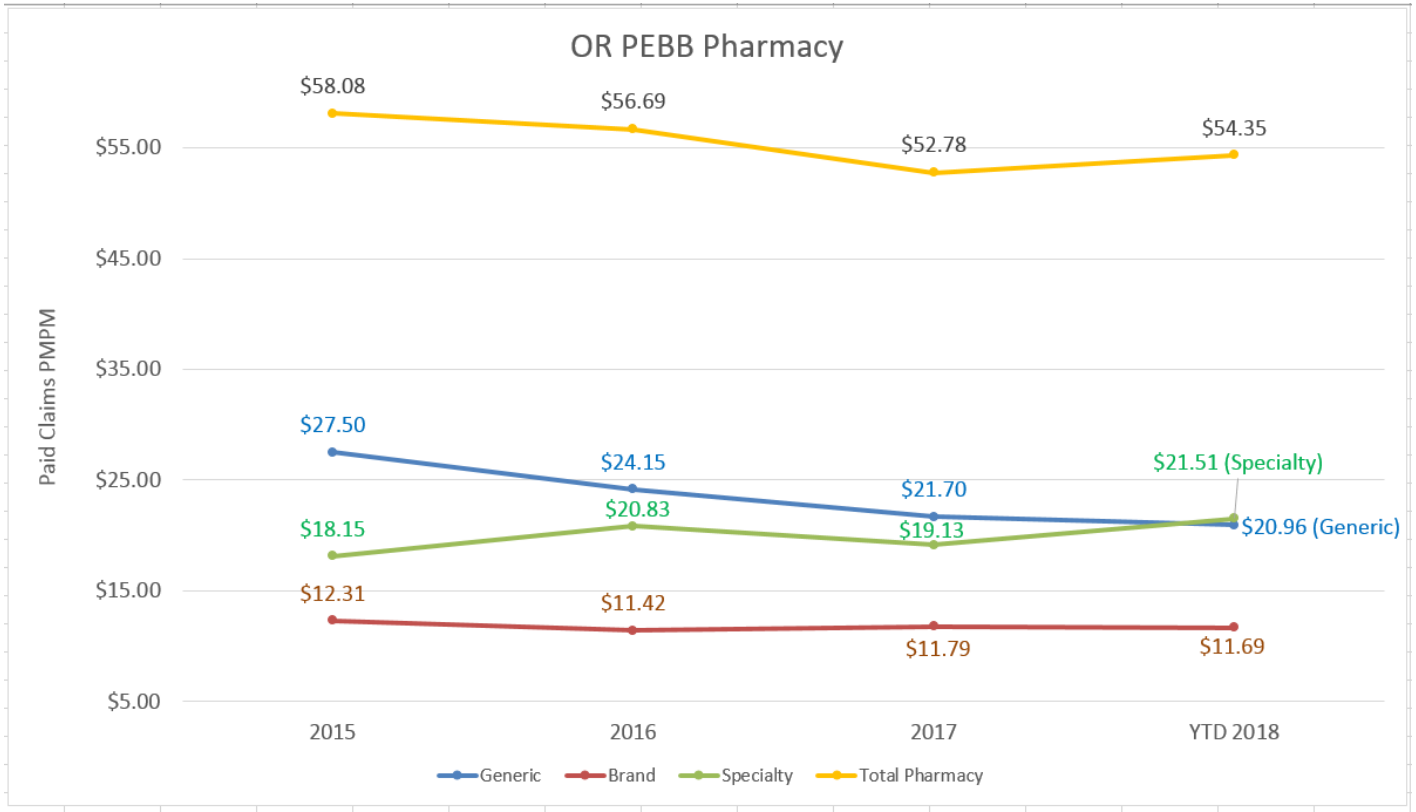
KAISER PERMANENTE®

Agenda

- Cost Overview
- Pharmacy Program Highlights
- Rebates
- Targeted Therapy Classes
- Site of Service
- Infused Medications
- Cost Containment

KAISER PERMANENTE®

Pharmacy Program – Overview of PEBB's PMPM Performance



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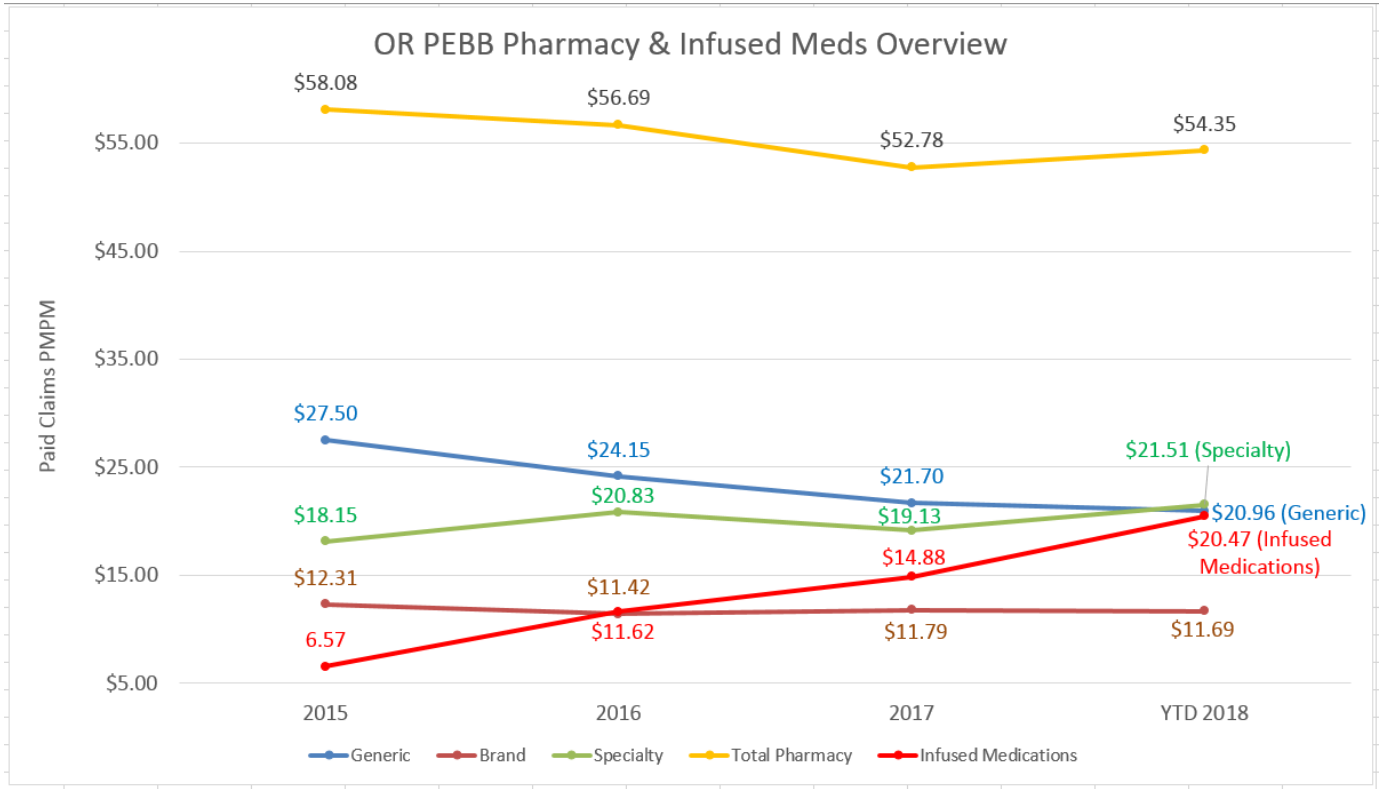
Pharmacy Program – Overview of PEBB's PMPM Performance



KAISER PERMANENTE®

Question: Describe your Medical Pharmacy program and capabilities.

Pharmacy Program

Evidence-based and guideline-supported medicine

Contracting strategy

Tight collaboration

Industry-leading concessions

Information sharing from KP pharmacy vs. drug manufacturer representatives

Physician participation in development

71% more outpatient prescriptions per store daily than Walgreens

more oncology treatments for patients every day than The University of Texas MD Anderson Cancer Center or Memorial Sloan Kettering Cancer Center.

4th largest non-profit acute care pharmacy health system in the country

KAISER PERMANENTE®

KP Pharmacy – How do we do it?

In Collaboration with the Medical Group:

- Our KP Pharmacy program is mutually exclusive with our medical group and operates as our own internal PBM and not a disjointed third party
- Clinic Pharmacists partner directly with our Physicians in disease management, medication adherence, and minimizing waste
- Our Physicians work in clinic and attend KP-sponsored educational events without the presence of pharmaceutical representatives
- Disease management protocols are built into our EMR
- High-priced specialty drugs are managed by a handful of subspecialists who are best able to care for these complex conditions and fully understand our protocols

Kaiser Permanente's Specialty Rx Strategy

Approach to Managing High Cost (Specialty) Drug Costs

Our primary goal is to provide members with affordable, safe, and effective care. Our integrated design offers unique advantages to ensure members are diagnosed early, treated appropriately, and have access to the medications they need.

- Leverage KP's Comprehensive Drug Utilization Management Programs
- Introduce New Benefit Design Options in Market
- Support More Rational Pharmaceutical Pricing

Strategy Reviews in Progress and Planned

Vision loss

due to confirmed biallelic *RPE65* mutation-associated retinal dystrophy

Phenylketonuria

Hemophilia type A

Sickle cell

Migraine prophylaxis

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Managing Specialty Drug Costs – Key points

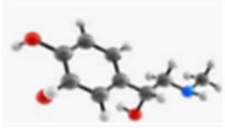
- Specialty Pharmaceuticals present a challenge to the entire U.S. Health Care system
- Drug Cost Management tools have been utilized and fine tuned in our system for decades
- We are expanding existing tools and implementing new tools as we address Specialty Pharmaceuticals
    - Physician expert review
    - Clinical pharmacists working with physician and patient
    - Appropriate use of non-drug therapy
    - Stopping ineffective treatments
- Our integrated culture is our differentiator

Question: What medical benefit therapy classes/drugs are targeted in your medical pharmacy program?

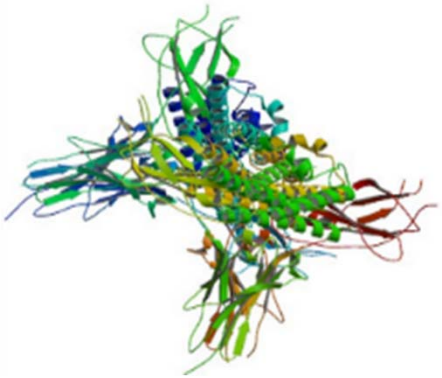
Biosimilars

Small Molecule vs. Biologics

Small molecule: Lisinopril
Molecular weight: 441.52



Large molecule: filgrastim
Molecular weight: 18,802.80



Neupogen biosimilar (Zarxio)
- Approved March 2015
- Litigation
- Launched Sept. 2015

Remicade biosimilar
- Approved April 2016
- Litigation
- Launched Nov. 2016

Enbrel biosimilar
- Approved August 2016
- Litigation

Humira biosimilar
- Approval September 2016
- Litigation

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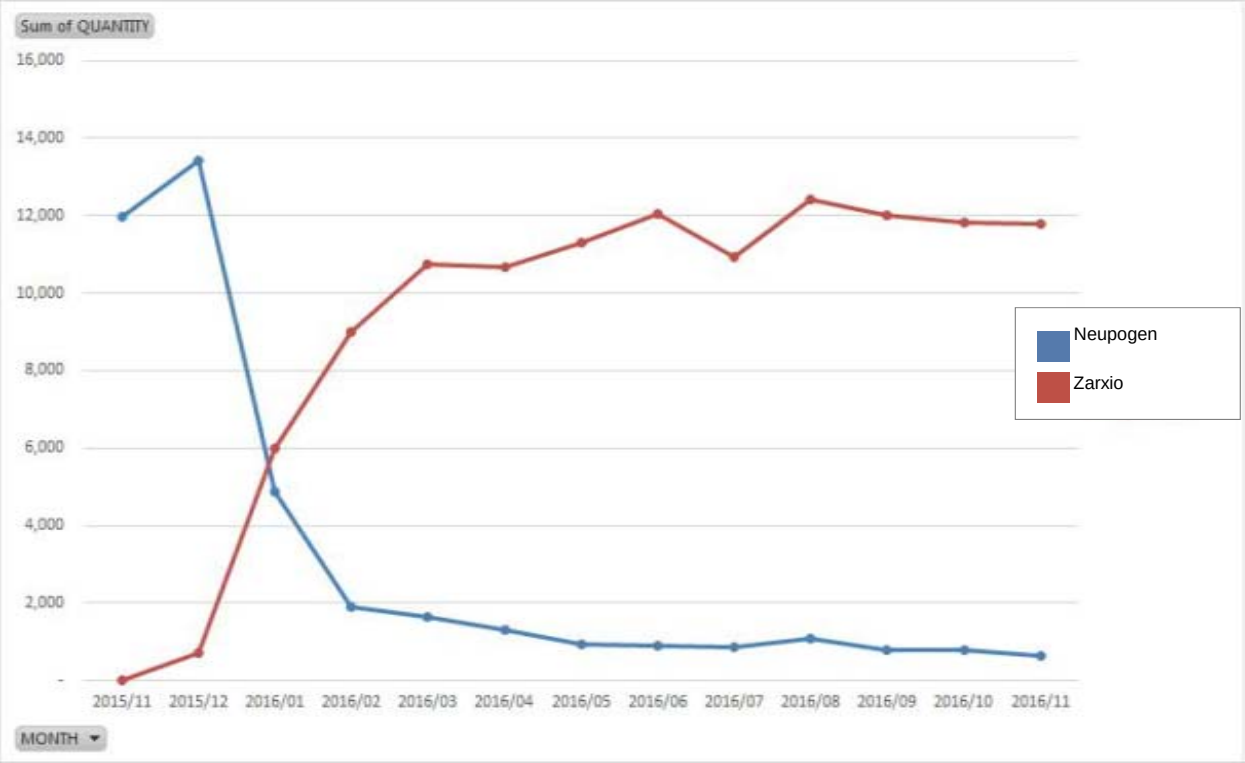
Biosimilars: Neupogen to Zarxio

Kaiser Permanente Market Share 98% / National Market Share 30%



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Pharmacy Program and Capabilities – Pharmacy vs Clinic-Based Injections

Multiple Sclerosis Medications

Date Paid	Total Paid Claims Pharmacy PMPM	Total Paid Claims PMPM Rutixan	Total Paid PMPM
2015	$3.19	$0.11	**$3.30**
2016	$2.65	$0.25	**$2.90**
2017	$1.77	$0.90	**$2.66**
YTD 2018	$1.25	$1.06	**$2.31**

Cost/Prescription/Year (Pharmacy): $64,000
Cost/Prescription/Year (Injection): $11,000

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Question: How are rebates recognized under the current program and to what extent are they shared with PEBB?

Rebates

- Minimal, applied to the gross cost of the drug
- Evidence-based formulary with a primary focus on safety, efficacy, and value
- Strategic purchasing
  - Leverages our purchasing power
  - Uses an annual bid cycle to secure favorable pricing
  - Maximizes economies of scale by volume and adherence and prescription patterns
  - Negotiates contracts ensure product consistency, maintain supply, and control certain price increases
  - Strategically purchases and warehouses products at risk of price increases

Question: What reporting regarding Specialty rebates under medical do you provide and at what frequency?

Rebates

- Not broken out separately
- Factored in our pricing

KAISER PERMANENTE®

Question: Do you offer any Reimbursement Management programs to shift site of service to the most cost effective setting? If yes, does a drug have to be managed through your Prior Authorization to be included in the Site of Service program?

Question: Is your site of care program mandatory or voluntary? Do you charge for this program? If so, is there an ROI guarantee for savings?

Site of Service

- Managed through our care model – examples:
  - Home Infusion
  - Outpatient Clinic
  - Nurse Treatment Room
- Mandatory with special circumstance exceptions
- Protocols are built into our system

Question: Please describe how you manage site of care redirection with specialist physicians whose practices are owned by a hospital/health system.

Site of Service

- Fortunately, we are the hospital/health system tied to our physician group
- For contracted hospitals, we have physicians/specialists/care managers monitoring utilization

KAISER PERMANENTE®

Question: Will you agree to a maximum of ASP+170% for all infused medications with no balance billing to the member?

Infused Medications

- Our current pricing for infused medications averages between 150% - 200% of Medicare

Medication	KP 2018 Price	Oregon Average 2017 (w/standard 3% increase)	US Average 2017 (w/standard 3% increase)
J1745 - Injection, infliximab, excludes biosimilar, 10 mg	$171.00	$216.00	$380.00
J0178 - Injection, aflibercept, 1 mg	$1,960.00	$2,297.00	$2,801.00
J9310 - Injection, rituximab, 100 mg	$1,637.00	$2,775.00	$2,918.00
J9228 - Injection, ipilimumab, 1 mg	$289.00	$321.00	No US Average
J0585 - Injection, onabotulinumtoxina, 1 unit	$12.00	$20.00	$25.00
J9171 - Injection, docetaxel, 1 mg	$4.00	$9.00	$40.00
J2357 - Injection, omalizumab, 5 mg	$67.00	$77.00	$113.00

Question: Understanding PEBB's annual cost-containment objectives, what additional Rx programs do you have, or are you developing, that would support said objectives?

Managing Pharmacy Costs through Collaborative Drug Utilization Action Team

2018 Initiatives

- Prescribe formulary medications 97% of the time
- Deprescribe medications when risks may outweigh benefits of continued use
- Encourage minimum dose and frequency needed to achieve clinical effectiveness
- Avoid using brand name products when a generic equivalent is available (99.5% generic)

KAISER PERMANENTE®

Pharmacy Support for Medication Adherence Saves Dollars and Improves Quality

Medication adherence

Increasing medication adherence is a cost-effective way to improve patient outcomes and reduce hospital utilization.

Good adherence comparison

Proportion of days covered is greater than or equal to 80%*

Medication prescribed for	Your group's average adherence	Kaiser Permanente regional average
Diabetes	75.9%	73.7%
High blood pressure	82.3%	80.3%
High cholesterol	79.0%	76.9%

* Proportion of days covered is the adherence metric used by Centers for Medicare and Medicaid Services. It is more conservative than and not comparable to the medication possession ratio measure used by many pharmacy benefit managers.

Estimated dollars saved

$749,046

Calculation: Estimate is based on the number of people achieving >80% PDC multiplied by the average cost savings for good adherence. Results by individual condition are aggregated for your group.

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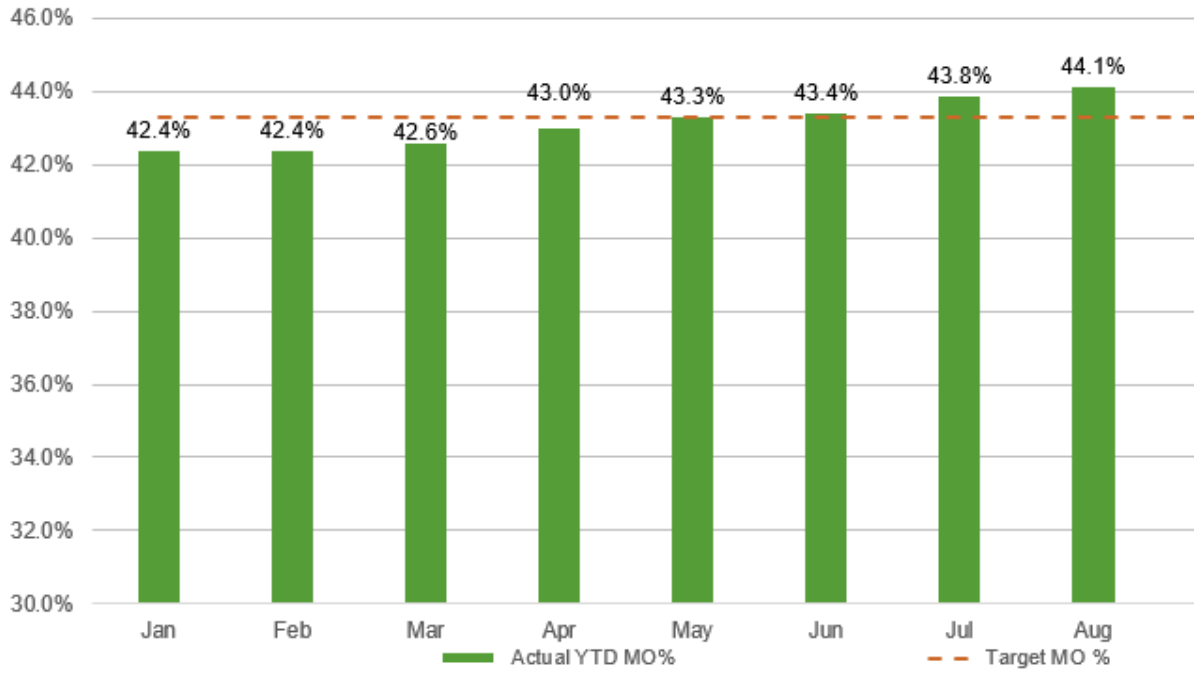
Saving with Increasing Mail Order Utilization



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Saving through Strategic Purchasing

- As one of the nation's largest health care organizations, we can impact the market share of pharmaceuticals. As a result, Kaiser Permanente wins significant pricing concessions from major pharmaceutical vendors. We also:
  - Use an annual bid cycle to secure favorable pricing
  - Leverage economies of scale by volume and adherence and prescription patterns
  - Negotiate contracts that help ensure product consistency, maintain supply and control certain price increases
  - Strategically purchase and warehouse products that are at risk of price increases

Saving through Effective Specialty Drug Management

The Kaiser Permanente National Specialty Pharmacy:

- **Provides access to limited- or exclusive-distribution products —** This helps avoid upcharges and results in savings for our members and commercial customers.
- **Conducts clinical reviews and case management —** Active pharmacist involvement helps ensure appropriate drug use and follow-up.
- **Is accredited by the Utilization Review Accreditation Commission (URAC) —** URAC independently validates our clinical care and service quality in the specialty pharmacy industry.
- **Achieved a patient satisfaction rating of 99.78% in 2017 —** The Kaiser Permanente National Specialty Pharmacy earned near-perfect approval from our members in the Quality of Service Survey.

In 2017, the Kaiser Permanente National Specialty Pharmacy achieved significant cost savings:

$8.3M

Costs avoided by clinical case management services

$28.8M

Cost savings realized from quality assurance and maintaining compliance with contractual, quality, and safety regulations

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Thank You!

KAISER PERMANENTE®

Appendix

Pharmacy Program – Overview of PEBB's Injectables

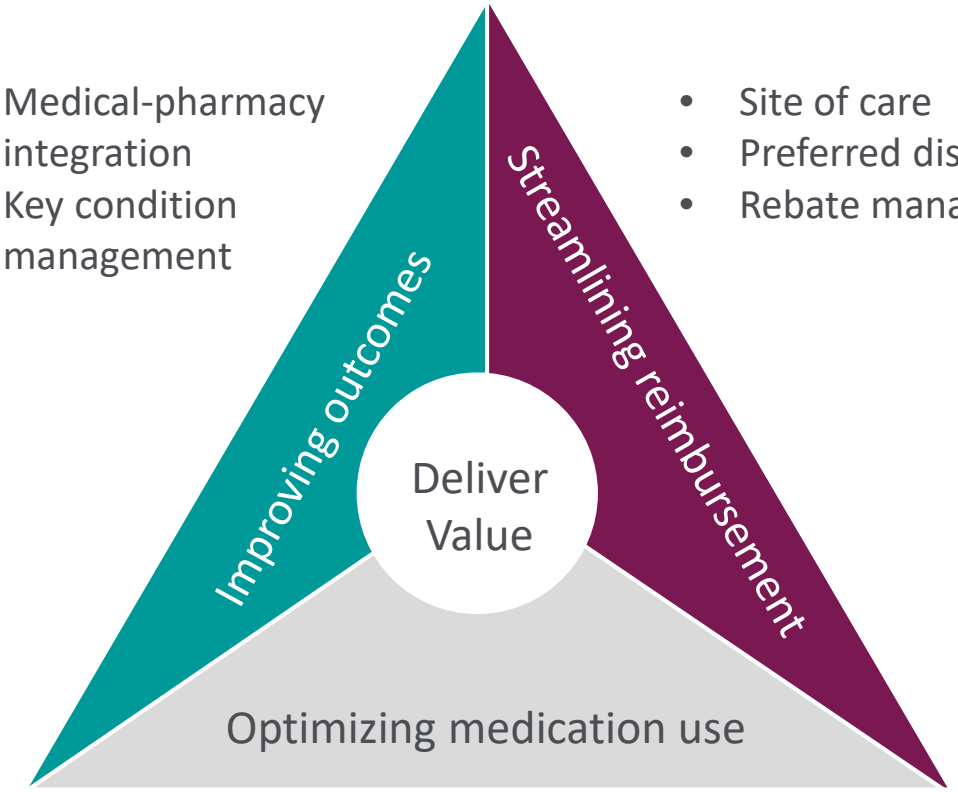
	Paid Claims PMPM			
Date Paid	Infliximab & Biosimilar	Spinraza	All Other Injections	Total
2015	$1.56	$0.00	$5.01	$6.57
2016	$1.95	$0.00	$9.67	$11.62
2017	$2.06	$0.00	$12.82	$14.88
YTD 2018	$0.99	$2.51	$16.97	$20.47

Moda Medical Pharmacy

Carly Rodriguez, Pharm.D
Pharmacy Director, Clinical Innovation

moda

Medical pharmacy management model



- Medical-pharmacy integration
- Key condition management

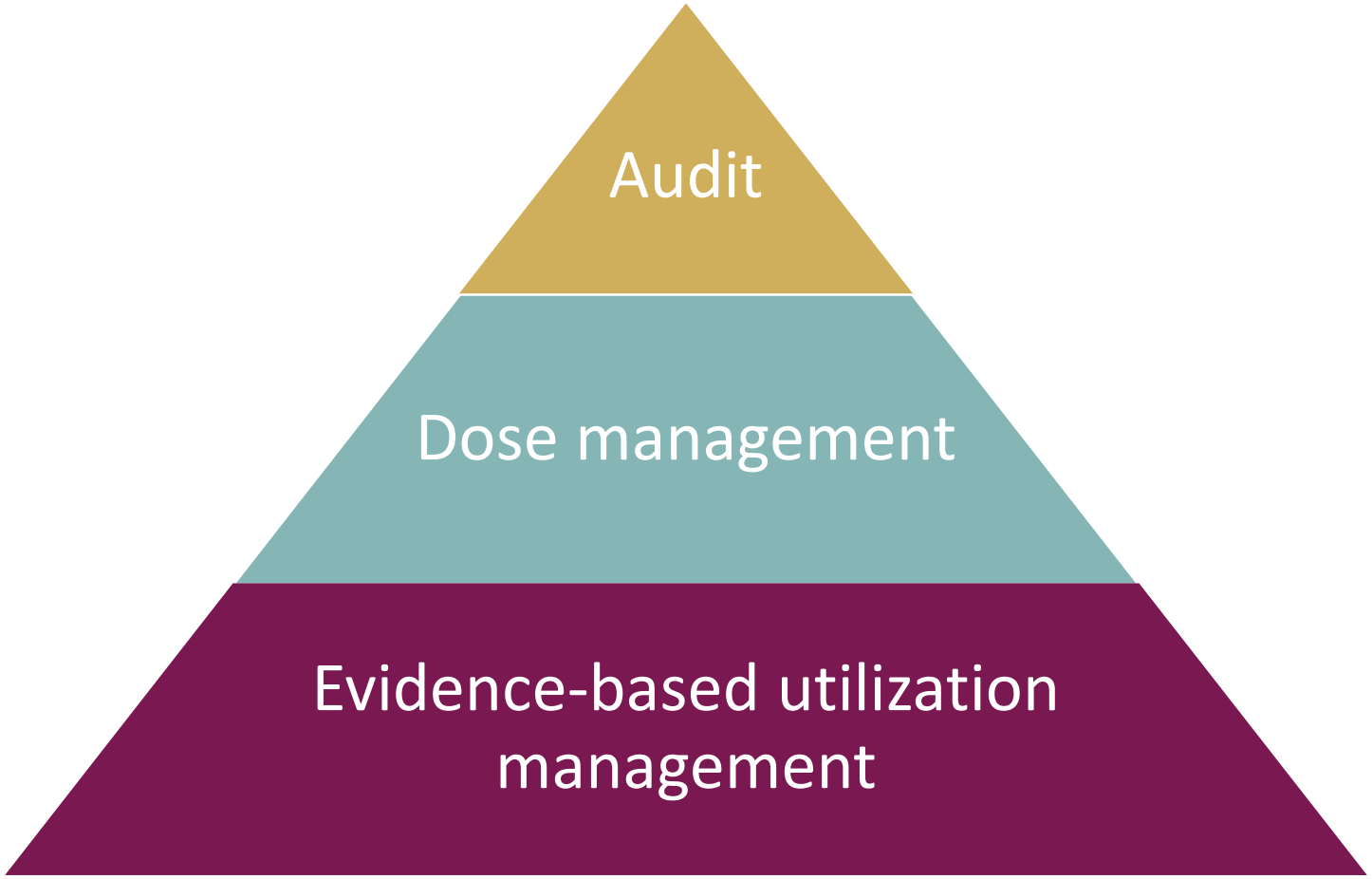
- Site of care
- Preferred distribution channels
- Rebate management

- Evidence-based utilization management
- Dose optimization
- Claim audits

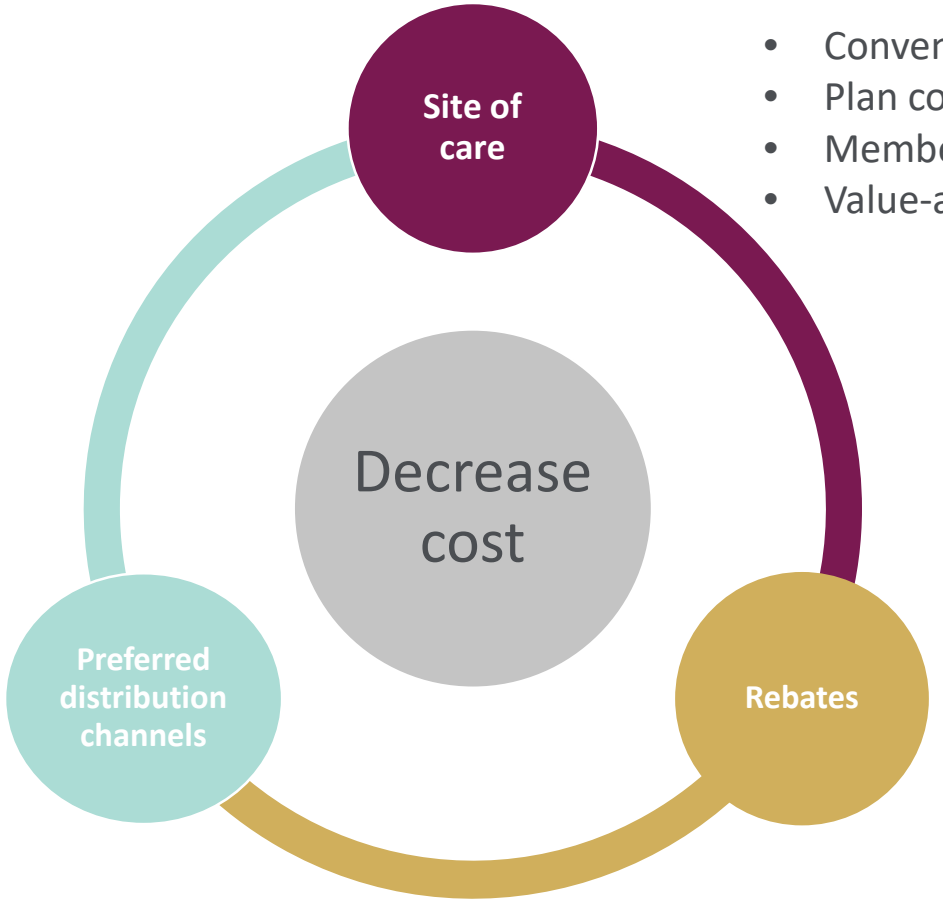
Improving clinical outcomes

- Medical-pharmacy integration
  - Manage a condition, not a benefit
  - Evidence-based drug choices
- Target key clinical conditions
  - Complex conditions
  - Poorly tolerated treatment regimens
  - Several products across benefits
  - High spend and/or high utilization
  - Variability in cost

Optimizing medication use



Streamlining reimbursement



- Convenient, quality care
- Plan cost-savings
- Member cost-savings or cost-neutral
- Value-add

- Better pricing
- More robust data
- Consistent member care

- Pharmacy rebates
- Medical rebates
- NDC capture

New opportunities

- Clinical programs
  - Hemophilia
- Expand channel management strategy
  - Specialty drugs
  - Self-injectables
  - Diabetes supplies
- Expand site of care scope
- Incentivize through benefit design

Questions?

PEBB Board Meeting
10/16/2018

Specialty & Medical Pharmacy Cost, Care, and Utilization Management

Today's Discussion

1. Medical Benefit Management of Medications
2. Site of Service
3. Contracting Opportunities
4. Rebate Management
5. Future Initiatives

Medical Pharmacy

PROVIDENCE Health Plan

Clinical Programs

- **Tailored clinical case review**
  - Collaboration with provider and specialty pharmacy
  - Review for dose and/or opportunities for therapeutic alternatives
  - All drugs and drug classes included in program
- **High cost case review**
  - Pharmacy and Care Management collaboration
  - Weekly Care Management Rounds: Outpatient + Inpatient
- **Hemophilia**
  - Case review for appropriate factor use
  - Best market rates of factor drugs
    - Rate negotiations or transfer site of care
  - Steer to hemophilia treatment center

Medical Pharmacy

Clinical Programs - Example

- **Member with rare disease**
  - Acute attacks - Multiple emergency room admissions
  - Expensive intravenous medications to treat and prevent attacks
  - High cost of infusion services
- **Specialty Pharmacy Team Interventions**
  - Pipeline Review - identification of new self-administered subcutaneous product
  - Collaboration
    - Provider to initiate prior authorization for new product and stop IV therapy
    - Limited distribution specialty pharmacy for procurement and member training
  - Outcome: projected reduction in drug spend by **$780,000 per year**
    - Reduction in ER and inpatient admissions and infusion costs
    - Projected **> $1 million reduction in medical costs** compared to prior year

Medical Pharmacy

Unit Cost

- **Drug Pipeline Review**
  - Procurement strategy, site of care, place in therapy, value based agreements, cost
- **Site of Care**
- **Dose Optimization**
- **Provider Contracting Collaboration**
  - Reimbursement carve outs/single case agreements for high cost drugs
- **Alternative procurement strategies**
  - Channel management

Medical Pharmacy

Unit Cost - Example

- **Spinraza - high cost injection for rare condition**
  - Traditional hospital buy and bill: $millions per year in drug mark-up
- **Specialty Team Interventions**
  - Provider Contracting Collaboration
    - Carve out in provider contract from general infusion reimbursement
  - White bagging
    - Letter of agreement with limited distribution specialty pharmacy
    - Bill insurance under member benefit and direct shipment to provider
    - **Care collaboration** prior to injection**:** ensure no medication wastage

Results: projected **> $3 million in reduction** in drug spend for 1st year of therapy

Medical Pharmacy

Inpatient Hospital High Cost Admission Review

- **Collaboration between Pharmacy and Medical Review**
  - High cost driven by drugs
  - Match clinical appropriateness of drugs to billed itemized statements
  - Screen for administration of outpatient drugs that require a prior authorization
- **Concurrent Review**
  - Weekly Clinical Rounds with Care Management
  - Consultation on medication issues for concurrent high cost admissions

Site of Care

- Voluntary program to transfer infusions from higher cost to lower cost site of care
- No additional charges or fees
- Physician practices owned by hospital/health system
  - Incentive to refer infusions to hospital infusion center
  - **Solution**
    - PSJH hospital infusion centers Portland service area
      - Carve-out for best market rates for highest utilized infusions
        - >$110,000 in savings through 7/2018 ***($0.12 PMPM reduction***)
    - Member engagement
      - Direct member contact
      - Discuss convenience/flexible schedule of Providence Infusion
        - Infusion rooms (2 in Portland area, 1 in Salem, 1 in Medford)
        - Home infusion

Specialty Pharmacy Team Interventions: Results

- High quality care at the most affordable cost
  - Improve clinical outcomes
  - Optimize medication therapy
  - Reduce drug spend + medical (non-drug) spend

- Reduction in drug spend realized for all PEBB Specialty Pharmacy Interventions

$3.4 million in savings for PEBB
$1.20 PMPM

Contracting Opportunities

- Specialty Pharmacy Contract: achieved best market rates effective 6/1/18
- Provider Contracts: continued drive to best market rates on infused meds
- PHP does support a PEBB maximum of ASP + 170% on all infused meds
  - However, PHP will continue to push for even lower rates

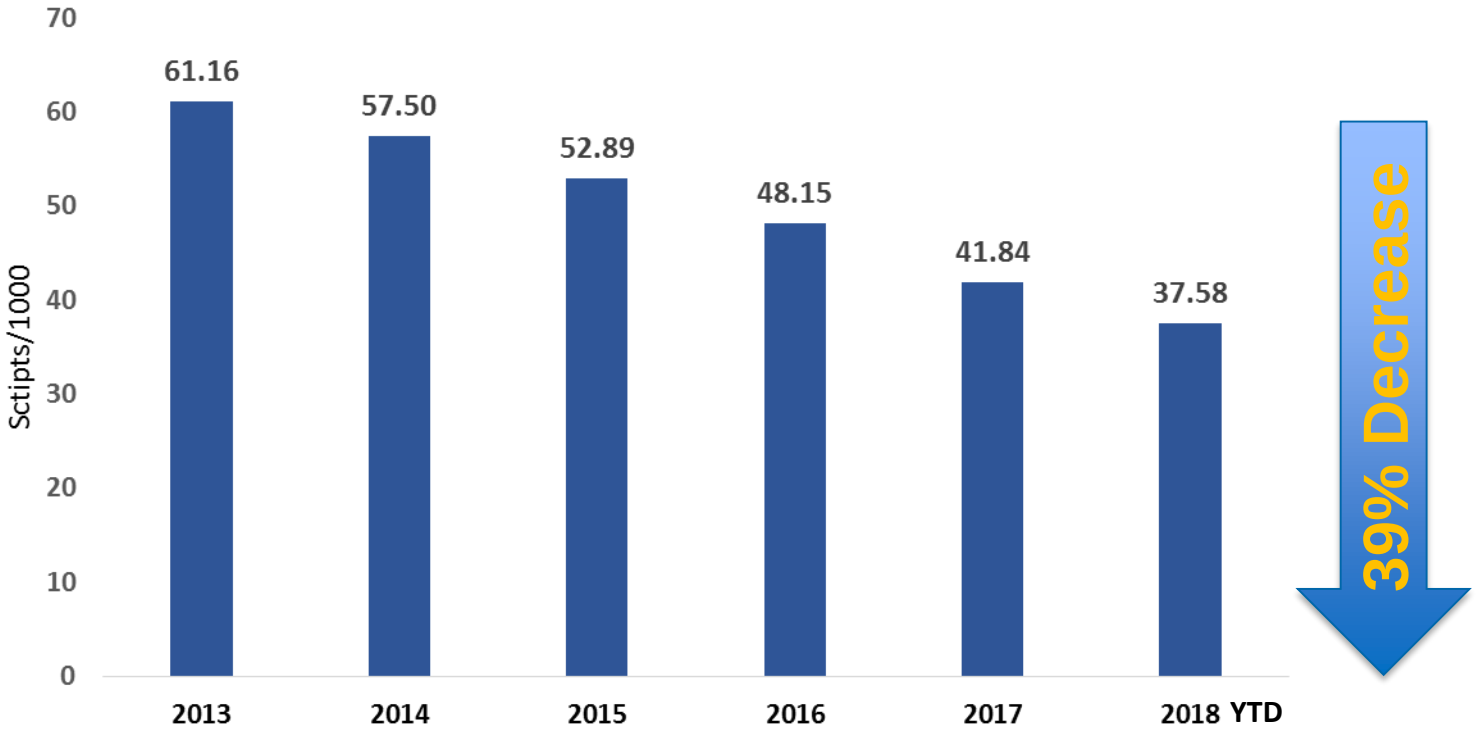
Rebates

Similar to outpatient RXs, rebates on medical infusibles are passed through at 100% to PEBB

- PHP directly contracts with manufacturers to garner rebates on preferred infused agents, resulting in the lowest net cost product for the payer/member
- Rebates for medications received under the medical benefit are included with bimonthly rebate payment and reporting that PEBB receives
- Indicated as “office and facility based rebates (infusibles)” on report

39% decrease in opiate use

PEBB Choice and Statewide combined



Looking Ahead

Whole person care

- Drug development pipeline almost exclusively new drugs to treat rare disease(s)
- Programmatic management of Gene therapy including planning for care coordination, reimbursement and clinical oversight
- Patient centered case/care management with targeted contracting
- Evaluation of criteria centered around disease states (i.e.: diabetes) rather than individual drugs
- Continued evaluation of place in therapy and reimbursement for biosimilars

PROVIDENCE
Health Plan