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**

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:30 a.m. – 9:35 a.m.</td>
<td>Welcome &amp; Approval of September 18, 2018 meeting synopsis (action)</td>
<td>Shaun Parkman, Chair</td>
</tr>
<tr>
<td>9:35 a.m. – 9:40 a.m.</td>
<td>State Employee Wellness Survey Funding</td>
<td>Margaret Smith-Isa, PEBB Program Development Coordinator</td>
</tr>
<tr>
<td>9:40 a.m. – 10:10 a.m.</td>
<td>Senate Bill 1067 Double Coverage &amp; Opt-out Elimination Fiscal Analysis (information/discussion)</td>
<td>Emery Chen and Robert Valdez, Mercer Health &amp; Benefits, LLC</td>
</tr>
<tr>
<td>10:10 a.m. – 10:35 a.m.</td>
<td>Pharmacy Benefit Trends</td>
<td>Virginia Rivas, West Market Pharmacy Lead, Mercer Health &amp; Benefits, LLC</td>
</tr>
<tr>
<td>10:35 a.m. – 11:05 a.m.</td>
<td>Oregon Prescription Drug Program (OPDP) Update</td>
<td>Trevor Douglass, OPDP Director</td>
</tr>
<tr>
<td>11:05 a.m. – 12:15 p.m.</td>
<td>Pharmacy Services and Programs (Medical Carriers) (information/discussion)</td>
<td>Dr. Keith Bachman, PEBB Medical Director and Sunshine Sommers, Manager, Clinical Pharmacy Services, Kaiser Permanente</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Carly Rodriguez, Director of Clinical Pharmacy, Moda Health Plans</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Helen Noonan-Harnsberger, PharmD, AVP and Aaron Masini, PharmD, Clinical Pharmacy Manager, Providence Health Plan</td>
</tr>
</tbody>
</table>
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

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


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.
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
What’s Included

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

What’s not included

• 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

Assumptions

ASSUMPTIONS AND DEFINITIONS
# Background

## Double Coverage and Opt-Out Scenarios

<table>
<thead>
<tr>
<th>#1</th>
<th>Double Coverage</th>
<th>Opt-Out</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PEBB / PEBB</strong></td>
<td>Jack and Diane both work for different state agencies. Jack and Diane usually both take the PEBB Medical Plan and cover their entire family.</td>
<td><strong>PEBB / PEBB</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#2</th>
<th><strong>OEBB / PEBB</strong></th>
<th><strong>OEBB / PEBB</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#3</th>
<th><strong>PEBB / PGE</strong></th>
<th><strong>PEBB / PGE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>
DOUBLE COVERAGE SCENARIOS
PEBB DOUBLE COVERED

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**

<table>
<thead>
<tr>
<th>Double Covered PEBB Family</th>
<th>Statewide Family Coverage (Annual Costs)</th>
<th>Providence Choice Family Coverage (Annual Costs)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2019</td>
<td>2020</td>
</tr>
<tr>
<td>Employee Premium Share</td>
<td>$1,274</td>
<td>$1,274</td>
</tr>
<tr>
<td>Spouse Premium Share</td>
<td>$1,274</td>
<td>$0</td>
</tr>
<tr>
<td>Family Medical Deductible</td>
<td>$750</td>
<td>$750</td>
</tr>
<tr>
<td>Pharmacy Deductible</td>
<td>$150</td>
<td>$150</td>
</tr>
<tr>
<td>12 Generic Drug Copayments</td>
<td>$0</td>
<td>$120</td>
</tr>
<tr>
<td>12 Brand Copayments</td>
<td>$0</td>
<td>$360</td>
</tr>
<tr>
<td>12 Specialty Drug Copayments</td>
<td>$0</td>
<td>$1,200</td>
</tr>
<tr>
<td>12 Primary Care Copayments</td>
<td>$0</td>
<td>$300</td>
</tr>
<tr>
<td>Total</td>
<td>$3,448</td>
<td>$4,154</td>
</tr>
</tbody>
</table>
## Double Coverage Finances
### #1: PEBB Double Covered

<table>
<thead>
<tr>
<th>Number Covered</th>
<th>Impact on Premium</th>
<th>Impact on Agencies and PEBB</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 1,963 employees</td>
<td>• Decrease in out-of-pocket costs of $3.3 million (coordination)</td>
<td>• <strong>Agencies</strong>: 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</td>
</tr>
<tr>
<td></td>
<td>• Total number of enrolled members decreases but cost per member (and premium rate) increases</td>
<td></td>
</tr>
</tbody>
</table>

**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

**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 IN PEBB AND OEBB

<table>
<thead>
<tr>
<th>Number Covered</th>
<th>Impact on Premium</th>
<th>Impact on Agencies and PEBB</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 550 PEBB employees in OEBB</td>
<td>• Dependent upon whether the member elects to be covered in PEBB versus OEBB</td>
<td>• <strong>Agencies</strong>: 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</td>
</tr>
<tr>
<td>• 650 OEBB employees in PEBB</td>
<td>• Based upon the higher benefit value and 1%/3%/5% contribution structure, it is likely that PEBB would pick up additional enrollees</td>
<td>• If all 550 OEBB employees drop PEBB coverage, savings to agencies of $0.5M</td>
</tr>
<tr>
<td></td>
<td>• Current OEBB employees covered as secondary could become primary under PEBB (max of $4.9M)</td>
<td>• <strong>PEBB</strong>: 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</td>
</tr>
<tr>
<td></td>
<td>• Dependents would become primary under PEBB (about ½ of covered dependents included above)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• ½ of PEBB dependents double covered in OEBB could become primary (max of $1.0M)</td>
<td></td>
</tr>
</tbody>
</table>
### Double Coverage Scenarios: PEBB and Another Employer Double Coverage

<table>
<thead>
<tr>
<th>Current</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PEBB Employee</strong></td>
<td><strong>Doubling Covered Under non-State Employer</strong></td>
</tr>
</tbody>
</table>

**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
<table>
<thead>
<tr>
<th>Number Covered</th>
<th>Impact on Premium</th>
<th>Impact on Agencies and PEBB</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>None</td>
<td>Agencies: No change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PEBB: No change</td>
</tr>
</tbody>
</table>
## OPT OUT SCENARIOS
### TWO PEBB EMPLOYEES

**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 FINANCES
### TWO PEBB EMPLOYEES

<table>
<thead>
<tr>
<th>Number Covered</th>
<th>Impact on Premium</th>
<th>Impact on Agencies and PEBB</th>
</tr>
</thead>
</table>
| • 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  
<p>| | | • PEBB: Elimination of opt-out payment to reserves (loss of $1.5M)  |</p>
<table>
<thead>
<tr>
<th>Current</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current</strong>: PEBB employee opts out and is covered by OEBB</td>
<td><strong>Future</strong>: 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</td>
</tr>
<tr>
<td><strong>Current</strong>: PEBB employee opts out</td>
<td><strong>Future</strong>: Dependent on election of coverage; largest impact on PEBB cost assumes PEBB is elected as medical coverage</td>
</tr>
<tr>
<td><strong>Current</strong>: Employees receives opt out payment</td>
<td><strong>Future</strong>: Employees electing PEBB would pay contributions and receive medical coverage</td>
</tr>
</tbody>
</table>

**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 Coverage Finances

### PEBB and OEBB Employees/PEBB Opt Out

<table>
<thead>
<tr>
<th>Number Covered</th>
<th>Impact on Premium</th>
<th>Impact on Agencies and PEBB</th>
</tr>
</thead>
</table>
| • 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 SCENARIOS

#### PEBB AND OEBB EMPLOYEES/OEBB OPT OUT

<table>
<thead>
<tr>
<th>Number Covered</th>
<th>Impact on Premium</th>
<th>Impact on Agencies and PEBB</th>
</tr>
</thead>
</table>
| • 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) |

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**OPT OUT SCENARIOS**

**PEBB AND ANOTHER EMPLOYER OPT OUT**

PEBB Employee Opt 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 SCENARIOS**
**PEBB AND ANOTHER EMPLOYER DOUBLE COVERAGE**

<table>
<thead>
<tr>
<th>Number Covered</th>
<th>Impact on Premium</th>
<th>Impact on Agencies and PEBB</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 2,032 employees</td>
<td>• None</td>
<td>• Agencies: No change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• PEBB: No change</td>
</tr>
</tbody>
</table>
## Total Impact of Opt Outs and Double Coverage

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

Excludes impact on OEBB costs and contributions
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
E V O L U T I O N  O F  T H E  P B M  M O D E L

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

HALF of total US drug spend by 2020

55% increase since 2011 in specialty drug spending under the medical benefit

87% of workers report health and drug benefits as extremely or very important

PIPEDLINE 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
**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
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
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.
More than a decade of continued and sustainable growth
Northwest Prescription Drug Consortium

1.2 million lives enrolled

Administered by moda

PBM Services
- Group Rx Benefits
- Discount Card

Rebate Administration
- Managed Medicaid
- Corrections
- 340B Programs

GPO/340B Program Services
- Fee for Service MCD
- Workers Comp

Features:
- Fixed administration fee
- 100% rebate pass-through
- Pass-through pricing
- Aggressive network guarantees
- Financial audits
- Annual market checks
- Innovative management programs
- Custom formularies

- Northwest Prescription Drug Consortium

Trevor Douglass, DC, MPH
OPDP Rx Discount Card Program

**Total Members enrolled through**

August 31, 2018: **307,645** Oregonians

- Member savings over past 12 months: **$12,427,732**
  - Total member savings last month: **$1,012,604**

- A viable program to assist members with closed formularies.
  - Program delivers discounts on brand and generic products at POS.

- Any resident of Oregon can enroll in OPDP.
  - 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

$87,600 in additional savings for PEBB

$986,000 in additional savings for OE BB
## Network Performance Summary

<table>
<thead>
<tr>
<th>Rx type</th>
<th>Overperformance 2017</th>
<th>Overperformance Jan.-Jun. 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail, Choice 90, Mail, and Specialty</td>
<td>$19.50 M</td>
<td>$13.70 M</td>
</tr>
<tr>
<td>Dispensing fees</td>
<td>$0.50 M</td>
<td>$0.32 M</td>
</tr>
<tr>
<td><strong>Total Overperformance</strong></td>
<td><strong>$20.40 M</strong></td>
<td><strong>$14.02 M</strong></td>
</tr>
</tbody>
</table>

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?

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
Agenda

- Cost Overview
- Pharmacy Program Highlights
- Rebates
- Targeted Therapy Classes
- Site of Service
- Infused Medications
- Cost Containment
Pharmacy Program – Overview of PEBB’s PMPM Performance
Pharmacy Program – Overview of PEBB’s PMPM Performance

OR PEBB Pharmacy & Infused Meds Overview

- **Generic**: $6.57, $12.31, $18.15, $27.50, $20.96
- **Specialty**: $11.79, $14.88, $18.13, $21.70, $21.51
- **Total Pharmacy**: $58.08, $56.69, $52.78, $54.35
- **Infused Medications**

Paid Claims PMPM

- 2015: $6.57
- 2016: $11.62
- 2017: $11.79
- YTD 2018: $11.69

Legend:
- Generic
- Brand
- Specialty
- Total Pharmacy
- Infused Medications
**Question:** Describe your Medical Pharmacy program and capabilities.

**Pharmacy Program**

- Evidence-based and guideline-supported medicine
- Tight collaboration
- Information sharing from KP pharmacy vs. drug manufacturer representatives
- Integrated System
- Competitive Pricing
- Standardized formulary
- Contracting strategy
- Industry-leading concessions
- Physician participation in development

- 71% more outpatient prescriptions per store daily than Walgreens
- More oncology treatments for patients every day than 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 \textit{RPE65} mutation-associated retinal dystrophy

Phenylketonuria

Hemophilia type A

Sickle cell

Migraine prophylaxis
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
### Biosimilars

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Approval Date</th>
<th>Litigation Status</th>
<th>Launch Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neupogen biosimilar (Zarxio)</td>
<td>March 2015</td>
<td>Litigation</td>
<td>Sept. 2015</td>
</tr>
<tr>
<td>Remicade biosimilar</td>
<td>April 2016</td>
<td>Litigation</td>
<td>Nov. 2016</td>
</tr>
<tr>
<td>Enbrel biosimilar</td>
<td>August 2016</td>
<td>Litigation</td>
<td></td>
</tr>
<tr>
<td>Humira biosimilar</td>
<td>September 2016</td>
<td>Litigation</td>
<td></td>
</tr>
</tbody>
</table>

**Question:** What medical benefit therapy classes/drugs are targeted in your medical pharmacy program?
Biosimilars: Neupogen to Zarxio

Kaiser Permanente Market Share 98% / National Market Share 30%
Pharmacy Program and Capabilities – Pharmacy vs Clinic-Based Injections

### Multiple Sclerosis Medications

<table>
<thead>
<tr>
<th>Date Paid</th>
<th>Total Paid Claims Pharmacy PMPM</th>
<th>Total Paid Claims PMPM Rutixan</th>
<th>Total Paid PMPM</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>$3.19</td>
<td>$0.11</td>
<td>$3.30</td>
</tr>
<tr>
<td>2016</td>
<td>$2.65</td>
<td>$0.25</td>
<td>$2.90</td>
</tr>
<tr>
<td>2017</td>
<td>$1.77</td>
<td>$0.90</td>
<td>$2.66</td>
</tr>
<tr>
<td>YTD 2018</td>
<td>$1.25</td>
<td>$1.06</td>
<td>$2.31</td>
</tr>
</tbody>
</table>

Cost/Prescription/Year (Pharmacy): $64,000  
Cost/Prescription/Year (Injection): $11,000
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:** How are rebates recognized under the current program and to what extent are they shared with PEBB?
Rebates

- Not broken out separately
- Factored in our pricing

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

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

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

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

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

<table>
<thead>
<tr>
<th>Medication prescribed for</th>
<th>Your group’s average adherence</th>
<th>Kaiser Permanente regional average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>75.9%</td>
<td>73.7%</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>82.3%</td>
<td>80.3%</td>
</tr>
<tr>
<td>High cholesterol</td>
<td>79.0%</td>
<td>76.9%</td>
</tr>
</tbody>
</table>

* 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.
Saving with Increasing Mail Order Utilization

![Graph showing mail order utilization percentages from January to August. The actual YTD MO% increased from 42.4% in January to 44.1% in August, exceeding the target MO% represented by the dashed line.](Image)
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:

<table>
<thead>
<tr>
<th>Costs Avoided</th>
<th>Cost Savings Realized</th>
</tr>
</thead>
<tbody>
<tr>
<td>$8.3M</td>
<td>$28.8M</td>
</tr>
</tbody>
</table>

Costs avoided by clinical case management services

Cost savings realized from quality assurance and maintaining compliance with contractual, quality, and safety regulations.
Thank You!
Appendix
Pharmacy Program – Overview of PEBB’s Injectables

<table>
<thead>
<tr>
<th>Date</th>
<th>Paid Claims PMPM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Infliximab &amp; Biosimilar</td>
</tr>
<tr>
<td>2015</td>
<td>$1.56</td>
</tr>
<tr>
<td>2016</td>
<td>$1.95</td>
</tr>
<tr>
<td>2017</td>
<td>$2.06</td>
</tr>
<tr>
<td>YTD 2018</td>
<td>$0.99</td>
</tr>
</tbody>
</table>
Moda Medical Pharmacy

Carly Rodriguez, Pharm.D
Pharmacy Director, Clinical Innovation
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

Deliver Value

Optimizing medication use

Streamlining reimbursement

Improving outcomes
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

Audit

Dose management

Evidence-based utilization management
Streamlining reimbursement

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

- Site of care
  - Better pricing
  - More robust data
  - Consistent member care

- Rebates
  - Pharmacy rebates
  - Medical rebates
  - NDC capture

- Preferred distribution channels
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
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
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

- **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

- **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
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
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

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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