Washington State Health Care Authority
Prescription Drug Affordability Board
Meeting Transcription
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Mike Neuenschwander: Are we all set up there, Nonye?

Nonye Connor: [Audio cuts out].

Mike Neuenschwander: -- you're not the last of the technical difficulties. So we will get started. Okay. Great. Thank you very much, Nonye and Simon for helping get us set up today. So welcome, everyone, to our second Prescription Drug Affordability Board meeting. Glad to have you all here. We have a new face, but I think a lot of people probably know you already, but since we are still getting acquainted here maybe we can go around and do introductions one more time just so that we can get to know all the staff, and everyone can get to know you a little bit. So maybe do you want to start with the Board members, Eileen?

Eileen Cody: Eileen Cody. I was going to say I started out in the 34th District, but you don't care about that. [laughter] I was in the Legislature for a few years as the Chair of the Health Care Committee. And I am a nurse, retired from group health Keiser in 2019, I guess, is when I retired after 41 years. So that is where my experience comes from.

Mike Neuenschwander: Great.

MaryAnne Lindeblad: Good morning. MaryAnne Lindeblad. I am retired but active in a variety of things locally. And I was here last time. So I did my introduction.

Eileen Cody: How many years as a nurse?

MaryAnne Lindeblad: How many years old [cross-talk] [laughter] over 40 years as a nurse, yes. Long-time nurse. Public health, just a variety of different things. Medicaid Director for nine years, so a variety of experiences.

Hung Truong: Hi, good morning. My name is Hung Truong. I am a pharmacist. So clearly, I am the Director of Specialty Pharmacy at Virginia Mason Franciscan Health.

Mike Neuenschwander: Great. And Doug, were you able to make in online with us today?

Douglas Barthold: Yes, hello. Good morning. I can't for some reason the video is disabled. It says that the host has stopped it, but I can hear you, and can you hear me?

Mike Neuenschwander: Yes, we can hear you.

Douglas Barthold: Great. Well, I will go on video as soon as I can. My name is Douglas Barthold. I am a health economist and research assistant professor at the University of Washington in the Comparative Health Outcomes Policy and Economics (CHOICE) Institute. Most of my research is around health policy and chronic condition management. So yeah, excited to be here for the meeting. Sorry I couldn't be in person.

Mike Neuenschwander: Great. [Cross-talk] Yeah. No, thank you. I know you are calling in from a pretty different time zone, so thank you very much for making this work for us.

Douglas Barthold: Sure.

Mike Neuenschwander: And now we are going to introduce the HCA staff. Donna, do you want to start?

Donna Sullivan: Sure. Donna Sullivan, Chief Pharmacy Officer with the Health Care Authority.

Mike Neuenschwander: Great. My name is Mike Neuenschwander. I am managing the Prescription Drug Affordability Program. I have been here not quite a year, but we are excited to work with this. And my wife is also a nurse. She has been a nurse for about 15 years.

Michael Tunick: Michael Tunick, I am the Assistant Attorney General. I represent the Health Care Authority and I will be the counsel for the Board. And my wife is not a Legislature, but she was a nonpartisan staff in the process of making an appeal. Oh, so she is with Transportation.

Eileen Cody: Oh. [Cross-talk] That's why I don't know.

Michael Tunick: Well, she has a different last name.

Eileen Cody: Oh, that, too?

Marina Suzuki: And I am Marina Suzuki. I am a House Economics Research Manager, so I will be helping you with the affordability review. And my background is a pharmacist.

Simon Borumand: I am Simon Borumand, on the staff with the HCA's PDAB team and working with Mike.

Nonye Connor: Hi. I'm Nonye Connor, and I am a Project Manager for the Pharmacy Unit, and I am helping us start this program. And my sister is a nurse, and my mother is a nurse.

Eileen Cody: Raised well.

Mike Neuenschwander: Great. So glad everyone could make it here today. So just kind of update if you will. As you know, this is a five-member Board, but we are still searching for the elusive fifth member. We have a couple of things that are hopefully in the works, but we will keep you posted as soon as we know if anything works out. Again, the Governor's office is in charge of the appointments, so we are working closely with them on that. Also in our previous meeting, our first meeting, just as a reminder for anyone out there in the internet world, we basically did the initial training and introductions for the Board., talked about the rulemaking process, training about public meetings, Robert's Rules of Orders, and a brief introduction to the bill, and introduced our other Board members that first time around. So that was what we did the first time. We also had a great meeting in Colorado last week with the HCA staff. That was organized by NASHP of the National Academy for State and Health Policy. While we were there, we were able to meet with Maryland, Colorado, Oregon, Minnesota, Massachusetts. I think that was most of them. There might be one or two that I missed. But we had some really great conversations about what the other states are doing and how their efforts are going, especially Colorado, since they are kind of blazing the way right now, but we are hoping to catch up here in the not too distant future. So we learned -- a lot of good lessons learned and seeing what they are doing and how they are working on creating their Prescription Drug Affordability Boards. So we will continue to collaborate with them and share resources as a Board. So just an update on some of the interesting stuff the staff is doing. In terms of today's agenda and what we are planning to discuss, as you can kind of see from our paper agenda, we are going to be talking about WAC, some of our reports, our policies, and also looking into how we are going to be moving forward in the future. And yeah, I think that is kind of it in terms of introductions and Board

updates. So lots of great stuff is going on, and we are hopefully starting to pick up speed as we move into this next year. So just to kick off our first official agenda topic item, we are going to have Michael, our AG, discuss with us a little bit. There were some questions at our last Board meeting related to our authority, our scope of work, and things such as that. So Michael will go over some of those questions and help discuss that topic. [Cross-talk] --

Michael Tunick: [Cross-talk] Yeah. Thank you. Just for the record, Michael Tunick, Assistant Attorney General. One of the questions was what were the payers that the upper payment limits will lie towards. And with this it is primarily some of the commercial health plans that are regulated by the Washington State Insurance Commissioner, and then also the plans that are offered to state employees and through the Public Employees Benefits Board Program and the School Employees Benefit Board Program. And I am going to direct you to it and actually just read from RCW 70.405.050(6) as I just sort of paraphrased there. That is the health carrier, or a health plan offered under Chapter 41.05 RCW. So the health carrier will have to cross reference the definition section of this statute with cross references the definition in RCW 48.43.055, and so the health carrier is paraphrased here. But [indistinct] a disability insurer regulated under Chapter 48.20 or 48.21 RCW in health service. This contractor -- health care and service contractor defined in RCW 48.44.010 in health maintenance organization as defined in RCW 48.46.020. So that is where I sort of over generalize and say the commercial insured is regulated by the insurance official [cross-talk] --

MaryAnne Lindeblad: Do we know what percentage of the lives that covers when you add all of those up? Do we know that?

Michael Tunick: I don’t. And so that is one where -- I'm sorry, Mike, I'm going to defer to the staff here. And then I know that a lot of plans are also self-funded plans, and I am going to get you to the next subsection of the statute, which actually says at (7) -- and I'm looking at the wrong statute here -- is an employer-sponsored, self-funded plan may elect to be subject to the upper payment limits as established by the Board. And so I can see your sort of ERISA plans can elect to opt in. And I suppose also in addition to the ERISA, self-funded also are the non-federal governmental self-funded plans, The ones that most of us would be familiar with is the Uniform Medical Plan offered to the PEBB and SEBB Programs. So that one is subject to the upper payment limits by a health plan offered under Chapter 41.05 RCW. So that is the PEBB and SEBB Program plans. Yeah. So unless there are anymore questions, that is sort of

the broad over generalization both overinclusive and underinclusive I think that explanation. And then the next question. I will refer back to my notes here. It was about sort of what about conflicts between federal and state law. And just again broadly speaking, if there is a conflict between federal and state law, the federal law controls under the doctrine of federal preemption. That is sort of the concept that if there is a conflict between state and federal law that federal law supersedes. And we see that with Legislature also with the local rules and sometimes the state laws preempt the county or city ordinances, and here it would be more about federal versus state. And then there was a specific question about the Inflation Reduction Act. And again, this is going to sort of be a overly broad kind of generalization, but the Inflation Reduction Act, particularly the drug price negotiation program that will have Medicare or CMS negotiating with manufacturers to set upper payment -- not upper payment limits -- maximum fair price is what that is called under the statute. That is going to apply for purchases for the people enrolled in Medicare plans. And so the guidance and the regulations coming at it now are for Part D plans as well as for Medicare Advantage Plans that also offer a prescription drug coverage, or it would be Medicare MAPD. And so with that though, that is really just drugs that are again just for the Medicare program, whereas what PDAB is doing with the upper payment limits is going to be like different payers. Rather than Medicare payers, it is going to be the commercial payers, so that is going to be the three largest in the state are Premera, Kaiser, Regence BlueShield, as well as the Uniform Medical Plan.

Mike Neuenschwander: I think Doug has a question.

Douglas Barthold: Yep, thanks. If it was just to summarize the first -- actually, could you just please just summarize the answer to the first question again?

Michael Tunick: Oh, yeah. Sorry.

Douglas Barthold: The comparator subject, so it was basically the fully-funded commercial plans and then those managed by HCA. Is that right?

Michael Tunick: Yeah, yeah. So with the -- yes, yes. The commercial plans and managed by HCA. And with the HCA plans, you, as a state employee, do get health coverage through the Public Employees Benefits Board Program, and so I you have not deferred up to that of that the plans that you have access to are Kaiser, which are offered under 41.05 through the PEBB Program but also

are still regulated by the insurance Commissioner and then Uniform Medical Plans. So those and then the SEBB Program has an additional carrier with Premera, which would separately be subject to these rules through their regulation by the insurance Commissioner. I will give that an in-person question.

Hung Truong: Yeah, so just so [cross-talk] oh, go ahead, Doug. Sorry.

Douglas Barthold: And just -- sorry, just to follow up on that -- and what about Medicaid?

Michael Tunick: Okay. So with Medicaid Managed Care, and so we have the fee-for service, and then a lot of people are under Medicaid Managed Care. And so the MCOs -- that is the Managed Care Organizations that the Medicaid contracts with to provide Medicare or Medicaid services to Medicaid clients. Those managed care organizations are subject to our truth of the definition. So, yes, the managed care so the health carrier or carrier under the definition in 48.43.005 that is cross referenced for applicability. So, yes. The managed care organizations, yes.

Mike Neuenschwander: Okay, thanks.

Hung Truong: I am Hung Truong, Board Member. Your questions relating to the ERISA plan. So you said that the able to elect. So who will make that decision? Is it the TPA or is it the plan sponsor that can make that decision?

Michael Tunick: I do not know. I will look into that for you. Obviously, I have not found that. That is a very good question that I have not thought of. Yeah. I will have to get back to you with that. Yeah. So those were the, I think, the main questions or sort of the conflicts and flaws and coverage. And then one thing I just wanted to say is although there is not a full room of members of the public here is that generally when your attorneys are providing advice, it is confidential communications, and it is subject to attorney/client privilege. When we are having these conversations in a public meeting, we are not -- there is nothing confidential or privileged about it because we are protecting that privilege or that confidentiality obligation. So I am virtually happy having these conversations during the meetings, but as soon as we have, so. Oh, as we get more into the details, I can either get back to you with an answer by email to the Board, or if something comes up outside, that you can email me or call me or talk to me during a break with a question. And so just something to keep in mind, like, even though we are not seeing lots of members of the public, this

is not a sort of confidential setting. This is a public setting, which you sort of don't get some of the advantages. So other professions also have their privileges and confidences. So I think it would be -- what is it? The priest penitent one, where [laughter] it is one thing to go to the confessional and tell a priest your secrets, and then there is another thing to go up to the pulpit and announce that to the entire congregation. And so, here we are announcing it to the entire congregation, and so if we want to keep it confidential, let's keep it in the confessional booth with just the priest. And so if there are no further questions, I will hand it back to Mike.

Mike Neuenschwander: Okay. Great. Any other questions from the Board? Wonderful. Yeah, and so thank you very much, Michael. You know I think that I know we have had some questions in terms of the authority and the scope, and so he is a great resource in order to help keep us on track. There are a lot of things sometimes we might want to do and like to do, but we have got to also make sure we stick within the regulation, so that way we are compliant and doing what our mandate is. So thank you very much. And then, also, you asked the question about the percentage of population covered. I made a note of that. We will make sure we look that up.

MaryAnne Lindeblad: Thank you.

Mike Neuenschwander: So thank you very much.

Eileen Cody: If you look in the report to the Health Care and Cost Transparency Board from OIC, I think it is in that.

Mike Neuenschwander: Okay.

Eileen Cody: I can't remember off the top of my head which report I looked at, but I think that is the one.

Mike Neuenschwander: Great. We will go investigate. Wonderful. Well, it looks like we are moving a little ahead of schedule and just kind of as a reminder our agenda here, these are suggested meeting times. All right? I wanted to make sure we gave ourselves a little room in case there is discussion or topics that we need to delve into a little bit more deeply, but if we don't have any questions and we are figuring stuff out quickly, then we can keep moving ahead of schedule. And it never hurts to get done a little bit early. Right? Then also, just a

reminder to us if we can speak up so the microphones in the room can hear us. That way the people in Zoomland can hear everything that we are saying.

Nonye Connor: And also if you can say your name before you speak, please, so the transcriber will be able to make a report of the meeting minutes. Thank you. Oh, you want that back?

Mike Neuenschwander: Okay. Thank you, Nonye. Great. Okay. So we will move onto the next part of our agenda here, which is just discussing the Washington Administrative Code of Rules, as we like to call them, so we are in the process of trying to finalize those right now. Just a little update of what has happened. So we sent out the previous draft of the WAC for Board members to look at and review in case you had any questions or thoughts on those. And that was up for external review during our last Board meeting. On November 21st, we had our public comment period, where people were able to come and call in and state verbally any issues or comments that they had. They were also able to send some in writing as well. And so we all received a handful of comments from that outreach, and our team assigned handout rules through this process has been working to finalize responses to those comments that we have received. The rules are now being set for final submission and should be ready by the end of this month. However, as noted in our previous Board meeting, they will not come into effect until 90 days after our next legislative session. So we are finalizing all of the administrative stuff on our side, but they still won't come into effect for a little while. So any general questions that anyone has from the rules thus far? No? Okay.

Hung Truong: I have one.

Mike Neuenschwander: Yep.

Hung Truong: Hung Truong, Board Member. Are there opportunities to make changes after it is finalized until the session 90 days after?

Mike Neuenschwander: Yeah. So the rules are a little bit more difficult to change. The process that we were talking about during our first initial Board meeting, I mean, it is a many months long process, and then once we get through that, it is kind of done until the following year. Right? So on one thing is we are looking at the rules, if you have thoughts or comments, keep track of those. And then this next late spring, early summer we start to look at those rules again. That is when we can start to make the changes, and then it is going to go through

that whole approval process, the summer, the fall, and then get finalized here again in the winter. So it is about a year-long process. And because the Board was brand new and wasn't even appointed until very recently, HCA needed to take that first stabilize at trying to get these rules set up so we can get the Board up and running and functioning. But yes, so later this spring will be our next opportunity -- late spring to start editing and looking at those. Oh, Doug.

Douglas Barthold: Thanks. Just to clarify when you say, "the rules," you mean the WAC, right?

Mike Neuenschwander: Yes. Yes. The Washington Administrative Code, also known as WAC, also known as "rules."

Douglas Barthold: Got it.

Mike Neuenschwander: Not to be confused with the WAC of the wholesale acquisition costs, so lots of acronyms and lots of names.

Douglas Barthold: Thanks. And so are we going to go through this document and the comments submitted by everybody? Or is this just going to be -- what is the plan for discussing this?

Mike Neuenschwander: Yeah. So basically when we send out the document a little earlier to have the Board review, if you guys have any comments or specific questions, we can discuss those now. The comments that were made by the public, we have just been working to address those and send back feedback on those as well. But if you have any specific comments or questions on the WAC, we can talk about that right now.

Douglas Barthold: I do, but I don't know if you want to [cross-talk] --

Mike Neuenschwander: [Cross-talk] Yeah.

Douglas Barthold: -- do it by section or by person. How do you want to do it?

Mike Neuenschwander: Go ahead and go down the list and we can talk about it.

Douglas Barthold: Sure. So my first question was just that -- because I couldn't find anything in the WAC about how we determine the upper payment limits or how we

calculate the savings to pairs, and I wasn't sure if that was something that we will add later or if that [cross-talk] --

Mike Neuenschwander: Yes.

Douglas Barthold: Or if that -- why that wasn't --

Mike Neuenschwander: Yeah. Yeah. So those parts we have not put in there yet because we have not discussed them yet. I don't want to put anything into rule that we haven't even thought about. Especially when it comes to upper payment limits and cost savings, these are all going to be extremely complex processes that we need to think through. And how is this all going to work legally, and how is this going to fit in? What date are we going to want to be using for this? So yes, those sections have not been included yet because we just haven't even talked about it yet at this Board.

Donna Sullivan: And, Doug, this is Donna. We took the initial stabilize of looking at the operational functioning of the Board as established in WAC when you read the RCW, the Legislature directed the Board to do a lot of work. One of them is creating an affordability review. That will be discussed by the Board. So I think it is discussed in the WAC or mentioned in the WAC, but the process is not there. The upper payment limit, the methodology. The Board has been directed to create that methodology, so until we do that work, like Mike mentioned, it won't be in the WAC. But once that work has completed, we will create it or put it into WAC through the process. And so there is quite a bit of stuff that is mentioned in the RCW that we haven't got into detail on the WAC for the particular reason.

Mike Neuenschwander: Yeah. So on the top of our list of stuff to do here starting this next year.

Douglas Barthold: Great.

Mike Neuenschwander: Any other questions?

Douglas Barthold: Yep. I don't know if anyone ever -- I don't want to take up all [audio cuts out] if anyone in the room wants to go.

Mike Neuenschwander: Nope. I think the floor is yours.

Douglas Barthold: Okay. So if I go to, let's see, Page 7 of the [audio cuts out]. Actually, sorry, Page 6. And so, this is again just to clarify sort of what these major sections are. And it is the way I am reading it -- 182-52-0035 is describing the review of drug prices. 0040 is choosing up to 24 drugs for affordability review. And the 0045 is the actual affordability review. Is that accurate?

Mike Neuenschwander: Yep.

Douglas Barthold: Okay. So in 0035, I am looking at the list of data considered relevant by the Board. And I think that -- and I have some thoughts and suggestions about what data we should be using and what I think we would consider relevant. So, first of all, whole acquisition cost, so I guess this is related to in 182, which is on Page 6 in section 182-52-0035(2)(a)(i) wholesale prescription cost is $60,000 or more per year or a course of treatment less than 12 months. And so I'm just wondering why you are focusing on the whole prescription cost. It seems to me that more relevant would be out-of-pocket costs as well as net costs so that the post-rebate cost to payers. So I was wondering if we can add those other data to the list or if there is a reason for why we are not using these?

Mike Neuenschwander: Yeah. So this as it is outlined in the rule, these are things that by legislation we are required to look at. So these were not constraints or items that we chose. This is per the Legislation what by law we are required to take a look at. And so this is kind of our starting point per the law of what we have got to look at, and then from there as we start to select drugs based on these criteria, then we can start creating our own methodologies for why we are selecting things and how we are going to review them. And these other two following sections, and I will talk about this a little bit more in our policies. This was one thing that I was going to review because I know this was a question that was asked in terms of exactly what we are doing and why. But, yes, these are also for the drug affordability review requirements. These are also outlined by law. And there are some "shall," like we need to do reviews, and then there are some "may," "we can review should we like." But again, I was going to talk about these a little bit more in the policy section.

Douglas Barthold: Great.

Donna Sullivan: And so, Doug, this is Donna again. I want to just follow up with what Mike was saying. The parameters in 182-52-0035, those are the guidelines that we have to follow in selecting that initial list of drugs as it is defined in the

statute. If we want to change those requirements, we will have to have legislative action to change those underlying requirements to the extent that we have more flexibility in conducting the actual affordability review once we have selected that initial list of drugs, I think there is some room within the legislation, and we could put that into rule. But the initial list of drugs, that is a very strict parameter of criteria we will have to follow to select those drugs.

Douglas Barthold: Okay. Thank you. And so just to make sure I understand precisely. So we have to look at these criteria, and that is what the law says.

Mike Neuenschwander: Correct.

Douglas Barthold: Can we also add to the list? Can we look at other criteria as well at this first stage? Or would that only be for the subsequent stages?

Donna Sullivan: This is Donna. At this point in time, I think we are really required to only use what is here in the statute, which is what we have reiterated [cross-talk] rule. Once we -- you know, the Board could look at other drugs and do other investigations, but that wouldn't be qualifying to get the drug on the list to do an affordability review. We have to follow these requirements, these constraints if you want to call them, in determining which drugs to conduct an affordability review for. Once we selected those drugs, we can look at many different things that are allowed in the affordability review process itself.

Mike Neuenschwander: Yeah. This is Mike. So, for example, Colorado has a similar set of criteria in terms of how they can create that initial drug list. It is a little bit different in terms of some of the numbers and whatnot, but generally speaking, it is the same. And so, for example, they came up with a list of -- I want to say it's like five to six hundred, maybe a little over 600 drugs, but then from that list of 600, then they are like, hey, well, this meets our criteria as outlined in the legislation. Now how are we going to whittle this down? We can't do drug reviews on 600 drugs. So what do we want to do? What do we want to say is wait or conditions that would whittle it down to a smaller list. At the end of the day, they ended up choosing five drugs, and they used a set of waiting criteria to figure out of that 600, which five did they want to take a look at? So that is the time when we could add some of our own criteria of, okay, this is how we want to prioritize this drug list.

Douglas Barthold: Okay, great. Thank you. Okay and my next question relates to this course of treatment duration because it seems like that [audio cuts out]. The way that this is worded -- my understanding of how this is worded now is that when we refer to a drug, it is we are treating that drug as a unit, as one thing that we are going to have to talk about the price for. But for many of these -- for some of these criteria, they are saying that we are looking at this wholesale acquisition cost over a 12-month period or a course of treatment. So does this mean that A.) we have the precise length of treatment for every indication, and also will we separate -- let's say that one drug, same exact molecule I will use for two indications, and one has a duration of treatment of 30 days, and the other one has a duration of treatment of over a year, would that drug enter our list of drugs as twice for both indications? Or would it just enter once? And how would we choose which course of treatment?

Donna Sullivan: So again, we are kind of getting into that methodology of how we are going to define a course of treatment. I think Marina might cover this in her presentation, but I'm not sure, but it is something that we are discussing internally. Some drugs, like cancer medications, they have six-week cycles, and then you have a break. So that six-week cycle may be a course of treatment versus the annual cost of taking that cancer medication for the entire year. Some drugs also are only administered once in a lifetime. Some of these gene therapies are a one-time dose, and so that would be considered over an annual course of treatment. So those are things that we still need to discuss on what does it mean for a course of treatment? You know, if something is given twice a year but is given twice a year every year, do we do an annual, or is it the first injection? So those are just things that we will have to discuss and define moving forward as the Board looks at that process.

Douglas Barthold: Okay. So does that need to be in this document, though? Those decisions about [cross-talk] --

Donna Sullivan: Not in rule, no. I believe what our intention was at some point in time was to put that in our policy as we have these conversations, and that way we are able to update those policies based on feedback that we get in these meetings on a more nimble basis.

Douglas Barthold: I see. So somebody said that we have the opportunity to provide the details about if there are ambiguities here in the rules, we can clarify that in the policies?

Mike Neuenschwander: Yeah. Yeah. This is Mike. Yeah, and that is going to be one of our big bowls and challenges here over the course of the next year is creating these methodologies. So right now we are working to try and figure out who we can pull this data from. What is the best way that we can organize it, sort it? What are the various factors that we need to look at and consider? Yeah. Then we will bring these methodologies for the Board and say this is what we found out, here is what we are thinking, here are the options. Let's discuss and figure out right, left, A, B, and then we can make that decision as a Board with the methodology, and then we can move forward to the next step. But yeah, there is a lot of -- the Legislation gives us some very high-level stuff, but there are a lot of details that we still need to figure out yet, and that is going to take a little while. It took Colorado two years, right? So there is a lot of good stuff that we are going to be digging into here in the near future.

Douglas Barthold: Okay. Yeah, that sounds good. And I guess I'm sorry that I'm I guess jumping the gun on these [cross-talk] details.

Mike Neuenschwander: No, no. That is [cross-talk]. This is [cross-talk] here for --

Douglas Barthold: [Cross-talk] I just want to be sure [cross-talk]. Yeah --

Mike Neuenschwander: Yeah. We are trying. That is the whole point. It is going through and looking at this, clarifying things and trying to plan for the future and set those expectations. So this is -- these are all great questions, and these are the things we are here to talk about, and so we will be tackling all of this stuff here.

Douglas Barthold: Okay.

Eileen Cody: Eileen Cody. I would add probably next year's report to the Legislature might include things where there is change where we found problems and need changes in RCW.

Mike Neuenschwander: Mm-hmm.

Eileen Cody: Which this year it is too early for [indistinct] discussion.

Mike Neuenschwander: Yeah.

Douglas Barthold: RCW?

Eileen Cody: That is law.

Donna Sullivan: Legislation.

Eileen Cody: Legislation.

Donna Sullivan: Revised Code of Washington is what it stands for, but it is the statute, the underlying statute. So, for example, Doug, some of the things that you talked about like using different parameters, we could say, well, using what is in statute, we got this list of drugs. Had we used this list of parameters, we would have gotten broadened Rx pool, and we could make a recommendation to the Legislature to consider updating the statute to increase or restrict whatever you decide you want to do in that recommendation. We could enact on it [cross-talk] --

Douglas Barthold: Okay, great.

Donna Sullivan: -- so that legislation was passed, but we could use it to inform the Legislature on changes that we would recommend.

Mike Neuenschwander: Yeah. This is Mike. One thing, too, I will say about all of these, whether it is the rules or the policies and procedures, again, the rules are more rigid. They are obviously more difficult to change, so those are going to be a little bit higher level, and the policy is going to be more in the weeds, and because we work the policies, we can change those a little bit more quickly. But all of these I am envisioning as living documents. Colorado has been learning. They have been making mistakes. They have been figuring things out. They have been changing their methodologies. They have been -- you know, it's a learning process through this whole thing, so I imagine very much as we go, we are going to be doing the same thing. And we are doing stuff that has not been done before, so it is going to be challenging, but it is also we are going to figure things out as we go. So I think there is a lot of room for us to grow as we find obstacles and figure out our way around them.

Hung Truong: Hi, this is Hung. You said there are changes in Colorado. Can we learn of those changes? Or is it something I can go to on their website? [Cross-talk] --

Mike Neuenschwander: So, for example, their website, and I was going to talk about a little bit about their drug review that they are having here a little bit later. Yeah, they

are going, and they have -- and I can talk a little bit more in detail later about some of the things that they have been doing and learning on the terms of, for example, just engagement and outreach as they are trying to set up their advocacy groups.

Hung Truong: And try not to reinvent [cross-talk] --

Mike Neuenschwander: No, well, and that is one of the reasons why I have weekly meetings with Colorado, Maryland, and Oregon. They have been incredibly helpful as program managers figure out what is happening. What is going on? What is good? What is bad? Our data teams have started meeting together every two weeks to try and figure out and get some more insight in case. So as we are setting up these methodologies, what are you doing? How are you doing it? So I think there is a lot of collaboration going on with that very purpose. And hopefully, we don't have to hit all of the same potholes. We can find our own new potholes. Great. Doug, any more questions?

Douglas Barthold: Yep.

Mike Neuenschwander: Go for it.

Douglas Barthold: All right. Next up is so I am on Page 8, Section 182-52-0055. This is about the authority to assess fines. It says here we have authority to impose fines on manufacturers. What about payers? So if we want, as I understand it, a critical part of our ability to improve patient affordability is to make sure that pairs pass on savings to the consumers. And so I am just wondering how do we enforce that? And does this -- do the rules here need to allow us to assess fines on payers in order to give our actions any teeth?

Mike Neuenschwander: Yeah. So this is Mike. So again, the fines were outlined in the legislation, saying this is who you can fine and the amount up to that you can do that. And so in terms of fines for any other groups, the legislation did not [cross-talk] authorize us to be able to do that.

Douglas Barthold: Okay. [Cross-talk]

Michael Tunick: Pardon me. Michael Tunick. The other thing is the reason for the fines is if there is an information request that is not complying with. So that is the manufacturer by statute that provide information upon [cross-talk] request.

So that is sort of the teeth to get that information is these fines, and that is a part, yeah.

Mike Neuenschwander: Yeah. No, thank you. Maybe those are [cross-talk] the limitations of the authority that we have to work with them.

Douglas Barthold: Okay. Um, so go ahead, Hung.

Hung Truong: Oh, I'm sorry. I was just reiterating, so it is still a No to payer that we are not able to assess a fine.

Douglas Barthold: And so that makes sense to me in terms of the acquisition information that we need to do our affordability reviews, etc. Where does it -- is there another part of this document? Another part of the rules has something about how we enforce our upper payment limits and how we enforce the cost savings passing to consumers. I guess, just the enforcement of the upper payment limits. And how does that work? Is that specified anywhere?

Mike Neuenschwander: Yeah. This is Mike. I don't believe there is any legislation around that or legislative language around that specifying that at this time, and so we don't have anything in the rules that would specify that.

Donna Sullivan: This is Donna. I think the only enforcement piece is that there is an annual report that the payers would have to submit to the Health Care Authority showing how they used the savings and how they passed it along to their members. But I don't think that there is any real enforcement activity that we could do to compel them to comply with the upper payment limits.

Eileen Cody: Eileen. I would add that it is probably under OICs authority currently because they review rates to see if they are not putting out as much money as they are claiming. That is where the Insurance Commissioners office because it is all of these that are covered under this are regulated by the Insurance Commissioner.

Douglas Barthold: I see. So if we [cross-talk] --

Marina Suzuki: [Cross-talk] I'm sorry. This is [cross-talk] --

Douglas Barthold: -- if we thought there was some.

Marina Suzuki: I just want to point out also we have a system program that is a Drug Transparency Program, and they do collect data from payers annually, and that data is going to open to the public. So that is another mechanism.

Donna Sullivan: No, it is not open to the public.

Marina Suzuki: Oh, it's not open to the public?

Donna Sullivan: No. No.

Marina Suzuki: Okay. [Cross-talk] ---

Donna Sullivan: We can use it for this Board, but the data itself is held very confidentially.

Marina Suzuki: Yes. Yeah, so we do collect data from them through that system program as well. So that is another mechanism that we use to collect.

Douglas Barthold: Thanks. That all makes sense. Okay, so it is essentially up to -- Eileen, what you were saying is that it is up to the OIC to sort of enforce whatever rules we design?

Eileen Cody: Well, they would be in their rate review when the carriers come in with their rate for the next year, the premium, they will -- they review all of the data that they carriers have, so they have to justify their rate. And if there is a big cost savings, that should be reflected. It should show up in those premiums.

Douglas Barthold: Okay.

Eileen Cody: Decreased premiums.

Douglas Barthold: Right. I see. So then I am new to state policymaking, so I wasn't sure if we needed to specify in our documents how the enforcement worked, but that makes sense what you are describing.

Mike Neuenschwander: Okay. Any other questions, Doug?

Douglas Barthold: No. That is all I have for the rules. Yeah, I guess. I just like to -- yeah, I will emphasize that I am looking forward to discussing the details of the methodology of how we conduct the affordability review. And I do think that one of the things that was mentioned by Donna was that we can potentially

in our legislative -- in our report to the legislature's offer some alternative criteria that we would be interested in using, I think that is something that I think would be very important for us to do. Because I think of this, specifically Section 0035, is an insufficient list of criteria for us to consider, and so I want us to potentially offer alternative methodologies to the Legislature when we make that report.

Mike Neuenschwander: Right.

Donna Sullivan: And I just wanted to clarify and reiterate that all of the data collected under the Drug Price Transparency Program is not publicly disclosable. It is protected under the open public's -- or the Public Disclosure Act in addition to the information collected or the prescription drug affordability Board, all of the information is confidential, proprietary, and not subject to open public disclosure. We take that very seriously. We have our own internal policies. I don't even get to see the actual data. I can see the summary level data, so we do have some safeguards that we have put in place. And we do take -- we can look at some of that information in an executive session, and we will keep that information proprietary and protected. But I just wanted to make that really clear that there is no misunderstanding.

Mike Neuenschwander: Right. Thank you. Yeah. And in terms of modifying or updating the legislation, I know last year we had some agency-sponsored legislation that we had submitted that didn't go through, but there are going to be other opportunities in the future for us to give input onto the legislation and for us to continue to refine and hopefully perfect this program as we move along. So right now we are working with what we have got. And we are getting the frame of this ship built, but we will keep moving along, and we will get it streamlined and all of the kinks worked out as we work through it.

Douglas Barthold: Excellent.

Mike Neuenschwander: Any other questions, comments on the rules? Okay. Great. So let us take a look here then at our annual report for the Legislature. This should be pretty quick, so I am not going to spend a ton of time on it. So as we started earlier this year, we started putting together this report. Every year the Board is required to submit a report to the Legislature. The executive summary goes over basically the establishment of the Board and what we are doing. On the following pages we have these pictures of these wonderful, amazing people who are our Board members and some short bios about them as well, so the

Legislature can get to know our Board members and who they are. We also discussed our administrative code or rulemaking, how we are drafting that currently, which we just got done discussing. Also our initial drug list that we are beginning to work on and some of the requirements that we were discussing here just right now about what is going to create that list and make it up according to the legislation. And so those are the things we are going to be looking at. In terms of we also set up a webpage. So we have a public-based webpage to communicate our meeting minutes and meeting materials, and then just the conclusion of what we have been up to. So next year these report processes actually start pretty early, a lot earlier than I had realized. This has got to go through multiple layers of review, so probably the middle to late next summer we will be working with the Board to discuss any of the things that we have been doing, the reports that we have been doing, the methodologies that we have been creating, that list of the fifth Board Member that we are still looking for who they may be. So that is our annual report, and you all will be very much involved in the creation of it next year, next summer, as we start to get into that. So any questions on the annual report? Okay.

Douglas Barthold: Sorry, I have one.

Mike Neuenschwander: Oh, go for it.

Douglas Barthold: Can you tell us more about the Advisory Board? And I don't know if this is what we are going to talk about later in the meeting, but I am just curious. Let me make sure I got that terminology right.

Mike Neuenschwander: Yeah. So the Advisory Board [cross-talk] --

Douglas Barthold: Yeah, the Advisory Board.

Mike Neuenschwander: -- is going to be a topic of discussion here for us as we move into next year. So we don't have a ton of things outlined on the Advisory Board yet. We will probably dedicate a large portion of an upcoming meeting to discussing that. I know, for example, in other states they use their advisory Boards to give patient feedback and information on how they feel about the drugs in their outlined reports. And so the advisory reports are important pieces to our PDAB Board to be able to gather any information and get input from those affected. But, yes, this will be something that we are going to be -- we don't have it outlined very much at all right now, but this is going to be a topic of

discussion of exactly how we want those to look, exactly what information we want to be getting from them, so it is a wide open space right now.

Douglas Barthold: Okay. Thanks.

Mike Neuenschwander: Okay. Any other questions or comments on the general report? Okay. Let's see. So we are move through our thing. We are about a half hour ahead of schedule here. What do you think, Donna? Should we take a little break now as outlined in the agenda? Or should we just push it through?

Donna Sullivan: Um, why don't we go ahead and keep going?

Mike Neuenschwander: Okay. So if it is okay, I think we can just kind of keep going and chat about the Board policies. So I have my plan notes over here. We have our Board policies here within our notebook. There were a few general questions. I just wanted to go over some general questions that were being asked. And then, also, Doug, you were talking about the affordability reviews and the methodologies that we would need. I was going to -- one of the questions was about around those and to provide a summary of exactly what we will be looking at. Again, as with the rules, we haven't filled out the methodologies here in the policies, so this is, again, things that in terms of our drug selection criteria, in terms of our methodology for the drug reviews, in terms of our methodologies for the upper payment limits, these are all things that we are going to be looking at because we haven't looked at it yet. We are not writing anything down because we don't have anything to write down. So one of the first questions I had was on Section 3(i), page number 10, and it was just referring to conversations with media and lobbyists, and the note was here as discussed in the prior Board meetings, conversations with coworkers who do not have a conflict of interest are not prohibited. So just clarifying who we can and cannot talk to. The second question was, The policies around the upper payment limits and cost savings calculation and affordability reviews asking where they are, and they will be determined later. Additionally, your question with the advisory groups has not been established yet. So these will all be in towards the end of the meeting. I am going to be going through our calendar of next year, and some of the what I am hoping that the dates that we are going to be able to get into stuff. Again, all of this is going to be a very fluid process, so some things might go faster, some things might go slower, but these topics, in terms of the advisory groups, upper payment limits, cost savings, are all going to be things that we will be discussing later. The cost savings, actually, will have a presentation my Marina today beginning some

education and discussion on that, but nothing in the policies as of yet, because we haven't decided anything. Then the questions around the affordability reviews specifically and just kind of a summary of what we are doing. So the first part is when we are deciding whether or not to conduct an affordability review, the Board -- and we don't have this information in here yet -- but this is just kind of reviewing the legislation as it stands -- when deciding to conduct an affordability review, the Board shall consider the class of the prescription drug, whether any therapeutically equivalent prescription drugs are available for sale, input from the relevant advisory groups established pursuant to Section 2 of this act, and the average patient's out-of-pocket cost for the drugs. That is deciding whether we are going to conduct an affordability review. Then for the prescriptions chosen for the affordability review, the Board must determine whether the prescription drug has or will lead to excess cost of patients -- so that is an important piece to note -- the Board may examine publicly available information as well as [cross-talk] collect confidential and proprietary information for prescription drug manufacturers and other relevant sources. And then it says, when conducting a review, the Board shall -- we must consider the relevant factors contributing to the price paid for the prescription drug, including the wholesale acquisition cost, discounts, rebates, and other price concessions, the average patient copay and other cost sharing for the drug, the effect of the price on consumers access to the drug in the state, orphan drug status, the dollar value, and accessibility of patient assistance programs offered by the manufacturer of the drug, the price and availability of therapeutic alternatives, input from patients affected by the condition or disease treated by the drug, individual with medical or scientific expertise related to the condition of our disease treated by the drug and any other information the drug manufacturer or other relevant entities choose to provide the impact of pharmacy benefit manager policies on a price consumer's pay and any other relevant factors as determined by the Board. So this is in legislation saying the things that we shall consider if we are doing -- or when we are doing a drug review. Then it also says, in performing the affordability review of the drug, the Board may consider the following factors: Life cycle management, average cost of drug in the state, the market competition and context, projected revenue, off-label use of the drug, and any additional factors identified by the Board. So these are all things as we are creating our methodologies that we are going to be looking at. And there are things that we are going to be putting into our policies. And then so the goal with this is for us to free basically a template of this is what we want to look at. And then working for Marina, for example, here is our health economist. Where do we

get this information? So this first time around, this is going to be a little bit more different as we are trying to piece together this puzzle for the first time, but then hopefully the goal is once we get a template, we know where to get the information. We know what we want to look at, then we can put this all together much more quickly for future drug names. Right? And then one thing I will also want to note for the Board, I think it would be really good to take a look at. I was cruising through a [indistinct]. Colorado had their first drug review report that they published, and it talked about -- was it Friday that they had their meeting? [Cross-talk] And so that was for Trikafta and is 580-some-odd page report if I am not mistaken. The summary, I believe, was about 22 to 24 pages, but then it had appendices A through P, so it was fairly lengthy. And I will be honest, I have not read through it all.

Multiple Speakers: [laughter]

Mike Neuenschwander: But the meeting was very interesting. I want to say -- I can't remember because it was kind of a long meeting -- but I want to say that they actually voted whether or not to consider the drug unaffordable, and I believe they voted not -- that it was not unaffordable.

Eileen Cody: Not, not unaffordable?

Mike Neuenschwander: Not. Yeah.

Eileen Cody: It was affordable?

Mike Neuenschwander: It was affordable.

Eileen Cody: Oh. [laughter] Sorry.

Mike Neuenschwander: Sorry. It is triple negatives [cross-talk] here. So that was a very interesting meeting to watch, and it is a very interesting report, so I would recommend taking a look at that. And I don't know if I want us to be doing 580-page reports for everything, but I think that is a good model for us to start with and take a look at.

Donna Sullivan: This is Donna. If there are data tables from studies, a lot of the times that is what makes it 580 [cross-talk] --

Mike Neuenschwander: Yeah. Yeah, Yeah.

Donna Sullivan: -- is the data [cross-talk] --

Mike Neuenschwander: [Cross-talk] Yeah. Most of it was the [cross-talk], yes, so --

Donna Sullivan: They might be 500 pages, but it is [indistinct].

Mike Neuenschwander: Yeah.

Hung Truong: This is Hung. Are we able to use other sources to have that information without having to do our own study? I mean, an example would be say [indistinct], right? And they have some information on therapeutic and cost. Instead of having to do a lot of that or -- I don't know.

Donna Sullivan: This is Donna. We do have the ability to collaborate with other states to the extent the information that is provided by other external organizations meets the requirements in the statute. For example, I believe there is a limitation around using QALYS or quality-adjusted life years, so to the extent that that other information that is available complies with that and does not put us in violation of our own statute. I believe we can use that information, or we do have limited funds to go out and hire an organization. [Indistinct] could be one of them or other organizations to compile the data for us. And when we are saying that we are doing the data, it is my expectation that we won't be doing it as the Board ourselves. We will be working with an external vendor or consultant firm to help compile that information to do all that analyses for us.

Mike Neuenschwander: Any other questions? Okay. Yeah, these are some terms of the policies. Again, once we flesh out these methodologies and start putting together how we want these reports to look, that will be then reflected and inserted into our policies for us to be able to continue and to refer back to. Let's see, another question was just talking about discussing the process for selecting a Chair. Then Section 3(c) of the policies have a pretty light section in terms of talking about the Chair provides the leadership for the Board that is over all Board meetings and provides -- it's on Page 4 of the policies, Section (c), it says to provide strategic planning to help the Board period the statutory duties or responsibilities. The Chair works with the staff to develop Board meeting agendas. The Chair also ensures member compliance with conflict of interest policy. The Chair is selected through the vote of the members of the Board. Members can nominate themselves or be nominated by other

members. Three members of the Board must vote affirmatively for a member to be selected. So there is also talked about this in the rule about [indistinct] this in here. There is also going to be a Vice Chair, so in case the Chair is gone off in Singapore doing something really fun, and the rest of us have to be here, then the Vice Chair can take over and run the meetings as well. So any questions in terms of how the Chair is selected or any expanding that we want to do upon that? Or does that sound pretty clear?

Donna Sullivan: And so this is Donna. So not today, I don't think, but think about who you would want to be a Chair because one of you will need to -- we will have to go through the election process for a Chair, and I am not sure if it will be -- if not this meeting, but probably [cross-talk] upcoming soon [cross-talk] -

Mike Neuenschwander: Probably next meeting.

Donna Sullivan: [Cross-talk] Upcoming soon once the rules have been filed, again they won't take effect until after the beginning -- or 90 days after the legislative session, but once they are filed, we will begin to follow them to the extent possible.

Hung Truong: And nominate the fifth member.

Multiple Speakers: [Laughter].

Donna Sullivan: Well, then there is the Vice Chair.

Mike Neuenschwander: That's right. Very clever.

Donna Sullivan: So then, yeah.

Mike Neuenschwander: Well, then maybe as an incentive we could get the Chair an extra fancy name tag or something.

MaryAnne Lindeblad: Or do they get a gavel?

Mike Neuenschwander: Ooh. [cross-talk] Okay. We can make that happen. [laughter] Okay, great. So yeah. And that is actually one of the things in our next meeting that I was thinking we could probably do and get finalized and get done.

Unknown female: Yes.

Mike Neuenschwander: Any other questions around that?

Eileen Cody: Just a thought. Eileen Cody. Just a thought after all of the discussion is whether we should add basically the chapters or the RCW and the WACs that go with this onto our policies, so when people ask for it, they get the whole gamut.

Mike Neuenschwander: Mm-hmm. Okay. Yep. Let's see -- any other questions, thoughts, comments before I continue on? No? There was another question around the executive sessions, and basically just as clarification. Executive sessions will be primarily for the reviewing of confidential information about the drugs or drug reviews, so we should not be doing them very often, but when we do most of them will be planned so, thus, won't require a vote. But should be need an ad hoc executive session, they can be called by the affirmative vote of three members. So can do an ad hoc, but generally speaking, if we need one, we are going to try and plan it out, so that way we can turn off the Zoom meeting, do the executive session, and then come back at a predetermined time. Okay? Any questions on that? No. And then the last topic that was brought up was just conflicts of interest and just clarification or a reminder if a member has any conflict, then they must recuse themselves for any executive session as well, discussions. Any member with a conflict cannot participate in a vote related to their conflicts of interest. And then members should disclose their conflict before recusing themselves as well. So just an update/reminder on that. So any other questions or comments related to the policies? Okay. Well, we are smoking through this. That is good. So maybe perhaps now do we want to do our break? And then we can come back and have Marina do her presentation. We were going to do that after lunch, but now we can do it before to keep this thing moving along. Hmm? Yeah? Okay. And let's take a break until 10:30. Does that sound okay?

Nonye Connor: [Indistinct].

Mike Neuenschwander: Okay.

[break]

Mike Neuenschwander: Great. Thank you very much, and welcome back, everybody. I'm excited to keep going here. So we are a little ahead of schedule, which is a good thing. I always like being quick and efficient. So we are going to be having Marina Suzuki now talk with us next about cost savings from the upper payment

limit methodologies. Per the Legislation, we need to begin discussing these methodologies of cost savings before January 2024. And as stated earlier, Marina Suzuki is our Health Economist for the PDAB and, as such, she has taken the lead on this. She was also with us at the Colorado NASHP Conference that I mentioned earlier and has been working with other states in NASHP to try and begin figuring this out. To caveat this, we are not looking for any decisions on this today as we are -- this is all still evolving. We haven't even talked about the upper payment limits yet, and we still are learning a lot more. This discussion is more around the education of the cost savings and to help us to start generating questions, ideas, and figuring out what we need and might want to think about and consider. And again, as upper payment limits are not going to be in effect for us until 2027 per our Legislation, this is still going to be a little way out, but we do need to begin this discussion per the Legislation as well. So, Marina, go ahead and take it away.

Marina Suzuki: Thank you. Nice meeting you because this is my first time joining here in person. And thank you for serving on this Board. So just to state an expectation up front for today's discussion, we are not going to vote on anything. It is truly information sharing and also idea generating. And we have to kind of jump through the slides as well as Excel sheets, and [indistinct] will help navigate documents, but we will start with this slide. Let's go to the next slide. Yeah. So the objective here is to determine a methodology to calculate cost savings based on the establishment of upper payment limits. I would say this is not like a one-time thing. This is going to be a process until we learn more about how we are going to set up UPLs and how this will be implemented for all of the entities and the pharmacy supply chain. So it will be a process, and what we have today is a starting point. So please don't think about this in a final methodology at all. This is a starting point. And the very nice thing is that that Colorado PDAB shared what they have complied so far, so we don't need to reinvent the wheel. So we will use that as our starting point. We will discuss what they did and also what we have discussed internally among the staff and also to collect your input. If you have any additional ideas, concerns, suggestions, I would love to hear that, so feel free to speak up. Or if you have any questions, feel free again to speak up and ask us. Okay. Let's go to the next slide. So this is just the language from our statute. I am not going read it line by line, but I want to point out a few things. So we have to submit some initial ideas to the Legislature at the January next year, so that is why we are discussing it today. And also, the language here it says that in the cost saving needs to be passed to the consumers. And by consumers, it doesn't say it has to be the patients

using the specific medication we select for the affordability review. It could be any patient or the consumers of the plans, so the language is very inclusive. And also another thing I am going to point out here is that the carriers are required to submit a report once they start using upper payment limit. So we do have some methodism to correct information and data from carriers as part of the annual report from them. So those are the things I just wanted to point out from the language here. Okay. So let's go to the next slide. Yeah. So we listed two potential approaches here. And again, we are not voting one over the other, and I honestly imagine that we may need to use as combined approach. But the big difference here is Approach 1 is to use just mirror methodology from the Colorado PDAB, so they developed their data collection sheet and everything, and we are going to go over that in a minute. But that is going to be Appendix A on the spreadsheet that we have. Approach 2 is slightly different in a way that we kind of discussed what can we do internally to use our data that we have. So instead of collecting all information from carriers, maybe we can use some data that we are collecting from our sister program [indistinct]. So that was Approach 2, and honestly, we maybe want to combine the approach at the end, but I just wanted to share what we have and what Colorado has. So let's switch to the spreadsheet, and you might have it as a copy on two sheets, and if you download Excel sheet from the website, it has all of the formula or the computations in each cell. If you have the printed version, usually that is just the very first page. So let's look at the first Appendix A or the Colorado version. Yeah. And I didn't change anything, so what we have is how I received from the Colorado PDAB. But they have a very nice [indistinct] out. Given that we don't know which drug, we don't know what a [indistinct] is going to be and how it is going to implemented. So it is kind of things are a bit open but try to capture sort of different perspectives here. And if you look at the top line, so this is three categories. Right? So one is the claim savings, the second category is the cost sharing savings, and the last one is the premium savings. So they are trying to capture What is the savings generated for the utility of the medication? and What are the out-of-pocket patient costs? So that is a cost sharing savings, and this is a printout of what -- if you click through the Excel sheet, they can actually choose if it is a copay or coinsurance. So a copay is usually a fixed amount like $10 or $20 patients pay for each prescription. Coinsurance is more of a mechanism that they have set percentages, like 10%, 20% of the medication cost, and that tends to be the case for some of the expensive specialty medications. Either way, we will capture the information on copay and also coinsurance. And to orient you to the whole spreadsheet, this data collection sheet is per plan, so it is insurance

A plan 1, then you will have one sheet, and we will collect the information on the sheet on each of the categories. And the same thing for another insurance or maybe the same insurance company but different plans, it is just going to separate data sheet. And also, they are asking to collect some [indistinct] information as well. Because if you look at the color of the cells, whenever you see the light gray, that is the information coming from the carriers, and whatever the information you see dark gray, that is the formula cells, meaning that it is going to be some calculated amount imbedded in the spreadsheet. So if you look at the light gray area, they are asking what the utilization per 1000 members per year with having the UPL. And also, they are asking, let's say this is the year we implemented UPL, but if we didn't, then what was the -- what can show the estimated utilization? The same idea for copays for insurance. Now we have the UPL, what was the data? But also asking if we didn't have the UPL, what the amount would be and then just trying to look at the differences. And how each carrier is going to estimate that amount is not specified, so that is why they have a [indistinct]. Like, how did you determine? So those kinds of fields are listed on the bottom. So if that is how their data collection sheet is set up. So this is laying out in a very nice way, and I am trying to capture the data conveyed and simply not just for the other [indistinct] cost, but the utilization in general as well as any potential changes in the [indistinct], and hopefully we set that goes down with the implementation of UPLs. So this is one approach, so we collect from data sheets for each plan, and we just compile all of the information internally, and that is how we are going calculate the cost savings. So that is going to be one approach. And for the second approach, if we can switch the spreadsheet. So the biggest cost is Colorado data collection sheet one idea that came up was, okay, can we use any internal data instead of collecting everything from prior years? So we tried to map out what we have and what information we still need from the carriers. And now you see the orange and green colors in this spreadsheet. Whenever in the field you see orange, that is from the Washington All Payers Claims Data. So for the APCD, they collect the utilization of the prescription, the reimbursement, that kind of stuff, and also some cost sharing information as well on the copays and the coinsurance. So actually, we can gather that information from APCD. And our system program, the DPT, again, the collect [indistinct] report from different payers or carriers, and we can get information on the premium from DPT. So that is the green field. So again, this Appendix 2. It is kind of similar to Approach 1, but it is just mapping out what information we might have internally. And some of the things we discussed with my colleagues, the data team, is that we want to make sure the data lines up. So that is usually the challenge. So if the

data is coming from a single source, it is very easy to handle, actually. But if you are combining data from carriers, APCD, DPT, from different data sources, then we want to make sure everything is consistent, and there is a mechanism to combine them. So that is going to be a challenge, actually. Yeah. So these are the ideas we just passed. And also, we are wondering -- so depending on the medication we select for the affordability review and for the upper payment limit, we kind of discussed, do we need to collect information on, let's say, therapeutic alternatives, not just the drug selected for the affordability review, but do we need to go like a bigger picture to capture the market. So that was another question that came up. And again, we don't have the exact answer yet because we don't know which drugs, whether or not there will be any therapeutic alternatives. Yeah, but those are the things we discussed. What questions do you have at this point?

Eileen Cody: Eileen Cody. So the three drugs that you have in comparison, you don't -- you are just using that as an example [cross-talk] so they are not real drugs.

Marina Suzuki: [Cross-talk] Yes. All yes. [cross-talk] Good point. Thank you. Yeah. So whatever they are [cross-talk] --

Eileen Cody: [Cross-talk] They aren't the same thing [cross-talk] --

Marina Suzuki: -- it is totally for visual purposes. It is just made up numbers.

Eileen Cody: Never can be sure [cross-talk] [laughter].

Marina Suzuki: Right. Yeah, yeah. It is just to give you a visual. Yeah.

Hung Truong: This is Hung. This question to Marina was, Are we looking at brand, generics, and biosimilars? I guess, going back to your comment on, Do we look at alternative usage? Right? I think that has got to be a criteria probably as a single source. Or is that multisource of when -- I think we talked about that -- we are looking at everything? It is not just brand. Okay.

Marina Suzuki: I think my question to you is whether you think when this could be our starting point, and do you think it is better to collect as company has the information from the carriers? Or should we try to combine data internally from other sources as well? Or we can still collect everything from carriers but use our internal data as a [indistinct] because that was another thing we discussed, too, to make sure whatever the data submitted to us matches this

other information. So for the [indistinct], we can use our internal data from APCD and DPT, but we do collect everything as part of the report from carriers. So that could be another approach as well.

Hung Truong: It is Hung again. I have a comment. I think the criteria is going to help us to determine that because, I mean, I would think we would have to choose from is what drug are we going to look at? And we have got to be able to compare apple to apple. And so when Donna is talking about that we are looking at a treatment as a one to three time versus a 12-month, how do we determine and how do we level the playing ground for all of these drugs for us to choose from? Because, I mean, a cure, like for example, is the Hep C. Right? I mean, when it first came out in 2014, we are talking about $100,000, but it is a cure, right? Whereas an MS drug is $6000 to $7000 a month, and it is on forever. It is not a cure. And so, what do we look at? Right? Is it the hep C with a one -- I mean, I think the criteria on how we decide what we choose, that is going to -- I mean, Doug brought it up. It is a loaded question on how we are going to make that determination, and I think there is just so many at play going from, is it a specialty drug? Is it not? Is it copay? Because each insurance is going to charge differently depending on the tier. How many? You know, is it formulary? Is it not? What is it lined up in the majority of their plans? There is just a lot we need to think of. Right? If it is not a tier 1, it is a tier 3 or 4, then we look at that.

Donna Sullivan: This is Donna. That information as far as like where it is placed on our Preferred Drug List or formulary is something that we take into account in our affordability review. I think as we kind of wade into this area we keep it simple. And the cost savings analysis -- you know, you brought up a good point. What are the savings that we are trying to look at? Is it direct cost of the drug itself? Are we going to try to calculate indirect cost, which is potential they didn't go on to get cancer if it was hepatitis C, which becomes a lot more complex, and I am not sure that we would really be able to get a great calculation from all of the different carriers and able to do those savings calculations the same way. From what I understand what Colorado did is that they took the cost savings from the individual drug. Like what would have been made from this drug without the upper payment limit compared to what you paid for with the upper payment limit and how that may have impacted the premium or cost sharing. And so those are great questions, but getting down to the indirect cost savings is going to be very challenging, and I'm hoping that at first at least few reviews we keep it more simple.

Hung Truong: I have a lot more comments, but I don't want to go down that rabbit hole.

Donna Sullivan: And this is Donna. So I mean one of the questions, too, when we look at the different approaches is we can create a mechanism like with Colorado, asking them to report what would you have paid or what is your reimbursement methodology? If they have, well, for brand name drugs it is wholesale acquisition cost is what we pay, or the lesser of wholesale acquisition cost or the submitted amount. We could ask them to give us the basis for the reimbursement and then what they would have paid if they used that benchmark. And I am saying that we have access to the wholesale acquisition costs through other data, and then we can compare the accuracy of what they are disclosing. If we don't have the reimbursement methodology using APCD, we will be at a disadvantage to try to figure out how much they would have otherwise paid unless, again, they would have to -- that is not in the data itself, so there would have to be some sort of reporting from the carriers on what the reimbursement algorithms were so that we could do that before and after calculation. So there are advantages of getting the information directly from the carrier. And I don't know what data analytics we have done, Marina, to look at -- we ask the carrier for a specific data set and then we try to compare it to the APCD to see how closely they align because I am certain there will be a percentage of disagreement between the two, and do we find that percentage of disagreement to be acceptable. Is it less than 1%? Is it a 10% difference? Because if there is a big difference, then we might want to go one way versus the other. So those are just some of the pros and cons to think about.

Eileen Cody: Eileen Cody again. That is one of the questions, I guess, that I have, and looking at the two options is hard to make a choice when you don't know. Are they going to be coming out the same? Or whether it is -- so I almost think that if we could do some preliminary, like where we actually have some specific drugs, they you use the data to figure it, so we can see the comparison of it. Or is it like you said, within a percent, it is then you do the easiest, Right? But if it is not, and it is worth the work, then we use the Board data I would say.

MaryAnne Lindeblad: Yeah. This is MaryAnne. I just would agree with what you just said because I think for me it would be much helpful to be able to look at some examples that would give us some kind of comparison, so I think it would be much easier to go forward in terms of a decision making process that we could

actually see what the results would be of using both or even something in between [cross-talk]. I don't want to make it too complicated. I mean, I think we all don't want to make it too complicated, but I think there is a need for certain components that you probably don't want to leave out.

Marina Suzuki: Right. Exactly. I [indistinct] I believe to be more conservative, especially the first time around trying to correct the comprehensive data as much as we can, and then see the internal quality check, and it matches. And if we can do it in [indistinct], then we don't need to ask for that but maybe the following years. But for the first time around, I agree it is better to be more comprehensive.

Donna Sullivan: And so this is Donna. We don't currently have carriers' metadata because we haven't implemented an upper payment limit, so we haven't asked them to submit this type of data. So until we have done that, we won't be able to give you a real head-to-head comparison of what it would look like from carrier submitted directly versus us using APCD. We could move forward with saying we are just going to collect the first year. The first upper payment limit will follow the Colorado, and we will get it directly from the carrier, and then we can have the opportunity to compare it to what we have in APCD and look to see how different it is, and then make modifications, but that would be years out from what we are doing. We could look and DPT data. I have concerns about what is being sent when we are asking for certain information to be submitted to us. We have to take into account how we have asked for it, and what did we ask for? You know? What did we include? What did we exclude? Can we compare this? And is it apples to apples that we can compare this to? Like APCD, from what I understand is pretty much claim level detail, whereas drug price transparency summarizing all the data so we can look at the different sources that we have, but we don't have direct carrier submitted based on upper payment limit.

Hung Truong: Are we going to use the HCA data?

Donna Sullivan: Well, you could use -- just a thought, we could use HCA data, and we could mockup an upper payment limit and look at what it would be on a drug and pick and particular drug and do a mock upper payment limit and just do reporting. That's a good idea.

Hung Truong: On how it would affect patient copay, not premium [cross-talk] --

Donna Sullivan: Right.

Hung Truong: [Indistinct].

Donna Sullivan: We would have to look at that. I only say we could. We would have to look at it. There are rules around what we can and can't use the ERB data for because we are the employer and the payer for health insurance. There are some limitations on us getting access to that data. And then Medicaid, there are questions about does this or does this not apply to Medicaid? Because there is federal statute around that, and the whole federal rebate program and all of that, so we could definitely try to figure out what we have available at our fingertips [cross-talk] --

Hung Truong: What if they are already enrolled in a managed care and those programs?

Donna Sullivan: Um, yeah.

Mike Neuenschwander: Wait. Doug, do you have a comment?

Douglas Barthold: Yeah, thanks. Great discussion. I agree with everything that has been said so far. So one of the questions that I have is in these two spreadsheets. Are these -- is this suppose to represent what the situation would be after the upper payment limit is instituted? So let's see plan here 2023, so are we pretending that it is 2024 and we are looking back at the data from 2023 during which we had an upper payment limit for these drugs?

Mike Neuenschwander: Yeah, sure. You are not going to have a cost savings until you have an upper payment limit.

Douglas Barthold: Okay. So basically, we are in the future, and we are looking back at what actually happened with the upper payment limit. So we have that it is some factual data on the upper payment limit. And I agree that I don't know which is better to use, the All Payer Claims Database or to use the carrier information about the actual costs and utilization under the upper payment limit. And I think that -- do we have any reason to suggest that [indistinct] why those two would be different? Why would the carrier report a different total cost and utilization that we would see in our data?

Donna Sullivan: This is Donna. They shouldn't, as long as we are asking for them to submit the exact same set of data for the exact same population, you would have to

go back in and look at what the parameters of what they are required to submit to APCD? How often are they required to submit it? How current do we think APCD data is? Is it lagging six months, eight months, a year? And then the APCD data does not include rebates, so if we wanted any rebate data, we would have to get that direct from the carrier anyway. And then trying to compare carrier submitted data with data pulled out of APCD, you are just caught -- there is more room for unattended discrepancy between the datasets.

Douglas Barthold: Okay. Well, that is big, the rebate issue. That would lead to big differences between the two, and to me suggests that we have to have the carrier reported data as probably our primary of information for the factual costs and utilization. I have other questions about sort of the counterfactual, but I don't know if everyone else has comments on that issue.

Hung Truong: This is Hung. I think going back to the rebate. I mean, that information is going to be extremely different to pull from the carrier just because they don't do drug-specific rebate. It is a class. It comes as a class.

Donna Sullivan: This is Donna. It is doable. Your pharmacy benefit manager has that level of detail because they have to bill it to the manufacturer at the NDC level. So it might be the carriers might hold it proprietary and confidential within our contracts between the pharmacy benefit manager and whomever they are negotiating rebates with and the manufacturer. We do get rebate level data at the drug level or Drug Price Transparency. So somebody knows what those rebates are. It may not be the carrier or the purchaser, but you can get to that [cross-talk] --

Hung Truong: Appreciate that information.

Donna Sullivan: Yeah.

Marina Suzuki: And another thing is that we value input from our stakeholder as well. And I know Colorado PDAB reached out to their Colorado carriers, and perhaps you want to do the same here by reaching to the Washington carriers and hearing and asking how are they going to implement the UPLs and what information should we collect? The format I want to make it as easy as possible for them. So what is the format? What is the best way for us to collect those on the report the data? So I think the reach out to the stakeholder is going to be our next step, as well.

Douglas Barthold: Yeah, I agree. That will be very helpful. But certainly my first reaction on this is that using the carrier input will be of better measure of costs. My other big question is around -- well, my next big question is about the counterfactual estimations. And so I guess in Appendix A. So Appendix A is the Colorado way, and then Appendix B is sort of our alternative option? Is that right?

Marina Suzuki: Yes.

Douglas Barthold: Okay. So in Appendix A, I guess this is column H. And do we have any information about how they would calculate the total costs -- yeah, how are they going to calculate costs under without the upper payment limit in the world that does not vision -- this counterfactual world that never occurred?

Donna Sullivan: So this is Donna. Normally, these are going to be outpatient drugs that are covered at a pharmacy, and they have contracted reimbursement rates that with their pharmacy benefit manager has with their network of pharmacies. So there might be methodology that says, we are going to pay average wholesale price minus 20% for brand-name drugs. And for generics, it might average wholesale price minus 50%, or they have a maximum allowable cost list, where when there is more than -- several generic manufacturers are going to make an average reimbursement based off of a price point across the different manufactures, we would have to get that methodology from the carrier or ask them to provide us with what they would have paid had they not had the upper payment limit in place. And I think that they would be -- it should be fairly easy for them to determine what they cost -- what that price would have been.

Douglas Barthold: I agree that, yeah, the price would be knowable, but what about effects of utilization, though? So I guess this would be -- because you have to -- we know what the utilization was in the real world, but if the price changes in the real world, how do we know what the utilization would have been if the price had not changed? Or how do they know that?

Donna Sullivan: So we are asking the cost per utilization.

Douglas Barthold: Yeah. Essentially, that makes sense to me [cross-talk], and there is going to have to be a utilization count in the counterfactual world to multiple that by to get the total cost without the -- well, I guess, to get to column J, we have to have utilization. Oh yeah, so now I see where I am looking. So column E is

actually what I am interested in. How do we know what utilization would be if the upper payment limit had not been implemented column E and Appendix A?

Donna Sullivan: I believe that -- this is Donna again -- the utilization would be constant. There is not a before and after utilization. We would have this is what the utilization was for this year, and this is what would have paid -- you know, this is what we paid with the upper payment limit. This is what we would have paid without the upper payment limit. We could look at the previous year's utilization, and we could look at a change in utilization, but the before and after cost savings is it becomes after the first year of cost avoidance, not a cost savings because they didn't actually pay less. They avoided paying $1000 per person on this particular drug because of the upper payment limit was in place. That first year we might -- we can calculate how much less they paid (PM) per member per month for the drug year over year, but the utilization in this analysis would be held constant.

Hung Truong: I have to assume that it doesn't change utilization with the [cross-talk] UPL. Our [indistinct] does.

Donna Sullivan: And this is Donna again. I mean, I think that is one of the things to look at as well, is does the upper -- and I think that might be directed somewhere in the report or in the legislation -- to look at did the upper payment limit appear to have impact on access to the medication? So was there less utilization? It is possible doctors will switch to a drug that does not have an upper payment limit, and that really isn't, for whatever reason they might do that, I am just speculating what could cause changes in utilization? It is not just the upper payment limit. It could be they failed that medication and they needed to change to a different medication for whatever reason a doctor might have. A Preferred Drug List update might have changed that would cause shifting from one medication to another medication. There are all sorts of reasons that we would have to look at why utilization might have changed.

Marina Suzuki: Yes. And this is Marina. Also the opposite scenario is that the drug is now affordable where patients can access it and utilization goes up. So we don't really know how the numbers will play out at this point. And as Board members, when we do collect data, we can either get the [indistinct] after the carriers based on their data or the information, or we could specify, please do these adjustments and make estimates. So we can set the parameters if you want to or help them decide based on their own information.

Hung Truong: This is Hung. So the cost sharing and then the premium savings, that is just a projection by Colorado. Right?

Donna Sullivan: Yes.

Hung Truong: It is just assuming once you put in what it is, the cost savings, nothing has been [indistinct].

Marina Suzuki: Right, right. Yeah, these all are like virtual numbers.

Donna Sullivan: And this is Donna, too. I mean, cost savings or cost share, depending on how the benefit design is set up, if you have a flat dollar copay, the cost share to the patient might not change because they pay $50 whether the drug costs $100,000 or $80,000, they are going to pay $50. If they are paying a percentage coinsurance, and I hope that it has a limit at some point if they are they expensive of drugs, if they are paying a 10% coinsurance of $100,000, you know that is $1000, right? I don't do math in my head. It might be $100. So that is different from 10% of $80,000, so that you could see is the -- and you want to make sure I think the idea would be is the plan itself calculating the cost co-insurance based on the price with the upper payment limit versus the price they would have paid. I mean, this is the conversation we have a lot now around if you prefer a brand over a generic, the brand upfront cost is so much more, it might be cheaper for the plan after rebate, but the plan may be charging the patient a percentage on the brand price and not the percentage on what it would have been for the generic. So that is something to look at with cost sharing. There may be no impact. And then where you might see more impact would be on premiums because if the plan is paying less, the patient share hasn't changed but the plan is paying less, then it is more likely [indistinct].

Hung Truong: This is Hung. I guess that is what my question is leading to is how do we protect the stakeholders in all of this because you can -- that system that is going on in the background, I mean, it is -- you know, we are worried about the pharmacy that is dispensing it that it is not on them to take the hit, right? Because there is not much for them. Then there are the PBMs versus the Pharma, right? And so it is just seeing where that saving is at and how that gets distributed is going to be pretty important to realize. Because someone is going to end up with the short end of the stick is what I worry about.

Marina Suzuki: This is Marina. So at the NASHP meeting, they did some simulation to talk about how [cough] about the UPLs at one set number and then let the market work it out and do the magic, or we can set up the UPL through the pharmacy supply chain to protect each end of its profit so that nobody goes under water, so that was that other simulation that they did. So they have ways we can set up UPLs, not just like one single number for a drug, but we can think about throughout the pharmacy supply chain to make sure the benefit or loss will be equally distributed among them.

Multiple Speakers: [Cross-talk] Yeah. [indistinct] --

MaryAnne Lindeblad: It feels like it. [cross-talk] --

Multiple Speakers: [Cross-talk] yeah.

Donna Sullivan: And this is Donna. Again, the statute states the UPL for a prescription drug established by the Board applies to all purchase of the drug by any entity and reimbursement for a claim. So to me that is setting it at the wholesaler level where then it becomes passed through -- at a minimum, passed through all the way up to the payer. So it does not say as an upper payment level established and applying to the purchaser or the payer or the carrier, it is any entity, which would include your pharmacies. So I am hoping that piece helps to protect the suppliers of the medication from taking that hit, but that is something that, again, we will have those conversations when we define how we are going to implement an upper payment limit.

Hung Truong: This is Hung again. Just like what you said that the contract is based on say AWP minus the [indistinct]. To change the reimbursement is changing the AWP, but here we are changing the payment, right? And so just thinking how that would [cross-talk] --

Donna Sullivan: This is Donna. It is almost like setting a maximum allowable cost for that [cross-talk] particular drug.

Hung Truong: Yeah, yeah, yeah.

Donna Sullivan: Is essentially what it is doing.

Hung Truong: Okay.

Donna Sullivan: And we do that for generics and today, and it is pretty common practice. It is less common for branding medications, but I don't believe it is unheard of for a payer to have a maximum allowable cost for a brand name medication.

Hung Truong: How will we make sure that the cost is going to be below the maximum allowable cost or reimbursement?

Donna Sullivan: That is not our -- this is Donna -- so that is where the manufacturer would have to make that drug available at that price. If it is not available for purchase at or below the upper payment limit, that is where I think there is concern for access issues within the state, and it is up to us to monitor whether there are access issues within the state. I don't believe there is anything in the statute that says we can force because there are state commerce rules, we cannot force a manufacturer to lower their price within Washington State, but we can set the upper payment limits.

Mike Neuenschwander: Any other questions?

Donna Sullivan: Doug has a question.

Mike Neuenschwander: Oh, Doug. Here we go.

Douglas Barthold: Hi. Sorry about my connection issue there. So just going back to the spreadsheet here, and I just realized a little bit was Hung was talking about. So when I look at the sections in this spreadsheet, claims savings, cost sharing savings, premium savings, I just want to make sure I understand that the cost sharing savings and premium savings are essentially the results of the upper payment limit. Right? Like it is the upper payment limit acts -- we have these -- sorry I am phrasing this poorly. But those effects are inputted into the claims setting section, and then any savings that go out to consumers are passed on via the cost sharing savings and premium savings. Is that correct?

Donna Sullivan: So this is Donna. I believe that it is the expectation for the purchasers or the carriers to pass on any savings to their members, whether it be through the cost share or through premium savings. And they are supposed to explain what they are doing. The example before is there may not be any cost share savings if they have [cross-talk] dollar copay. So it is not a guarantee. I think there is an assumption. It does say "any savings generated under the plan that are attributable to the established upper payment limit must be used to

reduce costs to consumers, prioritize any reduction of out-of-pocket costs for prescription drugs. And I believe we defined out-of-pocket costs in our WAC to include deductible, cost share, and maybe premiums as well.

Douglas Barthold: Okay. All right. So that makes sense. And so, yeah, I can see how that works in the premium savings section. I'm a little confused about the cost sharing saving section because, like you said, if it is just copays and the actual utilization is not changing, we are assuming the utilization is going to be constant. That is before I got kicked off. If utilization is constant and they are on copays, then why is there any cost sharing difference? I'm looking at column O in Appendix A, and I would expect that to be zero.

Donna Sullivan: This is Donna. I think there is the possibility, especially if we are looking at a high deductible plan that there might be an impact on cost share because the members paying 100% of the cost upfront until they meet their deductible, we have used examples of flat dollar copays, but the deductible would be considered part of out-of-pocket costs, so there might be a reduction in their annual out-of-pocket costs because they are not longer having to pay that large deductible up front. Or it could have been spread over a longer period of time so that it makes it more affordable because it is spread over a longer period of time. Or there could be a percentage co-insurance situation where they pay 10%, 15%, 20%, 50%. I don't know what they might be, which would also fall in there. I believe Marina said this is like a drop-down where it says copay. You could select co-insurance.

Douglas Barthold: Yeah. And that makes sense that if was co-insurance, that would make sense. But right now, it is all [indistinct] copay and so that is why I was wondering why it wasn't zero. And you mentioned that there is one possible reason there could be effects on the actual deductible amount within the high-deductible plan? Would that change?

Donna Sullivan: This is Donna. I don't think it would change the deductible, the plan design deductible, but if it is let's say a $2000 drug, and we would put an upper payment limit of $1000, the patient has a $6000 deductible, then their cost share has been cut in half, potentially, because now they are only paying $1000 a month instead of $2000 a month, so it is going to take the six months now to reach that deductible rather than having to pay $2000 per month and having to pay $6000 over a three-month period, so it would extend the time for them to reach their deductible. So that is just [cross-talk] --

Douglas Barthold: Okay. All right. That makes sense. So that is one of the ways that we could have the savings to your cost sharing, even if you only actually were paying for the drug on copay after your deductible. Okay.

Donna Sullivan: Right.

Douglas Barthold: All right.

Marina Suzuki: This is Marina. So Donna and Doug, thank you so much for this discussion. And if you want to collect the information on deductibles or even like out-of-pocket max, we can add that information to the data sheet. So I can -- you know, we are free to tweak the spreadsheet at this point or [indistinct] computer. It is going to be reviewed by [indistinct] process. So feel free to let me know if you have any additional ideas. That way we are appreciated.

Donna Sullivan: And this is Donna again. So if we are going to do that, just and FYI, we would have to have them report separately based on plan design of plan type. So if it is a high-deductible plan, they would have to submit a separate report. And this is where it becomes challenging. And from my experience with Drug Price Transparency is that they might have a 1000 plan designs that they are administering, and so we instead of having them send us a separate report on every single different possible plan design they might have, we lump them into like small group, large group, and I think an individual maybe. But just keep that in mind there are thousands of plan types across [cross-talk], so we are getting into the weeds of things, and it gets really complicated.

Douglas Barthold: So it looks like the way the spreadsheets that we have now are for an individual plan design, just judging by what I see in cell C5. There is a plan ID number, so that, to me, suggested that this would be for a single design.

Donna Sullivan: Correct.

Douglas Barthold: And so I totally agree that it would probably be a lot easier for us if they would just report at a more aggregated level than that, but then there is just going to be a lot more, I guess -- to me a lot less clarity around how any of the savings are calculated because we want to know within some aggregated level, whatever, 13% of those people had a $6000 deductible or something, and now they are not going to -- it will take them longer to reach that. Yeah, so essentially -- so is that a decision point for us to decide the level that we

want the plans to report, the carriers to report, like at the plan that we are at [indistinct] level?

Marina Suzuki: This is Marina. I might suggest you reach out to the stakeholders or carriers and ask them what would be the easiest for them to make a report so we can ask. Is it going to be individual, or if they have kind of groups of plans and they make decisions together, then that could be the sum of the data that we could get. So I think reaching out to the stakeholders might be helpful instead of asking or guessing and determining on our ends. I think, yeah, the stakeholder might be pretty helpful here.

Donna Sullivan: And this is Donna. Doug, I think part of your point might be that we come up with some options to present to stakeholders to get their feedback on the complexity of reporting on different types of plans. We did that for Drug Price Transparency. We have many different what we call reporting entities as far as benefit managers, the carriers, manufacturers, and pharmacy service administration organizations, but we did get feedback on the information that we are going to collect from each reporting entity, and it was very helpful. Once [audio cuts out] then we have to determine based on what we are going to get, what types of calculations were are able to make based off of that information. If we ask for this looks like, like you mentioned, Colorado looks like it is asking for individual plans that a carrier administers. And so it could be we would want that level of data so we can tell this plan saved this much money. How granular do we want to get into looking at savings? Or do we want to look at all small groups lumped together, where they might have different benefit designs, but it is less than 10,000 enrolled individuals per plan, so it is a small plan, and we could do that. So it is just maybe throw some options out there to stakeholders to provide us with an input that if we ask them what is the easiest, they will so no reporting at all. [laughter] So that, I think we need to figure out what is our -- how detailed do we want to get into the responsibility of us reporting out the same names and not making it too burdensome on the stakeholders.

Douglas Barthold: Right. And they also will have incentive to choose the reporting method that makes the savings look as small as possible and so [cross-talk] --

Donna Sullivan: Or as big as possible.

Douglas Barthold: No, well, if it is bigger savings, then they have to provide bigger premium discounts, right?

Donna Sullivan: Well, if it is -- this is Donna -- bigger savings, I mean, I don't know how, I mean, how we calculate, it would automatically result in bigger premium discounts because depending on how much you save, usually a million or so dollars in our plan has a very small impact on premium. And so it would have to be a pretty big savings to have even just a small premium [cross-talk].

Hung Truong: So are we defining consumers as the plan-sponsored consumer?

Donna Sullivan: Say that one more time.

Hung Truong: When we say, "consumers," right? Are plan-sponsored consumers in our definition? Right? So I guess the savings would go back thru the plan sponsor.

Donna Sullivan: This is Donna. The statute says they have to send it back to the patient either through cost share or premiums. And so that is a good point to when I say, "member," that is the consumer of the medication is the person actually getting the medication. To me, that is my definition that I tell myself. The plan sponsor might be the payer. Or if it is an insured plan, they are just the one that hired the carrier to administer the program. But I am pretty clear that the statute says the savings need to go back to the individual member either through reduced cost sharing or premiums.

Eileen Cody: This is Eileen Cody. But a premium reduction like for an employer would get passed on. I mean, well, it should get passed on to the patient also because the cost of insurance goes down.

Donna Sullivan: No. So now we can really go into the weeds.

Eileen Cody: Oh well.

Donna Sullivan: I love the weeds. What happens if the employer pays 100% of the premium? [cross-talk] Is there any cost savings sent to the patient? So that is where.

Eileen Cody: Although I see [cross-talk] --

Donna Sullivan: I don't know, but [cross-talk] --

Eileen Cody: I want to go work for that employer.

Donna Sullivan: Right? And that does happen. And that -- I'm not sure that that would be one of these fully-insured programs where this would happen, but I know that it is not uncommon in self-insured employers as an incentive. It is to pay the premium. And then you might have a $7000 deductible, but you don't have a premium. I don't know. But those are just kind of the things in the weeds that we will have to weed through, wade through, go pull the weeds, and [cross-talk] --

Douglas Barthold: Do we have to decide on that issue specifically?

Donna Sullivan: I don't think we have to. We have to come up with a savings methodology and to the extent that when things like this come up, how are we going to use all of these "what if" situations that could happen where we don't know if they do or not? Are we going to take into account of our methodologies? So again, we can make it more simple, or we could try to get really complicated. The more complicated we are going to get, the more challenges we will get on our ability to accurately identify a number that we are at a savings target point.

Hung Truong: This is Hung. I think that has got to be key because the questions go back to with the ERISA plan, who get to choose to participate adult and we make it complicated? They are not coming yet. The savings might not be worth it. I can see the TPA saying this is going to cost more to manage this than worthwhile.

Donna Sullivan: It is interesting -- bring up another point -- and it might be a gap in the legislation, and this might be an edit -- I'm taking it, Eileen [indistinct] -- Mike, Attorney Mike would be -- the statute says an ERISA plan could join voluntarily and use the upper payment limits. The question is, if they do choose, are they also required to report? And are they also required to pass savings along to their patient? Because [cross-talk] --

Eileen Cody: That would be legislative intent. [laughter]

Donna Sullivan: But it does -- I'm pretty sure it doesn't say that, so that would be something maybe to get feedback on. And that might be, I don't know, something that we just get personal feedback.

Michael Tunick: Yes. This is a sort of unique category of [cross-talk] --

Donna Sullivan: Public.

Michael Tunick: Yeah, yeah.

Donna Sullivan: Client.

Michael Tunick: Yeah, meeting in a public meeting [cross-talk] --

Donna Sullivan: Yeah.

Michael Tunick: Yeah.

Donna Sullivan: Not, no, no. [Cross-talk] Yeah, so I'm just -- so that's a good thing to get some clarification on.

Michael Tunick: But, yeah, we could read the statute. It says any savings generated for a health plan as defined in RCW 48.05 [audio cuts out] [indistinct] [00:44:33] what is necessarily say for their sponsor's self-funded plan. I would have to research.

Donna Sullivan: Yeah, that would be good, just outside of this meeting, and follow up with that.

Michael Tunick: Yeah.

Donna Sullivan: So you can see how fun it is going to -- how much fun we are going to have going down. Is there anything else left on the agenda?

Mike Neuenschwander: Just planning for next meetings in public.

Douglas Barthold: So I have some other comments about this sort of trade off that we face. And this relates to what Hung was talking about as well as Donna. It seems to me that if complexity is sort of a complex reporting system would, I agree, disincentive the ERISA plans from participating and be more work. And so I think we have to think about what the advantages of more complex reporting are. And, for me, I think that the big one there is accuracy. I think that if we allow the plans to -- how she said it -- the carriers to report at a more aggregated level and sort of, I guess, less detailed information, then we are not going to capture some of the complexities that actually really do matter for getting savings to consumers and actually to answer another question, I

would say I meant the same thing when I said consumers and not patients. And so to me that is the critical tradeoff, and I err, I guess, on the side of complexity just because I do think that the plans if they don't have to will deliberately obfuscate some of the savings to make it -- to protect themselves from having to give more back in premiums. So that is kind of my -- I agree that it is a tradeoff, but my gut says give us the details because, frankly, I don't really trust them to give, to be, to do what is in the best interests of the consumers rather than in the best interests of their profits.

Mike Neuenschwander: And I think there are some good things for us to ponder about. I think we have had some really good discussion. As I mentioned before, we don't need to make any decisions on this, but I think this is a good feel for us to -- you know, these are the kinds of things that we are going to be digging into a lot more and start getting the considerations and all of the different potential consequences or unintended consequences that we need to start pondering. So, Marina, do you have anything else on this?

Marina Suzuki: No. Thank you so much for your thoughts, ideas, and suggestions. Deformity I agree it will take some conservative approach, especially the first time around getting more comprehensive information as possible. And we will reach out to some stakeholders to get some input as well. And if you have any specific questions you want to ask to the stakeholders, feel free to send me the email or the information. I will try to compile them so that we can circulate and decide how we want to approach.

Mike Neuenschwander: All right, thank you.

Douglas Barthold: Can I just ask? So because Marina had asked about the two possible data sources of the [indistinct] versus just having the carriers report. Was that a decision point for us today, and did we decide?

Mike Neuenschwander: No.

Donna Sullivan: [Cross-talk] No.

Mike Neuenschwander: No. Again, this was much more like beginning conversation, some education about what are some of our possibilities, and I think things like this are really good because we start discussing, okay, well, what about this? What about this? What about that? How is this going to work? And especially with the expertise in the room here with other Board members and Donna

and our staff trying to put all of these pieces of the puzzle together because we don't have all of the answers. That is why we are here to do this is try and figure out that answers, right? So we don't -- we didn't need to decide anything today, but again, this is kind of to get us started thinking on this, and these questions are going to affect what we are looking at on the rest of this stuff as we are selecting drugs and doing the reviews beginning with the end in mind, right?

Douglas Barthold: Yep.

Donna Sullivan: And Doug, just for your [audio cuts out] and get a better idea of when we make decisions and when we don't. There will be like a written proposal and an official vote just for our decision making. That way -- I know a lot of meetings there is a lot of discussion and people think they makes decisions, but we didn't really make a decision, and so we want to make sure all formal decisions will actually documented with some sort of written proposal and a kind of official vote.

Douglas Barthold: Okay. [Cross-talk] Thanks.

Mike Neuenschwander: [Cross-talk] And that, of course, will be putting them into our policies as well, so that way we have our guiding documents to push us forward. This is what we did, and this is why we did it. Right?

Douglas Barthold: Do we vote anytime we make the change to the policies?

Mike Neuenschwander: I would say yes.

Douglas Barthold: Okay.

Mike Neuenschwander: Yep. Okay. Any other questions on this topic before we press onward? Great.

Douglas Barthold: I would like to say thanks to Marina for the great presentation.

Mike Neuenschwander: Oh, yes, definitely. Thank you, Marina.

Marina Suzuki: [Indistinct].

Mike Neuenschwander: So moving on to our two last things, so first looking ahead and I will talk a little about next year and some of our scheduling and trying to get this all on the calendar, and then also we will finish up with public comments. So in terms of looking ahead the idea was that we were going to meet every third week of every other month. Starting in January, we did a poll asking what days work best for everyone. And not all of our schedules align up perfectly, so there is going to have to be a little give and take. But generally, Wednesdays seem to be the day that was the best out of all of them for the group. So the third Wednesday of every other month starting in January, I think, is our poll. Does that sound okay? And then actually with January, there is also another thing that this -- okay, actually, booking the room is also a complication as well. So January we will have to make a little bit of a modification here but -- Doug, did you have a question?

Douglas Barthold: Yeah, is this -- would the meetings be all day like this? Or is this [cross-talk] ?

Mike Neuenschwander: So our [cross-talk] it really depends on the topics and what we have got to talk about. You know, again, I am one of those if I think the goal is we were going to book them out all day so that if we need to talk, we have the room, we have the time and we are on the calendar. But like today, if we can get done earlier, I don't think too many people object to doing work quicker rather than taking all day long.

Douglas Barthold: Totally agree. I don't know if there is a communication issue, but I have standing conflicts every Wednesday afternoon from basically as long as the University of Washington is in session. And so, basically, that is all year except for summer.

Mike Neuenschwander: Right. Is every other Wednesday was the only day where things even kind of overlapped with everybody.

Douglas Barthold: That's fine. I am just fine in the mornings. I'm just not going to ever be able to come to join after 12:30 on Wednesdays, except in summer.

Mike Neuenschwander: Okay. Any other Board members' thoughts or comments to that proposal? Eileen? [Cross-talk] --

Eileen Cody: It's a good so far [cross-talk] --

Mike Neuenschwander: Wednesdays? Okay. Okay, yeah, because everybody had something or other that was a conflict. But Wednesday seemed like it was the only chance that we had any sort of general overlap with everybody.

Eileen Cody: [Laughter] [Cross-talk] We both are retired. [Cross-talk] Tell that to everybody.

MaryAnne Lindeblad: Yeah [laughter] [cross-talk] --

Eileen Cody: And I'm kidding.

Mike Neuenschwander: Okay.

Eileen Cody: We'll talk about that.

MaryAnne Lindeblad: Yeah.

Mike Neuenschwander: So now that being said, I think if we can push forward on that, we will try and get things done in the mornings [indistinct]. Would that work? And then in the summers we can have more flexibility?

Douglas Barthold: Yeah, that sounds great. And I apologize that I cannot be flexible on this. We would have to -- because it is the courses that I teach, and rescheduling those involves a very complex process, and I have to basically go through and have the university change their entire schedule for my course and a bunch of other courses to have it fixed.

Mike Neuenschwander: Oh, so it is super easy you're saying.

Multiple Speakers: [Laughter]

Mike Neuenschwander: Okay. So okay, let's do that for now and, again, if we need to change if something is just not working, we can try and modify and do that. Nothing is set forever in stone. Then that being said, there also needs to be a little bit of flexibility on occasion because this is a very popular room and lots of other groups like to use it, and so other groups also have this booked out like months if not like a year plus in advance. And as we are pretty new, we are coming to the table a little bit late. So in January, I believe the only time that they were -- that Simon, you were saying that we could find it was January 31?

Simon Borumand: Yep, for Wednesdays.

Mike Neuenschwander: For Wednesdays, okay. So would January 31st be okay for everyone if we could do that? And so for the January 31st meeting some of the items, and I am going to go through kind of the rest of the year here. We have got six months, and we are going to be meeting every other month. And all of the subjects are subject change. You know, again, if we need more time to really dig into one methodology or whatnot, we can take that time, but if we could move more quickly as well so we can also adjust our schedule on our topics as needed. But for this next January meeting, things that are on the agenda are finalize our policies. We can go and vote on those. Selection of a Board Chair and a Vice Chair would be good things for us to do. Other things that I thought would be good to talk and begin discussions on are drug selection criteria, so working on creating that initial list, which our data team is doing right now, and then also the number of drugs we might want to review. Colorado, for example, only chose to do five, even though they could do more. So we can choose to do quite a bit more, but realistically, where do we think -- what goals do we want to shoot for? And then also maybe we could potentially discuss the advisory Boards because there will probably be something to start talking about sooner rather than later. So those are ideas for that. Then additionally, our next meeting after that, we have scheduled March 20th. So I think other things are continuing advisory Board discussions, and the drug selection criteria methodology. I think we are going to need a couple of meetings to probably hone that and pound that out. Following that is May 22nd. I'm hoping there [cross-talk] --

Eileen Cody: The third Wednesday?

Mike Neuenschwander: Is it the third Wednesday?

Eileen Cody: It would be the fourth.

Mike Neuenschwander: So when it is not on the third Wednesday, [cross-talk] then it's the room [cross-talk] --

Eileen Cody: [Cross-talk] Oh, then there is a reason.

Mike Neuenschwander: [Cross-talk] It's a room.

Eileen Cody: [Cross-talk] Oh, okay.

Donna Sullivan: Somebody in the PEBB Board meeting --

MaryAnne Lindeblad: It's sort of every other Wednesday -- [laughter]

Mike Neuenschwander: [Cross-talk] That's our goal [cross-talk] --

MaryAnne Lindeblad: Yeah.

Mike Neuenschwander: -- and then we adjust as needed. [cross-talk] --

Eileen Cody: Okay. Like I said, I'm going to see.

Mike Neuenschwander: We are the last to the table, so we are picking up what we can.

Eileen Cody: The 22nd.

Mike Neuenschwander: Twenty second. Yeah. [cross-talk] No, no. That is what -- yeah, that is our goal we are shooting for, and we will keep to it as firm as we can, and hopefully, next year we can get way ahead of the schedule and book out before everyone else does. Right? So there I am hoping if we could start looking at our drug review methodology, and if we can -- we have our drug list methodologies sorted out, then we can start dipping our toes into that as well as start looking at WAC or rules review because that will be about the time if we are going to start making some changes, seeing what we want to do, starting that sooner rather than later to make sure that we are drafting things and getting it ready for the process. July was our -- it seems like July is kind of booked solid for the room, so I think what we are going to need to do is Simon is going to take look at just what days are even available and then we can send those out and try and get a poll to see what days in July work best for people. Okay. Yeah. And if this is completely booked solid, then we can look at a different location.

Eileen Cody: Legislature is not around at that time. There are a lot of rooms [cross-talk] --

Mike Neuenschwander: [Cross-talk] Oh, yeah. Let's go hang out at the Capitol. That sounds great. Let's see. Then September 18th, start -- oh wait, in July, sorry, the topics I was thinking if we could continue our drug review methodology, begin looking at the legislative report, and if we could start looking at selecting drugs that we

would want, that would be ideal. September, our next one would the 18th, I think is what we got on the calendar for the room. We continue to look and finalize the legislative report, which will be due in December. September is going to start going through the all the internal review processes. And if we have been able to select our drugs, then maybe begin doing the additional drug reviews or put into the data together for that anyway. And then November 20th would be our final one for this coming year. And tentatively I have been looking at upper payment limit methodologies, cost savings a little bit more, and drug reviews. The further out we go, the more tentative the schedule becomes just because you got to get steps 1, 2, 3, before you go to 4, 5, and 6, obviously. Right?

Hung Truong: Mike, can you send a recap of that [cross-talk] --

Mike Neuenschwander: Yes, yes. We will. This is all very tentative. I just wanted to get it out there in case there are any glaring "this definitely will not work" or "I have" -- I oppose. And then, yeah, we will send out a recap of this. Any thoughts, comments, questions?

Douglas Barthold: Is the general approach that we will meet on those as long as we have quorum, which is three members?

Mike Neuenschwander: Yes.

Douglas Barthold: Okay.

Mike Neuenschwander: Then hopefully, we will have that fifth member soon, which will give a little more breathing room in terms of it. Okay. Well, then I think that -- oh, Doug.

Douglas Barthold: Yeah, so I just had a question about the January 31st meeting. You said we are going to vote on the policies. Is that like we vote to approve or not approve as they are? [cross-talk] --

Mike Neuenschwander: Yeah, and adopt them. Yeah.

Douglas Barthold: Okay, adopt them. And so would changes -- proposed changes need to be discussed, what, like now or before then or what? Or could we always change them later?

Mike Neuenschwander: Yeah. We can change them at any time. Right? As we are going to be going through especially adding these methodologies there are definitely going to be plan changes for this coming year.

Donna Sullivan: And this is Donna. So to the extent that the proposed changes, if you have changes to the WAC as it is written other than expanding on information that we talked about is like work to come, we would love to have any of those suggestions. If it is expanding on the conversation we had today about the parameters that we are using for developing the drug or the affordability review through all of that work we still need to do, we won't be making those changes or [cross-talk] --

Douglas Barthold: I see. Yeah, because I was just curious about all of the stuff I mentioned when we were talking about the rules, and then you said like, well, this is going to come from the policies themselves, I was thinking that I did want those added for, I guess it was Section 6(a) there. But that will come, I guess, in the next round or something like that.

Donna Sullivan: Once we change. So what I am talking about is the Board procedures, like how often are we going to meet? How do we select a Chair? Conflicts of interest. All of the more procedural policies are what we will be voting on next week, or as it is written that was in the document here. Any expanding on how we are going to do the affordability reviews, the upper payment limits, the savings methodology that is to come in the future as future work. We will have the conversations, we will determine the policy, we will vote on it, and then we will update the document.

Douglas Barthold: Got it. Thanks.

Mike Neuenschwander: Okay. Any other questions? Okie doke. Well, now I think we will go into the last section of our meeting here, which is our public comment. So, Nonye, you want to take it away?

Nonye Connor: Yes. Hi, Nonye speaking. So we will read off the list of stakeholder names who have pre-registered to speak. We will mute you. After that if there are any other stakeholders who did not pre-register, please feel free to raise your hands, and we will call upon you and unmute you. You can also use the Q&A box, and we will try to address your questions during the stakeholder time. If you did not fill out the stakeholder conflicts of interest form, please answer the questions as they appear on the screen. You have three minutes, and that

three minutes will start after you have answered the questions. Lastly, the meeting is being recorded, so please state your name every time you speak. And if you are present and you want to speak, please feel free to come to the table and speak. Thank you. The first person we have who pre-registered was Dharia McGrew, and I will unmute you. [Cross-talk] Let me put this --

Dharia McGrew: Okay.

Nonye Connor: Sorry.

Dharia McGrew: Hi. Good morning. Confirming you can hear me.

Nonye Connor: Yes, I can hear you. Let me share my screen [cross-talk] --

Dharia McGrew: Great, thank you. My name is Dharia McGrew, Director of State Policy on behalf of Pharma. I want to thank the Board and all the members for robust conversation today. Due to the late release of the meeting materials, we did not have a chance to fully review all of the documents yet but likely will be submitting some comments on the Board policies as proposed. I did not note in the meetings materials or in today's discussion whether there was deadline or public comment prior to next month's meeting. I would appreciate clarification on that if possible but, otherwise, we look forward to submitting comments prior to next month's meeting. Thank you very much.

Nonye Connor: Is there anyone else who raised their hands? There is anonymous question. When will the initial drug list be released?

Mike Neuenschwander: Um. We have to develop it first.

Donna Sullivan: We don't know.

Nonye Connor: Any other questions? No other hands raised. Anyone with any more questions? Okay. That's it.

Mike Neuenschwander: Okay.

Nonye Connor: No questions. No comments. No -- oh wait. Okay, hold on. Let me see. Let me unmute her. Weinstein, I'm going to unmute you. Give me a quick second and let me get to the screen. Okay, can you hear me?

Elyette Weinstein: Yes, I can. Can you hear me?

Nonye Connor: Yes.

Elyette Weinstein: Okay. I am a patient, and I am a member of the Public Employee Benefit Plan for the State of Washington. I am a retired state employee. And Member Barthold asked a question about enforcing payer provisions. When a payer has savings, how do you enforce the provisions? And although the Office of the Insurance Commissioner handles private plans, I am a member of a -- well, I am not a member of a public plan, but there are several PEBB plans that are not private, they are public. And the Uniform Medical Plan is a publicly-insured plan, and it is not enforced. There is no enforcement by OIC. So how is that going to work? And I certainly appreciate all of the questions of all the members. Thank you.

Donna Sullivan: And so this is Donna. I'm not sure I can answer your question as we discussed earlier in the meeting. There is no authority given to the Health Care Authority to require the carriers or plans to comply with the upper payment limit statutes. There are reporting requirements, but the Health Care Authority in itself is not a regulatory agency. So without action by the Legislature specifically directing Health Care Authority to enforce compliance upon the plans or the carriers. We are unable to do that at this time.

Elyette Weinstein: Um, can you do that in the future?

Donna Sullivan: And so this is Donna again. I mean, being responsible for managing the pharmacy benefits of those plans, any cost savings would be attributed to your premiums. We have looked at our net costs, net of rebate, all of that goes into calculating the premiums for members, so I would say we are doing it now and we would continue to do that in the future for our healthcare, our HCA administered programs, what I can't do is say that we an enforce it upon other plans other than those that we manage.

Elyette Weinstein: Well, then my question is there crosspollination between you and HCAs section that works with PEBB? Because PEBB negotiates with plans, and if the high costs of these drugs are driving up premiums for members, and this might affect, might help PEBB when it negotiates with some of these people or these plans. Because they have drug plans.

Donna Sullivan: Right.

Elyette Weinstein: This is Medicare.

Donna Sullivan: Well, this is Donna again. The Medicare program is a federally-managed program, which is outside of the purview of HCA's regulatory authority. We can choose the carrier to administer the Medicare program. I believe it is through United. We only manage what is in our self-funded programs, which is through Uniform Medical Plan itself and negotiate. The pharmacists who consult with our public employee's program are in my unit, and we work with the ERB Employee Retiree Benefit Unit in negotiating and looking at plan design and setting those premiums as far as drug costs go. Yeah.

Elyette Weinstein: So that's great because often the public plans are ignored. Thank you.

Nonye Connor: Okay. We have one more person, Ronnie. Give me a second, Ronnie, so that I can unmute you. [Audio cuts out] Ronnie [cross-talk] --

Ronnie Shore: I am Ronnie Shore. I am President of the healthcare advocacy group called Healthcare for all Washington. And I am a retired pharmacist and was very please to hear the questions that came up today, and especially to hear that you have reviewed and coordinated work with the other states that are working on prescription drug affordability plans Boards, and I think it is really important to not be doing the basic work that they have done already. I have reviewed the Oregon Prescription Drug Affordability Board reports, and they are redefining or helping to clarify all of those issues, and that information is available about how/why we are doing -- why you are doing what you are doing. And so I think it is important to share that information with the public. Perhaps our prescription drug affordability website could include the work of the other states that are looking at the individual cases. The issue that seem to be coming up today was about the information that you are able to gather and the value of that information in comparing just the prices, I think there is an important issue that we should all continue to look at, and it is that just making this information transparent, understanding like Donna Sullivan said at the beginning of the meeting, "We don't know what/who is getting the savings." There are so many non-transparent issues pharmacy benefit managers with pharmaceutical manufacturers. I think this process going through this process will be very valuable and will be a useful tool to clinicians. It is not just the cost that helps us make decisions, but it is an important variable that providers cannot see, and often pharmacists don't

even see it, and we can't really give the information that is needed to make some decisions. It is only a part. Cost is only a part of the decision, but it is something that providers and patients and all healthcare, all people in the healthcare system really need to have available. So thanks for the work that you are doing, and especially for not starting from Page 1 by using the information that is available from other Boards that have started this work. So thank you.

Donna Sullivan: [Indistinct].

Nonye Connor: I am checking to make sure if there is anyone else who has their hand raised. I do not see anyone else's hands raised. I do not see any questions in the Q&A box. Thank you.

Mike Neuenschwander: Thank you very much. The meeting is adjourned.

MaryAnne Lindeblad: Thank you.

[end of audio]