Total Cost of Insulin Workgroup
Meeting 4 transcription
December 6, 2022

Mary Fliss: All right. Terrific. So again, welcome, everyone. This meeting is being recorded. And today we are very, very pleased to have Travis Trolley from Utah joining us to describe the Utah program. Travis, a warm welcome. I appreciate that you're just coming off of some leave and so really appreciate your taking the time to help this team really understand some of the other alternatives that other states have employed. We're also going to be just by way of reminder, this group has two charges. The first charge is to look at the short-term emergency supply strategies, and the second job we have is to look at long-term cost strategies. We have spoken about how this is being used in other states, both of these two dynamics, and so we'll be going through just a quick summary. And again, for folks who are here last time, I really appreciated Jane Beyer of the OIC asking us to do a summary by state. Hayley has done a fantastic job pulling together a summary review of other states. We'll do a potential solution for Washington State that we will put in the report, and then we will go through Poll Everywhere questions to be able to respond to that as a team what our thoughts are. So we'll do the short-term, and then we have a cost analysis update. Then we will do the long-term, and then we'll talk about some next steps. And importantly, there will be a 10-minute break in between those two. And I also appreciate that there are some substitutes in today's meeting. We had a few of our members not able to make it today. And I'm thinking Nonye, if you could please go through the list of people who are here as substitutes.

Nonye Connor: Okay. We have Shari, who will be substituting for Barbara. Mary, do you want them to introduce themselves?

Mary Fliss: That would be fantastic.

Nonye Connor: Okay, perfect. We can start with Shari. Oh, Shari, I see [Cross-talk] --

Shari Meier: Sorry.

Nonye Connor: No, it's okay.

Shari Meier: I had to get myself unmuted and videoed again. So I'm Shari Meier. I'm a Health Policy Analyst with the Office of the Insurance Commissioner, and I have been there for almost two years now.

Mary Fliss: Awesome. Welcome, Shari.

Shari Meier: Yep, thank you.

Nonye Connor: And then Ryan here for Donna.

Ryan Pistoresi: Hi. So good morning, everyone. I'm Ryan Pistoresi. I'm the Assistant Chief Privacy Officer here at the Washington State Health Care Authority, and I am filling in for Donna Sullivan today. So thanks for having me.

Mary Fliss: Fantastic. Welcome, Ryan.

Nonye Connor: And we have Kelly who is here for Leah.

Kelly Memphis: Hi. Good morning, Kelly Memphis. I'm a Director of State Government Affairs here for the Healthcare Distribution Alliance. Leah had to do some travel, so I actually will be attending about the next hour, and then my other colleague, Matt de Loretto will be subbing in. So we just really value this group and wanted to make sure we were able to attend it. So thank you for accommodating us. And nice to meet everyone.

Mary Fliss: Wonderful. Thank you so much, Kelly. And can I ask that Matt just puts in chat or you put in chat when you're doing the transfer so we can make sure Matt feels welcome and is part of the team as well?

Kelly Memphis: Sure. Sounds good. Great. Thank you so much. All right, any other opening business that we need to cover before we turn this over to Travis?

Leta Evaskus: Mary, this is Leta. I'm just going to remind people that we do get the meeting transcribed. So if you could state your name every time you speak, it's easier for the transcriber to identify the speaker. Thank you.

Mary Fliss: Great. Thank you, Leta. Great reminder. So with that, I'll turn it over to you, Travis.

Travis Trolley: Mary, thank you. And thanks for the invitation and having me here. I'm Travis Trolley, the Director of Clinical Management and Provider Contracting for Public Employees' Health Program in Salt Lake City, Utah. In some earlier conversations and, in fact, some historic conversations with some of you on this call. My recollection of the discussion leading up to this was that we wanted to answer some questions. And so, I can certainly present and ramble on for a few minutes if it's helpful. If it's more helpful to allow the group to ask questions and get right to the root of the matter, I'm happy to do that. Unfortunately, I do have a hard stop at 9:20. So we have got 12 or 13 minutes to work with here, and I'm happy to proceed however it is helpful for the group.

Hayley De Carolis: This is Hayley with the Center for Evidence-Based Policy. Thank you so much, Travis. To set the stage and just put it in workgroup terms how we've been speaking about this program to spur everyone a quick summary. Utah is one of those programs that has an emergency access piece where they do allow for the emergency supply of insulin. But also, what Travis is here about is the long-term insulin program, which offers the general public the ability to enroll in the public employee health plan and access the insulin benefit at a lower price because there are not enough rebates. So that is why we invited Travis because that was a strategy that we've looked at. If there are any workgroup members that would like to jump in with a question, I would invite you to do that at this time. Or we have prepared a couple for Travis that I can start with, and then feel free to jump in as people would like. I can't see if anyone has their hand raised, so please jump in if you have questions. But I guess we'll start with just one. Travis, could you speak to the policy design process in Utah as far as the different options they were considering as a way to provide affordable access to insulin and why this specific one was chosen?

Travis Trolley: Yeah. This is Travis. A little background. Ultimately, the legislation sponsor, Representative Thurston, is better suited to speak to background. The piece that I'm familiar with is that Representative Thurston had asked us on a number of occasions predating the passage of the legislation if there was a way to get the post-rebate price of insulin to make that price available for the public. And it certainly took us a little time to figure out how we might do it within our system. I suspect, although I don't have first-hand knowledge, that he was having similar conversations with other divisions. Ultimately, we found that one PHP had said, figure it out how to do it, and two, we were able to stand it up very quickly. And so for at least from my limited view, I think

that part of the reason we got to where we are was that we had identified a way forward, and it was a way that we could stand up within a matter of weeks and not have to wait for either concessions from the manufacturers or concessions from another third party. We controlled all of the levers, and we were able to make it work.

Hayley De Carolis: Great. Thank you, Travis. I thought I saw a hand. Did someone?

Mary Fliss: And, Hayley, there is also a question in the – LuGina, I see your hand up, and I see that Kevin's question is also here. And Kevin's question is really about utilization that Minnesota has had access about a thousand times in the first year. Can you give us some volume of what sort of update you've had in Utah?

Travis Trolley: Sure. This is Travis again. I will apologize. I'm traveling, so I don't have access to my computer. I will get to the most recent numbers. I'll email them off. We fill approximately 90 prescriptions a month within the program, and so the volume is less than we anticipated. We've speculated that some of the reasons this is less is that 1.) this program got started as the pandemic was getting going, and 2.) as a consequence of the pandemic and high costs, the manufacturer has been offering insulin at reduced prices for individuals who apply through their programs. And so, we suspect that there is still significant volume going through the manufacturer programs. That's one of the reasons we see less in this program.

LuGina Harper: Hi, Travis. This is LuGina. I'm with PCMA. I'm a representative of PBM Industry. I just wanted to see if you could clarify for us the – because customer we're looking at the Utah program two ways, one for the emergency supply but also a [audio cuts out] solution for uninsured and underinsured. So I want to confirm if somebody doesn't have insurance, they have access to the post-rebate amount from the PEHP program. But how is that administered? If I'm an uninsured person in Utah, do I go to the PEHP website in order to access or enroll? How is that managed?

Travis Trolley: That's a very good question. This is Travis, again. We've created a separate website. Ultimately, this is the state's program. PHP administers it, but it's ultimately the state's program. So we have designed it in a way that we hope it looks like the state and not like us. In order to make the post-rebate price work, the member does have to come through. I mean, we have to enroll them. And so, we created a separate plan, or a separate group is a better way

to put that. The only benefit available within the group is insulin. And it is for the post-rebate price plus an administrative fee. We use that administrative fee to fund the time value of money between the time we settle the claim or reconcile the claim and we collect the rebate. So we do enroll members who are interested If they're not enrolled, the program, unfortunately, won't work. But for anyone willing to take the – think there are like seven questions. If they take the time to complete the seven questions, I'll receive an email with the information they need to process their next prescription. And they'll pay the post-rebate price.

LuGina Harper: And can you just share with us a little bit? If somebody is on a commercial insurance plan and they want to use this process, is there a process? Or if they want to use the system, is there a process that allows that to occur? Is it just uninsured and underinsured?

Travis Trolley: It's available to anyone. One of the cautions we'll throw out all of you are involved in government relations in some form. A fiscal note on this Bill is something that would have made it really tough to pass. We learned it very quickly, but one of the hard lessons was to put limitations on the program so that this program always pays as the primary, whereas the first payer never pays as a secondary or tertiary payer. This is not insurance. It's only the post-rebate price of insulin. And so, by doing that you limit the opportunity that somebody uses, say they're their primary insurance and then uses this as a secondary benefit, and it functions as insurance instead of as a means to pass on lower-priced insulin.

LuGina Harper: Okay. Thank you.

Hayley De Carolis: Thanks for those great questions. LuGina. There's one in the chat or a couple for Travis. Do you think the lack of full utilization is from a lack of education amongst consumers, or providers, or both? Is there a group that works to reach the uninsured who don't have access to a website? And what does full utilization look like?

Travis Trolley: That's a very good question. This is Travis again. I think that both knowledge within the public and within the provider community, or more correctly the lack of knowledge by those groups, is a contributor to lower utilization. Our experience was that we worked with the Diabetes Association in Utah, who was very helpful in getting the message out. We have also worked with the Pharmacy Association. If we had it to do again, we would spend more time

with those groups in trying to get the message out. We had also spent some time with the Medical Association in trying to get that word out. By way of volume, we had some initial estimates, and it's now been enough years that I don't recall what they were, but we had done some estimates based on the estimated number of diabetics in the community and the estimated uninsured rates and what we thought was going to come through. If I can find those, I'll share them with you, but I don't know. They are estimates. I don't know that they are terribly helpful at this point.

Hayley De Carolis: Great. Thank you. I think we have time for one other question. Leta, I see your hand up.

Leta Evaskus: Thanks. This is Leta Evaskus. Travis, how do you keep the program from being misused? In your seven questions on the website, does somebody have to prove that they have a prescription for insulin? Or can people start filling out the questionnaire and getting the free insulin for a friend or family member?

Travis Trolley: Ultimately, we have in the intent of the legislation, at least in our conversations with the representative, we're not aware of that anyone is abusing insulin. We certainly understand that there can be financial abuses in secondary selling or moving to other locations. Today, we've not seen any of that because we look at claims, volume, and number of units per claim. These are folks who are buying one or two units at a time and not large quantities. The other thing that I will point out, the state of Utah – in general, this is just a principle statement – uses an attestation pretty regularly not only within this program but within a number of other programs. For instance, if I go to have my driver's license renewed, I'm going to attest that, that I have satisfied all of the standards. And so, that's one of the principles that the state has used in trying to reduce the burden of managing multiple programs. We ask people to attest. Ultimately, if there's a problem, the state is happy to pursue folks who have attested and then – well, they have lied about the attestation is the fast way to say that.

Mary Fliss: Thank you so much. I know you had a hard stop at 9:20. We really appreciate your time. We'll probably continue to have the conversation and may have a couple of follow-up questions for you. But again, for you to take time out of your day, and I'm sure it's a busy day today. Please know we are very grateful for your time today.

Travis Trolley: Well, you're very welcome. It's fantastic to talk to you. Happy to correspond by email if it's helpful.

Mary Fliss: Very good. Thanks so much.

Travis Trolley: Thanks, everybody. Bye-bye.

Mary Fliss: Bye-bye. And for the transcriber, it should have said "this is Mary." But Lori, it looked like your hand was up. Did you want to go ahead and share what your question would have been so we can capture that and forward it on to Travis?

Lori Evans: Yes. This is Lori Evans. You guys might already know this information. But is the insulin that is offered through Utah – and I didn't know how to put this in my question – is it top-rated insulin? Is it insulin that I get through my employer? Or is it the second-rate insulin that they offer at Walmart? [cross-talk] –

Kevin Wren: Sorry, just to clarify. Those are analogue insulins versus regular insulin. I'm sorry.

Hayley De Carolis: This is Hayley. That is on their website. So while the meeting goes on, I can take a look and put it in the chat for you. The certain manufacturers that they had [audio cuts out] existing deals without the state Travis told me in our pre-conversation, so I can get that information off the website and put it in the chat in a few minutes.

Lori Evans: Thank you so much. I appreciate it.

Mary Fliss: Great. Thanks, Lori. Thanks, Hayley. Jennifer, I see your hand is up.

Jennifer Perkins: Yes, yes. I had a question. You mentioned a fee, and I just am curious how much the fee is and how often that would need to be paid for using the program.

Hayley De Carolis: This is Hayley that is another. They have an infographic with the average cost per, I think, type of insulin. That is also on their website. So let me just share the URL quickly, and then we can get that information. There is an average cost that they've estimated. Does that answer your question?

Mary Fliss: Yeah, that would be great. Thanks so much. Hayley. We'll look at the URL and, Jennifer, if we still have questions, we can certainly circle back to that. Great. Any other follow-up on the information shared by Travis? Okay. Great. Well, let's move ahead to the state comparison of policy options for short-term emergency supply. And, Hayley, I think I'm turning this back over to you.

Hayley De Carolis: Yes. And I am going to share my screen.

Mike Bonetto: Hey, Hayley, this is Mike. Can I just interject something quickly? So, Hayley, thanks for helping coordinate and getting Utah on the phone. I just want workgroup members to know that there was also outreach to Maine in Minnesota, but there has been some turnover just at the program level. So we weren't able to get folks on, but we still have the ability to ask them questions. But the folks who were responsible for implementing a lot of those programs aren't around. So that was a challenge that we had today trying to get it. The goal was to have a panel discussion with some states. We were able to get Utah, but if there are any other specifics around Maine or Minnesota, we can certainly do some follow-up with them. I just wanted to make that note. Thanks, Hayley.

Hayley De Carolis: Yeah. Thanks, Mike. So the next part of our meeting is going to focus on the short-term policy grid. This is something that was suggested during our last workgroup meeting as a way with the summary that we did of these different emergency options into an easy-to-read grid with some of the important elements that were identified during that meeting. And so, we will go through it. This first table has a description definition of each of the elements. The second table is just a high-level checklist for referencing. And then we'll move into what we have drafted as a potential Washington policy based on our conversations in the workgroup. And that will end up with some Poll Everywhere questions that we'll ask everyone to participate in, so we can gauge the workgroup's feedback on the short-term solution. So we'll go through these three tables. And then later on in the meeting after a little break and some new information, we'll do the same thing for long-term. So I just wanted to lay the land for everyone. I'm not going to go – well, I can go row by row. It's a lot of information, and I think the point of the grid was to put it in an easy-to-read, easy-to-reference table. But just to highlight, we have included the four programs, Maine and Minnesota, which are very similar, Ohio, which is a House Bill that was not specific to insulin, but just emergency refills for all non-controlled drugs, and then the Utah pharmacy policy amendments. So I just want to highlight for Utah, this is not the

program that we were just talking about but rather that program allowed for this as an updated statute to allow pharmacists to dispense emergency supplies of insulin. So this table will be just short-term emergency supplies. And the summary is that Maine and Minnesota both offer 30-day emergency supplies and require the manufacturers to reimburse for that emergency supply. I would say that is the distinguishing feature of those two policies versus Ohio and Utah. They do not require manufacturer reimbursement. It was just through the normal process, but Maine and Minnesota include manufacturers. We've included some information specific to insulin, the emergency prescription authorization. This was talked about in the last workgroup. And you'll see that all of the legislation is linked, and anything that we reference is also linked so you can check out for more information. We'll get into an important piece as the application part of this, which we'll get into just a little bit. Eligibility criteria. So for Ohio and Utah, there are not specific eligibility requirements, but for Maine and Minnesota, the Maine ones are they must be a resident not enrolled in a health plan that limits cost sharing to $75 or less, household incomes are less than 400% FPL, and then there are some criteria for if you are part on Medicare and how much you have spent on prescription drugs. So you'll see that these two do require proof of Minnesota residents in the form of an ID. And that is something that the workgroup we have talked about. The criteria that have been highlighted may be restrictive. All of these programs offer at least 30 days. So the first two for Maine and Minnesota, once in a 12-month period a 30-day supply. For Ohio, it's also a 30-day supply at first, but they can access them multiple times in a 12-month period with a seven-day supply in the next two points of access. And then for Utah, which runs a little bit differently, it's based on the exhausted prescription, and there are criteria for that, but it can be filled in an amount up to 60 days. So those are the differences. For administrative funding, this is really for state resources to run the program. An important highlight for the Maine program is that they levy a $75,000 licensing fee annually on the manufacturers, and they also allocated one state FTE to manage the program. And then for Minnesota, they do not assess that $75,000 licensing fee, but they did appropriate state funding for the program. The big chunk at the beginning is for a peer navigation program, the training of that, the curriculum, the certification, and then accessing it. And then that dwindles down as it's like considered a one-time investment. And then Ohio and Utah had no appropriations clauses attached to their Bills. Similarly, Maine and Minnesota for the copayment instructions are grouped together that they may charge $35 to cover the dispensing fee. Ohio and Utah did not have any language around that for the application process. So for Maine and

Minnesota, since it is a program that involves a manufacturer and there is an application online in a healthcare setting. So it's on the patient to fill out the application and prove that they are eligible versus with the criteria we went over earlier. And then they bring that to the pharmacy, and it's also on the pharmacy to determine eligibility at that point that they are trying to access the emergency supply. There is no application involved in Ohio and Utah's programs for the emergency supply part only. And then for reimbursement for Ohio and Utah, it is standard. But for the Maine in Minnesota programs, the pharmacy submits a claim to the manufacturer, and the manufacturer is responsible for either backfilling with supply or in the way of electronic claim and reimburse them at their acquisition cost for that. Moving on another important consideration that was brought up in our last workgroup meeting was whether or not educational materials were provided on the patient assistance programs. And so, in Minnesota, the pharmacy must provide an information sheet with how to access the Health Insurance Consumer Assistance Program. Similarly for Maine, they are required to have an information sheet and then they also were providing that extra service of trained navigators, so the information sheet includes contact information for those as well. And also the information on applying to the Long-Term Assistance Program, which we'll talk about later in the meeting. The workgroup was also considering whether or not it should be a requirement for the pharmacy to report to the original prescriber, and so we've listed the policies for this. Three of them require notification. Ohio requires keeping a record, and they have different time spans for that. And then we also just listed the general statewide emergency prescription authority, just for reference as a setting of the policy specific to insulin. And then for the last one, we've just noted any other specific identifying characteristics of the program. So in Maine, they did include some language about allowing pharmacists to dispense diabetic supplies along with insulin, which has been brought up in the workgroup several times. And then for Utah, same thing. It allows pharmacists to dispense supplies along with insulin. Those are the definitions. I see LuGina raise your hand. If you want to ask a question, go ahead.

LuGina Harper: Hi, Hayley. This is LuGina from PCMA. I'm also a pharmacist. So I just wanted to ask a question about the difference between the Maine and Minnesota program and then the Ohio and Utah columns. I just want to make sure I understand correctly. Because as a pharmacist, each state generally allows us to dispense an emergency supply. Say it's Friday night, or it's a long holiday weekend, and the physician is not accessible, or the provider is not

accessible, but the patient needs a refill of their medication, generally, there are some allowances made so that pharmacists can take care of patients during that emergent timeframe so to speak. So to me when I'm reading the Ohio and Utah columns, that seems more like allowances for pharmacists to engage in that emergency dispensing whenever prescriptions are out of refills, or the provider is not accessible, to allow us to dispense a product. But it doesn't necessarily mean that a product is being provided at a lower cost or no cost or whatever the case may be as opposed to Maine in Minnesota, which truly sounds like a program where there is some sort of provision of the product and an offset of the cost for that patient. Is that an accurate representation of the way these two columns – or these four columns mesh out, generally?

Hayley De Carolis: Yes, LuGina Harper. I think that is a great way to summarize it. I think we were thinking of a continuum of policy options with different intents, I guess. So, yes, I think that is a perfectly accurate way to summarize that.

LuGina Harper: And, I mean, I do like the way that you guys have a table for short-term, and then there is another table for long-term. Because, I think, for example, the Utah program is more of a program like Maine and Minnesota for using their PEHP post-rebate thing. That is where they are actually sharing some cost savings. So I just want to make sure I had it right in my head as far as how I was thinking about this short-term table.

Hayley De Carolis: Yes, I think you are definitely thinking about it correctly. And thanks for doing that summary. I think it's very helpful for everyone. Did you have any other questions, LuGina?

LuGina Harper: No, I'm sorry.

Hayley De Carolis: No, that's great. Thank you. [cross-talk] I think I saw Jenny and Jennifer had a question, Jenny. There you are.

Jenny Arnold: Yeah, I just wanted to highlight, thank you for calling that out. We talked about this briefly on a previous call. And I think about as payment versus scope. Pharmacists in Washington have the ability to authorize a one-month emergency prescription for patients if they are out of refills, and they can help to facilitate that. There are slightly different rules if there is a declaration of emergency where patients can just walk in with the prescription vial or their labeled vial to be able to get refills. So in

Washington, we have covered and already taking care of that scope issue around pharmacist refills. So yay! We get to check that box done. And so, then it's really on the payment side that we need to address and we get to focus on. So check that box for all of us. We did that through our rules rewrite a couple of years ago. Thank you.

Hayley De Carolis: Great. Thank you, Jenny. Jennifer, do you have a question?

Jennifer Perkins: I just wanted to comment because I'm looking at the – I'm not sure what our general statewide emergency plan is for just all medications here in Washington. But I just know that I have experienced this years ago, and I remember talking to a pharmacist about a patient over the phone that if someone is using pens, the pharmacy does not want to break open a box and fill a partial box of pens because they come in boxes of five pens. And so, I think that might be an issue, especially if it's a three-day supply. I see one of these is three days or if it's a week or depending on that, it's likely it's not going to be a full box for everybody. And so, I just wanted to point that out.

Hayley De Carolis: Thank you. That is an important consideration. And, yeah, I think that is a good thought to keep in mind when we go to the potential Washington policy, just make sure that we are thinking about whether or not that situation could occur and how to best handle it. So, thanks, Jennifer. Are there any other questions on the first table short-term supply policy options? Anything else you would like to see in terms of the elements or any other questions? Okay, I'm not seeing any, but feel free to jump in if you do have some. Moving on to this Table 2, which is the same information as the table above. It's just in a checklist format for easy reference, so it is the same information. There is not anything new to go over, just as a comparison to the different options. And I know I blew through that first table. I was a little concerned with timing, and now I realize that we have more. So Table 2 is summary information of the first one. I'm not seeing any questions, so I'll keep moving on, but feel free to interrupt. So in Table 3 is our potential Washington Emergency Supply Policy Recommendations. We went through the feedback from all of the workgroup meetings, the surveys, and then the policy options we have presented and tried to summarize what a potential policy might look like given all those pieces of feedback and make it representative of what the workgroup has expressed. So we do have some important considerations in this table that might warrant some discussion. So if you're seeing something that you immediately have a reaction to, feel free to bring that up, and we want to talk through those. So we'll go through

this table, and then we will move on to having a Poll Everywhere question so you can quantify your response and support for each of these different elements. So that is what the next part of the meeting will go over.

Kevin Wren: Um.

Hayley De Carolis: Oh, yep. Kevin.

Kevin Wren: Sorry. Excuse me. This is Kevin Wren. I just wanted to quickly highlight the copayment cost. It is $15. Is that what that says for consumers?

Hayley De Carolis: Yes, that is what it says. And that was based on some feedback. So that is our recommendation as of right now.

Kevin Wren: Okay. And I just wanted to make a quick point that we can make that $0 by just billing the government $15,000. I mean, this program was used like a thousand times by Utah, a thousand times by Minnesota. So I think we should work to make that copayment as little as possible in those barriers to entry as small as possible.

Hayley De Carolis: Okay, great. Yeah. Thanks, Kevin. So we will have a question specifically on that, too, for Poll Everywhere on how strongly you support each of these elements. I think that is great. But thank you for that feedback. We'll make a note. So for the summary of the policy, this would be a once yearly 30-day emergency supply of insulin and for table setting, that is because that is what this workgroup was directed to discuss is a 30-day supply, and other policies have made that once yearly 30-day. So that is what we have had, and that is what we are going with for this potential Washington policy. We have noted significant workgroup feedback to make it more, but that would be the summary. Emergency prescription authority, which would be specific to insulin, would be similar to Maine and Minnesota's program where it would require a completed application, and then the pharmacist could dispense the emergency refill of insulin along with related devices and supplies, which was another piece of important feedback from the workgroup. This Amount Supplied is where we note that there was significant feedback from the workgroup that the emergency supplies should be 90 days rather than 30 days, and they should be allowed to access the emergency supply more than once in a 12-month period. And this is where we wanted to have a discussion with everyone about the specifics about that. Emergency supply should be 90 days. Does that mean 90 days straight? Or does that mean people would

prefer 30 days and be allowed to access it three times during a 12-month period? That does seem to be a distinction that we need to make, and we have not considered yet, so we would love to hear some feedback now. The Poll Everywhere questions are just a Likert scale 1-5, so there is not room to provide any other feedback related to the question. So if you have feedback about 90 days that should be a one-time or multiple times in 12 months, this would be a great time to share.

Kevin Wren: This is Kevin Wren. I think it should be one 90-day supply, and then you can utilize that as many times as possible. I think you shouldn't make it complicated in having people to break up their three-month supply into different chunks. I don't know if that makes sense. Especially when you're struggling to afford insulin, we just have to make this program as easy to access as possible. And I think overcomplicating it with what months you choose is unnecessary. If we could just get our 90-day supply of insulin, that's all we really need and remove those barriers and make it as uncomplicated as possible. And being able to utilize it more than once a year. I mean, so many things can happen to your insulin. We have talked about it over again on this workgroup call. So, I mean, there are so many things that can happen to your insulin in 90 days. It can take a while to get coverage, see a provider, get a prescription. So I really think this 90-day supply piece is crucial, and I think it should be a one 90-day supply that you can access numerous times.

Hayley De Carolis: Okay, thanks, Kevin. Lori, [cross-talk] –

Mary Fliss: I'm sorry. [Cross-talk] Before we move on, Kevin, I just want to make sure I'm clear on that suggestion. So what you're asking for are 90-day supplies anytime that 90-day supply is needed.

Kevin Wren: Right.

Mary Fliss: Gotcha.

Kevin Wren: Thank you.

Mary Fliss: And it's not that we haven't heard the input around the 90 days. And Hayley, I apologize if you already said this, but the legislation specifically calls out for this group to be reviewing this policy, a once-yearly, 30-day emergency supply. So we'll certainly add any comments around indication from the

workgroup to expand that. But I think in order to comply with the legislation, we do have to answer this question specifically.

Kevin Wren: Yeah, I completely understand. Thank you.

Mary Fliss: Great, thank you.

Hayley De Carolis: How about we go to Lori and then Jenny.

Lori Evans: Okay. This is Lori Evans. I'm an insulin user, and I love Kevin's idea what he just spoke about. But I understand that is unlikely to be reality. So as an insulin user, who, on occasion struggles with finances, I would personally like to see a 30-day supply available to me multiple times a year. So not just a 90-day supply one time per year.

Kevin Wren: Yeah. I was saying 90-day supply multiple times a year. So I mean, either way, 30 days or 90 days, being able to access it multiple times a year, I think is crucial because, I mean, if something goes wrong within those 30 days, you're kind of screwed for the next 30 days.

Lori Evans: I understand that.

Kevin Wren: Yeah. Thank you.

Lori Evans: But I, personally, would like to see a 30-day supply option multiple times a year, and if something happens to my insulin within those 30 days, then I can reapply the following 30 days.

Hayley De Carolis: Okay. So what I'm hearing is a 30-day option and a 90-day option of being able to access it multiple times a year.

Lori Evans: Lori is suggesting a 30-day supply multiple times a year.

Hayley De Carolis: Got it. Okay.

Lori Evans: Yeah.

Hayley De Carolis: And Kevin is 90 days multiple times a year.

Kevin Wren: Correct. Thank you.

Hayley De Carolis: All right. Okay, great. Okay, great. Thank you both. Jenny, did you have a question? I think I lost you in my video. Okay, we'll keep moving on. But feel free to jump in if you have any questions.

Leta Evaskus: This is Leta. Jenny is on mute. She was talking but on mute.

Hayley De Carolis: Oh, okay.

Jenny Arnold: Yes, I was double muted. Thank you. So I do agree with Lori. I think a 30-day application once yearly as a pharmacist absolutely gives a patient an option to try to find care, but a 30-day supply multiple times a year I think is a better option. I don't know if we want to cap it based on the cost or if we want to have something in the application that allows for specific timeframe of concurrent refills. I think as a pharmacist, we could work under a CDTA and actually prescribe the insulin rather than based on criteria. Rather than just continuing to do a one-month supply so the patient can feel a little more secure and not feel like they have to get a 90-day supply. As we know, insulin storage conditions can be very tricky. If somebody is houseless, giving them a 90-day supply is potentially wasting additional [cross-talk] –

Kevin Wren: [Cross-talk] I'm sorry. [cross-talk] I completely disagree. I get 90-day supplies now through my pharmacy, and I can elect whether to get 90 or 30 days. So it really should be within the patient's right. I don't think it should be restricted by the pharmacist.

Leta Evaskus: This is Leta. Let's let Jenny finish speaking before we comment.

Jenny Arnold: No, that's fair. I really appreciate the perspective for sure and would definitely defer to the patient for their ability to store the insulin. So that is a very good point. Thank you, Kevin.

Hayley De Carolis: Jenny, I have a follow-up quick, quick question. Is there anything in the emergency supply policies that we have gone over that would restrict that pharmacist's ability to prescribe? Is there anything that any policy element we need to adjust to allow for that? Or could that exist in the structures we presented? Oh, I think you might be muted again.

Jenny Arnold: Oh, I'm on mute again. Let me look over that. I have a problem with my mute button. And I will consider that when I read it over again, and I'll let you know.

Hayley De Carolis: Okay, yes. Please let us know. I think that is a great point and not something I considered before. So thank you for sharing. Jennifer, did you have a question?

Jennifer Perkins: Yeah. I wanted to just contribute my two cents on the 90 versus 30 versus multiple times. In a perfect world, I would say all of them. If we had to choose, my preference would be because maybe we can't, maybe we are not going to get multiple times. So if we can't get multiple times, then I definitely prefer the 90-day over the 30-day. But I feel indifferent to if we were able to do 90 days all at once versus like 30- multiple times. I don't know. Just if we have to do only one, then, of course, the 90-day would be better than the 30-day.

Hayley De Carolis: Great. Thank you, Jennifer. William, and then Shari.

William Hayes: This is William. Thank you. I wanted to contribute to the discussion on the pharmacist CDTA process, which we are going to look into. But in terms of communicating the decision-making process on the 30-day supply and assisting the patient. As you know, I worked in Corrections, and our patients upon reentry sometimes are unhoused and don't have the ability to store medications. So the patients can communicate with the pharmacists, and I believe that is what the previous pharmacist, sorry Jenny, I think was trying to indicate that the pharmacist would be able to work with the individual patient and determine whether they needed it immediately the next month, or whether they couldn't maintain an amount greater than 30 days. And I just wanted to make sure that we keep that in mind. Not every patient is able to store 90 days of insulin. So we have to remember that we were working with unhoused or patients that are unable to maintain insulin. So I just wanted to comment on that.

Hayley De Carolis: Thanks, William.

Kevin Wren: I just have another follow-up. I'm sorry.

Hayley De Carolis: Could we go to Shari and then we'll go to Kevin if that's okay.

Kevin Wren: Yep.

Shari Maier: Thank you. And so, somewhat related to what the previous speaker was just mentioning about unhoused people, as far as the difference between allowing a 30- or a 90-day supply. I guess one of my questions, too, is as far as if it is a 30-day supply, and people would need to reapply, are they going to be able to reapply? Is that going to be an easy process for someone who is unhoused? Would it be a paper application? Or is this something they are expected to do online? Because if it is, obviously I think that is a little more complicated for people who are unhoused. And then the other question, since I haven't been involved in the workgroup discussions previous to this, I don't know if this has come up, but I didn't know if there had been any discussion about it. I know we are also going to be looking at some long-term solution options. And has there been any thought about how those two may integrate with each other? So, at a certain point, if someone is needing to use emergency supply X amount of times, does it make more sense, if there is this long-term solution, that they would be directed towards that option?

Hayley De Carolis: Yeah. Great questions, Shari. I think your first question related to applying multiple times is a great one and something we haven't seen in other state options that we went over because they do restrict it to one time every 12 months. So I think that important consideration that the workgroup will need to design a policy if we are going to do more than once yearly. Again, the legislative directive is to look at once yearly, but if we are going to include our feedback, that is an important consideration I don't think we have talked about. And related to your second point, I also agree that is something that the workgroup would need to figure out. If we are doing more than once yearly, how does that interact with the long-term option? I think we have addressed it in the workgroup. One way that we have thought about it is by providing information and educational materials that point to the long-term assistance. But in terms of logistics beyond that, we have not discussed that in the workgroup yet. So thank you so much for bringing that point up.

Shari Maier: Yeah.

Hayley De Carolis: So I think it was Kevin, and then back to Jenny.

Kevin Wren: Yeah. This is Kevin Wren. It seems like Ohio has the 60-day supply, and they haven't run into any problems. I would maybe – can we talk to them about why they chose to do 60 as opposed to 30? I mean, if they can do it, why can't

we do it? I mean, if you have a problem with someone housing their insulin, for 90 days, then you're going to have a problem with 60 days and 30 days. So I understand your reactions about unhoused people not being able to store their insulin, but I think this program is being utilized more than the unhoused. And while we should consider them, we should also consider the 1000 people who use this program successfully in Minnesota and in Utah. It's really frustrating to have these conversations again about 90 versus 60 versus 30 because we should be able to utilize it multiple times a year, and it should be as long as we need it.

Hayley De Carolis: Okay. Thank you, Kevin. I think it was Debbie, then Jennifer. And I will note, Amber, we got your feedback in the chat, too. So thank you for sharing. So Jenny, then Jennifer.

Jennie Seeley: Hi there. I want to move off the 30/90 day-supply if it's okay. I have two questions for this. First of all, a $15 copay, is that per 30-day supply? What does that look like? So a co-payment instruction – the pharmacy should be made whole, including dispensing fees through a copayment of $15. I think as we identify what our day supply is, we should be identifying if it's $15 for a dispense or if it's a $15 per day supply. Typically, we do per day supply, and I think that is a little easier for the pharmacy applications to put forward. And then the second question I would have is in other areas when I was reading over this, it looked like there were pharmacies that were registered as part of this process or part of this short-term program. And I'm wondering if we are considering something similar within this program.

Hayley De Carolis: I think that is a great question. Ryan, are you going to? And I'm not sure about the registration for pharmacies in the other state programs. I would have to look into that unless there is someone on the line who feels that they can answer that question.

Ryan Pistoresi: Hi. This is Ryan. I may be able to answer that. So I think in terms of the pharmacies that are registered, it is who is in a network. So like for the Utah program, it's through their Public Employees' Network. And so, if the pharmacies are contracted with that plan, then they are able to adjudicate the claims and get that process where they have the right price at that time because if they are not contracted, they are not going to know what that rebated price is. In terms of the copayment, that $15 was for the dispensing fee. So it's not tied to the amount of drug like a traditional copay is where a copay is typically at a 30-day supply. That is because the plan is paying for

some amount of drug, and then the member is paying for some amount of drug. And if you do a 90-day supply, that is three times the amount of drug, and that is where that member payment is. Because this draft policy is around the manufacturers paying for the supply of drug, that $15 dispensing fee should be the same regardless of whether it's a 30- or a 90-day supply, just given that it's only for that one-time dispensing fee.

Jennie Seeley: Thanks, Ryan. [Cross-talk] –

Hayley De Carolis: [Cross-talk] Thank you so much for that clarification. Sorry. Yeah, thank you. Okay, Jennifer.

Jennifer Perkins: Yeah. Thank you. This is Jennifer. Since we were discussing houselessness, I wanted to reiterate that $15 may be too much for these individuals. And then on another note, I wanted to just point out I think some of the frustration that my fellow diabetics feel comes from the fact that diabetes is a natural variation of the human condition. It's just the way that we are and our diabetic bodies have been over-medicalized that make it so that our systems monitor and gatekeep us for accessing our human needs. And then I wanted to read Amber Markland's comment, just because I want to make sure that it gets into the transcript here. Amber wrote, just to add to what Kevin just mentioned about it should be up to the patient whether it's a 30- or 90-day supply and not up to the pharmacist. We live in a world where things like insulin should be free medication for those that cannot live without it. There are gatekeepers put in place to ensure that this does not happen and why we are all here. For those of us that depend on this drug to live, this can be a very triggering and frustrating conversation. And I want to add to that, so please forgive us if we are. We probably are emotional because this is a very – it's a life or death for us. So thank you.

Hayley De Carolis: Yeah, Thank you, Jennifer, and thank you, Amber, for sharing. Okay, that was a great discussion on the amount supplied. I'm going to continue moving through the table. And feel free to raise your hand if you have any questions or anything to add. So moving on to the Funding Source. Like Ryan just mentioned, this would be similar to the Maine and Minnesota programs in that it requires reimbursement by manufacturers. And another funding idea that came up through the workgroup is the consideration of state FTE to administer the program and to help ensure patients, pharmacies, providers, and manufacturers are aware and able to resolve any issues. So that is something that we heard from the workgroup and included. We did not

discuss many specifics around the number of FTE or what the specific job would be, but we wanted to include that in the funding source considerations. And then moving on to Copayment, which Ryan also just laid out for us. That $15 would be to cover the dispensing fee. The manufacturers would be responsible for either sending the replacement supply or by filling the electronic claim that the pharmacy would submit to them. For eligibility criteria, the recommendation is to require state residency, which would mean providing a Washington address on an application form. It would not require the state ID, which is the next point. We had heard from the workgroup that requiring state ID would limit access of people who are undocumented, homeless, or visiting Washington, so the recommendation would just be to require providing a Washington State address.

Kevin Wren: I'm sorry. Just a quick clarifying question. So we are trying to get to help the unhoused, but they need an address? How would that work if you're homeless? Yeah, [cross-talk] –

Hayley De Carolis: Thank you, Kevin. The ArrayRx eligibility criteria is this right now. And I think that people are able to put shelter addresses if they are unhoused as their physical address. And I would invite Leta to share more about how that works operationally. But Kevin, did you have a follow-up?

Kevin Wren: No, that was perfect. Thank you.

Hayley De Carolis: Okay, great. Yeah. So that is eligibility criteria. The application process would be similar to Maine and Minnesota in the sense that there is one, and the patient would bring that into the pharmacy. But unlike those, the recommendation would be that the pharmacy would not be required to maintain additional copies of the application, which is what other programs require. And another workgroup recommendation was to ensure that the registration system be standard and easy to use. So the other programs provide applications online as well as in healthcare facilities. So I think that was an earlier question about how to access them. There are paper copies in the community and also online. Reimbursement Process. So we have gone over this several times, but the pharmacy would be supported by the manufacturer with replacing the stock or reimbursement from a claim. The majority of workgroup members supported requiring manufacturers to reimburse supplies, but some thought that pharmacies should be able to choose their preferred reimbursement process. That is note that we have included. And then another recommendation was to be to put a time limit on

the amount of time that manufacturers have to complete that reimbursement so that pharmacies aren't left waiting, and the example was 10 days. And then the last two elements of the policy would be providing educational material to everyone on how to access emergency supplies and should include other services or health insurance options that the state or can provide to patients. And then the last element would be to not mandate prescriber reporting requirements due to the administrative burden of that, which would be a break from the other emergency supply programs. Around the country, they do require that reporting. So I'm going to stop sharing – or let's pause and see if there are any questions related to the following elements that we just went over. If not, we do have Poll Everywhere questions, where you can submit your support for each of these elements. But are there any questions right now? Great, okay. We stopped sharing.

Hayley De Carolis: Mike, I saw you come off mute, I think. Did you have anything to add?

Mike Bonetto: I did. I'm ready to step in if you want me to help [cross-talk].

Hayley De Carolis: Great.

Mike Bonetto: You have just been going a million miles an hour. It's just amazing. So I want to just give a huge shout-out to Hayley. She has become this state insulin expert, and I don't think she had that understanding at the beginning of this project, so huge kudos to her. So I want to set things up as we go through this because we are going to be asking for your feedback on each one of those elements. So we have done this before. If you guys have a chance to get signed up with Poll Everywhere. The link is there. Can we put that in the chat, as well, on here, Hayley, so you can just link to that? Already there? Ronnie is ahead of me already. So it's already there, and you can do it on your smartphone. So you should be able to see this. And it's your choice if you want to be anonymous or fill in your name. Totally up to you. And I'll give everybody just a second to complete that. And as Hayley mentioned, we have set everything up right now on a scale of 1-5, 5 being "strongly support." But I also want to make sure that we capture some of this robust discussion that is been going on because sometimes it's – I mean it's nice to be able to quantify something, but we don't want to lose all of this additional information. So I want to make sure that we are going to use the chat in a way that if you have additional thoughts or comments, we can do that. So if you go back to if we think about that grid that Hayley just walked us through, and it had all of those elements. We are going to take each one step-by-step,

and have you do this evaluation of your own scoring on this Likert scale of 1-5. But I also want you to have the ability to add a certain comment or a thought that may not be captured in an actual just a number. So if we can go to the next slide. It's the first – there. So I'm going to give you an example. So you guys are going to rate this on a scale of 1 to 5. So as Hayley talked about the emergency prescription authority, upon receipt of a completed and signed application, pharmacists may dispense emergency refills of insulin and associated insulin-related devices and supplies. So you guys are going to then again, some of you are already starting to fill that out on a scale of 1-5. However, if there are additional thoughts or comments you want to make, what I am going to recommend, I'm going to do a quick test here. So in the chat, I just put an example. So I'd love for you guys, if we go through each element, if you have a thought if you could tag your thought to this specific element. So, for example, I just put in emergency prescription authority, x dot, dot, dot, whatever you want to talk about. We just want to make sure your comment is linked to this specific element so we can go back and say, okay, here is how everybody quantified it. And then here are the additional comments that we would be able to bring into that. So again, think about all the months of work that we have done with you guys, you guys have really started to whittle this down, and you're starting to get this set of core policy options. And now there is even some further refinement that we'll have at the end of the meeting, and then that starts to help shape the final report that will come out of this. I'm going to pause there. Any other thoughts or comments as I look into the chat if there are any other comments? I just saw something coming from Jennifer Perkins. Thank you. Jennifer, I just want to make sure that goes – I'm going to forward that. I just want to make sure that goes to everybody, as well. You don't need to directly. So, Jennifer, you talked about expanding emergency prescription authority, do not add barriers for pharmacists, such as a computer form. So all great comments I will put back into the chat. Okay, and I'll capture that. Awesome. Thanks, Jennifer. Okay. [audio cuts out] You guys have the routine. So just make sure that – I don't think we have got the scale listed at the bottom 1-5 on everyone, but everything is 1-5, 5 being strongly support for each one of these. Okay, Ronnie, let's go to the next one. So amount supplied, emergency supplies should be 90 days rather than 30. The one caveat I have is just knowing what Mary laid out before was that the legislation was clear that this workgroup was going to be looking at the 30-day supply. That doesn't mean that you can't have a recommendation that would go beyond that. I just want to make sure we are still meeting that intent.

Jenny Arnold: And 5 is strongly agree and 1 is disagree?

Mike Bonetto: Strongly Disagree. That's right. Thanks, Jenny.

Jenny Arnold: Okay.

Mike Bonetto: And William, I saw your comments in the chat. Thank you. So, again, if you have thoughts or comments on this one in the chat, you can put amounts of [audio cuts out] colon and then whatever you've got. Yep. Thanks, Shari. Excellent. And if there are other thoughts or comments in any other group discussion if you have something in the chat that you feel [audio cuts out] warrants further discussion, we are happy to have that as well. Want to make sure you guys feel heard, and we can get all of this stuff out here now. Three, two, one. Thanks, LuGina. I was just checking your comment, too. Need to ensure alignment between the Board of Pharmacy rules. I recall Jenny stating the emergency dispensing is limited to one 30-day supply right now. And, Jenny, that is what you had mentioned earlier. Correct?

Jenny Arnold: Yes. And CDTA is a Collaborative Drug Therapy Agreement. They do not need a collaborative drug therapy agreement, which is how many pharmacists prescribe insulin. We just have in our rules the ability for a pharmacist to refill a medication that a patient has as long as they have been to that pharmacy or the pharmacy can transfer the prescription or get some verification that the patient is on it without any collaborative drug therapy agreement prescriptive protocol standing order, they are allowed to refill an emergency medication. There are more allowances and flexibility if there is a declared state of emergency, then they just need the prescription vial or something like that, a medication list, or healthcare record that they can access. But if you're going, I know that there's still a gap there for the patient who moved and don't have an established pharmacy. But the vast majority of our patients already have that ability, and it's in the state law.

Mike Bonetto: Got it. Thanks, Jenny. Okay, Ronnie. Yeah. Let's lock that down. We'll go to the next. So again, Amount Supplied. A patient should be allowed to access an emergency supply more than once in a 12-month period. So I already had some good discussions on this one this morning. Great. Looks like there's some strong support for that. Checking for any comments here. Great. I'll give folks a few more seconds. Yeah, Shari, you brought that up earlier. Thanks. So we'll talk about our long-term solution. But I would like you to bring that point up [audio cuts out] at around the bridge going from the short-term to

long-term. It's a really good point. Okay. Three, two, one. Yeah. Thanks, Ronnie. Let's lock that. So Funding Source. Reimbursement by manufacturers as long as that covers pharmacy costs, including insulin and business occupation tax, the gross receipts tax. And, Jennifer, I saw your comment in the chat as well. Thanks. Okay. Waiting for any other changes here. Hold on a sec, Ryan. I'm just making sure that everybody is in. Looks like folks [audio cuts out] are in lockstep here. Let's just see. Thanks. Just a little bit more. All right. So really strong support there. And I would also say, if you are voting lower than the five and three or the one, if you have other thoughts around what that reimbursement or what that funding source could look like, I would encourage you to put that in the chat as well as underfunding source just so we would have a better idea. Okay. Ronnie, let's lock that. Thanks. So another funding source question. Propriate state FTEs to administer the program and help ensure patients, pharmacies, providers, and manufacturers are aware and able to resolve any issues. Yeah. Thanks, Jenny. That has come up in a number of our prior discussions as well, just keeping this program simple and easy to use for everybody, patients and pharmacists. Okay. Some strong support there, as well. Great. Ronnie, let's lock that one down. We'll go to the next. A pharmacy should be made whole, including dispensing fee through a copayment of $15. A little different here.

Lori Evans: I don't know what this question means. A pharmacy should be made whole? I don't get it.

Jenny Arnold: Meaning cover the cost of dispensing [cross-talk] –

Mike Bonetto: [Cross-talk] Cover the costs, right.

Jenny Arnold: [Cross-talk] including the vial, the labels, the processing fee, the B&O tax. So that is what that means.

Lori Evans: Thank you.

Jenny Arnold: And I think as Kevin mentions, a copayment would be the patient would pay it versus another method to reimburse pharmacies.

Mike Bonetto: So I've got a few things coming in the chat, and I'm going to back up. Hey, William, you had one on the prior one. I just want to make sure I capture that. You had, manufacturers should be responsible unless pharmacy company has a major deal with manufacturer already. Well, I learned based on

conversation earlier today that Walmart has a Walmart-branded analogue. And I don't want to go beyond discussing individual companies beyond that, but it appears that some major corporations have deals already with purchasing and dispensing insulins. And I would say that those deals should be considered when we are seeking funding. So I just want to make sure that we are looking at those companies that are already getting discounts and not reimbursing them more than they should be getting or asking the manufacturer that is already inked a deal with that company more money when it's already discounted at the pharmacy that they are selling it through. So it's essentially that I'm trying to [cross-talk].

Mike Bonetto: Got it. Yep. Okay. Thanks, William. I'm just going through the rest of these chats. LuGina, you got your question answered on the business tax that was included. Correct?

LuGina Harper: I think. I mean, because when Jenny was just talking about this question, she did include the tax. Is that right, Jenny?

Mike Bonetto: That was the intent here, I believe, that the [audio cuts out] [cross-talk] –

Jenny Arnold: [Cross-talk] Well, I mean I do think [cross-talk] –

Mike Bonetto: [Cross-talk] Again, pharmacy [cross-talk] made whole from all of that.

Jenny Arnold: Yeah, [cross-talk] the pharmacy probably won't. The $15 will cover the cost of the pharmacy to dispense that product in general, but it may not cover the full B&O tax. The previous question did specifically call out the Business and Occupation tax. So the Business and Occupation tax is one of the major taxes in the State of Washington. They tax businesses, including pharmacies, on their gross profits. That is challenging for pharmacies because so much money passes through a pharmacy for medications. The pharmacy doesn't keep that money, which would be a net. It's that, let's say, $100 that the pharmacy purchases a medication for $90 to dispense to a patient, they get paid $100 by the insurance company for that but then has to turn around and pay their wholesaler $90. So the pharmacy just gets $10 to cover the salaries and the labels and the software and the computers and the rent and all of that. The $10 would kind of be above those costs, whatever's leftover from that $10 would be their net, but they are actually taxed on the whole $100, even though that is not what they are keeping. And that is the challenge with some of just pharmacy in general. And I'm not trying to nitpick the business

of pharmacy, but that is where the question is coming from and the background. [Cross-talk] –

Mary Fliss: This is Mary.

Ryan Pistoresi: This is Ryan. Oh, go ahead, Mary.

Mary Fliss: No, go ahead, Ryan.

Ryan Pistoresi: All right. So this is Ryan from Health Care Authority. So I think the reason that we included the B&O tax in the previous one around the manufacturer reimbursement is around how the manufacturers could reimburse it. So as Jenny had mentioned, the pharmacy may be buying like $300 of insulin from a wholesaler. If the manufacturer were to only reimburse that $300 of the amount of the drug. It doesn't cover that B&O tax. And so, if the manufacturers were to fully reimburse the pharmacy for that cost, they'd have to do the $300 plus that B&O tax that would be levied on that pharmacy, or they would have to then reimburse the actual insulin, so that way they are replenishing the stock. So I think that is why the B&O tax was considered in the previous one because, as Jenny mentioned, it's going to be around the cost that the pharmacy is purchasing the insulin from a wholesaler rather than around this, which is the dispensing fee, which is the services that a pharmacist is providing to the patient for their care.

Mike Bonetto: Thanks, Ryan. Mary, did you have a comment? Mary, I'm guessing you may be checking time. I'm doing the same.

Mary Fliss: Right. Sorry. And also trying to figure out how to make sure I'm off mute. So, no, Ryan covered it beautifully. Thank you.

Mike Bonetto: Okay, thanks.

Mary Fliss: I'm also checking time.

Mike Bonetto: I know. I'm checking time too. So we are going to move through these next. And I am checking chat. So, Kevin, I got yours on copayment share at sliding scale. Great point. Kevin, you had another on the Utah/Minnesota example. And, Jennifer, years on just minimizing overall costs. Yep, got it. Thanks, guys. Okay. So we are going to keep going. We got a break coming up that we want to get to. So Eligibility Criteria. You guys have touched on this already. Utilize

ArrayRX current eligibility. All state residents qualify, no age or income restrictions, would not require ID or documentation of residence. All that is required is a Washington address. For those people who are houseless, they could put down shelter or leave it blank.

Mary Fliss: I'm sorry, it may be just me, but my content didn't move to that question.

Mike Bonetto: It didn't? Huh. Everybody else have that problem? Mine [cross-talk] –

Ryan Pistoresi: This is Ryan. I was able to go [cross-talk]. Mary, are you able to refresh?

Mary Fliss: Yeah, sorry. It refreshed. Thank you.

Mike Bonetto: You got it. Okay. Another few seconds here. Yep. Ronnie, thanks. Let's lock that down. That's good support there. Simple application online if possible. Thanks, William. So application process. Pharmacies should not be required to maintain copies of patient applications. Jennifer, thanks for that. Yep. Jenny, I just saw your comment on the waiving the dispensing fee. That is something we hadn't really discussed, but I like that. It will include that. It should not be required. Okay. I think we are good. Let's lock that one down. So good support there. We are going to go on to Application Process. Everything you guys have talked about. Registration should be standard and easy to use. I think we could probably flip through this one pretty quickly. I'll give folks just another few seconds here. Shari, I just saw yours. Yeah, that is a good comment. Consider whether how often people need to reapply. Ronnie, yeah. Let's lock that one down. Thanks. Okay, so Reimbursement. Pharmacies need to be supported by the manufacturer through replacement stock or reimbursement from manufacturer or through state funding. Great. A few more seconds there. Support. Okay. Ronnie, let's lock that one down. We have got to keep moving here. Thanks, guys. Allow pharmacies to choose preferred reimbursement process. Jenny, this kind of hit probably a little bit of what you were talking about. Right. Good support there. And, yeah, Ronnie. Let's lock that one down. Last one on Reimbursement. If manufacturers are to reimburse patients, policy should make sure reimbursement is timely, usually within 10 days.

Ryan Pistoresi: Hi. This is Ryan. Is it supposed to be reimbursed to pharmacies or patients?

Mike Bonetto: Pharmacies. Yeah. I just saw that, too, Ryan. That should be pharmacies.

Ryan Pistoresi: All right. Thanks for the clarification.

Mike Bonetto: Yep. Thanks. A few more seconds there. Great. Getting good support. Yep. Thanks, Ronnie. We'll lock that one down. Educational Materials. Educational materials should be provided to all patients accessing emergency supply and should include information on wraparound services and other health insurance options or state programs. A few more seconds here. We just have one more. And thank you guys for bearing with us. But this really helps put some clarity on how we can start to craft this overarching policy proposal. Okay, Ronnie. Great. Why don't we lock that one down, and we'll go to our last one. Prescribing Reporting Requirement. No mandated prescriber [audio cuts out] reporting requirements due to burden to pharmacies and unclear value. And if you are a "C," and if you're not in full agreement with that, if you have other thoughts on what that reporting requirement or reporting should look like, you can certainly put that in the chat, as well. Just a few seconds. Okay. Ronnie, you want to lock that one down. And I think, Ronnie, that is our last one. There we go. Mary, I'm 10 minutes over. I apologize.

Mary Fliss: No worries. Thank you so much because it's so important for us to get everybody's input. Right? I'm hoping we can make up a little bit of time when we do our data review because I know that the real value comes from us really being able to get input from this team as we turn to starting to develop the report. So let's go ahead and take a quick 10 minutes. And I look forward to having you back here at :20 to 11:00. And we'll still plan on wrapping up right at noon. So thanks so much, everyone. We'll be back in a minute.

[break]

Mary Fliss: 11:00. So here we are. The recording has started again. And let's go ahead and we'll start with a couple of introductions. As we know, Kelly had to drop off, and Matt has replaced her. Matt, could you please introduce yourself? I think perhaps Matt has stepped away. So let's go ahead and turn to Jennie Seeley. I understand, Jennie, you are here representing [indistinct]. Would you like to introduce yourself?

Jennie Seeley: Hi there. I'm Jennie Seeley. I actually work for – oh, let me put my video on. Hi there. So I work for Kaiser Permanente. I have worked for Kaiser Permanente for nearly 20 years, and many of those years have been spent in the pharmaceutical supply chain arena and the patient safety and quality arena.

So I'm really interested in this workgroup and the great work that everybody is doing. So thank you for having me.

Mary Fliss: Great. Thanks so much. And I think at this point I turn it over to Ryan. Ryan, are you kicking us off with this next section?

Ryan Pistoresi: Hi. Good morning, everyone. This is Ryan Pistoresi again from the Health Care Authority. So, as you know, we brought forward data analysis looking at the Washington State All Payers Claims Database to try to help provide some context and some numbers around the long-term strategies around insulin affordability in Washington. And today, Dan is bringing forward an updated cost analysis that helps take some of the comments that you would made [cross-talk] and help address some of the questions that you had. So Dan, if you're ready, you can take it away.

Mike Bonetto: Dan, you're muted. Sorry.

Dan Vizzini: Once again. I always get that wrong. Okay. So why don't we move? We'll try and move through these as quickly as possible. Why don't we go to the next slide. So just by way of background, the research that we conducted into the All Payer Claims Database was in response to legislation that was passed by the Washington Legislature in 2021. It was part of the previous insulin project that fed into this workgroup project. In July of this year at your initial meeting, we presented data from that research and got a lot of responses and questions, and so this is a way of closing the circle on that and responding where we can to the issues that were raised back in July. Next slide. July workgroup presentation are summarized here. Basically, it was an acknowledgment that the research was focused on insulin alone, and it did not pick up other costs that are associated with insulin treatment, including the cost of associated equipment and supplies and other kinds of medications that diabetics may be prescribed that are part of their treatment regimen The data that we collected from the All Payer Claims Database was aggregated. And by the rules of our research, we could not get into the specificity around [audio cuts out] the individual insurance plans or payer groups. We had to – the data had to be aggregated in ways that met the rules that we were given from the All Payer Claims Database Program. As a result, we had difficulty. And then the claims themselves are organized in such a way that we had real difficulty providing apples-to-apples comparisons for total payments and patient payments per unit of insulin dispensed. And then, also the workgroup expressed an interest in seeing to what extent there was a connection

between the data research that we had done and the 2019 Diabetes Epidemic Action Report. And so, we are trying to close the loop on all of these in this presentation. Next slide. So in looking at the action report from 2019, the report focused primarily on identifying the population of individuals who are either pre-diabetic or have diabetes as a diagnosis and the changes in that population, particularly from the preceding report in 2017. And so, there was not a whole lot that we could glean from that report that would shed additional light on cost and utilization of insulin itself. What I did here was to provide some high-level findings from the report that essentially talk about the incidence of diabetes in the state population and its growth over time. I'm going to move to the next slide just because this graphic from the report does a fairly nice job of sort of identifying the population with pre-diabetes, population with diabetes, and then hospitalizations and deaths. And it does provide a total cost. This cost is more of a macroeconomic metric of the impact of diabetes on individuals in a way that goes beyond just the cost of insulin itself. Let's move on to the next slide. So I took the information from the 2019 action report and tried to overlay it on top of the information that we had from the All Payer Claims Database. And this graphic attempts to account –

Mary Fliss: So Mike, I don't know if it's just on my side, but it looks like Dan is frozen.

Mike Bonetto: I thought it was my side. Thanks, Mary.

Leta Evaskus: This is Leta. Mine too. I thought it was me. Oh, well, maybe Ryan can start with this slide. I don't want to put you on the spot, Ryan, but I know that you and Dan have worked very closely on these slides – until Dan unfreezes.

Ryan Pistoresi: I can do my best. So on this slide, we are looking at the different distributions of the population. And so, if you start with the bottom, this is the number of patients that had a claim with a commercial insurance in the data period. Going up from there, the next small blue one is the Medicaid population, and just above that is the Medicare population. The blue line that is above that, kind of that maybe hazy blue, are the people not represented in our data analysis. So because the All Payer Claims Database does not get the entire state population, it only gets certain health plans that are required to report, we just wanted to acknowledge that of the data that you'll see in the following slides, it is not representing those that are listed in the top black tier, and that second blue tier. So just wanted to keep that in mind as we are

looking at the data that it does not represent the entire State of Washington, just those with the eligible commercial Medicaid and Medicare claims.

Dan Vizzini: [Cross-talk] Thank you for picking up as my Wi-Fi dropped. I'm sorry about that. I did want to jump in here and say that the top tier of this black bar chart is an estimate based on information that is both in the action report and statistics from the Washington Insurance Commissioner about persons uninsured and who do not have healthcare insurance. And so, it's an estimate, and my guess is that this is sort of on the high end of an estimate of the uninsured population in Washington State that is diagnosed with diabetes. It was a number that we have been wanting to try and get to for some time now, and so it's being presented here. But I want to emphasize that it's an estimate based on work that had been done by those two organizations. Let's move on to the next slide. So here are the high-level findings that we wanted to bring back to you that are based on work that we did, keeping in mind the comments that were made in the July presentation. The focus is primarily on commercial insurance. And here, you see in terms of the three main metrics of utilization that we focused on, paid claims, patients served, and units dispensed, that the commercial plans account for nearly three-quarters of all of that activity. And the table to the right is simply the aggregate numbers from the claims database for commercial claims, Medicaid claims, and Medicare claims. Let's move on to the next slide. It turns out that the increase in claims activity from 2018 to 2020 again, here commercial claims outpace changes in claims from Medicaid and Medicare substantially both in terms of the amount of claims that were processed, the patients served, and the units that were dispensed. Next slide. Then we looked at the kinds of insulin that were being dispensed and this stacked bar chart looks at insulin based on formulations. Long and rapid-acting insulin accounted for more than 80% of insulin use in 2020, based on the claims data and [cross-talk] –

Kevin Wren: Sorry.

Dan Vizzini: Yeah.

Kevin Wren: I just had then like Walmart insulin would be considered those short-acting and like intermediate-acting, I guess.

Dan Vizzini: I'm not familiar with what Walmart is dispensing. I'm assuming that Walmart's dispensing activity would show up in the claim status to the extent

that there were plans that are covering those prescriptions we're reporting to the claims database.

Kevin Wren: Thank you.

Dan Vizzini: But I'm not familiar with what Walmart is dispensing.

Ryan Pistoresi: And this is Ryan. Just real quick I wanted to show what the chat was saying, that short-acting is regular, intermediate is NPH. So does that help answer your question, Kevin?

Kevin Wren: Yeah. Sorry, this is Kevin. I was just saying how short-acting is prescribed. It seems like it's a very, very small percentage, if any.

Dan Vizzini: Yes. That's what at least in terms of the reported claims to the state in 2020, that is certainly the case. It's a relatively small percentage of the overall claims for insulin. So move on to the next slide. And then we looked at the growth in [cross-talk] –

Mary Fliss: Oh. Jennifer had a question, Dan.

Dan Vizzini: Oh, I'm sorry.

Jennifer Perkins: No worries. This is Jennifer. Honestly, it's more of a comment because right now we see that the regular insulin is a very small chunk of the insulin that is being paid for by Medicare, Medicaid, and private health insurers that you are capturing here. And I have seen some moves movement toward switching people over to those insulins from the analogue insulins, and I just want to point out, I hope this is not a trend that continues because I think that is not the best way to go for a majority of people because the research is not qualitative research, and I don't think the adequate quantitative research has actually been done to show that is effective. So I'm hoping that we don't move like that in Washington State.

Dan Vizzini: Thank you for that comment. This slide looks at the changes in insulin by these formulations from 2018 to 2020. And again, long-acting insulins are growing at a much faster pace than the other types of insulin that we grouped to get in this report. Next slide. So then we looked at [audio cuts out] at the average payments per claim for these various types of insulin, And what you're seeing here on the left is the insurance, the insurer payment per

claim, and then the average patient payment per claim across all of the insulins that fit into these categories. On the right side, we are looking at the increase from 2018 to 2020 of those average payments. So while these charts say on an average basis, the patient share is relatively small. The increase that is particularly in long-acting and rapid-acting insulins, the patient share increase is rather substantial, particularly the long-acting insulins. [Cross-talk] –

Kevin Wren: Sorry. Sorry to just interject. I don't know if it's clear, but usually you either use a long-acting with a rapid-acting or an intermediate with a short-acting or some kind of combination. And then people – I don't know – if you are on an insulin pump, you could use rapid-acting only. So I know the data might not show that, but that's just one of the basics that I think you should follow. Laura dropped a link in the chat. too, just if you have any questions.

Dan Vizzini: Yeah. Thank you for that, Kevin. We have done some and we did put together some simulated prescriptions to provide an example of how these costs play out. And in those scenarios, we don't have a patient using only one type of insulin. We have them using multiple types of insulin at different prescription levels. And so, what you get are a blended cost impact for different types of patients based on the insulins that they are being prescribed. The one thing I wanted to note about the average payments here is that the minimum that a patient pays and the maximum that a patient pays based on the claims data [audio cuts out] varies tremendously based on the insulin that is being prescribed and the insurance plan that they have. Let's move on to the next slide. So then we looked at the insulin products based on product type, and so we had these major projects autoinjectors, vials, syringes, and then a kind of catch all of other. And as you can see here, autoinjectors and vials represent again, more than 80% of the activity, with autoinjectors being provided to the majority based on the majority of claims. Let's move on to the next one. And again, here, autoinjectors while they are the largest portion of the claims' activity, and they also have the highest [cross-talk] –

Kevin Wren: I'm sorry. Is that like an insulin pump? I have never heard of an autoinjector before.

Dan Vizzini: Ryan, you want to help me out with that?

Ryan Pistoresi: Yeah. So this is Ryan. So I think these are like the Kwik Pens.

Dan Vizzini: Right.

Kevin Wren: These are Kwik Pens? These aren't – okay. [cross-talk] So then what is [cross-talk] –

Ryan Pistoresi: Yeah. So [cross-talk] Oh, go ahead.

Kevin Wren: So what are syringes then?

Ryan Pistoresi: So those are just prefilled syringes.

Kevin Wren: Okay. And then [cross-talk] –

Ryan Pistoresi: [Cross-talk] And then vials would be ones where they would draw up the insulin.

Kevin Wren: Okay. Gotcha. Thank you.

Dan Vizzini: Thank you for that, Ryan.

Ryan Pistoresi: I saw Jennifer had her hand up.

Dan Vizzini: Jennifer has a comment that reminds me of a big important point, the 30-day supply should include both types of insulin if a person is on two insulins. I would not want a person to have to pay double the amount for emergency insulin just because they take two types. This would perpetuate disparities. There are disparities in pump use by race, for instance. Charging people double because they can't afford a pump would not be ideal. Thank you for sharing that point and that comment, Jennifer. Let's move on to the next slide. So again, we looked at the cost per claim for insurers and patients. Similar kinds of patterns here, as we saw with the insulin formulations. And again, the most popular or the most prescribed type of insulin also had the highest by substantially highest increase in the cost for the average payment by a patient at 52% over that two-year period. Let's move on to the next slide. We took a look, and this is a case where we use the simulated patients. This is a patient that is taking a rapid-acting and a long-acting insulin as a part of their treatment regimen. What we did was look at the insulins that had the highest impact because of the deductible component of their plans. And what you see here is the average payment per claim for those specific

insulins based on the All Payer Claims Database. So, for instance, on the far right-hand column, the total insurer payment for both of the insulin types of insulin combined was over $500 per claim, and the patient component was actually even higher, almost $600 per claim. The most revealing piece here was just the size of the deductible component significantly high for these insulins that fall into this for the plans that are paying for these claims that fall into this category. Let's move on to the next slide. What I did here was to just simply show what the increase from 2018 to 2020 and the average cost per claim. And, again, this indicates that the insurance, the insurer component, actually fell while the patient component increase substantially and again driven primarily by the deductible. And then the next slide looks at it on a percentage basis. So you had these significant increases in the patient payment based on claims from high-deductible plans. And in the case of rapid -acting the drug, the insulin – the product that we selected for this analysis actually did not have a deductible for the plans that we were looking at. In 2018, the deductible was a new charge in 2020. Move on to the next slide. And then we looked at what was the cost to an uninsured adult with diabetes. What would those look like based on the claims data for 2020? So you can see that based on – and what these are the average claim total payments for these various categories of insulin products. And you can see that the range per claim is from roughly almost $300 for intermediate-acting up to $1100 for this category of concentrates. And then on the insulin types, a range from just over $500 for vials to almost $1600 per claim for powder insulins. And then the right far right column just simply takes those payments per claim and multiplies it times the average claims per patient per year to give you an estimate of the total payment per year that an uninsured insulin user would have to cover if the cost was entirely borne by them. I think the final comment I want to make is that the takeaway is pretty obvious from the claims data that the amount paid by a patient is completely dependent on the types of insulin that they are being prescribed and the plans that they are participating in. And that in looking at the simulations that we did on patients, it was clear that the insulin treatment regimen that they had in many ways was like a key that they had to shop around, essentially, for plans, if they had the luxury of doing that. Shop around for plans that would give them the best payment profile or minimize the payment the patient would have to incur based on the insulins that they are being prescribed, that the high-deductible plans might make sense for some insulin patients but not for others based on the insulin treatment that they were being prescribed. Ryan, did you have anything else that you wanted to add to this? I ran through this very, very quickly.

Ryan Pistoresi: Hi. This is Ryan. No, I think you did a great job, Dan. I wanted to at least see if any of the workgroup members had any questions or comments. Well, good. The data that are on the slides will be our [audio cuts out] you'll have these data. And if you have any other questions or want additional data from the research, don't hesitate to ask.

Mary Fliss: Yeah. And it looks [cross-talk] like William Hayes has a question in the chat.

Dan Vizzini: Yes, so. Oh. I think Ryan may want to weigh in on this question about whether we evaluated a difference between Type 1 and Type 2 diabetes. I think the way we got to this was in looking at a simulation or [audio cuts out] diabetic would be prescribed typically versus what different kinds of Type 2 diabetics would be prescribed. So, for instance, someone who is newly being prescribed insulin and may be on other drugs would have a different profile than someone, say a Type 2 diabetic who had a long experience with diabetes. Their insulin treatment regimens may look very, very different. And then the types of insulin that typically would be prescribed to a Type 1 diabetic might look different, as well. So we did take a look at it in that way, but we did not parse the claims data to separate out Type 1 from Type 2 diabetics.

Ryan Pistoresi: Yeah. I was just going to say that this was just the pharmacy claims data. There was no diagnosis attached to that, so we weren't able to do any type of differentiation between what insulin use is like between Type 1 or Type 2 diabetes or gestational diabetes.

Dan Vizzini: I think one recommendation might come out of this, the workgroup process, might be that the – and this was a suggestion that came up. It was to see whether or not the next round of the action report could include analysis on claims or insulin costs or treatment costs, more broadly treatment.

Mary Fliss: All right. And there is also a question from Ronnie in the Q&A.

Dan Vizzini: And, pardon me?

Mary Fliss: There is also a question from Ronnie. The categories seem confusing. Are the autoinjector and syringe and cartridge actually the same? Are cartridges for insulin pumps?

Dan Vizzini: Oh. [Cross-talk] –

Mary Fliss: And so, Ryan, maybe you could take that one?

Ryan Pistoresi: Yeah. So as you can see on this slide, we do have the autoinjectors, vials, syringes, the cartridges, and then the powder, which is like for the inhalation powder. So they are technically different. This is how they were submitted in the All Payer Claims Database. And if you're curious about specific products, we could take a look at and see. But I believe the autoinjector – a manufacturer may have their insulin be available as an autoinjector or as a syringe or as a cartridge.

Dan Vizzini: That is true.

Ryan Pistoresi: Yeah.

Dan Vizzini: Yeah, that's true. The characterizations of the insulin products came from the descriptions in the NDC inventory, the National Drug Code Coding System Directory. So that is where I got these and was able to develop these categories. The categories themselves are not data elements within the All Payer Claims Database. So these are linked to specific insulin products.

Mary Fliss: Any other questions for Dan or Ryan on the data?

Nonye Connor: We have Jennifer.

Jennifer Perkins: Hello, I have a comment. I was just reading Mr. Williams' comment in the chat box, and I wanted to point out that Type 1 diabetes, as far as I know, is not preventable in any case. There recently has been approved teplizumab, which can delay Type 1 for an average of two years. And the cost that I saw was over $200,000 for that without insurance. And you can try to contact them, and if your insurance doesn't cover it or whatever, but it is not preventable. And then I also wanted to point out with Type 2, that it is not always preventable. And for instance, I know that some tribes – I can't remember the name – but I know that like half of the tribe has Type 2 diabetes. And I think that there is an overemphasis on lifestyle changes rather than systemic changes as the causes of diabetes. And I'm not trying to talk negatively. I just don't want to hierarchize Type 1 and Type 2 diabetes as one being caused by a personal choice and the other as not, I guess.

Mary Fliss: Great. Thanks, Jennifer. Any other questions for Ryan or Dan?

Nonye Connor: Laura, then William.

Laura Keller: Great. I just wanted to clarify, so this is Laura with the American Diabetes Association. So when we are talking about autoinjectors, those are often insulin pens. And often they are smart pens now, so they actually kind of work like a smartphone. You can put your insulin information, how much you need to take on that, and a cartridge could actually be for an insulin pump, as well. So a cartridge based on the claims data that I have seen actually could potentially be like the pod insulin that sometimes is what you might think, but it's actually not. It's the cartridges, there are insulin pens that you can put a cartridge into a specific type of insulin pen. So there are different ranges of insulin pens. So hopefully, that clarifies some of that. So like the syringes just could be – it's a little confusing, I know, based on these titles for those people who aren't familiar with all the different ways insulin can be delivered. And again, we now have smart pens as well, too, which is a newer category of delivery for insulin via [indistinct]. I just wanted to clarify that. And the cartridges [audio cuts out].

Mary Fliss: I'm sorry, we sort of missed that last part.

Laura Keller: Cartridges are not used in the [indistinct] potentially [indistinct] you have vials that you draw up the insulin to put in your insulin pump. So a cartridge would not be someone most likely that is [indistinct], well. I just want to help clarify that if possible.

Mary Fliss: Okay. Thank you.

Nonye Connor: And then William.

William Hayes: Thank you. I just wanted to make sure that the intent of my question was not to stratify the difference between, and that's why I indicated gray. It's gray between the two. What the intent of my question was try to determine if there was any unfairness in the insurance company's decisions on how it charges people based on the fact that most people who are diagnosed as Type 1, or those who cannot produce insulin absolutely have to have insulin in order to survive, which is who is represented on the call, and I totally understand. And I do want to state I do have an uncle that is classified as what we call a Type 1 diabetic, requires insulin to survive. Is it are the

insurance companies unfairly charging them the same amount of money as an individual who could have prevented a disease. You know, it's an American thing that we don't focus on prevention in our healthcare. We make choices in our lives that allow us to get to the point where we require medications, and we have a healthcare system that, in my opinion – this is me speaking in my opinion – is unfair to everybody but unfair to some of those that actually require something in order to survive. And that is why we are talking about this. So it was just me seeking out to see if there was some higher level of unfairness to those that absolutely need that medication.

Mary Fliss: Okay. Thank you, William. Are there others? I can't see the names, Nonye, if there are other people with their hands up. All right. So I thank you so much, Dan and Ryan, for presenting us the information and really, really helpful to have. And sort of our final agenda item here before we get to wrap up is the long-term cost strategies and policy options. So we have 40 minutes left in this meeting. We'll go ahead and go through the policy options. It may be – and we'll play this by ear, but I'm thinking that maybe we'll need to do some of the Poll Everywhere. We submit them on our own with comments and that those are compiled by the Center. But we'll hold a good thought that we can get through all of this in 35 minutes and have 5 minutes of wrap up. And with that, Hayley, I'll go ahead and turn it back over to you.

Hayley De Carolis: Okay. Thanks, Mary. I think another option for time could be that we just go over the Washington long-term policy recommendations instead of going over the grid. Is that preferred, Mary, or would you like me to start from the grid?

Mary Fliss: So maybe we could do the summary box of the grid and then go into the Washington proposals. And if we need to toggle back and forth from there, we can do that.

Hayley De Carolis: Great. Okay. Thanks, Mary. So this is very similar to the earlier grid I went over, except that this is focused on long-term solutions. So again, we have Maine Insulin Safety Net Program and Minnesota, they are almost identical except for that licensing fee. And then we have the Utah insulin Savings Program, which is what we heard about from Travis earlier, through the Public Employee Health Plan. The public is able to access those posts rebate discounted insulin. So the elements are mapped out on Table 4. Like Mary said, I think we should move to Table 5, which is the potential Washington policy, but along the way I'll highlight where we got certain policy ideas if it's

important to tie back to Minnesota, Maine, or Utah. And then this is what we will be polling on is the potential Washington policy. So as we saw it based on work with HCA as well as the worker feedback, there are three arms to the Summary of Policy, which would be the ArrayRX Discount Card, ArrayRx Voucher Program, and manufacturer's patient assistance programs, which is what Maine and Minnesota are running. And for people that are new in the workgroup, there is a great presentation that Leta gave, I think, in Meeting 2 about the ArrayRx operations, which is on the website, if that is unfamiliar to you. So for the Eligibility Criteria, the proposed policy would use the current eligibility standards for ArrayRx, which is all state residents, no age or income restrictions, and that would not require ID or documentation of residence, it would just be required to have a Washington address on the form, which we talked about earlier. And so, this is for people that are houseless, they could put down a shelter or leave it blank. And also, we talked about access to the application and eligibility criteria could be through a public library. That was also a consideration the workgroup brought up last time. So besides having residents in Washington or an address, an additional requirement for the manufacturer patient's assistant would be targeting families whose income is less than 400% FPL. That is in line with the Minnesota and Maine programs for their eligibility for the long-term manufacture patient's assistance programs. So the application process, all individuals could sign up online and receive either a digital card delivered to their phone or a paper card mailed to them. This was another lesson learned that Travis shared with us, having the option to have to not just a digital card for some but offering both is beneficial. And then getting into manufacturer responsibilities, and this is kind of segmented between discounted insulin through the discount card, the voucher program, and then the manufacturer assistance card. So for the ArrayRx discount card, the Legislature could require manufacturers to offer insulin at a discounted price. That would be the responsibility of the manufacturer. Additionally, for the voucher program, manufacturers would bid on the RFP, and then their brand of insulin would be used for the voucher program. And then for manufacturer assistance programs, it's very similar to the emergency supply programs. They would be providing insulin to the pharmacies, and then also reimbursing. What is different from the emergency programs is that instead of the pharmacies determining eligibility, the other Maine and Minnesota require the manufacturers to determine eligibility, and the state has oversight if there are any discrepancies. The patients can appeal, and then the state makes the ultimate decision. But with normal operations, the manufacturer is responsible for determining eligibility, and then the patient

would bring that to the pharmacy. It was also noted in the other programs that manufacturers are able to send insulin directly to someone if there is a Direct Mail Prescription Service. We didn't talk about that with emergency, but it's an option for the long-term.

Mike Bonetto: Hey, Hayley.

Hayley De Carolis: Yeah.

Mike Bonetto: This is Mike. Sorry, I just saw LuGina's comment, and I thought, Ronnie, if you could scroll back up the top, I think it's really important as we lay this out. Yeah, right there. As you talk about that three-pronged approach from the policy summary, those three, just make sure we are clear on discount card, voucher program, and patient assistance. Right? I think we just want to make sure. And Leta, I didn't know if you wanted to weigh in just from an ArrayRx perspective and make sure that everybody is clear on the differences.

Leta Evaskus: Yeah. Thank you, Mike. This is Leta Evaskus. So the ArrayRx discount card has no formulary. Any Washington, Oregon, or Nevada resident can go online and join for free, and you will get a discounted price at the pharmacy that you are responsible to pay. The ArrayRx voucher program can be tailored so it could only include specific drugs, one drug class, etc. You could tailor it to have a 30-day supply, a 90-day supply, etc., and it will have billing information on the voucher that, for example, could be billed to Health Care Authority. It could also be set that 100% is billed or leave a copay amount very specific that the patient would pay. The manufacturer's patient assistance programs would be between the manufacturer and the patient. So that would not be billed to Health Care Authority.

Mike Bonetto: And Leta.

Leta Evaskus: Go ahead.

Mike Bonetto: Thanks. That's great. So just to clarify, the discount card is in place today, and it's something that you would be able to continue. The voucher program would be something new that would be specific to this insulin.

Leta Evaskus: Right. The voucher program already exists, but it's customized for each agency facility, whoever needs to use it. It is very much customized. So it's

not a program that anybody can join. It has to be set up, and then there is a certain population that can use it.

Mike Bonetto: Got it. Thanks.

Leta Evaskus: I think LuGina has her hand raised.

LuGina Harper: I do. Thank you. I'm just trying to keep it keep these programs straight in my head. So the voucher program would be like what the Utah program is where you get that post-rebate cost savings. Or is that [cross-talk] –

Leta Evaskus: Yeah, that is what we have looked at that. So since the voucher program, the voucher can be billed to the Health Care Authority, then the patient can pay that after-rebate price, but the pharmacy paid full price. So the Health Care Authority would pay the pharmacy the full price for the medication and then submit claims to the manufacturer and receive a rebate, so get paid back for that full price that they paid to the pharmacy.

Hayley De Carolis: And Leta, one follow-up question to that. The difference is for the voucher program, would people be enrolling in a – they wouldn't be enrolling in a health plan like they have to in Utah. It would be online process. It wouldn't require enrollment into a plan. Right? That is a distinction?

Leta Evaskus: Right? Yeah. It's still not health insurance. The voucher program, either the agency or facility that is in charge of that voucher program has to enter the people in – the patients who are participating – or we are looking at maybe we could set up something online where people enroll. So again, this would be something that is tailored for this specific program.

Hayley De Carolis: Okay, thank you.

Leta Evaskus: Jenny. I see your hands raised. Jennie Seeley.

Hayley De Carolis: Jenny, you might still be muted.

Leta Evaskus: Yeah, definitely muted again. Sorry. Thank you for calling that out. Voucher Program. The RFP manufacturers would bid on ArrayRx's RFP, so my assumption is then that if a pharmacy were to participate in this that we would have to be carrying that specific manufacturer's product. That is one question. But the RFP, will that limit the types, the Array, the form of the

insulin? So in other words, would we have only certain short-acting, certain long-acting that would be – certain vials versus syringes versus pens? You know what I'm saying? What are the limitations around that RFP?

Leta Evaskus: Well, we haven't put it out yet, so there are no limitations. It's whatever the Legislature says you need to provide this. So then the RFP would say, hey, we need you to give us a discount on your medications, and in return, we are going to give you this much – this many clients. So that is kind of how the RFP process goes. And we can include in there, you need to provide syringes or other supplies in there, so we just have to wait and see what the Legislature tells us to do. LuGina.

LuGina Harper: Thank you so much. This is LuGina. I just have a quick question. I want to focus on the ArrayRX voucher program because I'm thinking of that as similar to the Utah program, and I'm trying to understand. You talked about HCA paying the pharmacies for the drug, and it sounds like there – is that an element of the Utah program that PEHP is paying full freight, and then all the rebate stuffs happening behind the scenes or [cross-talk] – is that how it works?

Leta Evaskus: Yes.

LuGina Harper: Okay. Thank you.

Hayley De Carolis: It's basically, LuGina, just like to cover the cash flow timing of when the rebates are received, so the State of Utah is temporarily backfilling that amount.

LuGina Harper: Okay. Because I thought it works that, let's say the cash price is $100, and generally, there is a 20% rebate or whatever the rebate is, I thought that cost savings was passed on at the point of sale. I guess I didn't understand the whole funding behind the scenes.

Leta Evaskus: Yeah. And this is Leta again. The pricing is passed on to the customer, but the pharmacy still paid full price to get the drug in stock. [Cross-talk] So that is where Health Care Authority would be paying the full price to the pharmacy and then later receiving the rebate from the manufacturer.

LuGina Harper: Got it. Thank you.

Ryan Pistoresi: Really good questions, guys. Any others? I really want to make sure that everybody understands that three-pronged approach because that is kind of the layout for those long-term policy options. So those are some good questions. Thanks, Hayley.

Hayley De Carolis: Yeah. No problem. If anything comes up again, feel free to jump in. So I think we made it through the manufacturer responsibilities, which are different by the three arms that we just went over. So for patient responsibilities, patients would be responsible for enrolling online for the ArrayRx discount card arm, and Leta just went over that could be a possibility for the voucher program eventually enrolling online. They would also check for participating pharmacies, which right now, there were 1200 in the state. And then for manufacturer assistance programs, patients would need to apply directly with the manufacturer, who would then send them a proof of eligibility, which they would then bring to the pharmacy. So there's a little bit more. It is similar in processes but just a little bit different points of contact depending on how they are accessing the program. Pharmacy responsibilities are pretty straightforward. They would receive either proof of whatever part of the program they are accessing at the pharmacy and receive that discounted price. And then like Leta said, the pharmacy would be made whole through the voucher program by the state later. Jennie, I see you have a hand up.

Jennie Seeley: And again, being new to the group, you may have already established this. But the 1200 pharmacies in Washington, is that well-dispersed between our urban and our rural areas, or would we need to be working to entice pharmacies to participate in more areas where there are less served for healthcare services?

Leta Evaskus: Hi, Jennie. This is Leta. ArrayRX already has a network of pharmacies across Washington State. I believe there are about 1100 pharmacies in Washington State, and pharmacies all over the US can be used. For participating pharmacies, I could give you the link to the discount card where you could look up – you could put a zip code and see what the participating pharmacies are in that area. We have chains like Safeway, and then there are also small independent pharmacies that are included that are in rural areas or the islands. I'll put that link in the chat.

Jenny Arnold: And I would just add that 1200 pharmacies would represent almost all of the community pharmacies in Washington state, but all of the available options would be included for the most part, if that was the correct number.

Leta Evaskus: And that is Jenny Arnold. Right?

Jenny Arnold: Oh, yeah, Jenny Arnold with Washington State Pharmacy Association. Yes.

Leta Evaskus: Thank you.

Hayley De Carolis: Thanks, Leta, for that explanation. This is Hayley. And I just want to address Jennifer Perkins' question or comment in the chat. I support ArrayRx but would like to see support for Civica Rx and/or California's manufacturer mentioned as an option for long-term support, more manufacturers the better. We didn't include it specifically called out in the table. But correct me if I'm wrong HCA team and Center team, but I do see Civica RX in California. Oh, Mary, did you want to jump in on that?

Mary Fliss: Nope. Go ahead.

Hayley De Carolis: Oh, okay. They are options that are still alive and embedded in these policies because Civica RX could be a potential bidder on the RFP. Isn't that correct, Leta? So if we go through the voucher or the discount card, manufacturers, we are not limiting any potential manufacturers. Is that correct?

Leta Evaskus: Right. And again, the RFP hasn't been put out, so we can ask for whatever we want to ask for. We haven't been directed yet by the Legislature exactly what we are supposed to do. But yeah. We can ask for multiple manufacturers. We could say all manufacturers. We could say whatever we need to do. I think it was in Minnesota that the Legislature directed manufacturers to participate.

Hayley De Carolis: Mm-hmm. Yeah, I think they have a limit on it. They must be producing a certain amount or must be selling a certain amount of insulin in the state, but they did direct them. Okay. Thanks, Leta. And thanks, Jennifer, for your question. So moving on to the reimbursement process for the potential long-term policy. We did discuss this, that HCA or whatever [cross-talk] –

Leta Evaskus; I'm sorry, Hayley. Could we please bring up the grid again?

Hayley De Carolis: Yes. Can you not see it?

Leta Evaskus: Oh, there it is. Thank you. So sorry.

Hayley De Carolis: Okay. Yeah, let me know if it ever goes away. [Cross-talk] So for the reimbursement process, we did mention that HCA or whatever state agencies over the program would have to temporarily backfill to make the pharmacy full while they are waiting for their rebate. For the patient assistance program, manufacturers would be responsible for reimbursing pharmacies directly, like we have talked about.

Mary Fliss: Hayley, I know we are going super fast through this because we want to get to those questions. But I think at this point, we really appreciate the questions that we get and the ability for this team to really understand. I mean, this, this is our long-term strategy. So we are thinking that it may be better for us to just take our time to go through and really understand what these options are and then to administer the survey after this meeting. And hopefully, people will take the time while it's still fresh to answer and respond to the survey questions and provide also comments via email. So could I just get a sense of the group if that process works, yeah, knowing that we only have 20 minutes left?

Lori Evans: This is Lori Evans. Sounds good to me.

Mary Fliss: Great. And Jennifer, I see thumbs up. Terrific. William, thank you so much. All right. So if you're opposed, go ahead and put that in chat, and we'll try to revisit. But Hayley, I'll turn it back over to you. So we talked about the voucher, and we talked about the discount card. What is the third prong of the three-prong approach? Just want to make sure we are all super clear on all three of those.

Hayley De Carolis: Okay, yeah. Great. Thanks, Mary. For the third option – prong, I guess, is the Manufacturer Assistance Program. And to describe that, I actually scrolled back to our long-term solutions grid because I do think we can look to Maine in Minnesota for a quick overview of what that policy would look like. So same eligibility criteria that we have been going through. I'm going to skip that. The Application Process, so individuals would apply directly with the manufacturer. So these are manufacturers that are operating in these states. Both of the state Bills did require a certain volume of insulin sold. So smaller manufacturers do not need to participate in this program. But if you sell above a certain threshold – which I don't have off the top of my head, but it's in the legislation – then they are required to participate. So a manufacturer is required to offer a long-term patient assistance program in the state. Through that program, the manufacturer is determining the eligibility of the

patient. They work directly with the patient to get any extra information required for the application. Once they approve it, they send the patient a proof of eligibility, which is what that patient can bring to the pharmacy to access the 90-day supply of insulin, which is the typical order. I think you are able to order a lesser amount, but I think typically it is 90 days through the manufacturer program.

Mary Fliss: And the real distinction here between the voucher program. So the voucher program is the patient gets A.) the discount that is been negotiated with the pharmacy, and B.) the rebate that the HCA – if that is how the Legislature sets it up – is received so they pay a lower price. Under this program, however, the patient pays nothing but needs to meet the criteria around Federal Poverty Level and no other coverage. So those are really the key difference is one is a means-tested program, and the other is not means tested and yet there is a payment obligation under the voucher and not under the assistance, which is why we are thinking we would want to take advantage of both continue with the discount card, introduce a voucher program, and then also obligate the manufacturers to comply with a safety net sort of programs like Maine and Minnesota do. Okay. Thank you so much.

Hayley De Carolis: No, thank you, Mary, for laying it out clearly. That was I think very helpful. So the point is that the reason you might be wondering why there are three prongs. It's just like Mary suggested. It's so that you're covering as many people as you can see through the different avenues that are already available to the state. So for the reimbursement process, the manufacturer, again, would be responsible for reimbursing the pharmacy for the third patient assistance program. There are educational materials. I'm just going to see if there is any other major points to point out. The state does have oversight, like I said, of the application process if there is an appeal. And that seems to be the Maine State entity's responsibilities. So another thing to note just for the program comparison Table 4 is that these programs in Maine and Minnesota do have expiration dates. Maine's is repealed January 1, 2027, and then Minnesota is 2024 but does leave an area if the Legislature were to vote to continue that it would. And we also included in this table links to the manufacturer assistance programs in each of these states, as well as this was a question earlier about which types of insulin are covered by the Utah program. The brands are listed here. And also, I put in the chat a little bit ago a link to their flyer. So that is the background for the manufacturer patient's assistance program. I'm going to pause one more time and just see if anyone has any questions about the overlap of those three policies or any of them, in

particular, you want to talk about before we continue going through the grid. Okay, I'm not seeing any. So I think we left off at the educational assistance, which we included a policy recommendation to include educational program and information sheets to anyone who is accessing this program to identify individuals that might need help overcoming other barriers. So the State Entity Responsibilities. Worker members agreed to prioritize access to state-negotiated insulin prices through our ArrayRx as the top policy option. ArrayRX right now has interagency participation from Washington, Oregon, and Nevada state agencies. I put this on here because we did get feedback originally from the workgroup about prioritizing state negotiation power by teaming up with other states, and our ArrayRx has participation from multiple states. So just wanted to highlight that. So if this policy option were to go forward, ArrayRx would go out for bid for a preferred price of insulin and work with a discount card to get that discounted price available. The voucher program would be an additional arm of that, where the customer would get access to that post-rebate price at the pharmacy.

Mary Fliss: And just to be clear, Hayley, that workgroup that you're referring to is not this workgroup. So it is not this workgroup that decided this in other meetings, but it was the workgroup that we conducted in 2021. Correct?

Hayley De Carolis: Well, this workgroup, I think at the first meeting we did offer to rank choices of working with ArrayRx or multi-state negotiating power.

Mary Fliss: Gotcha.

Hayley De Carolis: Either in the first worker meeting or the second there was a survey.

Mary Fliss: Very good. Thank you.

Hayley De Carolis: And so, the HCA, or whatever the state entity overseeing the program would also need to cover the cashflow gap with state funds until the rebate is secured. So that is the state entity responsibilities. As you can see, all of these are related to the first two options. The manufacturer assistance program goes independently through the manufacturer and involves some state oversight but not to the extent of these options. So the workgroup requested in I believe probably the second meeting, but maybe the first, transparent financial disclosures from manufacturers, PBMs, and plans regarding what the plan paid member paid rebates acquisition costs. So basically, we heard from the workgroup that they wanted to prioritize exploring data

transparency efforts. We did hear from the HCA team that this would require an exception to the current Washington drug price transparency program, but we did include it in this policy because it was a resounding opinion of the workgroup. We did not include any program expiration dates, which is not like what Minnesota and Maine have done. They have put expiration dates on. And then the last row for this table is the other notes. We wanted just to highlight that ArrayRx could also be used for the emergency supply of insulin if the Washington Legislature enacted the same law directing insulin manufacturers to provide a discounted cost for emergency supplies. We didn't really talk about it directly within the emergency supply, so we wanted to note it here. And then another consideration would be providing patient navigators as part of that educational assistance like Minnesota has done. They did appropriate significant state resources to get that program trained and up and operational but wanted to leave that as another consideration that we heard from the workgroup how important educational resources are for navigating the system. So that is the end of the grid. So I think the plan is that the survey will be sent out to gather support for each of these elements, just like we went through earlier in the meeting, but this will be that reference table for you of all the pieces that the survey will touch on. Are there any questions about the full Table 5 potential long-term policy or anything related to the grids?

Mike Bonetto: Hayley, this is Mike. I would just add on. So again, thank you for taking time to go through that. I think just getting that level of clarity is really helpful. Just to verify on the survey that will come out. So I think it's going to work fine. So we'll come out with a survey as soon as possible. We'll make it into0 this platform that you guys have used before. But basically, like you've just done on the prior short-term emergency supply options, for every element, we'll have that Likert scale 1-5, but also, we'll leave the place for you to provide comments like you just did in the chat because we want to make sure we don't lose that. So that'll be coupled. And then we'll be able to come back and have that as an Agenda item for Meeting #5 to really talk through some of the details around that, which I think will be helpful. And, Hayley, thanks again for all that. It was great.

Mary Fliss: Yes, Hayley, really appreciate that great description. And I also want to circle back and make sure the question was answered around the potential of California insulin being included or the other insulin that we have talked about, the Civica Rx solution. So does anybody have any questions about sort of how those discounted manufacturers would interplay with this program? I

think I could tell everybody is at the end of a three-hour meeting that was just jam-packed with great discussion and lots of information. So I also sort of think about, well, how would it work with Civica? How do we really make sure those manufacturers that are coming in with deeply discounted prices? We have an opportunity through our systems to appropriately recognize them and make sure that they are being made available through all of the appropriate systems and that we are taking advantage when we have low-cost manufacturers entering the market. And I guess my other question for the team at large – when you think about this three-prong approach for the manufacturer the long-term solution, is there anything that you would change or have comments about in terms of the short-term solutions that we talked about? I know we had a lot of rich conversations about that. And, LuGina, I see you have something in chat here.

LuGina Harper: Yeah, sorry. This is LuGina. And my comment in chat was I know the table was very, very helpful, and I know there's a lot of data you're trying to present, but if we could just have a quick couple of sentences on what the discount card is with the voucher program and patient assistance program is to help us as we are answering these questions that will be coming to us, that would be really helpful.

Mary Fliss: Okay, terrific. Any other comments? And Mike, Haley, is that something that we can make available to this group as we move forward with sending out the survey?

Mike Bonetto: I have a recommendation, LuGina Harper. I think not only with the grid but something we can work on quickly to accompany that is just a little bit more detailed description of those three. So yeah, we'll circle back on that.

Mary Fliss: Awesome. Great. Thank you, Jennifer. All right. With that, let's go ahead and move to wrap up. Can we bring the agenda back up to the screen? Great. Thanks so much, Ronnie. All right. So we talked about – we had Travis. It seems like it was a long time ago. We had Travis talk to us about the Utah model. We went through the short-term emergency supply strategies. We got our cost analysis, and we went through the long-term cost strategies. And we will do our Poll Everywhere including a summary after this meeting. And in terms of next steps, we have a report due to the Legislature on July 1st. And within our processes, that means we need to submit our first draft so it can go through all of the reviews it needs to go through two months prior. And so, we will be submitting our draft for that process of review and approval by

mid-April. So we will be having our last meeting on March 16th. We will be bringing forward the information that we have received from this meeting and from the information that we'll be getting. I really liked, Shari, I think it was you that had the recommendation around asking medical providers about the impacts of not being informed when an emergency supply is filled. So I think we need to track that one down also. And we'll be starting to draft the report. You will be receiving a version of that, and that is what we hope to talk about in pretty good detail on the 16th. And then after that meeting, we will be incorporating your feedback and, as I mentioned, getting it through the approval process. There will probably be more review opportunities for you within that time period but just wanted to recognize that our time is sort of coming to a close here. The Legislature asked us to do two things. Right? It's the once-a-year 30-day supply as well as the long-term cost strategy. I think we are in a good position to answer both those questions as well as enhance some of that around, does it have to be a once-a-year 30-day supply, as we talked about earlier? So really appreciate everyone leaning into a three-hour Tuesday morning meeting. And with that, I will just ask if there are any other final questions or comments, Nonye, Ronnie, others, things that we have forgotten or we should make sure we let this team know about before we wrap up?

Nonye Connor: Nothing from me.

Mike Bonetto: Mary, I would just say that the email – the survey information, survey link, and all that will come, Nonye, most likely from you. Correct?

Nonye Connor: Yes. Yes. Yes. It will come from me.

Mike Bonetto: Most of the time. Great.

Nonye Connor: Yeah.

Mike Bonetto: Great. You can expect [cross-talk].

Mary Fliss: [Cross-talk] All right. Great. Thanks so much, everyone. Be looking for that message from Nonye. And would appreciate again a quick turnaround time just so we have all of this information fresh in our minds in this great discussion. And please make sure you also provide Nonye with any comments you have as you go through that since, obviously, it won't be in the chat function here. And with that, I hope everyone has a wonderful holiday

season, and we look forward to seeing you in the new year. Take good care. Bye-bye.

Mike Bonetto: Thanks, guys.

Nonye Connor: Bye. Thank you.

[end of audio]