

Washington Insulin Workgroup (WAIG) Meeting #1

July 8th, 2022

Washington State
Health Care Authority

Agenda

No	Agenda Items	Time	Lead
1.	Welcome and Opening Business <ul style="list-style-type: none">• Introductions and icebreaker• Meeting overview	30	Mary Fliss – Deputy, Clinical Strategy and Operations, HCA
2.	Review 2022 Legislation (SB 1728) and Scope of Work	20	Brittany Lazur – Center for Evidence-based Policy
3.	Overview of HCA Cost Analysis from SB 5203	50	Dan Vizzini – Center for Evidence-based Policy Mary Fliss – Deputy, Clinical Strategy and Operations, HCA
4.	<i>Break</i>	<i>10</i>	
5.	Overview and Discussion of Workgroup Survey Results	60	Mike Bonetto – Center for Evidence-based Policy
6.	Next Steps	10	Mary Fliss – Deputy, Clinical Strategy and Operations, HCA

Welcome and Opening Business

- ▶ Introductions and icebreaker
- ▶ Meeting overview
- ▶ Announcement about changes to Open Public Meeting Act

Review 2022 Legislation and Scope of Work

Background

- ▶ In the 2022 session, the Washington Legislature passed [HB 1728](#).
- ▶ Directs the Health Care Authority (HCA) to create a total cost of insulin workgroup and secure input from this workgroup.
 - ▶ Review strategies to reduce the cost of, and total expenditure on, insulin and provide a 30-day supply of insulin to individuals on an emergency basis.

Scope

Over the course of 5 meetings, the workgroup will consider the following:

- ▶ Strategies to reduce the cost of insulin and total expenditures for patients, including but not limited to:
 - ▶ A state agency buys drugs for resale and distribution (e.g., a licensed drug wholesaler)
 - ▶ A state agency manages prescription drug benefits on behalf of health insurers, large employers, and other payers (e.g., a registered pharmacy benefit manager)
 - ▶ A state agency purchases prescription drugs on behalf of the state directly from other states or in coordination with other states

Scope (Continued)

Over the course of 5 meetings, the workgroup will consider the following:

- ▶ Design considerations to provide a once yearly 30-day supply of insulin to individuals on an emergency basis.
 - ▶ For the emergency supply program, the strategies identified by the workgroup shall include recommendations on: eligibility criteria, patient access, program monitoring, and pharmacy reimbursement, if applicable.

Deliverables

(To be completed by March 31, 2023)

- ▶ HCA must submit to the Legislature a preliminary report by December 1, 2022, and a final report by July 1, 2023.
 - ▶ A draft preliminary report for HCA will be completed by August 12, 2022, which documents workgroup feedback from the July meeting and describes the subjects to be discussed at the remaining four meetings of the workgroup.
 - ▶ A draft of the final report for HCA's review will be completed by February 13, 2023.
 - ▶ A final report for HCA will be completed by March 31, 2023, which documents the subjects discussed by the workgroup and their feedback and recommendations.

Timeline

(Approximate)

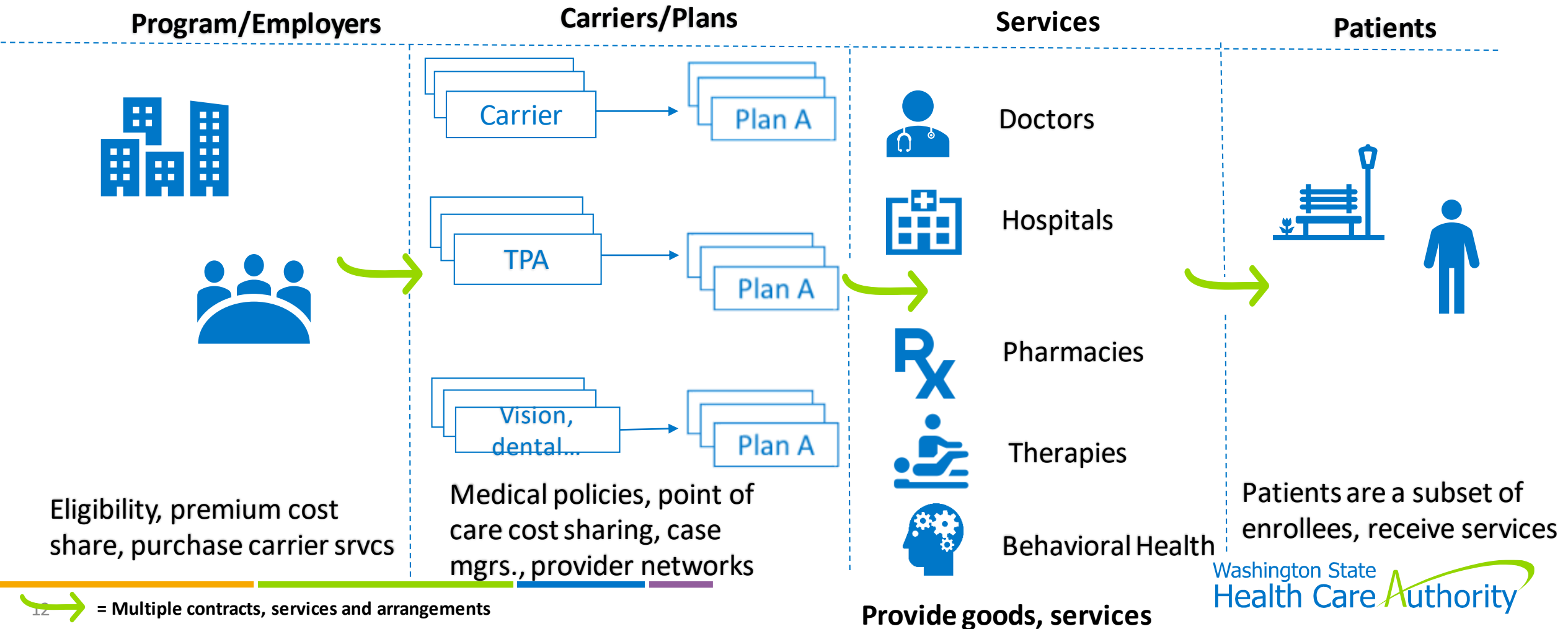
Task/Deliverable	Date
Total Cost of Insulin Workgroup #1	July 8, 2022
Preliminary report due	August 12, 2022
Total Cost of Insulin Workgroup #2	Late August 2022
Total Cost of Insulin Workgroup #3	October 2022
Total Cost of Insulin Workgroup #4	December 2022
Draft of final legislative report due	February 13, 2023
Total Cost of Insulin Workgroup #5	March 2023
Final legislative report due	March 31, 2023

Overview of HCA Cost Analysis from SB 5203 (2021)

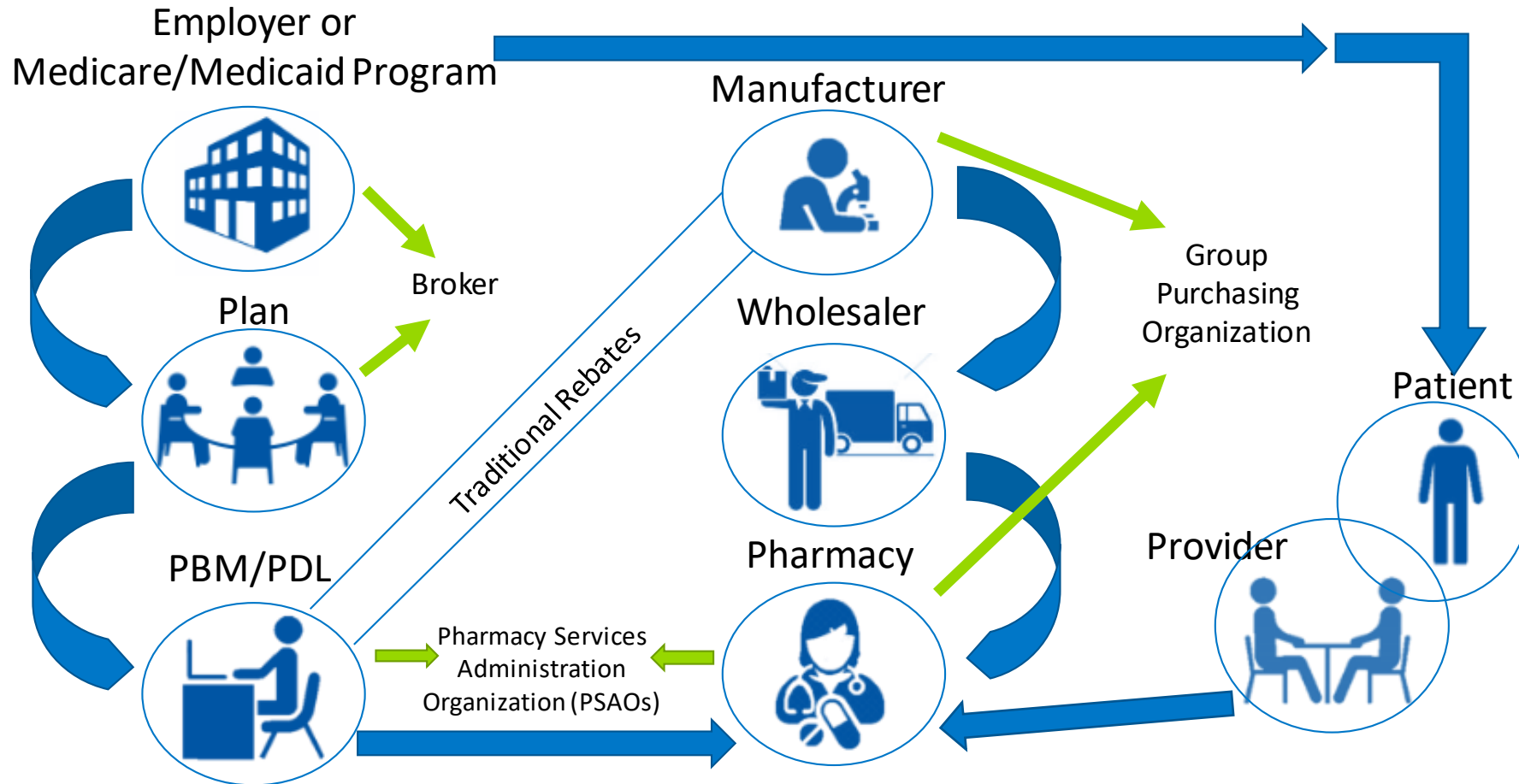
Background

- ▶ During its regular 2021 session, the 67th Washington State Legislature passed **Senate Bill 5203** directing HCA to establish partnerships to produce, distribute or purchase generic prescription drugs and insulin (ESSB 5203.SL).
- ▶ This work entailed reviewing Washington's All Payer Claims Database to produce useable data for utilization and total cost per year for insulin.
- ▶ The following slides highlight background information about the US healthcare system, pharmacy distribution and purchasing systems, and some key data findings from that body of work.

US Healthcare System Overview – Simplified



Pharmacy Distribution/Purchasing Overview – Simplified



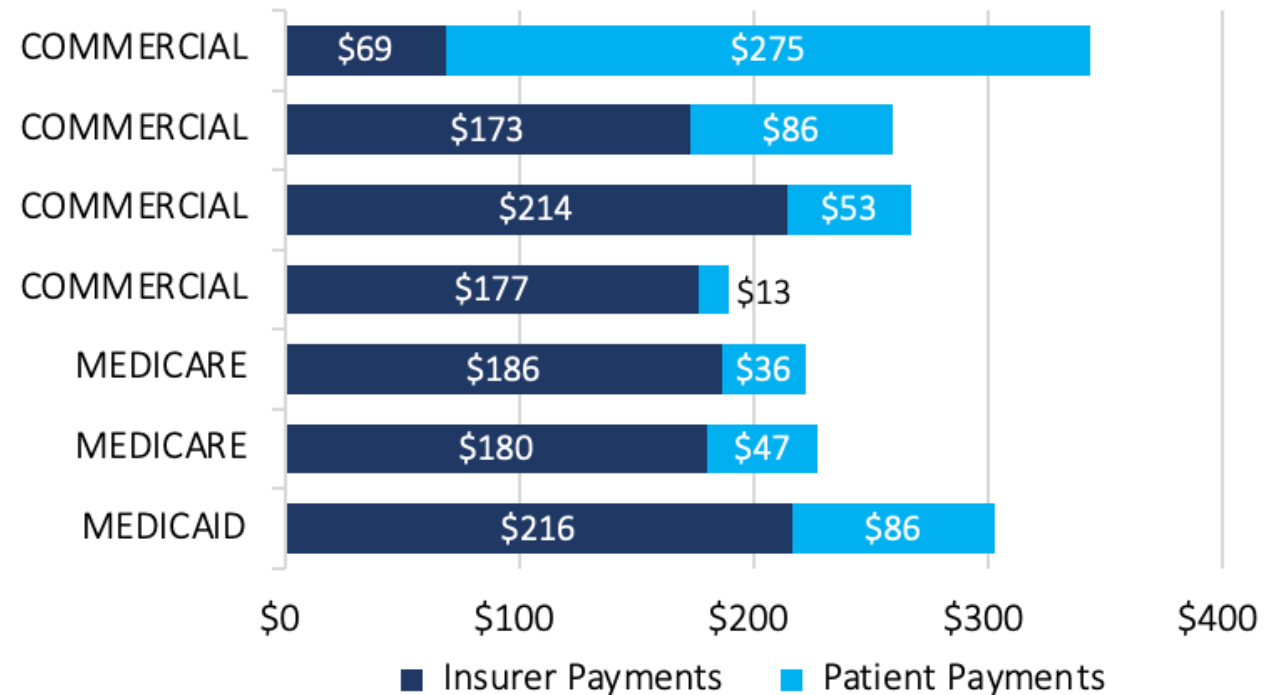
Summary Data - Paid Insulin Claims in 2020

	All Paid Claims	Commercial	Medicaid	Medicare
Aggregated Paid Claim Activity				
Paid Claims	1,615,977	1,171,021	180,140	264,796
Patients	378,146	275,630	35,852	66,654
30-Day Equivalent Prescriptions	2,404,774	1,728,527	217,279	458,946
Units Dispensed	33,394,192	23,702,909	3,208,044	6,482,946
Days Supply	65,382,381	46,698,860	5,858,298	12,824,673
Aggregated Financial Summary				
Total Claims	\$1,195,495,223	\$883,207,443	\$111,067,787	\$201,202,580
Total Payments – All Sources	\$945,413,126	\$681,191,622	\$101,332,746	\$162,877,168
Total Insurer Payments	\$885,866,666	\$650,076,979	\$92,248,298	\$143,536,429
Copayments	\$20,950,559	\$16,109,682	\$0	\$4,840,862
Coinsurance	\$23,862,573	\$4,500,826	\$9,084,448	\$10,275,599
Deductibles	\$14,733,328	\$10,504,135	\$0	\$4,224,278
Total Patient Payments	\$59,546,461	\$31,114,643	\$9,084,448	\$19,340,740
Average payments per 30-day equivalent prescription				
Insurer Payment	\$368	\$376	\$425	\$313
Patient Payment	\$25	\$18	\$42	\$42
Total Payment	\$393	\$394	\$466	\$355

Key Finding No. 1

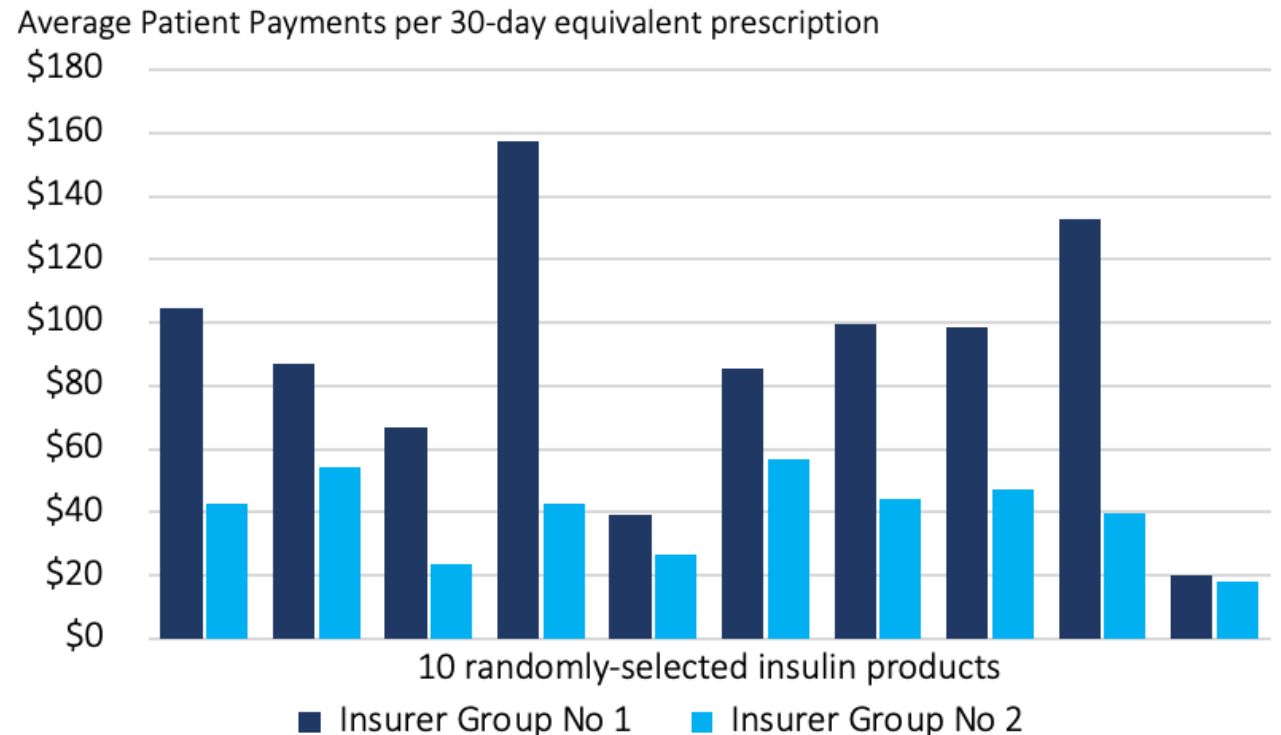
- ▶ Payments made by insurers and patients for a specific insulin prescription vary widely depending on the health plan and the insulin product the patient uses.

Average Payments per 30-day equivalent prescription



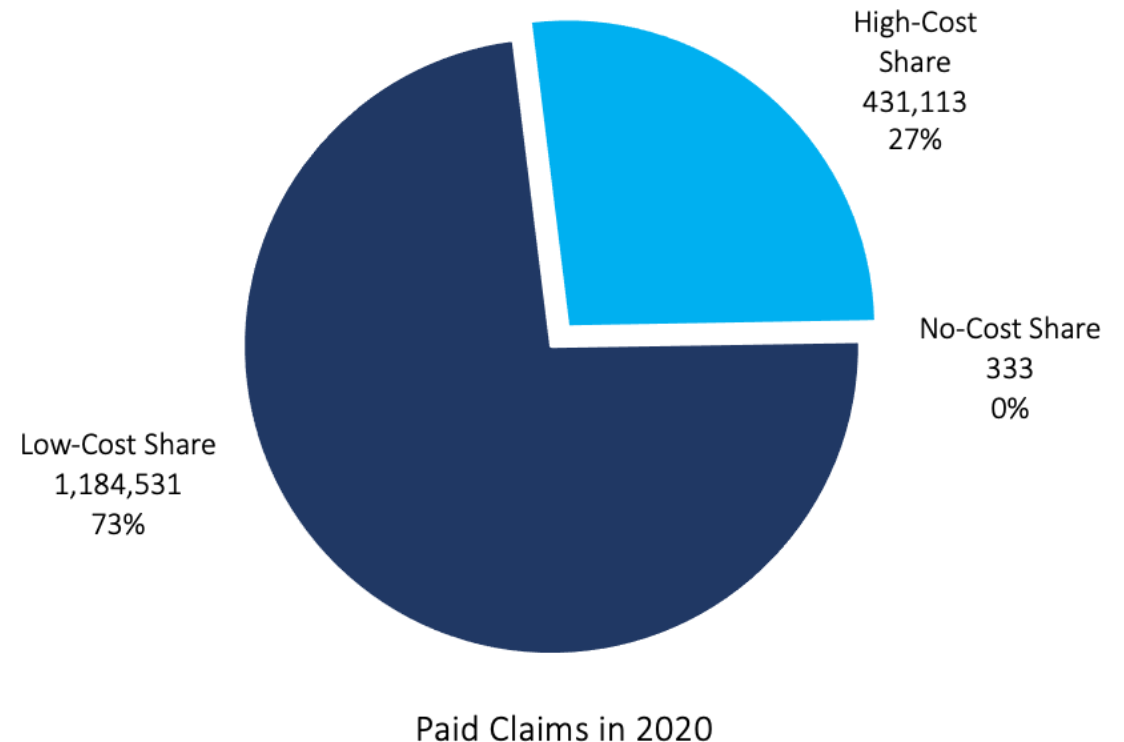
Key Finding No. 2

- ▶ Patient payments for insulin vary widely across insurers, insurance plans and insulin products. Payment structures may reflect insurer preferences for specific insulin products.



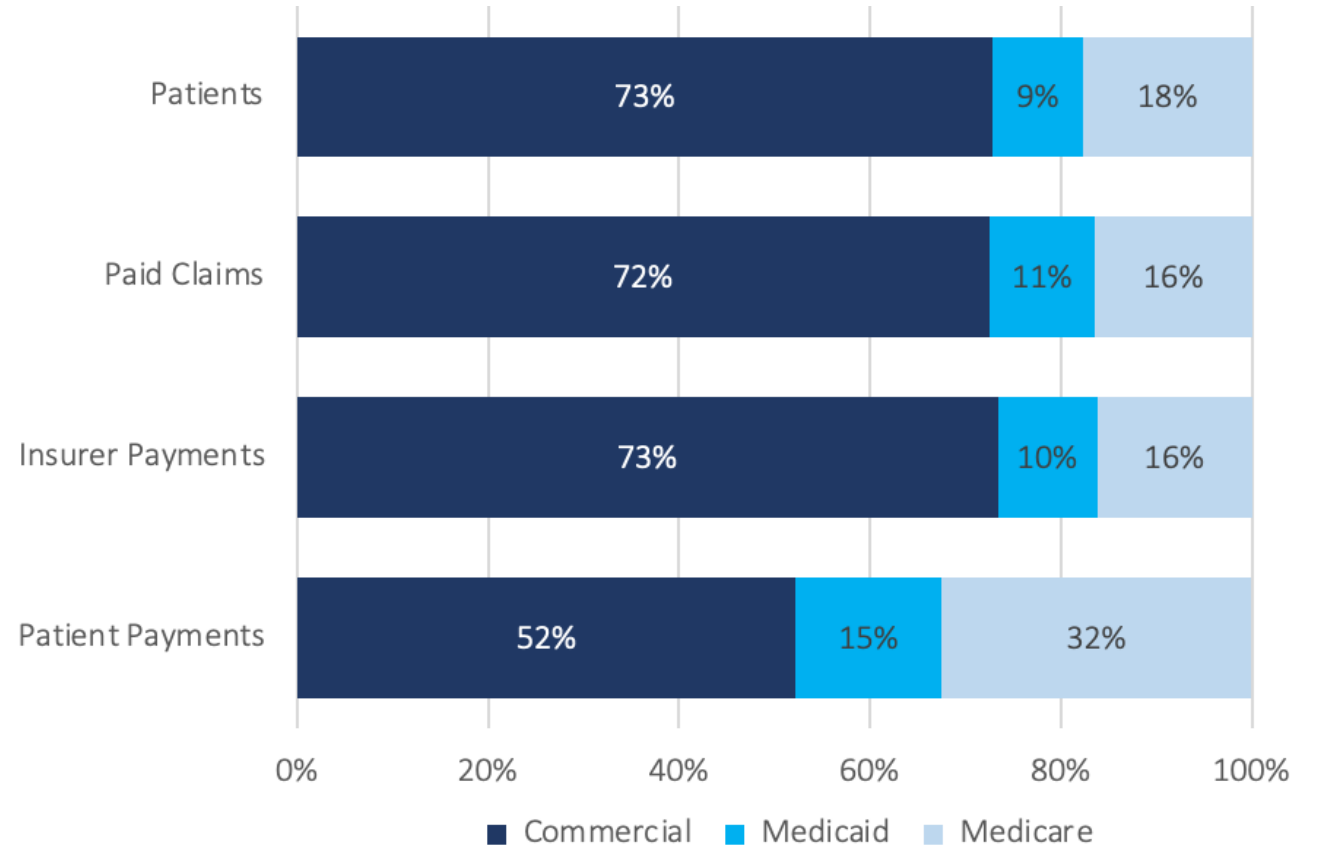
Key Finding No. 3

- ▶ 73% of paid claims in 2020 were “low-cost sharing” where patient payments averaged \$35 or less per 30-day equivalent prescription.
- ▶ “High-cost sharing” claims, averaging more than \$35 per 30-day equivalent prescription, accounted for 27% of paid claims, but more than 54% of patient payments in 2020.
- ▶ More than 22,000 patients are served by “high-cost sharing” commercial insurance coverage for their insulin prescriptions.



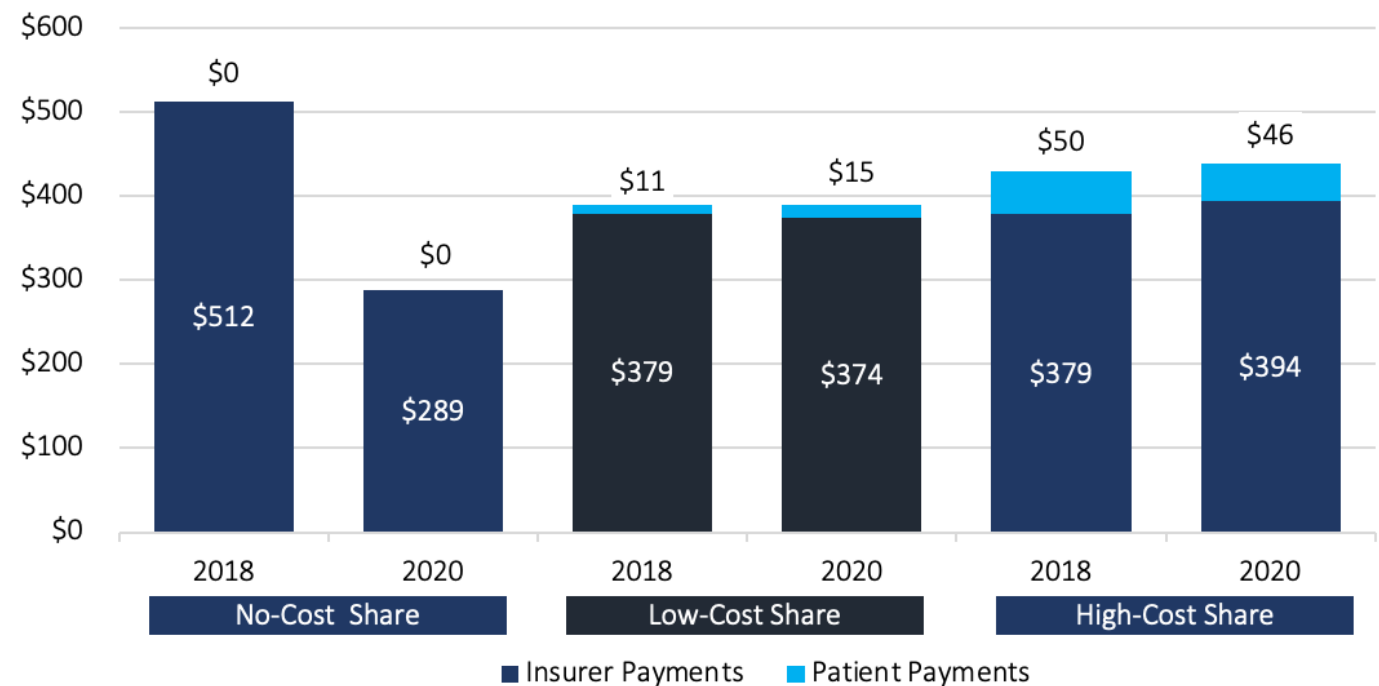
Key Finding No. 4

- ▶ Commercial insurers served the preponderance of insulin patients and filed the preponderance of insulin claims in 2020.



Key Finding No. 5

- ▶ Average patient payments for low-cost sharing commercial claims increased from \$11 to \$15, a 45% increase.
- ▶ By contrast, average patient payments for high-cost sharing commercial claims fell from \$50 to \$46, a 10% decrease.



Most Prescribed Expensive Insulin Products

based on average patient payments in excess of \$100 per prescription* in 2020

Product Name	Product Code	Patients	Paid Claims	30-Day Equivalent Prescriptions	Average payments per 30-day equivalent prescription		
					Insurer	Patient	Total
Humulin, KwikPen, 500 [iU]/mL	0002-8824-27	339	2,102	2,617	\$4,064	\$547	\$4,611
Toujeo, Syringe, 300 U/mL	0024-5869-03	304	1,825	2,342	\$643	\$116	\$759
Tresiba, Syringe, 200 U/mL	0169-2550-13	287	1,678	2,104	\$775	\$112	\$887
Humalog, Syringe, 100 [iU]/mL	0002-8797-59	219	1,222	1,601	\$1,145	\$1,020	\$2,166
Toujeo, Syringe, 300 U/mL	0024-5871-02	153	826	1,016	\$872	\$105	\$977
Humalog , Vial, 100 [iU]/mL	0002-7511-01	122	737	987	\$2,391	\$614	\$3,005
Humulin, Vial, 500 [iU]/mL	0002-8501-01	133	725	946	\$4,930	\$1,280	\$6,210
Soliqua, Syringe, 100 U/mL, 33 ug/mL	0024-5761-05	100	550	697	\$1,009	\$344	\$1,353
Humalog , Syringe, 200 [iU]/mL	0002-7712-27	105	332	606	\$1,048	\$532	\$1,580
Humalog , Vial, 100 [iU]/mL	0002-7510-01	68	283	423	\$451	\$105	\$556
Lantus, Vial, 100 [iU]/mL	0088-2220-33	34	148	211	\$243	\$699	\$942
Humalog , Syringe, 100 [iU]/mL	0002-8798-59	28	159	178	\$726	\$241	\$967

*List includes products with average patient payments in excess of \$100 per 30-day equivalent prescription

What are your takeaways
from these data?

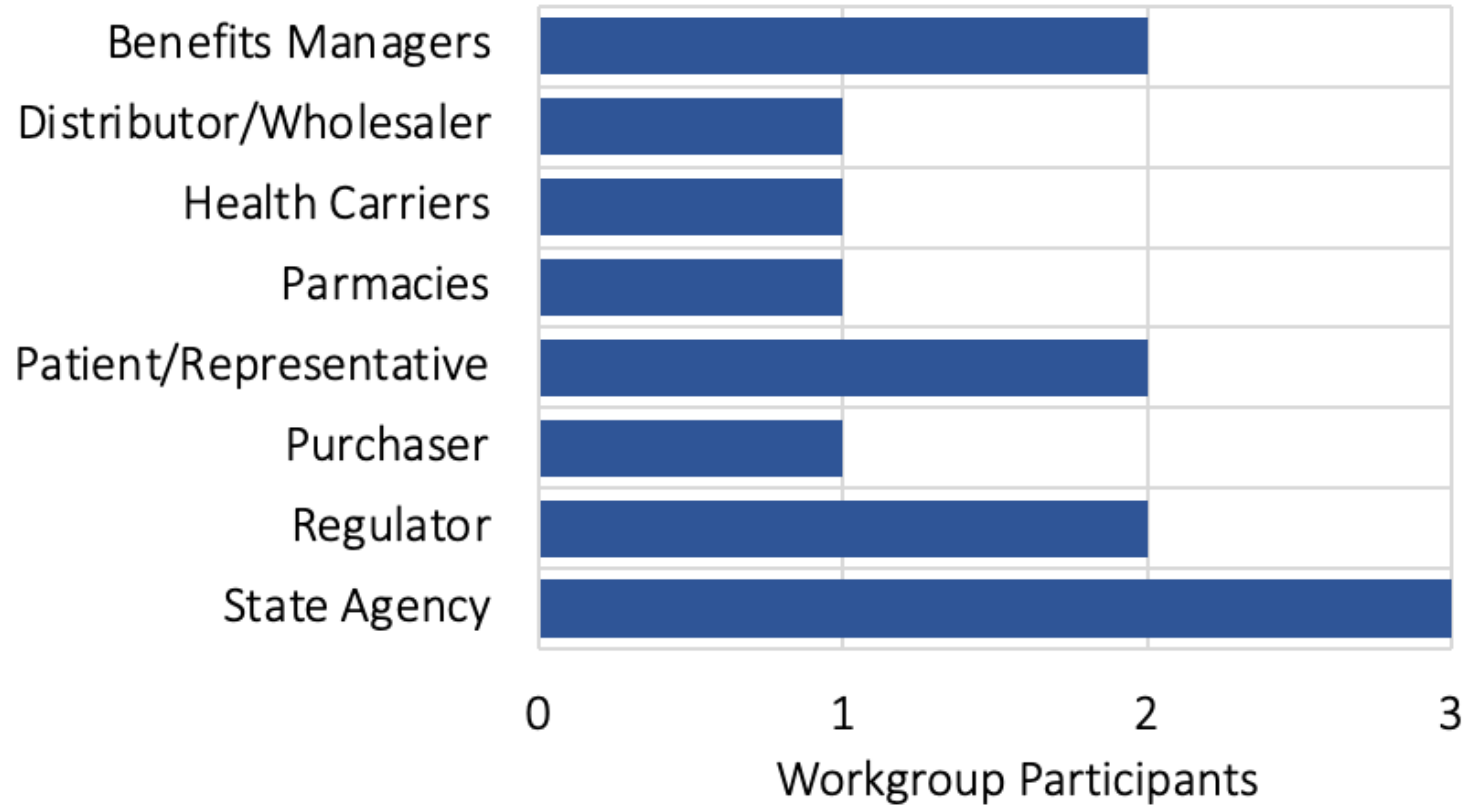
Do you have questions or
comments on the insulin
claims data?

Break
(10 minutes)

Overview and Discussion of Workgroup Survey Results

Survey Respondents

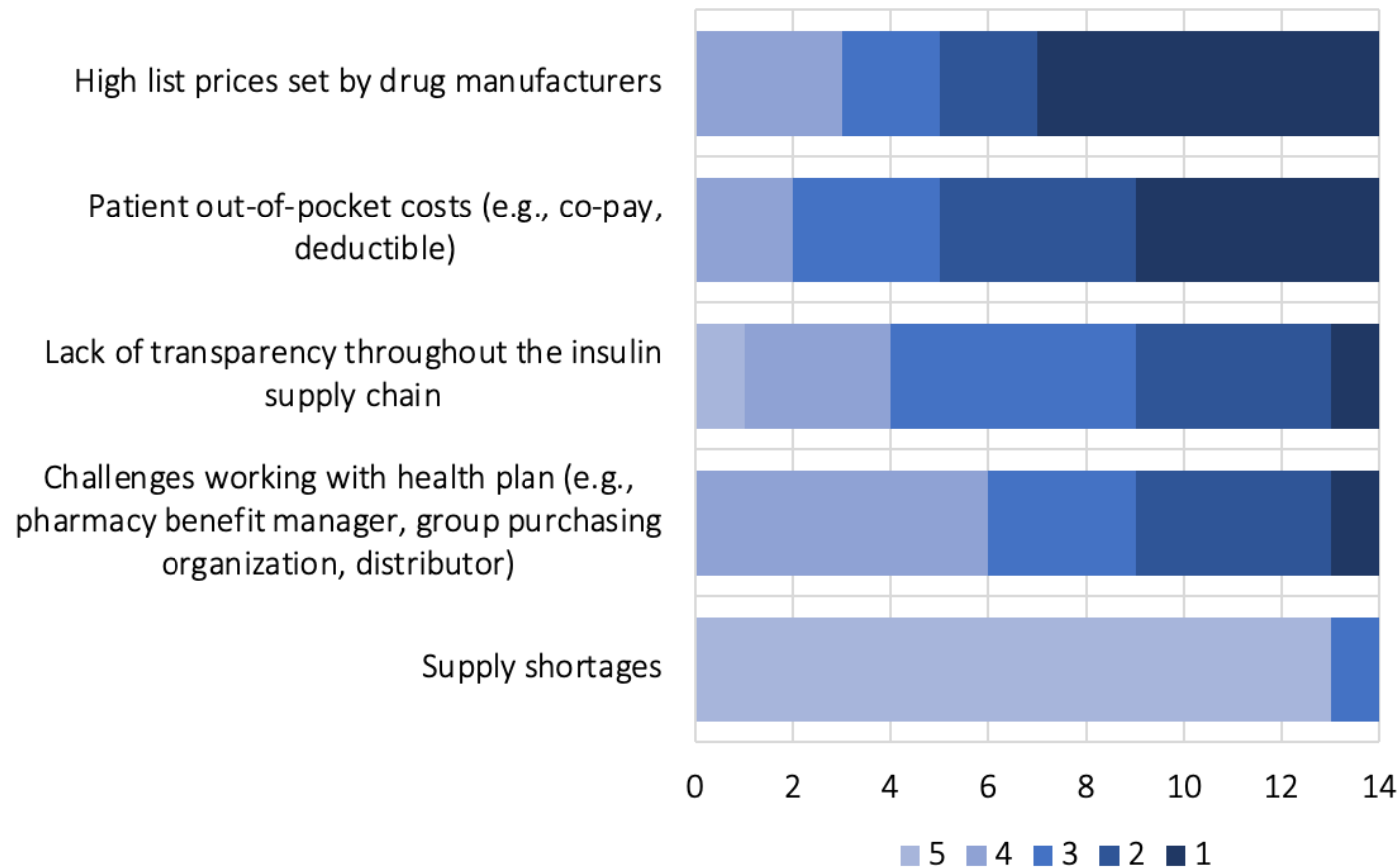
(13 respondents)



What do you think are the primary reasons why patients do not have access to affordable insulin?

- ▶ **Price regulation is not in place** and payer/state/federal strategies have not been adequately developed.
- ▶ **Prices** are too high.
- ▶ High **co-pays, deductibles, and co-insurance**.
- ▶ Lack of **insurance**.
- ▶ Lack of a **competitive market**.
- ▶ **Rebates** that go to PBMs and employers, but not patients.
- ▶ **Add-on costs** by supply chain and PBM costs.

How would you rank the importance of the following factors impacting the affordability of insulin? (1 – Highest, 5 – Lowest)



Composite Scores

High list prices set by drug manufacturers	2.1
Patient out-of-pocket costs (e.g., co-pay, deductible)	2.1
Lack of transparency throughout the insulin supply chain	2.9
Challenges working with health plan (e.g., pharmacy benefit manager, group purchasing organization, distributor)	3.0
Supply shortages	4.9

What strategies should HCA consider to reduce the cost of insulin and total expenditures for patients?

- ▶ Implement **Minnesota's Alec Smith Emergency Insulin Act**, allowing the uninsured to access a 30-day emergency supply. It was used over 500 times last year.
- ▶ Implement **Ohio's Kevin's Law**, expanding emergency dispensing authorization in Ohio up to a 30-day supply for all noncontrolled medications.
- ▶ Implement **Connecticut's co-payment caps**, capping insulin at \$25 for a 30-day supply, and insulin-related supplies, such as test strips, BGMs, and CGMs, are capped at \$100 per month. Other glucose-lowering medications are capped at \$25 per month.
- ▶ Leverage SB 5203, allowing WA to manufacture and distribute biosimilar insulin. **California and Maine also passed a bill like SB 5203**, allowing for multi-state compacts to address insulin affordability.
- ▶ Regulate PBMs like **Texas' HB 1919**, protecting community pharmacies and ensuring patient choice by prohibiting PBMs from steering patients to pharmacies they own.

What are your thoughts about implementing approaches taken in other states?

What strategies should HCA consider to reduce the cost of insulin and total expenditures for patients? (Continued)

- ▶ **Rebate reform**, tiering of insulin, co-pay caps, state run insulin saving program like Utah has.
- ▶ **Partnering with other purchasers** and, for those without adequate insurance, **passing on the drug rebate** to other.
- ▶ **Negotiate better manufacture pricing**, utilize government-based GPO, consider transparent GPO and consider utilizing owned distribution model.
- ▶ **Limit the options on preferred formularies** to any manufacturer that increases WAC for more than 6%, including for insulin.

What strategies should HCA consider to reduce the cost of insulin and total expenditures for patients? (Continued)

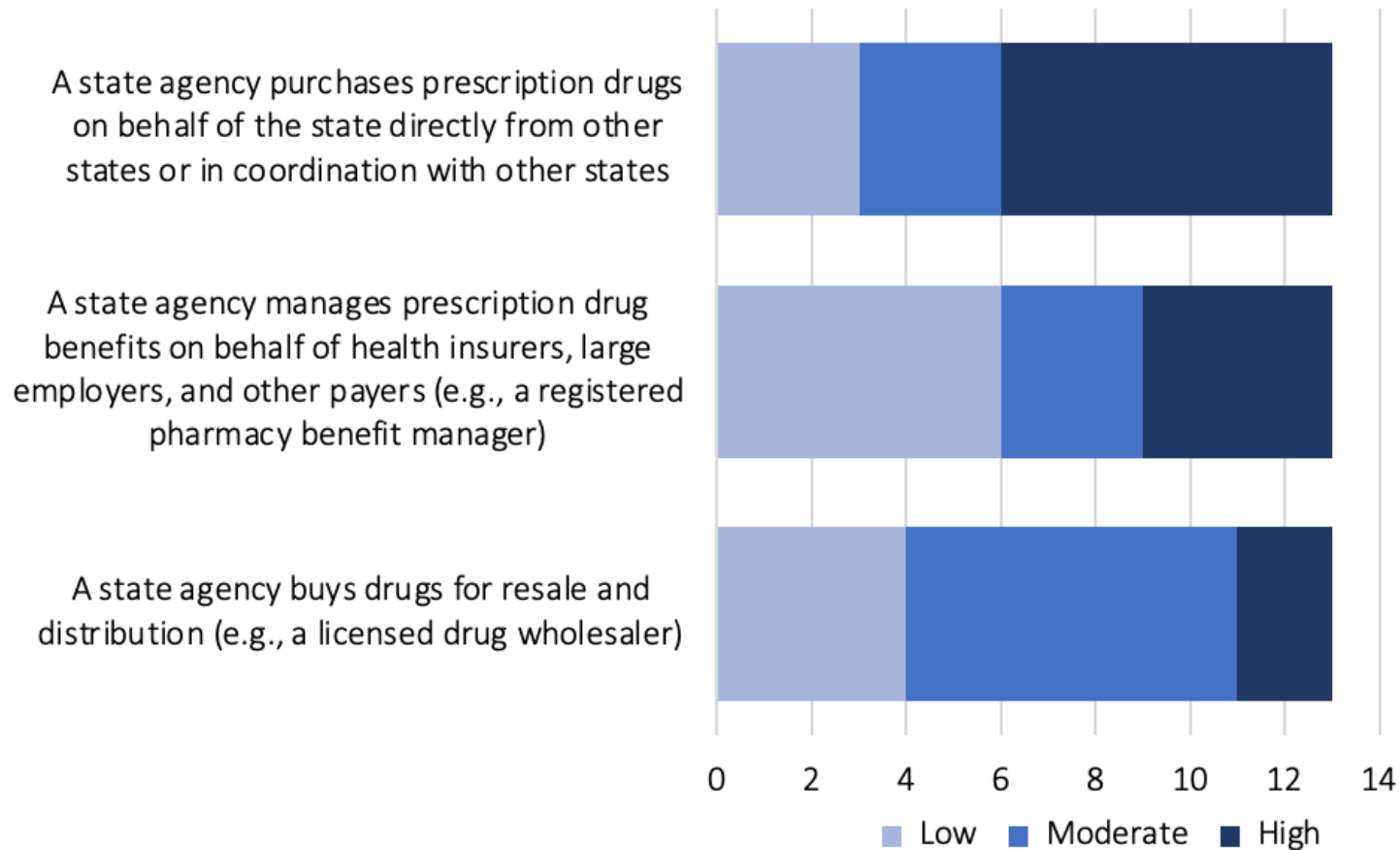
- ▶ **Transparent financial disclosures** from manufacturers, PBMs, and plans regarding the plan paid, member paid, rebates, and acquisition costs through quarterly disclosure.
- ▶ **Educate** and make patients top priority so that they can live a happy, healthy life.
- ▶ Require copays and coinsurance be set **based on drug price after the rebates are applied** to the cost of medications.
- ▶ Discount card. Dosage assessment.

What strategies should HCA consider to reduce the cost of insulin and total expenditures for patients? (Continued)

- ▶ Any policy being considered **must begin with what patient group is being contemplated** (e.g., uninsured, underinsured, and insured) as well as keeping in mind the total cost of insulin not just member out-of-pocket costs.
- ▶ PBMs have created innovative programs that **limit consumer out-of-pocket costs** to promote affordable access as well as **clinical programs** that improve care and patient outcomes.

What are your thoughts
about these approaches?

How would you rank the following strategies to reduce the cost of insulin and total expenditures for patients? (1 – Highest, 3 – Lowest)



Composite Scores

A state agency purchases prescription drugs on behalf of the state directly from other states or in coordination with other states	1.7
A state agency manages prescription drug benefits on behalf of health insurers, large employers, and other payers (e.g., a registered pharmacy benefit manager)	2.2
A state agency buys drugs for resale and distribution (e.g., a licensed drug wholesaler)	2.2

What challenges do you see in the HCA entering into a partnership with other entities (e.g., insulin manufacturer, pharmacy benefit manager) to distribute or purchase insulin?

- ▶ The **leverage** of one state or state agency might not be enough to drive the net cost down significantly.
- ▶ Potential **unwillingness** of the other entities to negotiate.
- ▶ **Greed. Control.**
- ▶ **Lack of infrastructure and expertise** for state to operate as drug distributor.
- ▶ Having a **consistent record of supply and distribution** that is transparent and accessible by patients (e.g., the COVID vaccine access framework).
- ▶ **Lack of funding** to support state-based purchasing coupled with lack of infrastructure and expertise to manage both purchasing and distribution of drugs.

What challenges do you see in the HCA entering into a partnership with other entities (e.g., insulin manufacturer, pharmacy benefit manager) to distribute or purchase insulin? (Continued)

- ▶ **Disrupting the current distribution systems** would be difficult and may lead to unintended consequences.
- ▶ Other **entities willing to partner** with HCA.
- ▶ The **middlemen** who keep rebates and make patients pay too much.
- ▶ Other entities are **not transparent** what their actual costs are.
- ▶ **Avoiding a cost push** coming from the additional competition for supplies.
- ▶ There is a **significant lack of trust** as the industry has proven time and time again that profits are more important than patients. PBMs and manufacturers exploit and extort the chronically ill and disabled.

What are your recommendations to overcome the challenges that you've identified above?

- ▶ Working with technology companies for **real-time inventory management** that is easily understood and accessed by patients, pharmacies, and distribution channels.
- ▶ Work with existing **government consortia**.
- ▶ **States should partner** across the US to ensure the coalitions can drive the cost significantly.
- ▶ **Create and fund public production of insulin**, small pharmaceutical companies to produce insulin (contracts to ensure they charge a reasonable price that would compete with others, and that they have to agree to make insulin for a certain amount of time to get funding).

What are your recommendations to overcome the challenges that you've identified above? (Continued)

- ▶ Make sure that **generics are prioritized** and allow ramp up for supplies.
- ▶ Have patient co-pays and co-insurance applied to the post rebate price of drug. Or continue to **cap copays**.
- ▶ **Education and awareness.**
- ▶ Create a solution that focuses on **price setting** rather than distribution services.
- ▶ Comprehensive understanding of entire drug supply chain.
- ▶ **Leverage expertise of current entities** such as existing distributors, wholesalers, PBMs.
- ▶ Comprehensive **understanding of federal and state laws** for this enterprise.
- ▶ **Assessment of funding, expertise, and infrastructure** needed to deliver any option.

What are your thoughts
about these challenges and
proposed recommendations?

What are your recommendations on how to provide a **once yearly 30-day supply** of insulin to individuals on an emergency basis?

- ▶ Create a **mandated benefit design**. For those without insurance, create a state program to provide that emergency supply.
- ▶ State funded program through the **discount card**.
- ▶ Supply them through **340B or Community Health Clinic Pharmacies**. Require insurance carriers to build this into their benefit design.
- ▶ Create a plan that allows pharmacies the ability to **provide the insulin even with an expired prescription**.
- ▶ Pharmacies to provide the insulin and have a means to **bill the state** if there is not insurance available and **pay a dispensing fee**.
- ▶ Work with **ArrayRx** to develop a strategy to cover the cost using their PBM.

What are your recommendations on how to provide a **once yearly 30-day supply** of insulin to individuals on an emergency basis? (Continued)

- ▶ Make it available to **first responders, schools, eligible pharmacies with urgent clinics, or some not-for-profits.**
- ▶ HCA **identify and analyze other state programs** that provide a 30-day supply of insulin to individuals on an emergency basis and determine best practices.
- ▶ **Low/no cost**, no advance prescription required.
- ▶ **Centralized system of record** able to be queried by stakeholders to understand utilization history. Ability to use systems such as the PMP (but better).

What are your recommendations on how to provide a **once yearly 30-day supply** of insulin to individuals on an emergency basis? (Continued)

- ▶ **Establish infrastructure** to manage purchasing, warehousing, distribution, eligibility, quantity, etc. for managing this program.
- ▶ **Clear policies and procedures** for the program (including clear identification of what entity determines eligibility for the program, guardrails around individual insulin products, dosage, and supplies).
- ▶ **Create awareness of the program**, easy to understand eligibility information, and how to request an emergency supply.
- ▶ **Ensure that the law doesn't sunset.**

What are your recommendations on how to provide a **once yearly 30-day supply** of insulin to individuals on an emergency basis? (Continued)

- ▶ Requiring manufacturers to **expand patient assistance programs** to cover more people with low incomes, giving them the chance to get a 90-day supply of insulin for no more than \$50 from their pharmacy.
- ▶ If a person doesn't qualify for the manufacturer assistance program, folks can get insulin through the **state's continuing safety net program**, in the same 90-day supply for the same \$50 co-pay. Minnesotans can take advantage of this provision every 90 days but have to reapply to the continuing safety net program every year.
- ▶ Ensure that folks without a valid ID can participate, allowing for students, visitors, temporary workers, and undocumented folks to access insulin through **Alec's Law**.

What are your takeaways
from this survey?

Do you have questions or
comments on ideas?

Next Steps



Questions?

HCAPharmacyStrategy&Innovation
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