Washington Total Cost of Insulin Workgroup
Meeting #1, July 8, 2022

Mary Fliss: Zoom meeting. It gave us that note that this was going to be a recorded meeting. So we will appreciate your doing that. So I am going to just go through the Task Force members' names and ask that you confirm your names and the pronunciation if I don't do that correctly. And your interest as well as an icebreaker. And let's share what your ideal vacation spot is. And if you have been there, that would be great to know, also. So, Amber, can we go ahead and start with you?

Amber Markland: Hi, nice to meet everyone. My name is Amber Markland. I live in Olympia, Washington. My son, Levi, was diagnosed with type one diabetes four years ago at the age of six. I'm eager to learn and accomplish some great things with this workgroup. Ideal vacation spot, I've got Tulum on the top of my list. So that's where I would go.

Mary Fliss: I'm sorry. Where is that?

Amber Markland: Tulum? It's in Mexico.

Mary Fliss: Tulum. Oh, very cool. All right. Great. Well, welcome, Amber. Barbara, let's go to you next.

Barbara Jones: Good morning. My name is Barbara Jones, and I am the Senior Health Policy Analyst with the Office of the Insurance Commissioner. So I'm very pleased to be here. As far as, let's see, top vacation. Gosh, there's been so many that have been delayed over COVID.

Mary Fliss: Right?

Barbara Jones: Yeah. So I think it's a tie between Portugal and Italy. So we will cause toss a coin on that one.

Mary Fliss: All right. Next, I have Chris.

Chris Bandoli: Hi. Good morning, everyone. My name is Chris Bandoli. I'm the Executive Director of the Association of Washington Healthcare Plans. I'm interested in this because health insurance plans have a big role to play in this, and we've

actively worked on the legislation over the years around this issue. Ideal vacation spot? I think I'm going to go with I would love to do a tour of the British Isles. I've been briefly 30-ish years ago. I imagine stuff has changed, and I have forgotten most of that anyway. So that would be. I would love to do that.

Mary Fliss: Awesome. Dan.

Dan Gossett: Good morning, everyone. I'm Dan Gossett. I'm on the School Employees Benefits Board. And I'm happy to be here this morning. Ideal vacation spot? Image Lake in the Glacier Peak Wilderness area.

Mary Fliss: Oh, very cool. All right. Well, welcome, Dan. Great to have you. And Jennifer?

Jennifer Perkins: Good morning, everyone. My name is Jennifer Perkins with she/her pronouns. I was diagnosed with diabetes in 2007. And I am a nurse and volunteer advocate and volunteer for the Children's Diabetes Camp, Camp Leo. And I am excited to be here with everybody. Yeah, and to make some good changes.

Mary Fliss: Great. And do you have an ideal vacation spot?

Jennifer Perkins: You know, like my husband says, we are at the destination. Washington is a wonderful place to live. And I am looking forward to going on a bunch of mini vacations all over the state to go climbing and river going down to some rivers.

Mary Fliss: I love that. Well, welcome. And Kat.

Kat Khachatourian: Hi, everyone. I'm Kat Khachatourian. And I am the PQAC-appointed representative here, the Pharmacy Quality Assurance Commission. In my day job, I work as the Chief Quality Officer for Physicians of Southwest Washington, which is also in partnership with MultiCare Health System, running the MultiCare Health System employee health insurance plan. My interest here is I have an extreme family history of diabetes and cardiovascular disease. So making sure that patients have appropriate access but also understanding the inner workings of health plan, PDM, and distribution to bring that expertise to the table, so we can figure out how to operationalize this really effectively. So we're really excited to be here.

Vacation spots? So we've been talking for the longest time about renting a catamaran in the Cayman Islands. And now that we have a 19-month-old son. That's a little bit on hold because I would be terrified to take him on a catamaran because he wants to explore everywhere and moves really fast. But hopefully, as he gets a bit older that will become reality. It was put on hold due to some of the tropical storms and all of that, and then COVID. And so, that will still remain on the bucket list.

Mary Fliss: Love it. Welcome. And Kevin.

Kevin Wren: Thank you. Kevin Wren. I have been a type one diabetic since 2001. My dad is a type one diabetic. My grandma lived for 50 years with type one diabetes. So it really runs on my family. I'm excited for this group. I think we first presented the idea back in 2019. It was kind of a game changer for me with diabetes, so I'm glad we're actually making these steps. But number one vacation spot. I've been looking at the little Hobbit houses down in New Zealand. Going there. We just did like a marathon of all the Lord of the Rings movies. So yeah, definitely somewhere in New Zealand.

Mary Fliss: Love that. All right. Welcome. And then Kat.

Kat Khachatourian: Is there another Kat?

Mary Fliss: Oh, sorry. Sorry. My names are moving around here. We did Jennifer. Oh, I skipped over Jenny Arnold. Apologies Jenny. Do you want to go ahead and introduce yourself?

Jenny Arnold: No problem. My internet kicked me out for a short bit, so [cross-talk] --

Mary Fliss: Oh, gotcha. Okay.

Jenny Arnold: It might have been my fault. I'm Jenny Arnold, and I am a pharmacist and also the CEO of the Washington State Pharmacy Association. And then was there an icebreaker?

Mary Fliss: There is, and it is your favorite or your ideal vacation spot.

Jenny Arnold: Oh, gosh, we had a great time. I don't know. Everywhere. I just love going on vacation and traveling and haven't met a place in the world I didn't enjoy

being at for one reason or another. So anywhere with good food and good culture and something to explore.

Mary Fliss: Great. Welcome, Jenny.

Jenny Arnold: Thanks.

Mary Fliss: And then Laura.

Laura Keller: Hi, Laura Keller. I'm the Managing Director of Advocacy for the American Diabetes Association. I've also lived with type one diabetes for gosh, 23 years now. So that's pretty fun. And I'm based out of Kirkland, Washington. My favorite vacation spot because I just like to go sit by an adult pool and chill at the Grand Wailea in Maui. That's my favorite hotel, my favorite spot. You'll find me and my husband there once a year, and I do nothing. Life is too busy. So we just sit and enjoy the sunshine and the palm trees.

Mary Fliss: That sounds lovely. Welcome. Um, and then Leah.

Leah Lindahl: Hi there. Leah Lindahl with the Healthcare Distribution Alliance. So we're the trade association for healthcare and wholesale distributors. And that's about 35 members with several operating in Washington. So happy to represent our industry in this workgroup. As far as vacation spots, I think like the rest of you. COVID kind of threw our world through a ringer. But when Kat mentioned putting something on hold, we were planning on going to Ireland, which is kind of our bucket list vacation for my husband and I, and then found out we were pregnant. So that also got put on hold. But besides that, I'd love to go to Ireland one day. And then there's also an ice castle in Finland that you can go and kind of stay in and see the Northern Lights. I have always wanted to do that, but that's quite a long-term goal.

Mary Fliss: Awesome. All right. Well, welcome. Lori?

Lori Evans: Hi, everybody. I am Lori Evans. I am a public member. I've been a type one diabetic since I was 10, so we're pushing on 43 years. And my ideal vacation spot is truthfully anywhere warm where I can relax.

Mary Fliss: Nice. Great.

Lori Evans: Thanks.

Mary Fliss: Great to have you. How about LuGina?

LuGina Mendez-Harper: Good morning. My name is LuGina Mendez-Harper. I'm a pharmacist. And I am here representing the Pharmacy Benefit Measure Association. I am I think I really associate with Laura, who talked about being around a pool doing nothing. For those of us who have children that are grown adults, that's always nice to just kind of take a take a moment and breathe. So my ideal vacation would be similarly doing what she said, which is sitting around a pool and just relaxing in warm weather.

Mary Fliss: Love it. Great to have you. And let's go to Lumi.

Lumi Nodit: Hi, my name is Lumi Nodit. I'm an Assistant Attorney General with the Attorney General's Office. I'm a representative of the Task Force for the Attorney General. My interest in this group, I guess, is I've been over the years involved in merger reviews, conducting investigations, as well as other work in litigation involving various pharmaceutical and various suppliers in the pharmaceutical supply chain and other health care providers. So I have some interest in that. And favorite vacation spot? I will say, I would love to go to South Africa just on a safari and New Zealand, as well, to explore some of those beaches where you can potentially see dolphins very close. That's what I heard.

Mary Fliss: Great. All right. Welcome. William?

William Hayes: Good morning. I'm William Hayes. I'm the Director of Pharmacy for the Washington State Department of Corrections. Professionally, I serve a large population that has diabetes that we take care of while they are incarcerated but also in preparation for returning to the general Washington community. Personally, I have a family history of diabetes, so it has impacted my life. And this is really important, and a really important topic to me. My ideal vacation location I visited, but I'm really looking forward to going to again, and that's Japan. It is a beautiful country. It's unique, and it's culturally different from the United States in many ways. And it's just nice to get away and be somewhere different.

Mary Fliss: Great. Welcome, William. Donna, let's have you introduce yourself.

Donna Sullivan: Hi, I'm Donna Sullivan. I'm the Chief Pharmacy Officer with Washington Health Care Authority. I manage our Medicaid Pharmacy Program as well as our public employees and school employees along with Ryan and Amy and Leta with the Northwest Prescription Drug Consortium, which recently rebranded to ArrayRx. And my husband and I really enjoy cruising. So wherever a cruise ship can go, we would love to be there. Our goal is to try to get to all the continents in the world. So my favorite vacation spot is really the entire world, I think, and just trying to see it all.

Mary Fliss: Great. So I'll finish with myself. My name is Mary Fliss. I'm the Deputy for Clinical Strategy and Operations here in the Health Care Authority, which means, like Donna, I work in the Clinical Division, and my work is really helping support various projects as well as working on contracting the legislative review process, as well as some of the Prior Authorization work. So I'm very pleased to be part of this important work and to continue to look at how we really make sure that Washingtonians are having access to high-quality care at affordable prices. So my ideal vacation spot, I am with you, Kevin. I would love to go to New Zealand. I'm not quite so specific as hanging out in The Hobbit homes, but I will add that to my list of things to check out and think about. So, thank you so much. And let me just see, did we have any guests who joined the group that are not Task Force members? And if you could identify yourselves. Any non-Task Force members, non-HCA employees, non-Center employees.

Leta Evaskus: Okay, I've unmuted Kim Weidner. [Cross-talk] --

Mary Fliss: Great, welcome Kim.

Leta Evaskus: You can unmute yourself.

Kim Weidner: Hi. This is Kim Weidner. I'm staff to the House Healthcare and Wellness Committee.

Mary Fliss: Wonderful. Welcome, Kim.

Leta Evaskus: And I have unmuted Petra Eichelsdoerfer.

Mary Fliss: Hey, Petra.

Petra Eichelsdoerfer: Hello. I'm Petra Eichelsdoerfer, United Healthcare Pharmacist Account Manager for Medicaid.

Mary Fliss: Okay. So you're very faint there, Petra. But it's Petra Eichelsdoerfer, who is with the United Healthcare as the Director of Pharmacy. Did I get that right, Petra?

Petra Eichelsdoerfer: Yes.

Mary Fliss: Awesome. Okay. That was a little bit better. Great. Welcome, and nice to have you here. So I think we did the meeting overview if you could go back to the previous slide, Leta or Nonye? Number two there. There we go. So, right. We did this review, so we've done that one. And then the last item on that list -- so you can scroll forward -- this is a meeting that's not subject to the Open Public Meeting Act. Of course, we're happy to have people if they'd like to join us, Petra and Kim. Great to have you. If you would like to -- and appreciate that Mandi is sharing your screen. So I'll get that straight for next time. So it is nice to have folks here, but we are not going to be living under the rules, which have certain requirements around how we conduct this meeting. But again, we're happy to have others join us, so if you would like to invite colleagues or friends to be part of these discussions, they are welcome. So with that, I believe -- Mandi, if we could go to the next slide, I am going to hand this over to Brittany for a review of the legislation that brought us together and the scope of our work.

Brittany Lazur: Great. Thank you so much, Mary. So as Mary mentioned, let's ground ourselves in the work in the charge of this workgroup here today. And so in the 2022 session, the Washington Legislature passed House Bill 1728, and this legislation directs the Health Care Authority to create a Total Cost of Insulin Workgroup and to secure input from this workgroup. So over the course of five meetings, we'll be reviewing strategies to reduce the cost of and total expenditure on insulin and to provide a 30-day supply of insulin to individuals on an emergency basis. Next slide. As I mentioned, there will be a total of five meetings that this workgroup will attend. And we'll be considering those two areas that I just touched on a little bit before, but let's go into a little bit more detail here. The first is to determine strategies to reduce the cost of insulin and total expenditures for patients. This is including but, of course, is not limited to a state agency buying drugs for resale and distribution, so the charge of a licensed drug wholesaler, a state agency managing prescription drug benefits on behalf of health insurers,

large employers, and other payers, so similar to a registered Pharmacy Benefit Manager. And then, finally, a state agency purchasing prescription drugs on behalf of the State directly from other states or in coordination with other states. Next slide, please. The second area that we'll be focusing on in these workgroup meetings is to determine design considerations to provide a once nearly 30-day supply of insulin to individuals on an emergency basis. And for this emergency supply program, we'll be focusing on recommendations around eligibility criteria, patient access, program monitoring, and pharmacy reimbursement as applicable. Next slide, please. So let's talk a bit about the deliverables for this project. So the Health Care Authority will be submitting to the legislature a preliminary report by December 1 of this year and a final report by July 1st of next year. And so as part of this workgroup, will be collating all of the determinations and the decisions and discussion points that are made during these workgroup meetings. We'll be creating a preliminary report that will be due in mid-August of this year. This will really focus on the discussions that we have in this July meeting and will really present a roadmap for the discussions that will happen at our four meetings in this workgroup. Then we'll move on, and we'll create a draft and then a final report for HCA to review and pass on to their legislature. Next slide, please. So here we have an approximate timeline of events that will be occurring over the course of our meetings together. So we're meeting here today in July. Welcome, everyone. We are also, as noted, a preliminary report will be due mid-August, so August 12th. The next four workgroup meetings are listed here on this slide. They are tentatively for August, October, December, and March of next year. And then you can see that we have two placeholders here for our work and our draft deadlines for the legislative reports, so tentatively in February and in March. Next slide, please. So before we move on, I just want to pause and see if there are any questions from anyone.

Leah Lindahl: I think somebody asked this in the chat too. Are these going to be the slide deck sent out to us?

Brittany Lazur: Yes, this will be made available to everyone after this meeting today. Thanks for your question.

Mary Fliss: Other questions for Brittany? All right. So let's go ahead and move on. So the next is an overview of HCA's Cost Analysis from work we've done that was mentioned during the introduction. So there was Senate Bill 5203 in the 2021 session that also asked us to look at the cost of insulin. So next slide.

And it directed HCA to establish partnerships to produce, distribute, or purchase generic prescription drugs and insulin, and it entailed us using the all-payer claims database to produce data for utilization and the total cost per year of insulin. And the following slides are going to give some background about the US healthcare system, the pharmacy distribution and purchasing systems, and then several slides about some key data findings from that work that we did just recently for 5203. So just as knowing that each of us come from a different understanding around how the systems work, I always like it when we have a meeting that is with a broad group of people that have just some common understandings around the basic functions of the US healthcare system. So if you could go to the next slide, please. So this sort of goes through in a linear fashion. An idea of programs, employers, carriers in plans, services, and patients. So Mandi, if you could just be clicking through as I speak. So we have Medicaid programs. We also know and appreciate the mention of the MultiCare Employee plans. They are working on who is eligible to receive the benefits under their plan and what the premium cost-share is. And then they also purchase carrier services from carriers or TPAs or special providers. And then, Mandi, if you could stop there, please -- who the carriers, TPAs, and other specific carriers develop plans. And those plans, several of them I know. Those of us who are under the benefits that are offered through the state have both different carriers and a TPA we can choose from. And within the TPA, we have several plans that we can choose from there. The plan really is helping or defining the point of care cost-sharing. And so there are two components. There is the premium that is going to be borne by both the employer program and in some cases, the enrollee. So typical employee plans have some share of the premium dollar or the monthly amount that is paid for accessing the care, whether you use it or not, is the premium amount that is set forth. The plans are usually driven -- how much that premium costs are driven by the medical policies that are set as well as in very directly by what is the point of care cost-sharing? The carriers and the plans also provide services like case managers, and very importantly, bring forward through contracting a group of providers who will be providing services. So, go ahead, Mandi. And if you can bring up the next series and that is, of course, as we know, doctors, hospitals, pharmacies, different therapies, behavioral health providing services to a subset -- and this is the next portion here -- a subset of patients who are enrollees seeking services. So they seek from this group services, and the amount they pay or what/who they can go to, or what policies they are under is very much tied back to the carrier and the plan that has been selected by the program or the employer. So the next slide is a deeper dive

when it comes to the Pharmacy Purchasing and Distribution System. So, Mandi, again, if you could go ahead. We start again with the employer program, who is contracted with a plan. In the case of Pharmacy, often the plan contracts with a PBM. So go ahead, Mandi. The PBM has a network of pharmacies, and they have established for each drug and for each version of the drug strength, the distribution mode, etc., what the cost they will pay, the pharmacy will be. Keep scrolling. Also, the PBM has negotiated with the manufacturer's rebates, so there are traditional rebates with the manufacturer. And the manufacturer contracts with a wholesaler, who distributes the drugs to the pharmacy. And if you could click through the next three. So the patient goes to their provider. In many cases, they are given a prescription. The patient then goes to the pharmacy to have their prescription filled. And if you could just go ahead and finish the rest. Just scroll through the rest of the slides. So there are organizations called Pharmacy Services Administrative Organization (PSAO) for smaller pharmacies. So those that don't want to negotiate directly with the PBM have the opportunity to have that negotiation done through a Pharmacy Services Administrative Organization or a PSAO. Oftentimes, employers will use brokers to help them with selecting and teeing up for different health plans, and this should probably be carriers and TPAs to help them with that selection. There are also group purchasing organizations that create contracts that are volume-based discounts between manufacturers and pharmacies to receive the drugs. There are many versions of this that you can find available to you on the internet. As I became more familiar with the pharmacy world, the amount of acronyms that are used is fairly staggering. And please do let us know and appreciate folks adding into the chat what the different acronyms refer to because we become so accustomed to them that they seem like words and not acronyms to us. So at any time, if you'd like us to stop or slow down, we are happy to do that. And with that explanation, I guess I'll pause there if anybody has sort of comments or questions around that that you'd like to share.

Kat Khachatourian: Mary, this is a great overview of this. So I just chuckled because I live in this world, and this is the simplified version, and it's still not easy to walk through.

Mary Fliss: Right. Thanks, Kat. Absolutely agree. And it looks like there is a question in chat. And I'll admit right now, I am not good at doing chat and presenting. So what is the timeline for getting 5203 off the ground? And actually, Kevin, do you want to go ahead and unmute? Oh, and thank you for the reminder. So I

guess, unmute, say your name for purposes of transcription, and ask your question.

Kevin Wren: Yeah. So last year, we passed SB 5203, which would allow the state to manufacture and distribute generic drugs and biosimilar insulin. And I'm just wondering about kind of the timeline of that and whether or not this group can utilize that to make insulin more affordable.

Mary Fliss: So I'll start with answering and then, Mike, could I ask you to chime in after me?

Mike Bonetto: Sure.

Mary Fliss: Great. So we have been working, as I mentioned, with the Center on the implementation of 5203 as well as for those of you who may be knowledgeable about the Naloxone Program 1195, which was also passed in 2021, relative to Naloxone. And through that we have been conducting and gathering different -- first, doing a deep dive on what is being done in other areas? What are the options? And then surveying those who are involved with these areas around the different strategies. And so, we have a report due on that work, which we'll be bringing forward what we found in the strategies that we're recommending, and then we'll be making decisions around how we move forward based upon those recommendations. But, Mike, if you could give a little bit more context for that, that would be terrific.

Mike Bonetto: Sure. Kevin, I think the catch is just the timing of finishing that report and having that go to the Legislature before it comes to this group. So it's just I think there is a great amount of information and some great work that's gone into that. I think it's just the timing. Once that can get finalized and then get presented, it would absolutely come here, and I think before for you guys to review and have some robust discussion. So I think it's just a matter of when we can get that submitted and then get this in front of you guys. But I think it's going to be a big help. I thank you for bringing that up.

Kevin Wren: Thank you.

Mary Fliss: Great. Okay. So with that, let me go ahead and turn this over to Dan for the discussion around what we have found as we've looked at the data and really digging into 5203. So, Dan?

Dan Vizzini: Yes, thank you. And that was such a great introduction. Those slides help explain a great deal about the complexity of the data that we've been working with. This presentation is going to be more at about 30,000 feet. I came to understand in this work that there is no end to the amount of analysis that could be done or would need to be done in the APCD to fully understand the complexity of the transactions that are going on. But lets at least start out by getting a grounding on what the total claims look like. And what we have in front of you is the claims for 2020. So we did an extract and aggregation of paid claims only in 2020, and we actually did pull aggregations for 2018, 2019, and 2020. So some of the analysis we'll get into that, as well. But what you can see here at a very high level to start out with is $945 million in total payments for insulin in 2020, involving over 1.6 million claims in 400,000 patients. As a general rule throughout the analysis, we have tried to do average payment calculations based on a standard. The standard we're using is 30-day equivalent prescriptions. So we're trying to look at the payments in terms of a monthly prescription and evaluate patterns based on that kind of metric. The other area I'll note is that the patient portion of claims is made up of copayments, coinsurance, and deductibles. And of course, these are all on top of the premiums that individuals pay for their insurance. And then, one thing I will note, these categories are -- the aggregations are further broken down by the type of insurance, so commercial, Medicaid, and Medicare. Medicaid includes the activities of the MCOs, so the MCOs are not combined in with the traditional commercial insurers. And about three-quarters of the claims activity is commercial. So clearly, the commercial market is the most significant market in terms of insulin claims, as you might expect. Any questions before we move on? Okay, let's go to the next slide. So, now that we have this sort of overview, what we've done here is to give you a snapshot of average payments per 30-day equivalent prescription for one particular insulin product. And the goal here was to give you an idea of just how different each of these various groups of insurers are dealing with or treating this particular product. And in the real world, it's far more complex than what these bar charts might suggest. The information that's being portrayed here represents the averaging of multiple health plans across multiple insurers. So we're looking for general patterns, essentially, from this analysis. And we're also trying to compare the components of these average payments that are attributed to the insurer versus the patient. And again, the patient's component is the sum of copayments, coinsurance, and deductibles.

Kat Khachatourian: And, Dan, quick question. Sorry, this is Kat Khachatourian. Is this standardized to per vial? Or is this an aggregate of anyone that might be

filling one vial to 10 vials or whatever their dose might be on a 30-day equivalent? Does that make sense what I'm asking?

Dan Vizzini: I'm not familiar with the detailed calculation that goes into the 30-day equivalent prescription metric. So there are differences. For instance, it's short or long-acting and the strength of the product itself. So there are in this particular case we are dealing with a specific insulin. This happens to be Humalog lispro, and the product is five syringes in a carton. So all of these bars are representing an average payment profile for that one drug. [Cross-talk] I was just gonna say, as we get into some of these other slides, the question that you're asking about the products, the different formulations of the products, the delivery systems, all of that are factors that help that are at work in terms of affecting what these average payments look like.

Kat Khachatourian: Great, thank you.

Dan Vizzini: So next slide.

Multiple speakers: [Cross-talk] [indistinct] --

Mary Fliss: [Cross-talk] Um, Dan, wait. [cross-talk] --

Dan Vizzini: Any other -- Oh, I'm sorry. [Cross-talk] other questions.

LuGina Mendez-Harper: I was going to say, a couple questions.

Kevin Wren: Yeah, I have a quick question. Do you have these totals on just insulin? Or are there, like, do you also look at supplies and see how those are covered? Or like continuous glucose monitors? Like, the other things? Not just insulin?

Dan Vizzini: No. The analysis only focused on insulin products, the drug products themselves. It's a great question because an analysis of the total cost of care would clearly have to include all of the other items that are required of a diabetic patient.

Kevin Wren: Yeah, that's like some of the things that we talk about as patients. It's like, insulin is really great, but if we don't have a needle -- it's like --

Dan Vizzini: Yes.

Kevin Wren: So I agree.

LuGina Mendez-Harper: Hey, Dan, this is LuGina. I just wanted to make sure I'm understanding this slide. So, for example, there are four different values that are annotated as commercial. Are those different values different insulin products or different plans?

Dan Vizzini: No. These are -- so a little background on the analysis. Under the terms of our data use agreement, we were not able to do this analysis in such a way that recognized specific insurers. So we're using data elements in the all-payer claims data, that database that aggregates insurers into groups. So these are for different types of commercial insurers represented here. Each type has multiple insurers in its mix and Medicare and Medicaid, but all of them the data here is about one specific insulin product. So all of these numbers don't involve any other types of any other insulin products, just this one type or this one product itself.

Laura Keller: Does this include both private insurers in these commercial buckets and things plans that are sold in the exchange?

Dan Vizzini: Yes. Yes. It's every claim that was processed and reported to the APCD is then characterized by the -- is given a flag for the type of insurer that is filing that claim. And then those types are used to aggregate the data.

Laura Keller: Right. So then do you have, like, for example, one of these could potentially represent the gold-level plans.

Dan Vizzini: That's right.

Laura Keller: Another could be like high-deductible bronze-level plans. Like that? Is that kind of how you divided up those commercial categories?

Dan Vizzini: That's correct.

Laura Keller: Okay.

Dan Vizzini: And I did not include it in the slide deck, but we could provide a comparison of their cost profiles for each of the plan types, so you can almost guess from those profiles what kind of plan it is.

Laura Keller: Yeah.

Dan Vizzini: But unfortunately, we could not even get a descriptive information about the plan type code. So I'm working with a two alpha code to describe a group of commercial insurers. It was intentionally made anonymous. Everything was intentionally made anonymous. Let's move on to the [cross-talk] --

Mandi: Oh, sorry, Dan.

Dan Vizzini: Oh, yes. Sure.

Mandi: I just want to confirm, Jennifer, did that answer your question?

Jennifer Perkins: Yes, it did. Thank you very much.

Mandi: Okay. Thank you.

Dan Vizzini: Yeah. And there's a question in here about rebates. The dollar amounts for the insurer payments throughout this analysis are not adjusted for rebates. So this is the dollar amount paid as reported on the claim.

Jenny Arnold: And then one last question. Is Apple Healthcare included in the Medicaid numbers? And is that why the copays are what they are for Medicaid?

Dan Vizzini: Yeah, so I believe it is, and it's not a copay. The only payments that are on the patient's side of the equation are coinsurance for Medicaid. But there are no copays, no copayments, and no deductibles associated with Medicaid claims.

Donna Sullivan: Dan, this is Donna. There shouldn't be a coinsurance for Medicaid. So I'm curious to see if that's somebody that might have another payer and that's just showing up as what their copay would have been with the other payer. But we would cover the full amount of the claim.

Dan Vizzini: Ryan and I were talking about this yesterday -- and Ryan, you may want to jump in on this-- but we were speculating about what percentage of these might involve insured insurance, folks who have insurance say from other states that are part of a claim. Ryan, do you want to jump in on that?

Ryan Pistoresi: Yeah. This is Ryan Pistoresi. I did get a chance to look at the data yesterday. So thanks for sending that over. Donna, you are correct. There are no patient

copayments. It is a co-payer. So it looks like this is another insurance that is paying for part of it. And I'm not exactly sure why it was categorized under this patient payments, but I can confirm that all of the Medicaid claims in the analysis showed $0 for patient copays for those prescriptions. So I think it's just kind of a relic of how the data was categorized.

Dan Vizzini: Thanks for that, Ryan. Appreciate it. Other questions?

Jennifer Perkins: I have a comment. This is Jennifer Perkins. It's kind of what Kevin was saying. But you know there's a cost of insulin, and while we have insulin, we cannot drink insulin. And so I just wanted to bring this up because for a future potential analysis, if anyone on this group is involved in collecting that data going forward, it would be beneficial to potentially include things like syringes, pen needles, and pump supplies, and that's because those are required for delivering it. And on that note, glucose monitoring just simply for safety purposes, if someone doesn't know or is not aware of their blood glucose level, and then even if they're giving insulin they may be under or overdosing if they do not have those. I just wanted to mention that because I'm not sure how aware everybody is of that.

Dan Vizzini: Thank you for that comment. I agree that in order to get to the full cost of care, we would definitely need to include supplies and equipment. Okay, let's move on to the next finding. So if the first one had to do with a single product and a group of payers, this one compares two groups of payers to 10 products. And the goal here was to use this to illustrate just how diverse these average payments calculate out to be across a group of 10 randomly selected insulin products as treated by two different groups of payers. These are both commercial payer groups. And so, you can see that there are some products here where there's a significant difference in how that group of payers is treating that product in terms of the preference that might give to it or in terms of the arrangements that they've made for the pricing of their coverage. So, for instance, here you have in the first group significantly higher patient payment for a 30-day equivalent prescription compared to the second group of commercial payers. And, again, this is intended to reinforce this idea that the variations really can be very significant based on the details of the plans, the way the plans are structured, the insulin products involved, and whether or not it's short- versus long-acting. Any comments or questions on this slide? Again, what we're trying to do is just simply drive home the fact that there is nothing standardized or predictable in terms of the way these patterns come out of the claims data.

Mike Bonetto: I'm just wondering, when was this data captured?

Dan Vizzini: This is again 2020 data. These are 2020 claims.

LuGina Mendez-Harper: Hey, this is LuGina. I have a quick question. I just want to make sure I'm understanding this correctly. So if I'm in insured group #1 and the highest copayment is around $160, and then the lowest that I'm seeing is around $20. Would this mean -- say Humalog is non-preferred, so that would have the $160 patient copayment versus Novolog as preferred, and that's what's getting the $20 copayment or [cross-talk] --

Dan Vizzini: Yeah, that's right. That's right. So these [cross-talk] --

LuGina Mendez-Harper: Okay. So you have this variation, but it's because of the preferred versus non-preferred placement. And while this one may be high, there's an option in a similar short-acting, long-acting, whatever type of insulin where it's preferred versus non-preferred.

Dan Vizzini: That's right. So each pair represents a different insulin product and how those two groups of insurers treat that product.

LuGina Mendez-Harper: Okay. So I think it's just I think that it would be a little more helpful to see, like, if you're talking about short-acting insulin and you have one that's $160 and one that's $20, that's because of the preferred placement. So because when you see $160, you're concerned, wondering how are they paying for this? But what it is the incentives for using a preferred versus non-preferred product.

Dan Vizzini: Mm-hmm.

LuGina Mendez-Harper: Okay. All right. Thank you.

Dan Vizzini: Yep. Let's move on to the next finding. So here what we did is look at the total universe of insulin claims and broke them down by payment categories. And I should define these. The no cost-share category means that there's no provider, no part patient payment involved. No copayment. No coinsurance. No deductible. The low cost share category represents claims where the patient share is at or less than $35 per 30-day equivalent prescription, and the high cost share category is everything else. Where the patient, the

average patient payment per 30-day equivalent prescription is more than $35.

Mike Bonetto: Hey, Dan?

Dan Vizzini: Yeah.

Mike Bonetto: Sorry to interrupt. This is Mike. Can you just give maybe just a quick background on that $35 and where that came from?

Dan Vizzini: Yeah. So before the 2022 Legislature passed legislation the keys on that, I was doing this research base and thinking about the debate that was going on in Washington DC in Congress and the Biden administration about capping patient costs for insulin at $35 a month. So I use that as my benchmark. It was just a way of differentiating the claims by the payments paid by patients -- imposed on patients. So that's where the $35 comes from. My understanding is that the most recent legislation from Washington is looking at that $35 figure, as well. So what you can see here is that the vast majority -- three-quarters almost -- of the claims fall under or fall below that average of $35 per 30-day prescription, and 27% are in that high cost share category. And those high cost share payments, while they represent 27% of the paid claims, they also represent 27% of the 30-day equivalent prescriptions. But they represent 54% of the total patient payments in aggregate.

Kevin Wren: I just have a question.

Dan Vizzini: Yep.

Kevin Wren: So I guess when we talk about, like who these copayment caps would apply to, are we just talking about that quarter slice right there of those people that have the low cost share?

Dan Vizzini: I wouldn't presume that. I think that's the work that's being done by HCA and this workgroup, and so I wouldn't presume that that would be the case. I just felt like it would be helpful to take that total aggregated population and break it down by some kind of cost set of course categories [cross-talk] --

Kevin Wren: Totally. Thank you. [cross-talk]

Mary Fliss: Yeah, if we could go to Lori and then Kat.

Lori Evans: Hey, so I'm just a community member. So my question is, why are we even taking into consideration the Medicaid? If there is $0 out-of-pocket for people who are on Medicaid, why is that even part of this analysis? Am I missing something here?

Dan Vizzini: No, you're not. And actually, we begin from this point on to turn our attention to the commercial plans. So both Medicaid and Medicare, the federal rules that regulate how much of a payment they make, and then in Medicaid, the policy decision to have no patient payment sort of sets them apart from the commercial insurers. So the rest in Findings No. 4 and 5 were working primarily on the commercial plans and their payment structure. So a good point.

Lori Evans: Okay. Thank you.

Mary Fliss: So Kat, and then LuGina.

Kat Khachatourian: Great, thanks. So for transcription purposes, Kat Khachatourian. One other comment, I know the all-payer claims database doesn't have rebates, but I don't recall if the all-payer claims database requests data from manufacturers on the coupon cards that are used. Because when looking at the high cost-sharing in our plans, typically, if patients are taking a non-preferred or a claim that results in a high cost-sharing, that is often offset by a manufacturer coupon assistance or copay assistance card that reduces the out-of-pocket, which the plans and PBMs often don't have line-of-sight into. So that's my question. Has that data been requested from manufacturers to be submitting that information to the all-payer claims database?

Dan Vizzini: I don't know the answer to that question. I think it's something that we should follow up on for the workgroup. And it may warrant additional analysis in the APCD as you move forward.

Laura Keller: Yeah, This is Laura Keller with the ADA. That's going to be hard sort of data to get, though, and to quantify because some of those cards only work for so long. Right? Like, some of them work for two months. Some of them work for six months. Some of them are $1 amount figure. So while I do think that's important information, I think we just need to set expectations that is going to be card information to quantify and categorize, and every card has a

different plan. And then there are also different financial requirements that you have to meet for different ones. So that is cool information they have if we can get it, but it's going to be a challenge.

Kat Khachatourian: Completely agree with you, Laura.

Mary Fliss: LuGina?

LuGina Mendez-Harper: Hi, for transcription purposes, this is LuGina Mendez-Harper. I wanted to just dovetail on a question that Lori Evans asked about why we are including Medicaid if there is not a cost-share. One of the things that's important for us to always keep in mind is that we're trying to look at the total cost of insulin. And while a patient's out-of-pocket expenses, whether it be a deductible, a copayment, or coinsurance are important. It doesn't represent the total cost of insulin. So I think we need to keep in mind that there is the payer, whether it be Medicaid, commercial insurance, or Medicare that is also paying a portion of those total costs of insulin. So that's another reason why we're looking at the Medicaid and Medicare commercial segments in total.

Dan Vizzini: Good point, very good point. Any other questions on Finding No. 3? Let's move on to 4. So, this is just further emphasizing the fact that the commercial claims really do represent the significant share of all claims. We're comparing, or we're reporting here both patients and the number of paid claims, also the insurance payments that are made, or the insurer payments that are made in aggregate. They represent the largest portion. And then you can see the shares that are attributed to Medicaid and Medicare from the APCD. The patient payment component, I think for me this represents -- this begins to show some both complexity and issues around the APCD. So for instance, the Medicaid portion is as we discussed earlier, not really a payment made by the patient. It's an anomaly within the APCD that we probably should adjust for here. And then in Medicare, I believe that this is sort of reflecting the various parts of Medicare in terms of the payments that they're making for insulin. And let's move on to 5. So, in this case, what I've done is in looking only at commercial claims and breaking them down into these payment categories and then looking at 2018 versus 2020. So what kinds of changes were being reported from the APCD? On average, payments by the insurer and average payments by patients, again, for a 30-day equivalent prescription across those two years. And so, the sum total of the two components of the stacked bar represents the total average cost of the

claim. And then the numbers represent and show the insurer component and the patient component. So there's something going on with commercial claims that resulted in a significant reduction in the amounts paid for what those claims that fall into the no-cost share categories. There is a certain small percentage of commercial claims where there are no payments attributed to the patient. They are in the low cost share class category. The total payments were relatively unchanged, and there was a slight reduction in the insurer payment and a more notable increase in the average patient payment in those low cost share plans or category. And then in the high cost share category, you had actually a reduction in the average patient payment and an increase in the insurer payment. So some movement across each of these groupings across these two years. Again, there is so much going on underneath these numbers that you're all probably painfully aware of the variations because these are groupings in commercial insurers. You're looking at changes in the structure in the insurance coverage and the cost-sharing with patients, patients switching health plans, or the drugs that they're using, changes in drug pricing, and to what extent are patients using in-network versus out-of-network pharmacies. All of these kinds of things are in play that would impact changes in these average payments over time. So any questions on this slide? And I see a comment in the chat. This is from Kat. [cross-talk] --

Kat Khachatourian: Yeah. Hi, Dan. [cross-talk] --

Dan Vizzini: [Cross-talk] You just want to speak through this?

Kat Khachatourian: Absolutely. Yeah. So this is Kat Khachatourian. And so I just put a claim, or I guess a comment, rather, on the rebate when we think about the total cost of insulin and the gross cost versus net cost. So how much the payers pay, or the insurers pay as represented by these bar graphs is often reduced somewhat significantly, and that's the quote that I put in the chat, so between 30% to 50% and sometimes as high as 70%. So the economics is obviously very complex and whether what the PBM is contracted to collect, what the manufacturer is contracted to pay, and those types of things. But I note that in this group there is not a manufacturer represented here to be able to comment. And I don't know if that was intentional, but when we think about the economics of this, that's another player at the table that probably has some insights on what could lower the actual total cost of insulin.

Kevin Wren: Yeah. And I'd just like to chime in, too, that those rebate programs just from a patient perspective are not a viable solution. I mean we need an internet connection and a printer to do these things. So there are a lot of people who are left out of those rebate programs.

Kat Khachatourian: Well, and Kevin, just to be clear, I am not commenting on a payment to a patient for rebate. These are the health plan contracts with the PBM. The PBM defines the shared decision-making on what products are preferred -- so what insulin products the patient has access to -- and based on those agreements, the plan, and the PBM collect the rebate in order to produce the plan or PBM paid costs for that insulin product. So by no means am I suggesting that a rebate to a patient is a viable solution. I'm just saying that from an economic standpoint, that's another line item on the accounting report. That if we were to say to Novo, Lilly, and Sanofi, which are the three big makers here, you need to reduce your total costs. I think that they would push back and say that the health plans and PBMs need to reduce their expectation of rebates.

Kevin Wren: Mm-hmm. No, I totally agree with you. I'm just saying from a patient perspective and having to try to use those programs, they're not a viable solution.

Kat Khachatourian: Nope. [Cross-talk] --

Jenny Arnold: I think two different buckets. Right? Kat's talking about the back-end rebate between the manufacturer and the insurance company, which is different than the Patient Assistance Program or a different kind on the front-end patient side. So this is on the backside. What I think Kat is trying to highlight is what the insurer is paying for the insulin is not actually -- that's what they would pay the pharmacy for it. It's not actually at the end of the day after the rebate what that insulin actually cost the insurance carrier.

Kat Khachatourian: Exactly, Jenny. That's correct.

LuGina Mendez-Harper: This is LuGina. And I wanted to just make sure I think I'm dovetailing on what Jenny Arnold just said. And these figures, I just want to make sure I understand. The figures that we're looking at for Key Finding No. 5, that's from the all-payer claims database, so it doesn't reflect any rebates. It's just [cross-talk]. Right? [cross-talk] --

Dan Vizzini: Yep, [cross-talk] that's correct.

LuGina Mendez-Harper: It just claimed. Okay, yeah.

Dan Vizzini: That's correct. [cross-talk]

LuGina Mendez-Harper: So again, that's what Jenny was saying, is that it's reflecting what claim payment is but doesn't reflect the aftermarket adjustments that happened. Okay, thanks.

Dan Vizzini: We're only getting the picture of the marketplace and the economics that is reported to the claims database that we're acknowledging is incomplete. Are there any other questions? Or I see -- so there is a Jennifer. Do you want to speak to your comment in the chat?

Jennifer Perkins: Oh, yeah. I was just making a comment that I was wondering if that's why it's not on there, simply because it's not transparent on how much these rebates -- like the PBMs, how they negotiate. That's not publicly available as far as I know. So I'm assuming that's why it's not here.

Kat Khachatourian: Yes, absolutely, Jennifer. So none of that is publicly available to anybody, which I think is a part of the problem, but nobody talks about it. And this is Kat commenting from a health plan perspective, interacting with PBMs. I think that there is a lot of opportunity for additional discussion.

Jenny Arnold: And I mean, there are two sides to that coin. Right? One is its private companies negotiating what they're going to pay. And they're both for-profit companies, oftentimes. And just like you don't get to see what the grocery store pays dairy gold for milk, I mean, I think there's that side. The problem is that healthcare is so essential, and insulin is a key side of that. And so it just feels different, even though it's market-driven forces that are really driving this the same way.

Dan Vizzini: Thank you, Jenny. Okay, let's move to the next slide. So, I thought it would be worthwhile to look at the drugs themselves. So this is a listing of a dozen insulin products. I included their NDC codes. And this list is sorted by 30-day equivalent prescriptions. So, in other words, these are the most prescribed, to use a term -- the most prescribed of the highest-cost insulin products based on the average patient payments per 30-day equivalent prescription. All of these had average patient payments in excess of $100 per prescription

in 2020. And you can see in looking at the product list that there are different strengths, much higher strength products on the list, as well as different delivery systems, syringes, vials, for different product types syringes, vials, Kwik Pen. And both in terms of the average payments in the all-payer claims data were calculated from the all-payer claims data, and you see really significant differences across these products in terms of both the average insurer payment, the average patient payment, and the average total costs or total payment for the products. But I wanted to focus on those highest-cost products that are also the most prescribed that most shown up as prescribed in the database.

Kat Khachatourian: And, Dan, this is Kat Khachatourian. The most prescribed seems a little surprising to me when thinking about the Washington State landscape. Understanding that Novolog has a much higher market share, I believe. [cross-talk] So that is a little surprising to me that Humalog and Humulin are showing up here so frequently.

Donna Sullivan: I think it's probably more appropriate to say these are the most frequently dispensed because it is at the NDC level and not rolled up to kind of a product level, and we know that the prescriber doesn't pick an NDC. So you know, this is based on these had the most claims.

Kat Khachatourian: Short note, Donna, I totally understand that. Oh, and maybe it's based on the most prescribed expensive. [cross-talk]

Dan Gossett: Expensive.

Mike Bonetto: Yes. It's --

Kat Khachatourian: And that would make sense for Humulin and Humalog to be nonpreferred.

Donna Sullivan: Yeah.

Kat Khachatourian: Going back to the earlier comment, I would expect to the Novolog and Novolin products to be less expensive because they are more often preferred products on at least Washington State formularies.

Dan Vizzini: Yeah, if I was to redo this table -- thank you, Donna, with the most dispensed products based on the data that we have, and regardless of the payment, you would see a completely different list.

Kat Khachatourian: Perfect. Thank you for that context.

Dan Vizzini: In fact for the workgroup, that kind of data, we can certainly provide that kind of data as part of the information that will be distributed to you. So I'm going to stop here. There is significantly more information that we can get into. I wanted to kind of keep this portion of the overall work session today to those findings that we thought were most interesting, maybe most important in terms of the work that you're doing. But as I said, we have a significant amount of data that we pulled down from the APCD. The only limitations on it are that they are aggregations of detailed transactions. And if the workgroup and the HCA want to do more granular investigations into the claims data, then that certainly can be done by looking at the transactions themselves in more detail.

Mary Fliss: And, Dan, did you see Petra's question in the chat?

Dan Vizzini: Yeah. So it says for purposes of this chart, how is expensive defined by average patient payment of $100 or more or something else? Yeah. So in order to get on this list, at a minimum you had to have a product that across all of the claims your average patient payment was for a 30-day equivalent prescription was more than $100 in order to get to this list. So essentially what I did was I took 500 or almost 600 aggregations of claims data. I summarized it for each discrete insulin product -- each discrete NDC code. And then I calculated the averages of payments made by the insurer and the patient for those claims and then selected only those that were at $100 or more per 30-day equivalent prescription for the patient. And then I sorted it by the number of 30-day equivalent prescriptions that were the total for that product, and that's what made the list. I hope that makes sense. Any other questions about the data generally or about this slide or any of the other slides in the presentation?

Donna Sullivan: So Dan, I do have a question for you. Is there the possibility that for the first one, the Humulin that there would be claims where it was copayment was less than $100, as well, for the patient, Dave? So that doesn't represent all claims for that particular NDC?

Dan Vizzini: Yes. That is certainly the case in each of these. For each of these products, they could show up as we showed in the first two slides. They could show up as low cost share products for certain commercial insurers. So yeah, it is

possible that that could be the case. So I'm only looking at those transactions where the payment was more than wherever the share was more than $100 for the patient. Let me try and explain that a little bit more. The aggregations took each insulin product and aggregation was made of all of the claims by the combination of an insulin product and the insurance group. And so, you've got discrete aggregations for that combination of factors. So if we have a dozen or more payer groups, in insurer groups, including Medicaid and Medicare, then each product could show up in 10 or 12 different aggregations. It was the only way to break down over 1.6 million transactions in a way that could provide at least some picture of the patterns that were showing up. I hope that makes sense. And then Kevin has a question I'm not sure that I can answer. Mary or Donna, you might want to take a look at that.

Mary Fliss: I'm not seeing Kevin's question.

Dan Vizzini: All right.

Mary Fliss: I think that may have gone just to you, Dan. Oh, yeah. The question is -- you want to just do it, Kevin?

Kevin Wren: Yeah. There you go. Sorry, wrong question. Sorry.

Dan Vizzini: I could read it.

Kevin Wren: Yeah. Yeah.

Dan Vizzini: Okay. So Kevin asks, "Are there any touch points with the state's diabetes epidemic action report? I'm just wondering how we can use this data along with other datasets." It's a great question.

Mary Fliss: Yeah. Thanks for that question. So there is a report produced, I think it's every other year, in collaboration with the Department of Health. And we can certainly go back and do a crosswalk between what we're finding there and sort of the conclusions that we've come to here. But Donna, others, have you been more engaged with that biannual diabetes group?

Donna Sullivan: No.

Mary Fliss: Anyone else on the Task Force involved with that, or have comments around how what is presented in those reports aligned to what we've talked about here?

Laura Keller: Laura Keller with the ADA. We engage and I work very closely with them. A lot of times that report that they're talking about doesn't talk about the cost of insulin specifically. So I don't know. Their work is a little bit more specific just to the numbers of people with diabetes, the status of things like that. But we could also make a request of them and ask if they could provide some of that information if they have it.

Jenny Arnold: You might. [Cross-talk] --

Mary Fliss: Whoever was talking, welcome to hear your comments.

Jenny Arnold: It was not related to the report. Sorry.

Mary Fliss: Okay.

Jenny Arnold: Just in general.

Mary Fliss: Great. So, Laura, that is a publicly available report. So we will have as a takeaway, and Nonye, if you could make note of it, we'll review that report and have an ability to respond to that and answer that question, Kevin, when we get together next.

Jenny Arnold: I think my takeaway from the data is that it's great data and great analysis, not knocking that. I just think it highlights that we need to know more because I don't think anybody is here even on the high cost share data that was captured between $40 to $50 on a high copay or high cost share plan. That's not enough to bring us all here together. That's not what we're talking about. I think it is that the real challenge comes with the uninsured individuals comes with some of those higher costs, higher copay, coinsurance, and I think that it's not probably the vast majority of people with diabetes is what I've learned from that data, that the average person with insurance probably has manageable costs with their insulin. And so I think it's more. It's highlighting to me that maybe where we're wanting to come together and play Whack-A-Mole isn't on every single plan in that design. There is clearly, as we saw some outlier plans where the patient is paying most of the cost of their insulin in some cases, how we help those

without insurance be able to better access insulin because that data didn't seem so striking to me as -- it didn't really seem like there was a problem to solve based on just looking at that data and looking at the total cost of insulin that was paid for and knowing that is before rebates, I think we really need to drill down on where those issues come from and what they are.

Dan Vizzini: Yeah, if I can comment, while the vast majority of the patients represented by the claims data seem to be in that arbitrary $35 and below grouping, there are still 22,000 patients out there who were represented in that paying more than $35. And the vast majority of them are in about, I think, a $40 to $80 range. We have a handful of individuals or small groups of people who are paying thousands of dollars or hundreds of thousands, $500-, $600-, $700-, $800,000 per 30-day equivalent prescription, and some even three to three times that, but they are a tiny, tiny population who are represented. And the other thing I'll note is that what I saw from 2018 to 2020 was a significant increase in the use of coinsurance. So copayments, if I remember correctly, either were stabilized or reduced as a percentage of the total payment made by or associated with a patient. But coinsurance went up significantly. There is something about the decisions that are being made in the marketplace to make that shift [audio cuts out] occur to reformulate the insurance coverage that drives that. So I love your term Whack-A-Mole because that's sort of what this feels like, that you're going to bang on one mole and another one's going to pop up. It's like squeezing a balloon. So it's a good observation. Thank you, Jenny.

LuGina Mendez-Harper: Dan, this is LuGina. I just wanted to make sure I understand. On slide #5 or point #5, where you talked about average payment for people who have commercial health plans, and it talked about how [cross-talk] --

Dan Vizzini: [Cross-talk] can you go back?

LuGina Mendez-Harper: Sorry, [cross-talk] I think it was your #5 slide. Yes. So here, when you were talking about the high cost share, you were talking about the people that have payments higher than $35. But if I'm looking at this data correctly, for that third segment between 2018 and 2020, the cost-share for patients with a high-cost sharing plan design went down. Is that correct?

Dan Vizzini: That's right. Yep.

LuGina Mendez-Harper: Okay.

Dan Vizzini: Yeah, so this suggested to me if I was to look at individual -- if I could have been looked at individual insurers, there was a shift in the cost burden from the high end to the low end, but because the low end went up by $4, this is like 40% to 45% increase in the patient chair in the low-end group, and this is a 10% decrease in the high-end group. So that would suggest [cross-talk] --

LuGina Mendez-Harper: One question. Again, I don't have familiarity with the all-payer claims database, but is there data in there as to what is happening with the list price of insulin in relation to this?

Dan Vizzini: What we have are charges that are associated with the claims. And there's a -- Mandi, can you go up to the first of the data slides? It's like slide 14, I think. So we didn't talk about this in part because I don't feel like I adequately understand the differences here. But if you look at this $1.2 billion in claims, the claim amounts, the charge amounts on the claims of $945 million in payments. The difference between the two are either caps in the payment amount or discounts that are negotiated by the insurer. But the actual claim includes an amount for what is called a charge. And so there is something going on in here that approximates I would assume the actual cost of the products.

Kat Khachatourian: Yeah. And Dan, this is Kat. From a process standpoint, if you take the total payments of all sources as a percentage of total claims, that will yield what is most likely the what's called the average wholesale price minus the percent discount rate that is contracted between the Pharmacy Benefit Manager and the health plan. So you're spot on as far as the discount rate. But that's the bill versus the allowed is how I look at total claims would be billed and total payments would be what is the allowed costs.

Dan Vizzini: Right, right.

Kat Khachatourian: And so that is what that yields when I look at this at this data.

Dan Vizzini: Yeah. So Donna has the comment that the charge is probably the pharmacy's usual and customary cost with the pharmacy billed the plan. But yeah, I did a run of the percentages of differences between the percentage of total payments to claims. And yeah, it's a fairly constant percentage across the years 2018, 2019, and 2020. So I guess to answer the question, the claims

data has at least charges in it. Now it doesn't really -- I did not see in the data dictionary other measures that would get cost in the way I think about cost, and that is the manufacturer's cost.

Mary Fliss: And I see that Lumi has her hand up.

Lumi Nodit: Yes. So I was thinking of these when looking through the various claim points here. Is this tracking just solely insulin? Or does it include an alternative to insulin and switches, if that is something that was tracked? Because for purposes of cost-share, maybe there are some shifts there.

Dan Vizzini: Only insulin.

Lumi Nodit: And when you look at these 100 or over, is that also the same? Or do they only track just the amount for just the insulin?

Dan Vizzini: Yeah, that's correct.

Mary Fliss: Okay. And Kat?

Kat Khachatourian: Thanks. And so, Dan, when I look at this and thinking about Lumi's comment there, we typically look at this kind of data as a per unit cost in order to neutralize the effect of coinsurance and the total units dispensed. So when we think about the insulin pens or the insulin vials that you mentioned in the earlier part of the call, the per unit cost of that would be dividing what the 30-day cost by the total units dispensed in order to get a more apples-to-apples comparison. So, for example, if a patient is using 10 pens per month and paying a 20% coinsurance for those 10 pens per month, their cost on a 30-day supply is going to be significantly higher than a patient who is on a lower daily dose of insulin and paying a 20% coinsurance of a single box of five pens. So, when I think about that, it's been a couple of years since I've looked at the specs on the all-payer claims database, but I don't remember if the quantity dispensed is one of those data elements. I know that the day's supply is, but I would imagine that the specific quantity dispensed would be a requirement. So I think it would be a more meaningful understanding on -- well, maybe not more meaningful, but a more --

Jenny Arnold: Apples-to-apples?

Kat Khachatourian: Yeah, a more apples-to-apples comparison across commercial payers to look at a per unit cost.

Dan Vizzini: Yeah, so here are units dispensed is a data element that we collected, and it wouldn't take too much effort to redo a lot of these calculations or to come up with a calculation differentiating the insurer's payment and the patient's payment on a per unit dispense basis. If you felt that that would be more meaningful, I'd be more than happy to do that.

Kat Khachatourian: Yeah, I think that would be more meaningful because as diabetes worsens for patients, there are all kinds of things that can impact the average daily insulin dose. If someone is on a sliding scale, or if they're on a fixed dose, there are just a lot of different variables. So I think that while per 30-day equivalent is a starting point, it would tease out among that some of the dose variations, and I think it would decrease some of the vast variations that you might be seeing in the database as far as what people are paying for 30 days.

Dan Vizzini: I got a question about that.

Jenny Arnold: Hello. Just -- sorry, I'll just highlight at per unit means like the quantity dispensed for those who are diabetics. We aren't talking about a unit of insulin. We are talking about a unit dispensed, so it would be like one, and it's challenging with insulin because is it one vial or 30 mL or 10 mL? It might actually still be hard in the database to capture.

Kat Khachatourian: Yeah because that can vary based on pharmacy dispensing software and PBM. Yeah. So I think understanding how many different variations you see in that field. If it's one, does that mean one box or one vial, exactly to Jenny's point, versus 10 for 10 mL or 1000 for units? So I think just understanding what is being populated in that field would give us a sense of whether that would be a more meaningful analysis or if it would just send us down a rabbit hole.

Mary Fliss: So this is a great discussion. I really appreciate the interest in the data. And I know that we could talk about data for a very, very long time.

Kat Khachatourian: Thank you for the process [cross-talk], Mary. Thank you for the process [cross-talk]

Mary Fliss: So just also wanting because our next step is getting a quick break. And then I want to make sure we're really having that opportunity to dive into the survey results. And so, we have folks taking action items back. And, of course, you'll have this slide deck afterward. So as you review it, if you have additional questions that you'd like to ask the team, we will also be sharing the contact information where you can be connecting with us. So, Mandi, if you can go now to the slides. And I think the next slide is "Break for 10 minutes." So I have that it's 11:46. Let's go ahead and try to come back here at 5 minutes before noon. And we will then be diving into the survey results. And also, I'll start with -- it looks like we had another couple of guests join us, so we'll start with a quick introduction. And then, Dan, I will turn it over to you. So see everyone in 10 minutes.

[break]

Mary Fliss: Thanks, Leta. And welcome back, everyone. So the next part of our conversation is really about the survey results. Again, so appreciate those who were able to respond and provide lots of great comments that Mike will be walking us through. Before we get there, though, it looks like we have another guest who has joined us, Ronnie. Leta, if you could please unmute Ronnie. And Ronnie, if you could introduce yourself to us.

Leta Evaskus: Ronnie, you can unmute yourself.

Mary Fliss: All right. Well, Ronnie may have stepped away. I'll go ahead and add a request in the chat and with that, I'll go ahead and turn it over to you, Mike.

Mike Bonetto: Awesome. Thanks, Mary. I think we've got everybody else coming online. Well, guys, we want to take some time, and we've got an hour. And we want to not only go through the survey results but really facilitate a discussion, much like you just had with Dan on this on the data, which was fantastic. You guys were kind of interjecting and asking questions. We want to go through the survey results with you, as well. I think the survey results were really nice to have this initial input and feedback from many of you, the majority of you, that started to tease out certain insights and perspectives that it's hard to get at during a group call. So we were able to consolidate a lot of that. What you're going to see are a series of slides that we can go through and then stop and have some discussion. But these are higher-level general themes that came out of the survey. You will see the full survey results shortly. We just finished compiling that, but you'll be able to see all of that. So

just know that today what you're going to be seeing is the consolidated form within a lot of these slides that hopefully will start to generate some of this discussion. If we go to the next slide. So we've got 16, I believe, of you on the phone today on the Zoom call, and we've got 13 respondents. So again, a large majority of you completed this. And you can see the layout of how that occurred from State Agency folks to Benefit Managers, all the way through, so a good cross-section of representation. So we've got a series of questions that we'll go through with these answers. But I really want to make sure that we leave this forum for some discussion, and we're really leaning on all of you. So some of you really leaned in when asking Dan a lot of questions, but we're really going to lean into many of you who responded. And you may be seeing this. If you're one of the three who didn't respond, if you want to make sure that you have some input, please do so. Same thing as before. If you are going to have a comment, raise a hand. I'd like to keep this as informal as possible. Just make sure you state your name, so we have that for the audio and recording purposes. Next slide. So the first question that was asked was, "What do you think are the primary reasons why patients do not have access to affordable insulin?" Again, high-level themes were teased out here. Anything in black is just there for emphasis only. Price regulation is not in place. Prices are too high. Some are high copays, deductibles, and coinsurance. Lack of insurance. Lack of a competitive market. Rebates that you guys were talking about earlier go to PBMs, employers, but not to patients. Add-on costs by supply chain and PBM costs. So the next question we had was, "How would you rank the importance of the following factors impacting the affordability of insulin?" 1 being the highest, 5 being the lowest, and the highest being that rank of importance. So it may be easier if you take your eyes over to the right. You can look at that overall composite score. So you look at those areas. So, one, high list prices set by drug manufacturers with a composite score of a 2.1, meaning that it's closest to 1. Patient out-of-pocket costs, also a 2.1. And then you can see down that scale lack of transparency throughout the supply chain, challenges working with the health plan, and then supply shortages. If you look over to the left, then you'll see those bar graphs, and you can see the quantity of how many people ranked. You'll see that's why high-list prices set by drug manufacturers are the top because they had the most number 1s. It may be nothing too surprising, but it's again, nice to get this feedback from you guys. You can see how this workgroup is starting to categorize and prioritize certain areas. We'll go to the next slide. So we had this question, "What strategies should HCA consider to reduce the cost of insulin in total expenditures for patients?" And we got a lot here. So highlighting Minnesota's legislation, highlighting

Ohio's, as well as what Connecticut has done on copay caps. Similar to what we were talking about earlier with Washington Senate Bill 5203, what California and Maine have done, and then PDM regulation within Texas. So I want to pause here for a little bit because you guys are subject matter experts and bring a great deal of knowledge to this, and I think we wanted to poke a little bit more. You know, individually, you guys wrote some of these things out. We would love to hear a little bit more from you on any of these where you have highlighted.

Kevin Wren: I think most of those surveys and answers are ones that I submitted. But I think for me as a patient, I think the most important is the Minnesota bit. I think that covers all insured and uninsured people at risk of rationing. And the crux of this group is to address how patients access insulin. And I think that applying to everyone and giving them that emergency supply is really critical. It was used by Minnesota, I think, 1000 times last year. So that's 1000 times someone would have been rationing that they saved them from. I think that's like the biggest charge of our group is to make something like that a reality. But then also that other piece of applying people with health insurance that are just struggling to afford their medicine. I think this program would apply to one in four people with a state-sponsored health plan. So that's huge. Again, people at risk of rationing or affording their meds. But then also looking at a kind of a broader view in what Connecticut passed. And that insulin is as we said on this call already, it's not the only thing. People need supplies in order to monitor their blood sugar or just deliver the insulin itself and putting caps on that because those can be really expensive, and if you're rationing insulin, you're rationing supplies. And if you're rationing supplies, you're not managing your diabetes as best as it could, which, again, is the crux of this group. And then what we passed last year in allowing the state to manufacture drugs and insulin. Right now, it costs between $3 and $6 to produce a vial of insulin, and it costs $300+ as the list price. So allowing the state to actually make the market competitive would definitely help patients and the state in controlling these exorbitant costs of insulin.

Kat Khachatourian: Yeah, and Kevin. This is Kat. Thanks for your comments. And just contemplating these things with the law being used 1000 times. And I don't remember if you said in Minnesota. And I guess that's where my mind goes is, are we creating a lot of infrastructure for less than one-half of a percentage of people that would be in need? And I think that's where my question goes, as far as when we think about the goal here, are we solving for the people

without insurance who are admitting to the EDs because they don't have access to medication? Is that the use case, or [cross-talk] are we trying to solve a more global question? That's my -- at least when I think this through because we already looked at the data that was presented, it seems like the vast majority of insulin -- understanding that's not pen needles, that's not needles, and not test strips, but a lot of tests -- I think we did a similar analysis on test strips. The vast majority of test strips would also be covered at a low or minimal cost, at least from my perspective as a Benefits Administrator. The other piece of this, when I think about the state's ability to manufacture, I would love to understand more. And I think that this is just a gap in my knowledge of supply chain capabilities of the state and the government to be able to make that a sustainable pathway for all patients. And then the third and final comment I have is, if it's a 30-day supply per year, I feel like that's a band-aid, not a long-term solution because, obviously, people are diabetic and need a drug for more than 30 days out of 365. So I would love to at least have a stepwise roadmap or have this group be working on a stepwise roadmap to have a more sustainable process for all patients that would need it throughout the year, rather than just being a safety net or a local mission trip that gives a 30-day supply and then says, "Yeah, we've done a great thing," and then 335 days a year people are struggling.

Mike Bonetto: Thanks, Kat. Great, great comments. To LuGina and then Jenny. Oh, LuGina, your still [cross-talk] --

LuGina Mendez-Harper: I'm on mute. Sorry, hi. This is LuGina. one of the things that I kind of want to dovetail on what Kat was saying. The question is asked, what strategy should we consider? But I think things that we need to use as the foundation for when we're looking at various strategies is one. What patient population are we talking about? Are we talking about insured? Are we talking about uninsured, or underinsured? Because the State of the Union for those groups is very different, especially with the data that we just saw. And then the other thing to keep in mind with all these strategies is a lot of the things that are mentioned here are talking about mechanisms to address patient out-of-pocket costs. But we need to really make sure that we have a broader perspective at looking at the total cost of insulin because that's the complete picture that we need to be looking at. So I just wanted to share those perspectives as two important things that we need to keep in mind anytime we're talking about any of these strategies.

Mike Bonetto: Thanks, LuGina. LuGina, just a follow-up. Does anything when you look at this list and maybe something that Kevin highlighted with [indistinct], does anything kind of stand out or resonate to you?

LuGina Mendez-Harper: Well, I'm familiar with the Minnesota program, and I spent some time looking into that. I know it's run through their Board of Pharmacy. But copay caps certainly is an important strategy that has been used in several states. But that only addresses a patient's out-of-pocket expense. It doesn't. It doesn't address the total cost of insulin that's being paid for by the entire insured market. So that's a concern. And I think a couple of other strategies that are newer may not have been captured here. I know Civica Rx has announced that they're going to be working toward producing some biosimilars of three of the major insulins. And I think actually either today or yesterday California announced that they also have like $100 million, or something dedicated to also producing biosimilars to insulin. So there's a lot happening. But again, from my perspective as a Benefits Administrator, we want to look at the whole picture. Like, what is the total cost of insulin, and what are we doing? Do these strategies impact the uninsured or the insured? And how do we help all of those patient populations because they're all in need?

Mike Bonetto: Yep. Thanks, LuGina. Great, great point. Jenny.

Jenny Arnold: A great, interesting list here, and I agree with Kat. I won't duplicate what she said. I will say we do have a law like Ohio's Kevin's law, and our pharmacists can dispense an emergency supply for up to 30 days, so we can take that one off the list. And I do wonder about the potential impact of generic manufacturing of insulin from the standpoint that you still get in then to benefit design where if the benefit isn't designed to include generics in the benefit because we've seen some benefit designs that have insulin that preferred brand name, insulin. So I wonder about the impact really on insured patients, if that would really have that effect. And I mostly just think that we really need to bucket our work into uninsured and how to help them. And then as LuGina mentioned, the total cost of insulin because those are two very different pathways to solve, and conflating the two, I think, is not going to do us service. So, one, I think those who don't have insurance and/or can't afford copays or coinsurance may be possibly looped in there. And is that helping them to better access the Apple Health Care plans? Is that passing a law that those who have diabetes or certain disease states have a greater discount so that they can afford the Apple Health Care Plan? So then they fall

into the insurance bucket and have negotiated rates and rebates and things for their drugs. You know, the possibilities there is one bucket versus how Washington kind of leverages and lowers the overall cost of insulin, which is the title of this workgroup. But what is it that we're wanting to solve? And, frankly, I'd suggest we prioritize one over the other and have that discussion, too.

Mike Bonetto: Jenny, thanks. That has been brought up a couple of times. And LuGina, I think we got some slides here that probably highlight some of your comments from the survey is my sense. Can I we just pose that to the group in terms of the prioritization of populations? We've got some public members, and we have several diabetics who are participating. And as we talk about this prioritization of uninsured versus commercial versus anybody else, I'm just kind of interested in this initial reaction. Lori, you've got your hand raised.

Lori Evans: Yeah. So I am a public member, like I said before, with 43 years of type one diabetes. And as the previous speaker was speaking my hackles were coming up because you're talking about uninsured people and access to insulin. I've had medical insurance my entire life, and there have been multiple times that I have struggled to cover the cost of my insulin. And I know that this isn't part of the workgroup, but my CGM, the supplies for my insulin pump, I've struggled. And I hope that we're not looking at the uninsured people as we are looking at the insured people. I work for DSHS. I have great coverage, but I have a lot of medical conditions and a lot of copays. So if we could just alleviate some of that, it would make a difference in my life. Thank you.

Dan Vizzini: Thanks, Lori.

Kevin Wren: Lori, I hear you. I've rationed insulin myself, and it's why I'm here and why I'm fighting so hard for this because I might have died. And a lot of these things wouldn't have applied to me as someone working two jobs into the recession. And even with insurance, sometimes it can change your prescription and you're just stuck because it's a Friday night, and you have to go to the ER for a new prescription. And so, I help people now who are rationing insulin or like in between coverage. So it happens for so many different reasons, and for me, covering the uninsured is the most important. Having that Alec's Smith bill is vital. I mean, it was just used over 1000 times in Minnesota. That's 1000 times someone didn't ration and didn't gamble with their life. That's most important. If we're going to triage who we are

saving, that's number one. And then, again, copayment caps and expanding that to include things like continuous glucose monitors and technology and test strips because insulin is useless without a needle. And even if you have a needle, if you don't know your blood sugar, it's again useless. So making sure that they have everything and that just insulin is not enough. I think those are the two biggest priorities for me is for people who have insurance to be able to afford all of the supplies that they need from keto strips to glucagon, all the things so you don't have to be burdened by the cost of just managing your chronic condition because any cost on top of all the other things that go into managing diabetes, this should not be one, so I think making them as accessible as possible. Personally, I don't think we should pay any money for this but establishing basic copay caps is the perfect first step to preventing anybody from rationing. I don't have to crowdsource insulin for somebody if we have this program where I can just send them to their local CVS and no questions asked. They get needles, they get their insulin, and they don't have to worry about all these things that we're talking about right now.

Mike Bonetto: Yeah. Kevin, great point. And I think the way Kat, I think you've framed it well with your opening comments around that glide path. So what can we do to really make things more affordable for folks today but looking at a long-term glide path to reduce total costs? Right? And I think that's something for this group to continue to be thinking about. Yeah, Jennifer.

Jennifer Perkins: Hi. Well, I just wanted to point out that I think the reason why we see so many potential ways to go about this on the screen. And this is not all of the options that we have because this is a complex issue. And as a nurse and a person with diabetes, I am concerned about the 0.5% of people who are having issues accessing. And I don't want to create a false dichotomy that we have to exclude either the 0.5% or other people. I know that we have a limited amount of time, and so we can't get all of our hopes and dreams met with this, but I definitely agree with Kevin on getting the Emergency Insulin Act, even though it does only apply to the 30 days for those situations that people need that just emergency insulin, I think that's a big priority. And long-term, you mentioned long-term. I believe that SB 5203 and expanding the means of production and working with other states to potentially add competition to this market that has a stake in the future of the people with diabetes, I think is really important and potentially transformative for people with diabetes. And earlier, I didn't mention this takeaway, but one of the takeaways I had from those slides earlier was that those were not including people that were uninsured because those were all claims. And so, those

didn't include people that were uninsured. And so we really don't know, based on any of that what is going on with the folks who are uninsured. And another thing we did not include was the long-term cost of what it's costing us when people don't have this access around regularly. Are they getting kidney failure? Are they going blind? Are they getting amputations and the costs of dialysis and all that stuff isn't really being captured that could be really reduced and improve the quality of people's lives if we can get a lot of this stuff done. And so I don't want to say, "Oh, we can only focus on one thing." I think that we should try to cover as much ground as we can in the time we have.

Mike Bonetto: Great. Thanks, Jennifer. I'm going to keep us moving. But Laura, you got a question.

Laura Keller: Yeah. So one of the things that [audio cuts out] [indistinct] that the [cross-talk] --

Mike Bonetto: Laura, sorry, you're breaking up a little bit on us.

Laura Keller: [Audio cuts out] that Utah has a plan where you can buy [audio cuts out] [indistinct] state purchasing plan.

Mike Bonetto: Yep. Laura. Sorry. You're breaking up a little bit on us.

Laura Keller: Sorry, my internet. I'll put it in the comments.

Mike Bonetto: Okay. Got it. Thank you. And I think we've got a point here on the following slide on Utah. I think you mentioned Utah. So yeah, that sounds great. Guys, great discussion. I'm going to keep us moving because we've got a lot more to get to. So we're going to go through that. You guys just kind of talked through that, which is great. So the next question. What strategies should HCA consider to reduce the cost of insulin total expenditures for patients? Much of this you guys have already started to unpack a little bit, but you'll kind of see the list again, high themes that came out of the survey, rebate reform, tiering of insulin, copay caps, a state-run insulin-saving program like Utah, Laura, what you just mentioned, partnering with other purchasers, negotiate better manufacture pricing, utilize government-based CPO, limit the options of preferred formularies. I'm going to hit a few more slides, and we're gonna come back and have a bigger discussion. So you guys had a lot of this. Can we go to the next?

Dan Vizzini: Yep.

Mike Bonetto: So transparent financial disclosures for manufacturers, PBMs, and plans. Education for patients, required copays and coinsurance be set based on drug price after rebates are applied, and discount card, dosage assessment. Last one. So again, strategies that we should consider to reduce costs and total expenditures. Any policy being considered must begin with what patient group. So, LuGina, I'm guessing this may have been your comment, but that's something you guys should be talking about. PBMs have created innovative programs that limit consumer out-of-pocket costs. So again, trying just to capture some high-level themes that came out of the survey, but now I'd like for some of those comments to get expanded on based on who wrote those if you want to give a little bit more background and insight behind those. Kat, yeah.

Kat Khachatourian: Yeah. So if we go back, I think, two slides. Mine was the one about the economics from every person involved in the distribution from benefit design all the way through getting drugs. So maybe one more around the quarterly [cross-talk]. But there was a quarterly reporting. Oh, yeah. Transparent financial disclosures. This was mine. So thinking about leveraging what infrastructure we already have in place, i.e. the all-payer claims database, but having an additional data set that would have transparent financial disclosures because I think there is a lot of murkiness among every part of the process. Healthcare is complicated as it turns out. And so that, I think, is a starting point of what are the levers, and then what are the limitations? Because if we squeeze on copays, then what is going to be the monthly [cross-talk] premiums that patients have to pay? If we squeeze on the rebates, then what? It's just if we squeeze one end of the balloon, there's going to be a pop-out and unintended consequence. So that's my comment around that. And thinking about also distinguishing which patient because I think the levers for the uninsured patients are very different of being able to connect through patient assistance or charity funds and those types of things versus the insured patients. And then even among the insured patients, there are some federal limitations on what can reduce patients' total cost of care and plan costs. So I feel strongly about that how do we solve for the many but also understand that if we implement an 8020 rule, it's not going to fix the entire problem. But I think if we try to fix the entire problem, we're never going to get anything done because we're going to let perfection get in the way of good.

Mike Bonetto: Hey, Kat. Just to follow up to what you just put out here, any examples that come to mind in terms of are there any models that you would say, "Oh, this is something we should be looking at in terms of how this transparency could look?

Kat Khachatourian: Yeah, absolutely. So Medicare Advantage plans have as a part of their required financial disclosures to CMS. It's called DIR, so direct and indirect remuneration reporting that all the health plans have to report what the rebates are that they're getting on drugs. And then, conversely, the Medicare plans also have to report to the all-payer claims database. So I don't know if there is an infrastructure for State partnering with Federal and getting through those turf wars on getting data accessibility. But there may even be a pathway to be an authorized data accessor with CMS to that DIR reporting to have a better understanding of that piece of the pie. Jenny -- I would ask Jenny Arnold to weigh in on the pharmacy acquisition cost transparency. I'm not familiar with if there is a mechanism for that one. But I think that would touch us on the PBM and plan for the plan-paid, member-paid, and rebates. And then additionally on the manufacturers, I know that they through the 340B pricing have to report to HRSA what their costs are as far as the manufacturing cost as well as the rebates, the 340B, and in order to support the best price and 340B requirements. So I do know that there are other agencies that collect some semblance of that data, but I'm not sure on the acquisition cost front.

Mike Bonetto: Got it. Jenny, thoughts on that?

Jenny Arnold: I don't believe that there is tracking on the pharmacy side where acquisition cost. But I think there's better data to some degree about what the pharmacies end up calling (NADAC) National Average Drug Acquisition Cost, is a fairly close estimate of that. It's not exact, but we can also kind of try to do some polling and gather that for insulin in particular. I also know our office, the Insurance Commissioner, has access to a lot of the Pharmacy Benefit Manager contracts and payments, and some of that. And so somebody from OIC might be able to weigh in on what they see from there. And if that is different than the all-claims database and some of the data that they're seeing out of there, that might be another opportunity to look at the data transparency. And then I agree. I don't think there's anything about rebates, in general, being captured.

Mary Fliss: So I know we have Barb Jones here from the OIC. Barb, is that something you could speak to? Or do you want to take that as a takeaway?

Barbara Jones: Thanks, I made a note, and I will go back and check with my team and find out that the contracts are confidential. So what elements we have and what can be shared? I will take that back. Thank you, Jenny.

Mary Fliss: Excellent. And it also looked like Kevin, you were speaking, but you were on mute, so we passed you up. [cross-talk] --

Mike Bonetto: Yeah, yeah.

Kevin Wren: I just had a quick question about 340B because I thought Eli Lilly or one of those drug manufacturers had tried to get out of providing resources for 340B.

LuGina Mendez-Harper: This is LuGina. I just want to clarify. Again, I'm not a manufacturer, but I believe what some of the manufacturers are doing in relation to 340B is limiting access to 340B pricing to what is called contract pharmacies. So a hospital or health system is a 340B entity and, right now those hospitals can contract with other pharmacies, for example, Walgreens or CVS, to provide services to their patient population. And I believe what's happening with the manufacturers is that they're limiting the ability of those contract pharmacies to access 340B pricing. I will defer to Kat and Jenny to see if I misspoke on that.

Kat Khachatourian: Yeah. So LuGina, I can expand on that. So Kevin, there are, I think, about 34 manufacturers that have signed on to the 340B opposition. So there are a lot of manufacturers that are limiting or trying to limit access to purchasing. It is focused around contract pharmacies as a starting point but, additionally, the covered entities are facing scrutiny around their distribution and their internal auditing. And so, HRSA, I think is trying to figure out which direction is the best way to go. But there are required financial disclosures on all sides around what portion of products are you distributing to 340B-qualified patients and that sort of thing. So, yes, Lilly is one of them. Novo is another. There are a lot of manufacturers that have signed on to try to limit that pathway.

Jenny Arnold: There are a lot of different complexities and concerns, and the way the Pharmacy Benefit Managers are trying to contract with contract entities is another side of the coin. [cross-talk] --

Kevin Wren: And we only have so much [cross-talk] --

Jenny Arnold: I say we stay out of 340B for now except for maybe better-educating pharmacies about uninsured patients about accessing them and getting care through them as a means to maybe more affordable insulin as a potential solution.

Mike Bonetto: Thanks, guys. Mandi, can you go back a few slides? Up to the first rebate one. And, Laura, I don't know if you still have -- yeah, that one. So the top one, we have referenced is Utah. But, Laura, you put a comment in the chat. And I'm not disclosing that I can't, but even in the 5203 works, obviously, there's been analyses of Utah. But, Laura, I didn't know if you want to talk anything more about what Utah has done in terms of some applicability here.

Laura Keller: Yeah. Hopefully, keeping my video off will be helpful. Can you guys hear me okay?

Mike Bonetto: Yeah, we got you back again, yeah.

Laura Keller: Okay. Yeah, so I worked with the Bill sponsor, and if this was an ADA bill and helped it pass because I have to cover [audio cuts out] [indistinct] covered Utah at the time with my states. And what they did is they set up an online system where people apply online. They get emailed a card. So the fiscal note on setting up this program is very low. Now, you are limited to the insulin that the state employee plan uses. So they chose whatever that one brand is that the Utah State Employees plan does to be cheaper. And then the people can just bring in their card. They apply online. In Utah, their Bill was quite interesting in that it had a lot of different facets. It also had a copay cap involved. But for those that either were uninsured or had a high-deductible plan, where you had to meet that deductible first, you could also qualify for this particular program. And the last I checked, they had, I think, somewhere between 6,000 and 8,000 people on the plan. Like I said, I don't cover Utah. I haven't covered Utah in the last year, so I'm not as accurate on that. But it has an interesting thing. I know there was a lot of talk about how do we handle the uninsured? The copay caps are great, and Utah did that and this for those who are uninsured because this would be a more consistent program or

purchasing plan than other options for those who are uninsured because that still is a serious issue.

Mike Bonetto: Laura, thanks so much. Appreciate that. LuGina, do you have a question?

LuGina Mendez-Harper: Hi, Laura. This is LuGina. I actually covered Utah, as well, in the past. My understanding of the Utah program is basically what they did was they took the state employee plan contract and savings that their PBM or TPA or whatever it is they have. They're taking the savings that the state plan had negotiated on its behalf and then they're extending that to uninsured patients. Is that correct?

Laura Keller: That's correct.

LuGina Mendez-Harper: Okay.

Laura Keller: [indistinct] And then what they do is they [audio cuts out] that the bill was written in the state so they can charge a very minimal, like very minimal administrative fee just to keep the website open. So a fiscal note to get started, I think, was like less than 15,000. I think it was actually less than 10. But again, don't quote me on this. I can get this information and share it with the group -- to get it started to create the website, and then they just email. You apply online, they email it, and then they can buy through the employee plan. That is correct for that.

LuGina Mendez-Harper: Okay.

Laura Keller: And they have contracted so that you can buy long-acting, fast-acting, and pens all through that plan. So they have all of those options, but it is just one manufacturer because that's how they have chosen at this time to keep their costs down.

Mike Bonetto: Thanks, Laura. Lori, I saw you had your hand raised.

Lori Evans: Yeah, I do. So I'm a state employee, and I know that the plans vary significantly. Like, I have Kaiser Permanente. My three-month copay for insulin is $100. But I have a co-worker who has Uniform, and her insulin for three months is $10. So when you talk about state employees, the Utah program where people can purchase at state employee's copay it doesn't exactly make sense to me.

LuGina Mendez-Harper: This is LuGina. What I was trying to say is I think what the Utah plan is doing is leveraging the cost savings that have been negotiated for the state employees and making those cost savings available to uninsured patients.

Laura Keller: That is correct.

Lori Evans: Okay, I'm still confused. So my insurance, I pay $100 for three months. My coworker, also a state employee, pays $10 for three months. So what are these?

Laura Keller: So in Utah, they have one large plan for all the state employees that they are using. So there might be different pockets of state employee plans in Washington, maybe for like teachers or maybe state employees who work for the government. But in Utah, they chose the plan for their largest state employee group, and that is the one that they're using.

Jenny Arnold: Well, and just to question, is it that what I think I'm hearing isn't so much that their coinsurance is the same or their copay is the same, it's that the state has negotiated what they will pay for insulin. As we've talked about with rebates and just when you have insurance, they have a negotiated price for things. So, oftentimes, at the hospital if you don't have insurance, you pay one price at the hospital, If you do have insurance, your insurance carrier has decided that they pay X across the Board for certain admissions. This to me is they have negotiated a price for insulin and that patients can buy that negotiated price versus the sticker price that might be higher and oftentimes is what cash pay individuals have to pay versus what an insurance carrier has negotiated for a price. So what you're talking about is the then patient's coinsurance, but this I think means that they can pay that negotiated rate. That would be my assumption based on what I heard you all saying, but I do not know the Utah bill.

Lori Evans: Okay, so I work for DSHS, a State of Washington State employee. My coworker also works for the State of Washington. Maybe I'm missing something here. She has Uniform coverage. She pays $10 for three months' worth of insulin. I have Kaiser Permanente. I pay $100 for three months' worth of insulin. We are both state employees.

Donna Sullivan: I can speak to that, Lori. This is Donna from Washington. So it's the plan. It's the difference in the health plans and their preferred drug list on their

formulary. So UMP has insulin in a Value Tier, I believe, as well as the higher Cost-share Tier, and that's why. I'm not sure if you're actually taking the same insulin either.

Lori Evans: We are.

Donna Sullivan: But that's why it's capped at $10 in that Value Tier. So what you would pay for insulin under this program, it would be like what Jenny was saying. We, through ArrayRx, who manages the pharmacy benefit for Uniform Medical Plan negotiate, their Pharmacy Benefit Manager has negotiated reimbursement amounts with the pharmacies, and then we also have rebates. And so, what Utah has done is, they are passing that net rebate price to an individual in Utah, who may or may not have insurance. They might be uninsured, or it might be a better rate than what their health plan is buying, and if they have a high-deductible plan, they haven't met their deductible, it might be a larger discount, and it would be more cost-effective for them to buy through this program. And just a spoiler alert, that is one of the things that we're considering doing in a similar program through our ArrayRx discount card as something similar. We just haven't quite got there yet.

Mike Bonetto: And, Donna, thanks for that. And I'm gonna put a pin in this just so we can keep moving. But Laura, I think that the highlight is we still need some clarification on really how this would work. And I think what we're trying to do, we're just fleshing this stuff out right now. So you can almost be guaranteed in future meetings, we'll take a deeper dive into Utah and understand what that could look like here. But this is really the first step of just getting your insights and perspective, which I think is just been really helpful. I'm going to keep us going. So this next one we talked about. How would you rank the following strategies to reduce the cost of insulin and total expenditures? So same thing, if you look on the right-hand side, you'll see this total composite score, 1 being the highest. That means that's where you would rank as highest priority down to 3. So, we have 1, 2, and 3. You'll see a state agency purchases prescription drugs on behalf of the State directly from other states or in coordination with other states that rank the highest. That got the most number 1's. The second was a state agency that manages prescription drug benefits on behalf of the health insurance, large employers, and other payers, e.g. a registered PBM. And then the third estate agency buys drugs for resale and distribution. So again, just getting a temperature check of where you guys are in terms of how you would start to rank some of this stuff. So we're gonna go to the next one that says, "What challenges do

you see in the HCA entering into a partnership with other entities, whether it's a manufacturer or PBM, to distribute or purchase insulin?" So a concern would be the leverage of one state or state agency might not be enough to drive down costs, the potential unwillingness of other industries to negotiate, greed, control, lack of infrastructure and expertise in the state to actually do this, having a consistent record of supply and distribution, then overall lack of funding. Going to hit another slide here. Other challenges are disrupting the current distribution system would be difficult and may lead to unintended consequences, other entities' willingness to partner, middlemen who keep rebates, and a lack of transparency, avoiding a cost-push, and then you see this comment of lack of trust. So the next one that we had we listed these challenges if you were going to have HCA move in this direction. Then the next question was, "What are your recommendations to overcome the challenges that you've identified?" So the first one being working with tech companies for real-time inventory management, work with existing government consortia and other partnerships with states to ensure a bigger coalition and create and fund public production of insulin. Then one last slide here. Make sure that generics are prioritized, make sure patient copays and coinsurance are applied to post rebate price or continue to cap copays. We talked about this before. Patient education and awareness. So there is a focus on price setting, leverage expertise of current entities, understanding of federal and state laws, assessment of funding expertise, and infrastructure. So can you just keep it back there, Mandi, one? Just so, again, we've kind of framed this up and what you've identified as some critical challenges of HCA moving in this direction. You've identified some of these issues of how you would overcome this. But if you guys highlight -- any of you who highlighted some of these main points, again, love to dive into a little bit more detail and get your insights here. Yeah, Kat.

Kat Khachatourian: Okay. So I'm the one who talked about the technology and the Unified and the COVID experience and that sort of thing. And my thinking on that is going back to if we segment patients on either uninsured, underinsured, or emergency supply, I think that using the COVID experience as a starting point of being able to understand, hey, I'm running low on my insulin, and I can't afford it's, I'm on a fixed income, and it's not the first month, I haven't gotten whatever the situation. I need an emergency supply and have that as emergencyinsulin.org or whatever it might be, that a patient can Geo Map themselves to who has insulin around them that they can access. That's conceptually the idea I had around partnering with technology companies. We can identify [cross-talk] --

Mike Bonetto: The real-time aspect of it.

Kat Khachatourian: Yeah, I mean, we can identify restaurants that are open and order deliver to us in the next 20 minutes, but we can't figure out where to access drugs. I think that just fundamentally always blows my mind. So I think that that's for when we think about Kevin's points and a couple of the people who have had comments around rationing and an inability to afford copays, so having some criteria to go through, but I think using the COVID infrastructure as a starting point. Not that the COVID infrastructure was perfect, but I think it was much better than other things that we've tried to do in the past. So that is, I think, one piece of it. And then when thinking about the financial comments that I've already made previously, I think everybody has to work together, and I think everyone has a perspective. Some of the distrust I understand, but I think everyone has a perspective on innovation, competition, and production. But we all have to figure this out if we're going to make drugs more accessible to patients and more affordable to patients. And so, I think everyone wants to burn the system down and start over again, but I think there is some good that we can leverage existing infrastructure and understand what could work and what could be retooled versus reinventing the wheel. And then the final comment I have is around the distribution and supply chain. Having served on the PQAC and understanding the pieces that go can be quite problematic around wholesalers and people who do repackaging. That can go awry really quickly if you don't have a consistent clean production and supply chain and distribution and all of that. It can go awry really quickly, and there can be some bad actors. So I would be a little hesitant for the state to jump into that and then have a contract with somebody to do that. I just feel like going down the path of being a wholesaler or repackager or distributor just gives me a bit of pause for the people who would, again, add more greed into the mix to make money off of a state contract.

Mike Bonetto: Thanks, Kat. Kevin, I saw you had your hand raised.

Kevin Wren: Yeah. I just want to echo all that Kat said. I thought that was great. I totally agree, especially about the mistrust. But I think again, also, we're not the only states that are doing this and are exploring these things. So again, looking at Utah and those other states have a set precedent or are doing things differently but still trying to tackle the same thing. I think it would be great to connect with them. I know, especially in California, they're trying to juggle

this along with the state manufacturing. So I mean, we're not the only ones doing this. But I also appreciate that everyone here is all trying to make insulin accessible. I feel like we're all on the same team, even though we're working from different angles. It's just great to see how people are thinking of things that I wouldn't have anticipated. But yeah. So far, this is great.

Mike Bonetto: Thanks, Kevin. Yeah, William.

William Hayes: In the same vein, it's really frustrating to me that -- and I've said this in other arenas in which I've worked -- that we're all working towards the same goal, and we can't work together. I think we need to find a way to work together amongst states. I didn't mention when I introduced myself that I'm also on the Northwest Prescription Drug Consortium, ArrayRx Steering Committee, and that's one of the things that we're trying to do there. But as the Director of Pharmacy, we are a member of a Consortia GPO that is a multi-state consortium, and we leveraged that power to obtain lower costs. So if there's any way that this workgroup can continue to find ways to connect with other states and gather as much information and even connect, I think we need to do that. I agree with Kat in the sense of contracting with another entity. But if there is the capability to utilize a state resource to wholesale or distribute, that could be a consideration because we can control that as opposed to contracting. That, that I would like to keep on the table as a discussion point as we continue to move forward. So I lost my train of thought, but we have lots of time to discuss this. But those are the things that were really hitting me. We need to cooperate. The states are doing a whole bunch of work, and we need to work together.

Mike Bonetto: William, thanks for that. Guys, it looks like we have about 11 minutes here, and we've got one more section to go through. We'll go through this, and then we'll wrap. So I appreciate you guys hanging tight. It's a great, great discussion. So this last section -- this was a question that was asked -- what are your recommendations on how to provide a once yearly 30-day supply of insulin to individuals on an emergency basis? You guys have already kind of touched on this in some of these conversations, but this is what you guys had outlined some of these overarching themes in the survey results. Mandated benefit design, the discount card. You guys had talked about 340B Plan that allows pharmacies the ability to provide insulin, even with an expired prescription. And it needs to bill the state if there is no insurance available and pay a dispensing fee. William just mentioned ArrayRx. Next, available to

first responders, schools, eligible pharmacies, urgent care clinics. Identify and analyze other [cross-talk] state programs. Oh.

Barbara Hewitt-Jones: Sorry. Kevin had a question, but it was directed to me. So I think, Kevin, please correct me if I'm wrong. You're asking, so do you think you could provide an update on what's going on with SB 5203? [cross-talk]

Kevin Wren: Yeah. That was just on a slide. [cross-talk]

Barbara Hewitt-Jones: On Senate Bill 5203?

Mike Bonetto: Yep. And we'll probably take -- and again, part of that as I mentioned before, is just the timing of what can [audio cuts out] get disclosed as they continue this report. And we'll probably do even more next time, depending on how far along they are.

Kevin Wren: [Cool, thank you.

Mike Bonetto: Low, no cost, centralized system of record. Established infrastructure to manage purchase warehousing, distribution, eligibility quantity. Clear policies and procedures. Create awareness of the program. Ensure the law doesn't sunset. And then the last one here, requiring manufacturers to expand patient assistance programs to cover more people. State safety net program. And like we were talking about before with other states, Alec's law. And we can go back to any one of these, but does anything else stand out? Anybody want to highlight some key other insights to some of these recommendations? LuGina?

LuGina Mendez-Harper: Hi. This is LuGina. I have a quick question for Kevin. I know that you've mentioned the Minnesota law a couple of times. When I was looking at the program a couple of days ago, they have a 30-day emergency provision, but then they also have a 90-day pathway for folks who need additional support. Is that within the scope of this workgroup to talk about more than just a 30-day supply? Or do we just stop there?

Kevin Wren: I wondered that myself because 90 days seems like a better number. But yeah. I was curious about that, too, and the extent of what we could cover because, again, if you're rationing insulin, you're probably rationing your supplies. So without a needle, insulin is kind of useless.

Mike Bonetto: So, guys, I think it's a totally fair comment. You've been tasked to give some report back to [indistinct] on the 30-day. There's no reason that you couldn't have that recommendation that also said, hey, as in discussing this, we talked about the importance of a 90-day, as well.

LuGina Mendez-Harper: Okay.

Kevin Wren: Yeah.

LuGina Mendez-Harper: I appreciate that. I just again, when I was looking at the Minnesota program, I was like, oh, they have more than just a 30-day. And so I just wanted to make sure that that's something that we could consider. Thank you.

Mike Bonetto: Thank you. And Leah, I just saw your comment here in the chat echo comments made by Kat. But there would be a significant cost. And Leah, if you wanted to weigh in, feel free. I'm trying to read yours here.

Leah Lindahl: Oh sure. Sorry for the trouble. I mean, I think there are a lot of issues and costs with just trying to stand up a wholesale distribution arm with that FDA inspection, approval, working with the pharmacy quality assurance commission, etc. So I'd be happy to go through some of those concerns, or even share them via an email or something for everybody. [cross-talk]

Mike Bonetto: Oh, Leah, that would be outstanding. Yeah.

Leah Lindahl: Yeah, absolutely.

Mike Bonetto: I'd love that.

Kevin Wren: I'd also be happy to connect any of the legislators that sponsored the bill. They are really willing to talk to members of the public just to talk about the nuts and bolts of how this was accomplished.

Leah Lindahl: There was one version in the last Legislative Session I saw floated around an emergency assistance program. And my concerns with it, I think, may be some of what Kat reflected, which is the infrastructure to stand up. And it was going to be assessing the manufacturers a fee and having pharmacies be able to access and dispense or apply for reimbursement or replacement of a free dose that they dispense once in a -- the amount of infrastructure to stand

up a program like that and cost behind it, I think would be better diverted into helping patients with their copay or coinsurance versus an entirely separate program separate from anything else. And so I just want it to be I don't want our administrative burden to outstrip the benefit. I think a little bit of KIS, keep it simple, in terms of putting the resources in the right place. And I'm not commenting on Minnesota's. It sounds very different than what I had read. But I think that there's probably a simple -- well, if it was simple, we would have already done it. And if it was easy, we already would have done it. But I'm hoping that we have something that really makes an impact without creating entire administrative burdens that cost more than it really ends up saving residents.

Kevin Wren: Yeah. I think our main priority should be covering the uninsured and not focusing specifically on copayment caps. Like, I think this bill was specifically meant to make sure that people aren't rationing at the cost of the state. So if we look at the economics of it, we should also look at the economics of rationing insulin and how that's a nightmare. And how many people have died from it and are still continuing to struggle with not being insured and not being able to afford their medicine?

Mike Bonetto: You guys have given us a lot to tee up even for the next meeting. So this was, I think, exactly what we wanted to get out of it, and I can't thank you guys enough. I know we've got 3 minutes here. Anything else from -- Mary, I'll turn this over you in just a second, but anything else from HCA Center colleagues before we look to wrap? Mary?

Mary Fliss: Great. So, Mandi, next slide, please. And next slide. Great. So again, thank you. This was three hours of talking, and I really appreciate it. It was very clear that everybody was engaged, continuing to lean in. I really appreciate Jenny, you saying that if it was easy, it would be done, and if it was simple, we'd already have it figured out and it would be done. And so, it's just going to take a community of us to really be thinking about this prioritizing the work, thinking through the options, and then really being able to bring forward a great recommendation. So we have here if you have additional questions, where you can contact us. So it's the WAGproject@ohsu.edu. Please send in any of your additional comments you may have. And also appreciate that we had guests, Jennifer, Kim, and Ronnie. Thank you so much for joining. Would also invite you to use this web address for anything that you would like to share. Leah, I'll invite you to share your comment.

Leah Lindahl: Thank you. Sorry, real quick. I had the opportunity to listen to a presentation at the Women in Government Conference about a week ago, and there was one discussion from the Diabetes Leadership Council kind of on this issue, in general. So just wanted to offer that group up. They have a lot of information on their website. As far as legislative considerations that they are recommending, and things. So just another resource that people might want to check out before the next meeting.

Mary Fliss: Great.

Leah Lindahl: Diabetes Leadership Council.

Mary Fliss: Diabetes Leadership Council. Wonderful.

Leah Lindahl: Yes:

Mary Fliss: Thank you so much. And with that, I believe the next meeting is in a couple of months. I can't remember what slide that we said when the next meeting was. Mike or Brittany, do you recall off the top of your head when we're having our -- Mandi, you can make it back to that slide in our last minute here. Yep, we are looking I believe, guys at the end of August. And Mandi, you can correct me, and Nonye, but yet, but I don't think we have a date solidified yet.

Mandi: No date solidified yet.

Mary Fliss: Okay. So late August, we'll look forward to getting together then we will be using this information to produce that first preliminary report which is essentially going to be letting folks know that we've started this. We've been doing this work, the survey work, the gathering of the information. And then we will be looking forward to discussions this summer, fall, and then the winter, and wrapping up in the spring. So thanks so much. We'll talk to you again in August. Bye-bye.

Mike Bonetto: Thanks, guys.

[end of audio]