Washington Total Cost of Insulin Workgroup Meeting
August 25, 2022

Mary Fliss: Awesome. So, we're here today. We have quite the full agenda. It's great to see everybody again. We will have folks taking roll call outside, but it looks like we have several Committee members here. It's great to have you, including Amber, Barb Jones, Chris Bandoli, Dan Gossett, Hayley De Carolis, Kevin Wren, Leah Lindahl, Lori Evans, and Lumi Nodit. And then our great staff from The Center, Mike Bonetto. And then, Ryan, you're here also. I see that Donna Sullivan is trying to reach us. And I think that I missed -- well, if you could just let me know. Oh, and Hayley, thanks so much for reminding me. You're also with The Center. And I think William Hayes was joining, as well, but I don't see him yet as one of the member attendees. Did I -- oh, here he is. Hey, William. Did I miss anybody who was on the Committee that would like to introduce themselves? All right. And it looks like we have four guests who are with us. And if we could just give a minute to allow them to introduce themselves. Carissa, could we start with you? And Nonye, do you have to unmute them?

Nonye Connor: Yeah, I can do that. Hang on, just a second. All right. Carissa?

Carissa Kemp: Hi. Can everybody hear me?

Mary Fliss: Sure can.

Carissa Kemp: Hi, my name is Carissa Kemp, and I am the Director of State Government Affairs for the American Diabetes Association. I recently started working in Washington.

Mary Fliss: Excellent. Welcome, Carissa. The next person I have is, Bhavya. Apologies if I mispronounced your name.

Bhavya Student: Yeah, that's correct.

Mary Fliss: Great, and would you like to introduce yourself?

Bhavya Student: Yeah. Hi, everyone. My name is Bhavya. I'm a student at the University of Washington School of Pharmacy.

Mary Fliss: Excellent. Welcome. And next, I have Sierra. Hopefully, I pronounced that correctly.

Sierra Student: Yep. I'm Sierra. I am a fourth-year Pharmacy student with WSU.

Mary Fliss: Love that. Next, we have Ronnie.

Ronnie Shure: I am Ronnie Shure, a retired pharmacist. Or actually, I failed at retiring, so I'm currently practicing as a consultant. Hi. And I'm President of Healthcare for All Washington Advocacy Group.

Mary Fliss: Awesome. Great to have you here, Ronnie. And, finally, Ryan.

Ryan Student: Hello. My name is Ryan. I am a student pharmacist at the University of Washington School of Pharmacy.

Mary Fliss: Excellent. Well, it is always wonderful to have students with us and participating in important government processes. Thank you so much for joining. And thank you for all the Committee members, taking time out of your schedule to have these important conversations with us related to how do we really think about the total cost of insulin and make sure that we are pursuing the healthiest Washington possible. So we have quite a full agenda this afternoon. In addition to the welcome, I was hoping to review the agenda, which includes this afternoon. Leta Evaskus will be going through with us the ArrayRx Solutions. And then we have Hayley who will be talking about the work that was done around researching, the research related to the distribution, or purchase of insulin that was commissioned through legislation in Senate Bill 5203. We'll take a quick break, and then we'll come back and have a conversation about the results of Survey #2. Again, really appreciate this team leaning in and participating in those surveys. It really does help quite a bit. And Mike and Brittany will be walking us through that. And then finally, a wrap-up and a talk about the next steps as we move forward. Is there anything else folks would like to talk about today? Awesome. And I see Donna, you're able to join, and another Committee member with us. So thank you. And Jennifer, it looks like you were able to join since we did the welcomes. Did I miss anybody else on the Committee to welcome? All right. So, Leta, I'll go ahead and turn it over to you.

Leta Evaskus: Thanks, Mary. Okay. Hi, I'm Leta Evaskus. I'm the Northwest Prescription Drug Consortium Operations Manager at HCA. And I'm going to go over what

ArrayRx is. ArrayRx Program Services currently include Pharmacy Benefit Management or PBM services, a Discount Card, a Voucher Program, drug manufacturer rebates, and Medicaid programs. We offer true transparency in Pharmacy Benefit Management services by offering Pass-Through Pricing. ArrayRx participating programs pay exactly what the pharmacy has paid for the drug. Typically, payers are billed more than pharmacies are paid, and the billing party, usually a PBM, keeps the difference, also referred to as "spread," which can increase costs for participating programs and members. The ArrayRx card -- somebody is not on mute. If you could mute yourselves -- the ArrayRx Card provides a state-backed prescription drug Discount Card to all residents and member states. The ArrayRx card allows underserved or uninsured individuals to realize savings on their prescription medications for the same discounts available to large state purchasers. The Voucher Program allows public facilities to provide continuity of care. The same medication a detainee is on when entering a facility is what they're given and written a prescription for upon discharge. This program is currently used by the Department of Corrections, county jails, and state hospitals. 100% of manufacturer rebates are passed through to the participating programs. Neither are ArrayRx nor our Pharmacy Benefit Manager keeps any portion of rebates paid by manufacturers. ArrayRx has an independent third-party consultant conduct annual market checks of network rates to ensure we are competitive in the market. There are contractual requirements in place that trigger pricing negotiations if the market check shows better pricing by competitors. This is our Delivery of Service. So the ArrayRx Steering Committee is made up of public officials from the founding State programs, which are the Washington and Oregon Prescription Drug Programs and other State-participating programs. The Steering Committee has governance and oversight over the ArrayRx services, contractors, and subcontractors. Moda Health administers the Pharmacy Benefit Management services including Member Services and all clinical program management and specialty pharmacy fulfillment. And Moda contracts with Navitus, who provides the claims processing platform, administers the network pharmacy contracts and provides rebate administration with manufacturers. So together they offer flexible, responsive, and configurable pharmacy program management services for the 1.2 million individuals enrolled in ArrayRx programs. Today I'm going to show you how the Discount Card Program or Voucher Program could be used for discounted insulin and how the vote Voucher Program could be used for a free 30-day supply one time a year. So what is the Discount Card? The ArrayRx Discount Card users get the same negotiated drug prices as participating programs. All state residents qualify. There are

no age or income restrictions. There's no membership fee. And all FDA-approved prescriptions are eligible for discounts and how the Discount Card works. Each user -- so each individual would enroll online. You automatically receive a digital card, which you can download to your phone, or if somebody doesn't have a phone or a printer, they can contact Customer Service and get a paper card mailed to them. Use the online tools to find participating pharmacies near you. There are 1200 pharmacies in Washington. And check prices online. You show the card at the point of sale and pay the discounted price. You can save up to 80%. The Discount Card cannot be used with insurance to pay copays, and charges are not applied to your insurance deductible. So how the ArrayRx Discount Card can work [cross-talk] --

Mary Fliss: I'm sorry. Leta, do you want us to wait and hold on questions? Or would you like to take questions as you go?

Leta Evaskus: Let's see, I could stop after how the Discount Card -- like I'm going through how it is used right now, and then I'm going to go over how it can work for insulin. So I could take questions then, just about the Discount Card before I go into the voucher.

Mary Fliss: That sounds great.

Leta Evaskus: Okay. Okay, so how the Discount Card could work for insulin. So all of this is hypothetical because the state hasn't been directed exactly what to do yet. So if manufacturers are required by law to provide a discounted price on insulin, then diabetes patients could enroll online and receive a digital card or a card by mail. They would show the card at point of sale to a participating pharmacy and receive the discounted price. Okay, why don't I stop there if people have questions about the Discount Card?

Mary Fliss: Do you want me to just go ahead and read them to you from chat?

Leta Evaskus: Oh, sure. Here, I can open up the chat over here.

Mary Fliss: Oh, great.

Leta Evaskus: Okay, how would a homeless person access this program or undocumented individuals? And what's the actual cost for patients? How is this different from manufacturer discount cards? What is the wait time for receiving these services? Okay, so a homeless person can be signed up online by any clinic or

support service that they could go to for health services. So you can sign up another person, or they could call the Customer Service number and get signed up. If they don't have a smartphone or a way to print their card, they can get it mailed to a shelter or a clinic where they receive care. Undocumented individuals. There is no clarification needed of seeing documentation or a driver's license or social security number, so anybody can sign up. You just need a Washington address. Or in case of a homeless person, you could put in a shelter or leave that blank. The actual cost for patients, you can go online and use the tools for the Price Check to see. You type in the drug name, and it will populate with pharmacies near you where you can buy it. And you can see that at some of the pharmacies, the price might vary a little bit. The discount, it should stay pretty close, but you can see you might go to a pharmacy that's maybe a little bit further away that for some reason they have a little bit more of a discount. So you can see that online before you go. It's different from manufacturer discount cards because this covers all FDA-approved prescription drugs. Manufacturer discount cards are only for their drug. And the wait time -- there is no wait time because you'll receive the card right away when you sign up and you can take it to the pharmacy. And Donna put in, you could go to the public library and use the computer there to sign up if you're homeless. Would there be any referral for the patients to get this one month of insulin for longer-term support for patients to gain access beyond the emergency supply? Okay. Well, I haven't gotten to the emergency supply yet. So let's hold that until we get there. Does ArrayRx profit at all from this partnership? ArrayRx gets an administrative fee for using the card, but it's not -- this is only to pay for the services. It's not a for-profit. Since we are the state, we do not get a profit from this product. Donna, did you have something to add? Yeah, I was just going to add Moda does not profit off of this. It's not like the GoodRx Program, where they're skimming a percentage off of the top of what they're charging the client and paying it. There is an admin fee that's built into what the member pays at the pharmacy. I believe it's like $1 that goes to Moda or something like that, but that's just for administering the program. There is no percentage of the amount paid or anything like that. And that's one of the reasons why we like our card better than GoodRx because it is not a profit-driving generating card.

Leta Evaskus: Yeah. And also GoodRx goes off of coupons. So if you're buying the same drug with the GoodRx card, the price is going to shift because you might go once and they have a coupon for a lower price, and the next time your price might be higher. So with ArrayRx, the prices are consistent. And I see -- well, the

negotiated price. So in this case this scenario that I'm showing right now, this would be if manufacturers are required by law to provide a discounted price. So next, I'm going to talk about how this would work with the Voucher Program, and we'll talk about negotiated price. So let me go on with the voucher for right now. Okay. So what is the Voucher Program? It's currently used by facilities to ensure continuity of care and prescription drug therapy upon discharge. And it's used to provide public sector entities a way to serve eligible populations with a controlled pharmacy benefit. So how the program works: Recipients use the voucher at a participating pharmacy to have their medication refilled at no cost or for a predetermined copay. Covered medications are paid for by the facility or public sector entity sponsoring the program. So how the ArrayRx Voucher Program could work for insulin: So ArrayRx would put out a request for proposals for discounted insulin prices. We would get responses from insulin manufacturers. The winner's insulin brand would be used for the Voucher Program. So diabetes patients would go online, sign up, get a digital card, or paper card mailed, show the voucher card at a participating pharmacy, and the ArrayRx negotiated price will be charged to the cardholder. So the negotiated price is not going to change over time. Let me see the other questions here. Okay. So Kevin asked if is it possible to allow a 90-day supply because it can take a while to get situated sometimes when getting a prescription. Yes. Yes, definitely.

Donna Sullivan: I want to jump in there. Kevin, when you're talking about a 90-day supply, are you talking about the emergency supply that we were talking about? Yeah. So that's something that that we would need to discuss. You know, that could be a recommendation that we make back to the Legislature in our report. But the statute itself is specific to a 30-day supply. So that's the reason why we do that. We can do anything that we're allowed and funded to do, but that would have to come from the Legislature.

Leta Evaskus: Right. Thank you, Donna, for that clarification. Okay. So looking at the 30-day emergency supply. So Minnesota law that was changed for their 30-day emergency supply so that you could get an emergency supply for a copay of $35. So if we want to do something the same, the Washington Legislature would have to enact the same law directing all insulin manufacturers to provide a free or minimal copay for a 30-day emergency supply one time a year. So if the Legislature enacts a law directing manufacturers to provide the free 30-day supply, or if the RFP that ArrayRx puts out for discounted insulin could include a 30-day emergency supply one time a year, either way insulin would be paid for by the manufacturer. So how the Voucher Program could

work for the emergency insulin is people -- diabetes patients would sign up online, get the digital card or paper card, and each voucher card would be programmed with eligibility for a one-time 30-day supply of insulin for each calendar year. They would show the voucher at a participating pharmacy at the point of sale and have the insulin filled at no cost. So in this case, then our ArrayRx Pharmacy Benefit Manager would invoice the manufacturers.

Mary Fliss: Leta, in this case, we would still need to get the legislative approval for funding what the expenses of that would be. Correct?

Leta Evaskus: Exactly. Yeah. So the scenarios that I put here is either all insulin manufacturers have to provide a free 30-day supply or the manufacturer that we contract with for the discounted price supplies a 30-day free supply. So not knowing yet what the ledge is going to do [cross-talk] scenarios. Yes.

Unknown female: I have a question here from Ronnie. She asked [indistinct] ArrayRx can be used with other insurance, can it be used instead of using insurance? Patients experiencing under-insurance because they may have exorbitant copayments.

Leta Evaskus: Yeah. You can't use -- the Discount Card as it currently is, you can't use it for copays. You choose one or the other currently to use at the point of sale. And you can ask the pharmacy, which is cheaper to use, the Discount Card or your insurance. But if you're trying to pay down your deductible, then you're going to have to go with your insurance. If you have a high-deductible health plan, then you could choose to use the Discount Card if you're getting a better discount because you're not going to reach your deductible anyway. Well, I guess Medicare got rid of the doughnut hole, didn't they, as far as when you're paying out-of-pocket? Okay. And that was the end of my presentation. So if there are other questions, I'll open it up.

Mary Fliss: And Leta, do you see the question from Leah in the chat?

Leta Evaskus: Okay, thank you. Is the pharmacy then reimbursed for their initial purchase of the insulin? So are you talking about the free supply of insulin? Yes. That would be covered by the drug manufacturer.

Leah Lindahl: Thank you.

Leta Evaskus: Okay, how would people learn about ArrayRx? So, ArrayRx already exists. Here's our websites that you can check us out on. If we went forward with this with the insulin, then there would definitely be advertising and notices out to providers and patient populations to let them know that this is the route that the State is taking to enact the legislative directive of discounted insulin.

Mary Fliss: And, William, it looks like you have your hand up.

William Hayes: I just wanted to offer a little bit of information on the Voucher Program. The Washington State Department of Corrections uses the Voucher Program as part of the ArrayRx system for our patients. And it functions similarly to any insurance program. And we are able to control our formulary and manage what we pay for. The system is pretty seamless for the individuals that pick up medications on behalf of our patients, and they don't have to pay a copay. They simply present the voucher or the information for billing, and that is charged back to the agency. Through the billing process that we've set up. The system runs very well. There is some management associated with it that we have set up with the contractor, Moda, but it is a very good program, and it has saved the State a lot of money as compared to what we used previously when we purchased medications directly with the community pharmacies and paid the cash price. The companies that we've worked with individually for specialty drugs or compounding seem to be happy with the reimbursement that they're getting from the Discount Card have welcomed us as returning customers. From that perspective, as a pharmacist, I feel that they are not unhappy with it. So I think it's a good option for the workgroup to consider as something that we can utilize. It's a positive for the department, and I think it may be an option for the State moving forward.

Leta Evaskus: Thank you, William. So I have some other questions. Would there be a separate campaign about educating pharmacists about the emergency access aspect? Yes, once we know what direction the State wants to take with the emergency access, then that will be put in place with the pharmacies. If the Voucher Program was used, our Moda Health, our contractor, would communicate with the network of participating pharmacies and about how that is going to work reaching those who are undocumented and our homeless a system to identify and support disparate groups. Yes, we would definitely put out information to all the clinics, all the homeless outreach programs to get people signed up for this. Since it would be a State initiative, it would be publicized. Let's see, has a bid process for TPAs to administer the

formulary and drug list and pharmacy network been conducted outside of just ArrayRx? Are you talking about -- so this is Kat -- are you talking about for ArrayRx Voucher Program and Discount Card currently?

Kat Khachatourian: Yeah, I guess. Just based on the previous colleague's comments, the Department of Corrections uses this. I'm not sure that it's a foregone conclusion that Washington State as a whole would use it. But that's more the nature of my question is. Are there other providers or third-party administrators that have similar functionality to ArrayRx and similar infrastructure in place that are being evaluated in comparison? Or is ArrayRx the only one that HCA is considering right now?

Leta Evaskus: Well, ArrayRx [cross-talk] --

Donna Sullivan: So I can take that question, Leta. I'm sorry. So there's actually a State law where the legislature passed a Bill back in 2003 or 2004 that created the Prescription Drug Consortium, which is ArrayRx. And it also directs all state-purchased healthcare programs to purchase through the consortium unless they can demonstrate that they can purchase cheaper elsewhere. So as a state entity, we are required to bid and reprocure to a public procurement for the services, and so we've reprocured this work several times since 2004. At first, Express Scripts was our administrator. And then when we reprocured, we selected Moda. Moda continues to win the bids, just because of the level of service and the amount of partnership that they are willing to provide compared to other vendors. So for our program in Washington because of the statute, we would be looking to ArrayRx to provide these services.

Kat Khachatourian: Perfect. Thank you for that additional context.

Donna Sullivan: You're welcome. And then we also partner with MMCAP Infuse, which is a group purchasing organization that is administered by the State of Minnesota and many states and public entities purchased through them. So we are partnering with other states that are looking out for other states, as well.

Mary Fliss: Perfect. Any other questions for Leta?

Unknown male: I have one last question. There was some, I don't know, backlash from the manufacturers concerning the emergency provision in Minnesota. They

challenged it. I'm wondering, do you foresee, I mean, them cooperating with this process and this system?

Leta Evaskus: Well, I guess it depends on the process. If we go out for RFP, Healthcare Authority already did this for hepatitis C virus, and we had manufacturers submit lower costs. And we currently have a Medicaid contract and a non-Medicaid contract to lower the price on Mavyret. So we've seen that they will cooperate with that. And in Minnesota, the law stated that manufacturers have to allow a $35 copay for the emergency supply. And it's working. They did it. I'm sure there's always going to be backlash.

Mary Fliss: Great. All right. Well, Leta, thank you. Oh, wait. Does ArrayRx include DME?

Leta Evaskus: What's DME?

Mary Fliss: Durable Medical Equipment. So I'm assuming, Jennifer, you're talking about supplies -- diabetic supplies?

Jennifer Perkins: I'm talking about like syringes and just other modes that people administer insulin through. I'm not sure if that's included in this at all.

Donna Sullivan: It isn't a Discount Card. We can do whatever we want with the Voucher Program.

Jennifer Perkins: Oh, thank you.

Mary Fliss: And William.

William Hayes: This is William. We actually include it in our Voucher Program, so it's something that we've included for our patients.

Mary Fliss: Great. Thanks, William.

Leta Evaskus: Yeah, the Voucher Program would be more configurable than the Discount Card in this situation.

Mary Fliss: All right. Well, thank you so much, Leta, for the presentation and team for the discussion, really leaning into what this means, what options around ArrayRx look like, and how it's been working historically in Washington State. So great to have that as sort of our arsenal of information. Right? And, hopefully,

Leta, we can invite you back as we continue these conversations as we would like potentially more detail around some of these services.

Leta Evaskus: Yeah, I'll be here.

Mary Fliss: All right. Terrific. So next agenda item, where we will be doing our deep dive into the research relating to distribution or purchase of insulin that was part of 5203. So with that, I will turn it over to you, Hayley.

Hayley De Carolis: Thank you, Mary. My name is Hayley De Carolis. I'm a Policy Analyst with The Center for Evidence-Based Policy. And this presentation will go over the work that The Center and HCA completed related to Senate Bill 5203 and how that work is relevant for this workgroup. So beginning with just a little bit of the Bill background: It was passed in 2021 and directed HCA to establish partnerships to produce, distribute, or purchase insulin and generic drugs. HCA contracted with The Center for Evidence-based Policy to work on four key tasks related to implementation of the Bill. And this presentation is a summary of some portions of that work that are related to this Affordable Insulin Workgroup. Next slide, please. The presentation will follow this flow. We'll start with the findings from our survey of policy options, which focuses on the four policies listed here. Then we will move on to a Washington-specific insulin policy recommendation. And we will end with other tools and considerations we made for improving access to and affordability of insulin. Next slide, please. So beginning with the Policy Research Findings, the next slide will show the four insulin policies we will talk about. And one more slide, please. We're going to start with California's Affordable Drug Manufacturing Act. Next slide, please. On his first day in office, Governor Gavin Newsom issued an Executive Order which included directives regarding prescription drug purchasing aimed at increasing affordability for all and improving efficiency in drug and state purchasing. And related to that in 2020, the California State Legislature passed Senate Bill 852, or the California affordable drug manufacturing Act, which required the California Health and Human Services Agency (CHHS), to enter into partnerships to produce or distribute generic prescription drugs only if the resulting price realized savings addresses market failures and improves patient access to affordable drugs. Cost reductions must be realized by public and private purchasers, taxpayers, and consumers. And the prioritization criteria for selecting which generic drugs to include was focused on the drugs that would have the greatest impact on lowering costs for patients improving public health and increasing competition while addressing shortages in the drug

market. Similar to Washington Senate Bill 5203, Senate Bill 852 did not specify specific parameters or metrics for measuring savings or affordability. And additionally, Senate Bill 852 required the partnership to produce at least one form of insulin, again only if there was a viable pathway to produce a more affordable form. And CHHS is partnering with Johns Hopkins University Bloomberg School of Public Health Drug Access and Affordability Initiative to conduct the research and analysis related to the prioritization of the generic drugs to look into producing. Next slide, please. So some key components of this work in California starts with the fact that it was spearheaded with Executive level leadership, including Governor Newsom. The intent of the legislation was to increase access, affordability, and cost savings. And implementation of the Bill has begun in the current Fiscal Year 2023 Budget. There is $100 million allocated for the CalRx Biosimilar Insulin Initiative to produce insulin at a lower price, and $50 million of that is set aside for development of a California-based manufacturing facility. And then another $50 million is allocated for a contract partnership to develop the most popular short and long-acting types of insulin. So that's the first policy option that we reviewed in our report. Next slide, please. The next one we looked at was our ArrayRx. Next slide, please. And I won't spend too much time on this since we just had a great presentation from Leta, but as you all know, here are the five services that ArrayRx operates, formerly known as the Northwest Prescription Drug Consortium. Next slide, please. And some key component that we highlighted of ArrayRx is that it has state government oversight and is public interest mindset as a full-service PBM program, program and price transparency, audit rights, and 100% pass-through on pharmacy costs and rebates. There is potential for ArrayRx to act as the GPO for the insulin efforts in Washington. And another key component is that the Discount Card is already fully operational and covers all FDA-approved drugs. So there's potential for that to be leveraged in a timely manner. Next slide, please. Moving into our overview of Civica Rx, next slide, please. In 2018, seven health systems and three philanthropic organizations collaborated to establish Civica Rx, which is a 501(c)(4) Social Welfare Organization with the mission of serving patients by making quality medications available and affordable for everyone. Civica Prescription's initial aim was centered on addressing chronic drug shortages by ensuring a safe and stable supply that precludes pricing spikes. And two main operations were to produce generic drugs with existing FDA-approved manufacturing facilities that are privately labeled for Civica Rx, and then also developing abbreviated new drug applications to produce Civica Rx generic drugs. The organization is a nonprofit with funding raised directly from customers like retail drug

purchasers, such as health systems and insurance companies, and philanthropies. As a result, there is no incentive to increase prices to create a higher return and Civica Prescription's membership includes more than 55 health systems, with more than 1500 hospitals representing approximately 1/3 of licensed hospital beds in the US. Civica Rx also works with the Department of Veterans Affairs, the DOD, and 340B hospitals. The organizational model, which is termed a healthcare utility, means that every member has the same access to essential services at the same low cost. And member health systems jointly prioritize drugs for Civica Rx to pursue. The stability and predictability in purchasing and pricing it at is advantageous for both health systems and manufacturers. And using a third-party logistics company, drugs are shipped directly from the manufacturers to the members, avoiding wholesalers and group-purchasing organizations. Next slide, please. So Civica Rx is the most recent venture named Civica Script. It's a separate public benefit limited liability corporation working to launch with the developmental and production of 6 to 10 generic drugs that would be available on the market starting this year. Civica Script recently announced they would manufacture three insulins in vial and pen form, which would be sold at one low transparent price for all. The price for vials will be capped at $30 and no more than $55 for a box of five prefilled pens. The first insulins will be available for purchase in 2024 and will be manufactured in the Civica Rx's manufacturing plant. And Civica Script members will not have distribution rights but will be contractually obligated to pass savings directly to plan members and regularly publish aggregated annual savings to aid in price transparency. Next slide, please. This is a graphic from Civica's website comparing the average cost for the uninsured population for vials and pens and then the recommended Civica Rx price. And so, as you can see, they're estimating that the savings could be around 90% for uninsured patients. Next slide, please. Some key components of Civica Prescription's policies are the single price for all purchasers. The fact that the company is funded solely by direct customers and philanthropic organizations, so there are no investors seeking a financial return and that the initial business lines leveraged existing manufacturing and industry expertise. Next slide, please. So the last policy approach that we reviewed was the Utah Insulin Savings Program. Next slide, please. In 2020, the Utah Legislature passed House Bill 207 Insulin Access Amendments to establish an Insulin Discount Program within the Public Employee Health Plan, so individuals with that plan coverage could purchase insulin at a discounted post-rebate price. Additional legislative direction was minimal beyond mandating that the Public Employee's Health Plan set an administrative fee that allows the program to

retain only enough of the rebate to offset the costs to the state risk pool. And this legislation became effective in July 2021 and is now named the Utah Insulin Savings Program. Next slide, please. Some key components of this program is that it's a single benefit plan that only includes insulin. And the typical savings for the uninsured is between 50% to 70% versus a pharmacy's usual and customary price. Individuals are responsible for setting up for the program, and outreach is done through PBMs Network Pharmacies, diabetes advocacy groups, and pharmacy associations. The program leverages existing infrastructure and expertise of the Public Employee's Health Plan, including its pharmacy staff and its contract PBM. The program also has the authority to use state reserves to cover program costs while waiting to collect the rebates, which is an important feature. There is a small administrative fee to disguise the confidential pricing and account for the states temporarily covering the rebate costs. And we did hear from state representatives that the program usage volume is not as high as anticipated, and the majority of the participants are insured, and there has been very low participation of uninsured individuals. Next slide, please. So now we're moving into a Washington-specific recommended policy approach The Center included in the final report. Next slide, please. So after conducting the policy review, interviewing representatives from the different policies, and then collaborating with HCA, The Center team put together a report that included a potential policy recommendation for insulin. And the policy approach had two components, a competitive solicitation process and then leveraging the ArrayRx Discount Card Program. So the strategy of this approach begins with ArrayRx going out to bid for a preferred price and then passing that negotiated rebate through to the consumer at the point of sale through the Discount Card. This Prescription Drug Discount Card allows for real-time enrollment, like Leta said and requires only a name, email address, and birthdate. For uninsured individuals and those with high out-of-pocket costs. This would leverage the State's existing Discount Card Program to create a benefit population, and individuals on government-purchased plans would continue with their existing benefit process. Next slide, please. This policy approach does focus on finding solutions for uninsured and those with private insurance, particularly those with high-deductible plans. Because these populations can face the steepest barriers to accessing insulin due to costs since individuals on Medicaid access insulin without any copay, so they are not the target population for this specific solution. Individuals on government-purchased plans would continue with their existing benefit process unless HCA or otherwise decides to pursue negotiation for a low-price suite of diabetic agents and not solely insulin. In that situation, we think

it might be appropriate to include government purchase clients in the target population. And that would be a suite of diabetic agents like supplies, as an example. Next slide, please. So, this policy approach leverages the existing infrastructure of the ArrayRx Discount Card and its negotiating power that has been increasing as more states join, following active recruitment, like Nevada, who joined in February 2022. Additionally, Civica Rx could be a potential source of insulin for the non-Medicaid population per its announcement of manufacturing three insulin products in early 2024. And then lastly, this approach ensures simplicity for those on government purchase plans because it continues with the existing benefit process. Next slide, please. There are some operational considerations for this policy approach, including one assumption that the ArrayRx Discount Card operations are not affected by the recent passage of Senate Bill 5610, which required cost savings for prescription drugs to be counted against enrollees' obligations regardless of payment source. Another consideration is that HCA would need to use state funds to backfill the cashflow gap that would exist until the rebate from the drug manufacturer is received. And this policy would also need to allow enough time for HCA and ArrayRx to complete a competitive procurement process, which could take between 6 and 12 months we estimate. Next slide, please. The report also included three additional tools and considerations for policies that would increase affordability and access to insulin. Next slide, please. The three strategies we looked into are State-run manufacturing, a white labeling program, and a public health distributor, which we will now cover in the next section of this presentation. Next slide, please. To increase affordability and access, Washington State could decide to manufacture its own insulin. And after speaking with an industry expert, we estimate that this would cost approximately $300 million and four to five years to implement. Manufacturing a drug would require significant investments in capital and staff to meet purification and potency standardized testing and to secure needed authorization approvals from the FDA. And so, due to the cost, length of time, and specialized staff experience required for this type of manufacturing effort, we did believe that this would require a significant reprioritization of State resources if moving forward. Next slide, please. White labeling is a less expensive and quicker option than manufacturing. This process would start with by securing a state-level license as a manufacturer or wholesale entity and then establishing warehousing capabilities to receive the drugs from the manufacturer for distribution. A new distribution system would need to serve hospitals, retail pharmacies, and other dispensers. A major component of white labeling drugs is quality

control, requiring state staff resources to assess the quality of manufacturing for the drugs produced, and we need to maintain contract oversight. And one major obstacle to white labeling that we found was that manufacturers have little incentive to offer meaningful discounts from existing generic prices. So the best way to secure a meaningful discount is to guarantee large volume purchasing over several years. We found in our research that guaranteeing purchasing volumes for five years was generally necessary for price concessions. And we found we assumed it might be uncertain if Washington would be able to guarantee a consistent volume great enough to secure discounted pricing. And a multi-year commitment seems risky in the volatile drug marketplace and with introduction of generic insulins predicted to increase in the next 12 to 36 months. Next slide, please. Another potential policy tactic would be creating a Public Health Pharmacy Distribution Program using experience from the Washington State Liquor Control Board model, where liquor stores were state-run with centralized infrastructure. The public health distributor would purchase and distribute drugs that align with the state's public health mission, for example, insulin or the hepatitis C medication. A Public Health distributor then might be used in combination with some of the approaches described in the report. To stand up a public health distributor, Washington would need to secure a pharmacy license and wholesaler license to purchase and take possession of the drugs. And a funding source would need to be identified for this policy option, which would mean state general fund or grant funding among other options. Through this approach, it might be possible to leverage the state's existing mail-order pharmacy services, through ArrayRx Discount Card. If ArrayRx is successful in negotiating lower prices, for example, Civica Rx's low-price insulin, then residents can access those drugs through the Discount Card and the public health distributor or mail order service. There would need to be state staff resources dedicated to standing up the distributor. Managing the public health distributor and the timeline to implement could be 12 to 24 months is what we estimated. And I believe that is the last slide. So I will pause now for any questions on that part of the presentation.

Mary Fliss: Yeah, it looks like we have one from Kevin who asks, Maine passed a similar bill as California. Did you look at their legislation, too?

Hayley De Carolis: I am blanking for a second. We definitely looked at something from Maine, I believe. I don't know if it was insulin. I'll have to take another look in the break. I don't believe it was in the final report, but it may have been in our initial policy survey. I can bring that back.

Kat Khachatourian: And Hayley, this is Kat. One quick question around the sustainability plan. I know in PQAQ when we have gone down the path of assessing these kinds of the things, we had to assess a sustainability plan. So have there been any thoughts or discussions around partnering with different organizations to evaluate cost offsets of this initiative? Or is it really out of scope for the nature of this discussion?

Hayley De Carolis: If anyone else from The Center or HCA wants to jump in on this, I do feel like it wasn't covered in the report because that was like a later step that would need to be considered. We did consider some cost and operational points in the report. But I believe what you're speaking about was a little bit more detailed than what we provided early on in this process.

Kat Khachatourian: Okay, perfect. Now, that's helpful context because just when -- you know, as a pharmacist, and I'm sure some of my other pharmacist colleagues on here probably share the sentiment of as a single supply or insulin affordability is sort of the tip of the iceberg when it comes to this disease state. So just understanding the patient population and the really great opportunity to potentially engage these patients that may benefit from a more holistic picture of care.

Hayley De Carolis: Thank you. Yeah. That's a great point.

Mary Fliss: Great. And then, LuGina asked the question, is the report The Center prepared available in the public domain?

Hayley De Carolis: It is not publicly available. And there was no legislative requirement for it to be public. For the insulin portion of our work, this was done in concert with a naloxone policy, which there is a report on that for the state legislature, but this one is not. I don't know if anyone in The Center team if we were -- I believe these slides might be going out. Correct me if I'm wrong,

Leta Evaskus: I think we'll be posting them on the HCA website.

Hayley De Carolis: Okay. It is the same information in the report that is in these slides, though.

William Hayes: I agree. Yeah. Thanks, Hayley.

Mary Fliss: Awesome. Well, Hayley, thank you [audio cuts out]. And it looks like Nonye will be sending the slides again. These slides do essentially provide the information that was contained in the report. And this slide deck will be going to workgroup members after the presentation. So you don't even have to go out to our website to find it. Any other questions for Hayley before we turn to our 10-minute break? All righty, then. Well, again, thanks so much, Hayley. Yes, agree, LuGina. Both of the presentations have been very helpful. I know it's a lot of work to pull together a slide deck like this. These have been very thoughtful. And so, a big thank you both to The Center staff as well as to you, Leta, for pulling these together. So let's go ahead and take that 10-minute break and come back here right at 10 minutes after 3:00. So we'll talk to you soon. Thanks so much.

[break]

Mary Fliss: Back everyone. So glad that you came back. And we have another segment of our agenda here that starts with the survey results. And again, really appreciate all of you who took the time to respond to the survey. It's always particularly helpful getting that sort of feedback. After the survey results, we'll do a quick review of next steps, and then we'll wrap up for today. So with that, I'll go ahead and turn it over to Brittany and Mike to walk us through these results.

Brittany Lazur: Before we start -- sorry, Ronnie has a question.

Mary Fliss: Okay.

Mike Bonetto: Yeah. I saw that too.

Mary Fliss: Okay. Okay. Okay.

Mike Bonetto: I was going to hit that. Yeah. Thanks, Mary. I saw Ronnie had put a question there around -- and I was going to lean on my colleagues, Hayley, and Susan. I don't know if you saw his question, guys. But Washington Vaccine Association offers a model of cost savings. Was that model evaluated in the insulin analysis? I don't know if you guys wanted to expand on that.

Hayley De Carolis: I can try. I think it's Susan Chopin, but I think we thought that was more of an approach may be for naloxone. And if I remember why, I think just because of the resources required to operate a system like that, we focused for insulin.

We thought that the Discount Card would be a more simple approach, leveraging a program that's already up and running versus the additional resources that would be required to run something like the Vaccine Administration, but we did review it. We did not focus on it related to insulin, however. That's my recollection.

Mike Bonetto: Thanks, Hayley. Susan, any comments from you on this? Putting Susan on the spot. She may have left. But, Ronnie, I know we did look at that. And I if we have any other material, we can send that out to you. Okay. Well, let us jump into Survey #2 results. So a couple of things. So Brittany and I are going to tag team on this. And again, I thought what worked really well last time was you guys doing some of the pre-work of getting your thoughts down and then us coming back and then having a more robust discussion. We want to do the same thing today. So you're going to see your answers and results, but then you're going to see some of those comments. But then we want to have more open dialogue of you guys can maybe expand on some of your thoughts on some of your initial things that you wrote down, and then we'll go through those questions. And then we've got several open polling questions that we'll do in real-time. We want to see if there's been any shift because Leta just gave a great overview of ArrayRx. We had some ArrayRx questions that not sure everybody really knew about that could change some of the thinking. So we just want to make sure we're all on the same page. Okay, so with that, can we go to the next slide? So just seeing composition of survey respondents from the first survey to the second survey, we still had 13, just a little deviation in terms of those respondent groups. But for the most part, it has stayed the same, which is great. And if we go to the next. So if you remember the first discussion we had, we were really trying to focus on okay, if you guys had to look at to prioritize populations, what would that look like? So we had this question on a scale of 1 to 5, 5 being strongly support. How strongly which would you support focusing on the uninsured population versus the commercially insured? So again, this was on a scale of 1 to 5, and you'll see that down there. Your average score for the uninsured 4.2, commercially insurance 2.8, and you can see that distribution. So that was just on that 1 to 5 scale. Now, the flip side is that we had another question. If we go to the next slide. We wanted to have more of a binary choice. So that should read up top in order of priority. 1 should be the lowest priority and 2 as the highest, as you'll see that reflected in the scale below. So we really kind of force people to say, okay, listen. If you had a chip, choose one, and there was not as much of a difference, as you can see. Right? And so, we did have four just not voting -- not applicable. So that's why when we saw that result,

that is worthy of some additional discussion with the group today. Right? So we saw the 1 through 5, and then we see this. We want to get a little bit more information from you. So if we go to the next slide, we've got two slides with your comments. And we're just going to take a little time. I want to make sure people can review these. So what other feedback do we have focused around population prioritization? Patients on insulin pumps may have higher out-of-pocket expenses. So testing supplies have a total of higher expenditures. The focus here is the second bullet, uninsured are the most vulnerable, so there should be a focus there. Third bullet, if we only prioritize 30-day emergency supplies, that is not a long-term solution. I think you guys have talked about that at length even last time. Fourth, we should mitigate patient costs to the full extent possible. Costs to patients that lack of treatment a more consequential than the carriers, PBMs, and manufacturers. I'm going to just pause there. So any folks who wrote -- if those were some of your comments, anybody want to expand on any of those before we move to the next? We have one more slide with another set of comments that we'll discuss. And we'll go yeah, Kevin. I saw your hand raised.

Kevin Wren: Yeah, I did the second comment. I help uninsured people and underinsured people all the time source insulin by sending it to them in the mail as opposed to using one of these purchasing programs because of the cost. They are already strapped for cash. So I help at least one person a month who is rationing insulin. They had a commercial plan, or their deductible is too high, or there are like a million reasons why. So I understand that there's a large pool of commercially-insured people, but the pool that is smaller of the uninsured is the most critical. I hear stories about rationing all the time. In other states, it's still a problem. I mean, I'm having to break the law to send them other people's prescriptions. So I think we need to prioritize them ahead of commercially available people because they might have trouble affording their supplies but, again, having one of these 90-day supply emergency access things, whether you're insured or not, is critical.

Kat Khachatourian: Hey, Kevin. This is Kat, and I would love to -- and this maybe ties into my comment, which is number three, is that even if it's a 90-day supply, what is the long-term sort of sustainability plan for these patients? And if we're prioritizing like a subset of a subset of a subset of the population, are we using resources wisely in order to address the issue? And are we really getting to the root cause of this versus putting a Band-Aid on? So that's just sort of my plug, And I can appreciate trying to do the best for the patients that you're supporting. I just worry if we focus on sort of the situational

specifics versus trying to get to the root cause of why and solving around how do we connect patients to resources for a longer-term solution that's more sustainable for improved outcomes. And I think my perspective goes more towards the intent of this being a legislative priority.

Kevin Wren: Yeah, I totally agree. I mean, these are just Band-Aids, and a federal price cap would solve all of this conversation. And there's the potential for doing that, but, I mean, right now, I do understand the urgency for both groups, but if I'm triaging as a patient advocate, the most vulnerable or the most at risk. And I don't want to hear a story about someone rationing and dying in our state. I don't want to have to say somebody's name every single time I testify. I already talk about Levi, Amber's son, who testified in front of the court about being afraid of rationing insulin at six. So, commercially covered people, I think we can find a way to mitigate the solution for both of them. And I do agree that we need to take a long-term solution on copayment caps. And emergency access programs are not a solution. I mean, they help, but it doesn't get to the root cause like you said.

Mike Bonetto: Kevin and Kat, thanks for comments. I'm going to do a few follows, but I want to hear other thoughts, comments here. Jenny, I just saw you post something.

Nonye Connor: Kat must have posted something earlier.

Mike Bonetto: I did. I'll get back. Yeah, thanks, Nonye.

Jenny Arnold: I have a little bit of background noise, so I typed it. But the thought was maybe. I mean, I think that's an interesting comment, Kat, of questioning assumptions, where I think 90% of Washington State -- this is a 10,000-foot eyeball number -- have insurance versus 10% that are uninsured. Maybe it's helping that 10% access health insurance is the real long-term solution for that group, whether it's affordability or help navigating the system, which I think helps probably all populations. Not those with diabetes versus, and then other solutions for the insured.

Kevin Wren: I also want to just comment that, I mean, coverage gaps happen all the time. So there's no reason why this emergency program can't apply to the uninsured and the insured, and then we pass something else to talk about the uninsured and a different group. But I think specifically about insulin, patients need a 90-day supply, and they need it for $0. That is my hard stance. And that would solve the problem here in Washington of rationing.

Anybody with insurance or no insurance, I think. Just it's really hard for me to make these concessions because I'm doing this every day helping people. Whether or not they're in Washington State, there are still people rationing insulin agree long-term solutions need to be applied to this because it's gotten out of hand for so long. But at the same time, there are certain members of this group who are part of the pharmacy industry. So I can understand why you're concerned about commercially available people. But the people who are dying are uninsured. And the people who are suffering complications are uninsured for whatever reason or underinsured for whatever reason. Until we have universal healthcare in Washington State, we need these kinds of Band-Aid solutions to allow for a 90-day supply whether or not you have insurance. I mean, yeah.

Mike Bonetto: Yeah, I think I would just echo this, and I want to keep us moving. But to Kat's point and to Kevin's, I don't think it has to be an either/or, even the way the legislation was drafted. Right? So there really is getting, Kat, to your point, getting at some of those root causes. But at the same time, what are those immediate Band-Aids that you can think of from the adversity standpoint? So I think everybody kind of thinking about it in those frameworks, I think that would be kind of even some of your recommendations of what I'm hearing from you guys in the report. I'm going to circle back, Kat. You did have something in the chat just around your work looking at Walmart. Did you want to comment on that?

Kat Khachatourian: Yeah, absolutely, because I was looking into this. Some of the proposals that we've walked through around the ArrayRx and the Civica in some of the other states, and Walmart has their private label option. And I don't know the challenges for partnering with Walmart or maybe other entities that may have access to the ReliOn brand and [cross-talk] --

Kevin Wren: Can I talk on that? Because that's a huge problem within our community of Walmart as being the solution. That's regular insulin. It's not fast-acting. So we're getting $35 insulin, but it's like, essentially, dog insulin. That's what they use for animals because it's not as reliable as the short-acting name-brand ones. So I'm really wary of talking about that as any kind of solution.

Kat Khachatourian: Sure. So appreciate those comments, Kevin. So the second part of that is the Novolog insulin is an option and obviously less affordable. But leveraging existing infrastructure and seeing what could be expanded versus net new trying to create infrastructure. Maybe a more affordable option is just my

operating thought of we may not have to reinvent the wheel, or HCA Washington State may not have to reinvent the wheel but build on existing infrastructure and expand it to make sure that it does meet the patient needs. And then the second part of that is around connecting to resources. And, Mike, I really appreciate your comment of, yes, let's say from an infrastructure standpoint, Kevin encounters these patients, gets them access to a 30-day, 90-day, whatever the landing spot is, then also has a mechanism to connect those patients to resources that can help them to get a longer-term solution that can address their longer-term needs versus just that emergency supply. So I like that consideration of the and.

Mike Bonetto: Right. I'm just making a few notes on that. Thanks, Kat. Appreciate that. Okay. Other thoughts here? Okay, let's go to the next slide. So the same thing, just some additional feedback. Priority for commercial insurance stems from the diversity of plans and level of impact, some prior to reaching deductibles with populations are important. Same people, simply different times in their lives. So, again, a little mixed. Right? So again, just based on how we scored uninsured versus commercial scale 1 to 5, and then on the binary on the 1 to 2 range. But I think this is good feedback. And I think you guys had this discussion last time and not necessarily thinking of this as an either/or and thinking about this as that short-term, long-term how do we create some of those Band-Aids, but then how do we really create that long-term success pathway, as well? And, again, we're going to come back to this, so you guys are going to be asked again on even some of the ranking, so hang tight. Okay, next slide. I think I may turn this over to Brittany.

Brittany Lazur: Thank you. So this next question really gets at emergency supplies. Again, the first iteration of this question is with that ranking from 1 to 5, with 5 being strongly supported. How strongly do you support discussing the Minnesota Alex Smith Insulin Affordability Act versus the 30-day emergency supply proposal? And you can see here they got an average score of similar average score, so really split here on these two options. So if we go to the next slide. So a different reframing, again, like the last question that you saw. How would you rank these two proposals from 1 - lowest priority to highest priority? Same options here, emergency supply and then the Minnesota Act. And you can see they're pretty similar, as well. Minnesota Act got a little bit higher priority at 38%. So if we go to the next slide, I have some of your free answer questions here. The feedback on the emergency supply access, these considerations. So to consider including syringes or pen needles. Some clarity could be given around whether we need to focus on 30 days or could

expand to a 90-day supply. Some people advocating that that would make a world of a difference, as we've heard here today. Again, more advocating for greater transparency and clarity in this process and striving to get the patient out of the middle. Again, stuff that we've heard today, as well. And another underscoring that 30 days might not be enough for the emergency supply. Any thoughts here?

Kevin Wren: I'll just chime in. I thought both of these were great. I'm like the second, third comment. I mean, to me, it's just the difference between an already existing program that allows 30-day supplies or potentially amending it to be something specific to Washington State and allowing possibly a 90-day supply. I think they're both great, but 90 days is a world of difference. It takes so much time to just get a prescription sometimes, 30 days isn't enough. Especially if you're uninsured or even underinsured and you have a gap, and you're, like, I don't know what to do. The 90 days is way different. So I just want to reiterate that.

Brittany Lazur: Thank you. Anyone else want to weigh in, as well? I think we have one more slide pertaining to this, so let's go to that next slide. Just one more comment here. Trying to remove as many barriers as possible, again, as you've noted here today. Any other comments related to this question around emergency supply access?

Kevin Wren: I also just want to state that BIPOC communities face rationing way higher than whites, so this is a very strong equity piece. And when we talk about social determinants of health, this goes at the heart of drug affordability as providing a safety net in case someone can't afford the medicine they need to live. So I would just stress again a 90-day supply is great. Please.

Brittany Lazur: Great. Thank you. I think I'll pass it back to Mike for the next question.

Mike Bonetto: Great. Thanks, Brittany. So we then asked you some questions on access to state-negotiated price. And so, again, on a scale of 1 to 5, 5 being strong support, how strongly would you support exploring access to state-negotiated prices through ArrayRx versus collaboration with other states? Again, preface here, this was before you had Leta's background. Right? So I think everybody was doing the best they could to make some determination of this. So this is where we're going to get into a little bit more discussion on it. So state collaborations, you can see that score. It's a little bit higher than ArrayRx. We're going to see if that changes that a little bit based on what you

just had. But that's where you guys landed. And then, again, the next slide, you're going to have a forced ranking between the two. It came out a little differently. So their highest priority was with ArrayRx. And I just wanted to poke a little bit more on that. Now, since you just had this overview of ArrayRx, Kat, what you were just talking about in terms of having the longer-term solution, even talking about Walmart, I'd love to hear you guys talk a little bit more about the viability of what you see with any of these types of plans. Whether you've just heard from Hayley on Civica Rx and the others, a lot of detail that you've got in-state right now with ArrayRx. So if we can go to the next slide. We've got several comments here. So what, if any, feedback do you have before the work will be considered around potentially expanding access to state-negotiated insulin prices or state partnerships? So integrate data and publish on total diabetes impact improved outcomes. Understanding the time and effort required. Either option could be the best long-term solution. Need to understand more about cost benefits. Sure. State partnerships might be the last option. Improve our resiliency to the potential supply chain issues. So those are your, I would say, comments pre-ArrayRx presentation and background. I'd love to hear more from you guys around how you're thinking about Leta's overview and potential for ArrayRx.

Kat Khachatourian: So, Mike, I'll weigh in. So I feel like I understand the need to have infrastructure for administration and ensuring that if it is a single supply per year that that is regulated in some way. I'm encouraged by the Department of Corrections already utilizing with success. But I'm wondering if we could explore looking at the Moda capabilities that are there and if there would be an opportunity to leverage the connection to care management resources, as I've mentioned. And I don't want to be a broken record on that, but I think it's a unique opportunity for the vulnerable and hard-to-reach population if we have an encounter point of being able to make sure we are supporting those patients when we have that connectivity and seeing if there could be infrastructure to route those patients to Moda's Care Managers or nurses something along those lines. By no means do I have all the answers, but that's the theme of where my mind is at.

Mike Bonetto: Thanks, Kat. [cross-talk] -- I was [cross-talk] on Donna or Leta on that. Sorry, Jenny. Were you just saying -- were you just trying to comment?

Jenny Arnold: I was just building on what Kat was saying, which is if patients are having a hard time affording their insulin, I agree with Kevin, that's life-threatening and not okay. But I think that from Kat and I's perspective, and just to be

clear, we're trained pharmacists, but we don't have any connection of -- like that's a healthcare provider and no connection to the pharmaceutical manufacturers or drug makers. I think that to us, that's a symptom of a bigger problem, that if they aren't able to afford their medications or are uninsured, then they may not be getting regular hemoglobin A1C checks. They may not be getting the blood pressure medications and kidney protective medications they need, and foot checks, vision checks, part of that bigger picture. And that's why addressing why they're uninsured, it needs to be, I think [audio cuts out] well.

Mike Bonetto: Got it. That's helpful, Jenny. Thank you for that. Can I go back? [cross-talk] -- oh, go ahead. Who else was going? Sorry.

Leta Evaskus: This is Leta. I had a comment just on, I believe that was Kat's comment about using Moda. So one thing that we've learned with the Eliminate Hepatitis C Program is that we need to meet people where they are and giving care. So we have the same issue with finding homeless people who are hepatitis C positive and getting them treatment and care. And so, working with local health jurisdictions, clinics that treat homeless people, that is going to be the best option because that's where they feel comfortable to go for care right now, then introducing someplace where they have to call or some clinic that they're maybe not comfortable going to.

Kat Khachatourian: Sure. No, Leta, that makes total sense. I understand a lot of distrust of the system, and some of the clients that are managers encounter may not be super receptive to that onboarding process. And that's where I think leveraging some of the infrastructure that the dual-eligible special needs population plans have in place. And, again, I don't have all the answers. But if there's a way for a partnership, or the intake folks at the homeless shelters, if there's an infrastructure to support that connectivity so it's not completely reliant on the client to take the next steps.

Leta Evaskus: Right.

Kevin Wren: Hm. Thank you for that clarification, too. And I appreciate you, Kat. I think you're asking some great questions. And I totally agree with you on kind of a holistic approach to this. And like my focus is purely on insulin because I know we need supplies in order to use insulin, but it's not written into the law that we have, so we have to go back to the legislature and then try to pass something. So just focusing on insulin and hearing about the actual ArrayRx, I

think was really helpful for me to answer some of those basic questions that I had and serving those underserved populations. And the fact that it's been used by Corrections is great. I would just be curious about scaling it to this population. It's a bit different group. But, I mean, I loved all the things that I heard today. I think they're all great and the solutions. So I think what we're presenting is a lot of good stuff. So I appreciate you guys chiming in and asking these good questions. And your feedback is great, too.

Mike Bonetto: Thanks, Kevin. Yeah. So I think to Kat and Jenny's comments. I think well noted that in addition to insulin and the price, we're still looking at how to best incorporate supplies, and even maybe, more importantly, the care management, the wraparound. Right? How does that get incorporated? So just thinking about that from a report standpoint how this gets incorporated is helpful. Oh, William, I saw you had your hand raised.

William Hayes: Yeah. The only thing that I wanted to speak to is the state partnership. process. And that comes from my experience working with MMCAP Infuse. I find that -- and I don't know how we would be able to make this work from a full-state process, for an all-state resident process, but it works well for the government level. And maybe just the entire state working together with other states, we can find a way like the federal government does, to build a process where when states work together, we have the power to say to the drug manufacturers, "we don't want to pay the price that you're making us pay." And that's kind of what we are doing at the government level when we are working with MMCAP Infuse, and we're able to negotiate those lower prices so that the state doesn't have to pay as much as the private companies have to pay. And I think I don't want to put the state partnerships a lot lower in the work that we do because there are -- I know it's difficult because we all have different priorities. But I know that drug cost is a huge priority. And if we can find a way to work together like Washington and Oregon are doing with the Consortium, and Nevada is coming on to join us with that. If we can continue to expand and find ways to do that in new ways. I mean, the PBM arena is part of that. But if we can find ways to purchase drugs at lower costs in new ways outside of what exists now, maybe we can fight the power of the drug manufacturers. So I don't want us to think that working with other states needs to be as low as some of us think because it will be hard, but it should be something that we should try.

Mike Bonetto: That's great, William. Thank you for that. Before I move on, any other last comments, questions, even regarding this and everything around what we've just been talking about with ArrayRx or state collaboration?

Jennifer Perkins: I wanted to talk about the state collaboration in that I think that that would be a fabulous option for bringing resiliency to our system because with such limited numbers of manufacturers -- let's say something happens to just one of them. That's a huge deal. We've seen the supply issues with products coming out of Ukraine, and then we've seen the baby food formula shortages from Abbott. And I just think if we have more manufacturers available, then that would really make it more resilient to shortages like that.

Mike Bonetto: Got it. Thanks, Jennifer. Anybody else? Okay, let's go to the next one. I think I'm going to hand it off. Brittany, back to you.

Brittany Lazur: Yeah, thank you. So our next question here was around data transparency. Again, rating it on a scale of 1 to 5, 5 being the strongest. How strongly do you support exploring data transparency efforts related to the price of prescriptions? And this received an average score of 3.9, as you see here. So moving on to the next slide. Some additional comments around data transparency. We may run into authority arguments with PBMs. Transparency has been proven to be hard to get. Proprietary information is often an issue. Transparency efforts should focus on pharmaceutical manufacturing, pricing, not negotiated reimbursements. Transparency is important, but the current efforts are not providing a sufficient insight. There are issues regarding confidentiality and trade secrets that could delay work. And while there's transparency occurring right now, we don't believe additional transparency measures with lower drug costs. So any comments around this feedback?

Kat Khachatourian: [cross-talk] This is Kat [cross-talk] something. [cross-talk] -- Sorry.

Unknown female: Sorry. I just want to put out something interesting. And that's that if we did partner with another state, and then they did actually get up and running with producing and manufacturing our own versions of insulin -- if California does that, then they could potentially share this information, and we could see how much it actually costs instead of trying to ask these other folks, "Hey, will you please tell us what this costs?"

Mary Fliss: Well, yeah, Jennifer, I appreciate that comment. And it makes me think also of the discussion we had around some of those other efforts related to the Civica right in that slide that said here's the price that Civica is planning on offering. So, absolutely, when Civica does it, if California does it, we should have a very good platform there to say instead of trying to dive into data definitions and what's included and what's not included, maybe really use what other organizations are able to come forward with prices and say, well, that seems like that answers that question.

Kat Khachatourian: And this is Kat. So just weighing in and connecting a couple of these things together. So the transparency discussion on manufacturer pricing and authority arguments from PBMs, it was almost like this is an economic discussion. If you trace -- and there are tons of publications out there about tracing the dollar from the amount that goes into research, the amount that gets rebated to plans and PBMs, the amount that gets allocated to 340B purchasing other countries, it's a pretty convoluted economic equation to go through. So I'm just trying to think through the value of this. And one other area around transparency. And I don't know if HCA or others have looked into the ability to become a covered entity in order to access 340B pricing on drugs. And this is a question mark because there has to be a covered entity, a prescriber that is serving an underserved population, and a qualified patient, who, to some of Kevin's points, would be those patients who are most likely to be uninsured and not on Medicaid in order to meet the qualification parameters. But just wondering if leveraging an existing channel would maybe be a more fruitful path and just making it more clear or lead to access versus the convoluted economic picture that I think some of these points would dig into.

Kevin Wren: I mean, Eli Lilly backed out of 340B earlier this year, so there's no reason why they can't get out of that, as well. So just to that point, it's something that we're tracking because it means less access for people who are vulnerable. But I was wondering about tying these aspects of transparency to penalties for the manufacturers, if there's a way to do that, or if we have discussed that.

Donna Sullivan: I mean, that would have to be something that the legislature would have to pass as far as any type of penalty if they failed. If they pass a law that requires them to provide an emergency supply, that law would also have to include any authority for the Healthcare Authority to penalize a manufacturer who doesn't comply with the law.

Mary Fliss: The other question I had on these comments is the third one down -- transparency efforts should focus on pharmaceutical manufacturer pricing, not negotiated reimbursements. I'm just wondering. Is that reference to negotiated reimbursements with the pharmacy, or with the health plan, or about the pharmacies price that they've set for patients? Okay. Well, we don't need to stop here any longer. It sort of, again, speaks to that point of the complexity of data transparency.

Unknown female: I didn't write this one, but I agree with it, that at all levels, really, would be ideal to have the transparency. But this one makes the most sense because a pharmaceutical manufacturer could choose to lower their prices tomorrow to a reasonable price, and then we wouldn't need this Committee here now. And I think that if people saw in that disparity and how much it costs to make and how much they're charging, if that was just out in the open, I think there would be outrage that is lacking right now.

Brittany Lazur: Great. Thank you so much. I think one more slide in the section. Let's move on to that next slide. So additional feedback here. Like for total diabetes management as well as weight and comorbidities. Rebate reforms highlighted. Considering how the cost of other diabetes medicines prescribed usually before the injectable insulin is pushing patients to switch to insulin sooner since that is a cheaper option. And then a comment on state patient assistance programs for PrEP to prevent HIV could use this as a last resort. Any additional comments or feedback? If not, I think I'll turn it back to Mike. I think we have a few Poll Everywhere questions to stimulate some more discussion.

Mike Bonetto: That was great. Thanks, Brittany. So we are going to engage you guys. As you look at these bullets -- I would love it if you've got a browser open to go to this link. Poll E-V dot com forward slash C-E-B-P-O-H-S-U 300, and Erin was so kind to put that in the chat, so you can just click on that. When you pull that up, you can be anonymous, totally your call, and you can just press that skip. You don't have to put in your name. And you should be seeing a question up in just a second as we go to that next. So I'm going to -- everybody's already there. Good. So just let me read this so we're all on the same page. So on a scale of 1 to 5, with 5 being strongly supported, how strongly would you support the workgroup exploring options to provide access to state-negotiated insulin prices through the ArrayRx Solutions for all Washington residents? So we want to come back to this just after this discussion today with you guys now having a little bit more detail around

ArrayRx. Have you changed your position? Does this give you a little more insight? Give you guys just another. So 67% strongly support, 70%?

Kevin Wren: [cross-talk] that medication was super helpful. I'd like to review it again, too, if you can provide that.

Mike Bonetto: Absolutely.

Kevin Wren: Thank you.

Mike Bonetto: That will be part of the packet, yep. Erin, are you looking up locking?

Erin Sanborn: Yeah, that sounds good.

Mike Bonetto: Why don't we lock that in? Great. That's helpful, guys. Thanks. So we're going to go to the next one. So similar, just what we what you guys were asked before, same thing, scale 1 to 5, 5 strongly support, how strongly would you support further evaluating a recommendation for Washington to collaborate with other state or nonprofit insulin programs, Utah, California, and nonprofit manufacturers. So just trying to get a sense of where you are with this. Obviously, we've got ArrayRx here, but then looking at other sort of collaborative models.

Kat Khachatourian: Can we caveat this to I don't think we should go down the California path and build our own manufacturing facility?

Mike Bonetto: We can put that in a note, Kat, if that's where others are, as well.

Kat Khachatourian: Okay, that's --

Mike Bonetto: I'd love to hear from the others. Yeah, yeah.

Kat Khachatourian: Yeah, the estimates of 300 and something million to build a manufacturing facility is really -- it's like, what are we going to actually gain from that? It gives me a bit of pause.

Erin Sanborn: As opposed to partnering with some of those states who are [cross-talk] --

Kat Khachatourian: Exactly.

Erin Sanborn: [cross-talk] infrastructure investment.

Kat Khachatourian: Yeah.

Erin Sanborn: Yeah, yeah. I'll give you gays another second. Looks like it's about stable.

Mike Bonetto: Okay. Thanks, Erin. I'll lock that in. And we've got one more for you. So again, you see these two options? ArrayRx and you got a collaboration with other states. And now, how would you rank them? So we're just trying to get a sense from you guys. If you had to prioritize when you start looking at those options. This obviously isn't set in stone, but this just gives a sense of where you guys are right now.

LuGina Mendez-Harper: Mike, this is LuGina, can I ask a quick question? I want to make sure I heard correctly during the ArrayRx presentation that currently it's a program that can't work. If you're insured, you have to choose either to use ArrayRx or to use your insurance. Is that a correct statement? I want to make sure I heard that correct.

Leta Evaskus: This is Leta. Yeah, the current Discount Card Program. You can't use it with insurance. The Voucher Program currently is also outside of insurance because it's either the facility that pays or whatever public entity is going to pay for it. Yeah. So both are outside of insurance.

LuGina Mendez-Harper: Okay.

Kat Khachatourian: And another clarifying question on ArrayRx. I know they mentioned, or there was mention that their only revenue is from an admin fee. Is that publicly disclosed, their administrative fees, on the per claim or --? It's usually a per claim or per population sort of figure in addition to if they're administering rebate contracts because that's usually where I see working on the health plan side, seeing some of the PBMs, very ambiguous language around that they are able to retain an admin fee. But what that admin fee actually is, is usually not disclosable. So I would just want to make sure that if we go down the path of a third party that every component of revenue that they obtain as a part of this is transparent.

Donna Sullivan: Yeah. So I can speak to that. So we have like a page and a half long definition of what is and isn't a rebate or an admin fee. It's really not that long, but it is pretty long. So yeah. They're not allowed to keep -- like with the

manufacturer, all the revenue that they receive from a manufacturer related to a rebate or business, they're not allowed to keep any of it. So the admin fee that they get is what we pay for them. And so, any profit that they get would be through the rates that they're charging us.

Kat Khachatourian: Okay. And the admin fees that they charge to the manufacturers are also disclosable.

Donna Sullivan: It's not disclosable. It's disclosable to us.

Kat Khachatourian: Okay.

Donna Sullivan: It's not publicly available, but they have to disclose it to us, and they have to pass it through.

Kat Khachatourian: Okay, perfect.

Donna Sullivan: And we're able to dive in and audit that trail, as well, where most of PBM arrangements, that's a roadblock for the payer.

Kat Khachatourian: Absolutely.

Mike Bonetto: Great. Kat [cross-talk] --

Mary Fliss: Mike, just a [cross-talk] --

Mike Bonetto: Yeah, yeah. Mary, please.

Mary Fliss: -- quick comment before we go on to the next survey question. Just a reminder that this is for the workgroup members. And so, other staff and guests if you'd like to make comments, we'll gather those after.

Mike Bonetto: Thanks, Mary. Yeah, great catch. I think, yeah, we can lock that, Erin. Thank you.

LuGina Mendez-Harper: Hi. This is LuGina again.

Mike Bonetto: Yeah.

LuGina Mendez-Harper: So one of the nuances that we have -- and I just want to make sure that I'm articulating this clearly -- because earlier we were talking about whether or not we want to focus on the uninsured versus the underinsured. And I don't think it's a choice of either/or, what I think is important is to understand the approaches and the possible solutions we have vary depending on if we're talking about an uninsured person versus an insured person. And this question here is an example of that. And with our understanding of ArrayRx, I mean, it sounds like a fantastic program for uninsured folks or potentially people on a high-deductible health plan, but it may not be as good of a solution for commercially-insured folks since you can't use the Voucher or the Discount Card as a secondary form of payment.

Leta Evaskus: This is Leta. You can if the legislature passes a law or directs HCA to make an affordable insulin program. Then the way we would do it would be then carved out of private insurance where you use this if this is a better deal. But I think that most insured people are well covered and can afford their insulin.

LuGina Mendez-Harper: Right, right. And that was just my perspective for all of these solutions. Because if you're asking me this question for an uninsured population, I would say ArrayRx.

Mike Bonetto: Yeah, yeah. No.

LuGina Mendez-Harper: But if you're asking me for an insured population, well maybe that collaboration with other state programs may be more a more effective approach. So, again, I just don't want it to be conceived as like its one or the other. No. It's just like, okay, what patient population are we talking about? And what are the solutions that we have available to us? And this was just an example of one where my understanding was that ArrayRx was a little bit more limited of an option for the insured patient population.

Mike Bonetto: Thanks LuGina. Donna, I saw your hand raised.

Donna Sullivan: Yeah. There was some legislation that passed last year that I'm really curious to find out more about how the Voucher Program would interact with that. Because that program prohibited -- it basically required any health plan to consider any payment by anybody for a prescription drug to be counted towards their out-of-pocket. So I'm thinking if there's a Voucher Program, it basically is the same thing as if the manufacturer is paying for it. It's really then a manufacturer coupon, and it would then have to be counted towards

the member's out-of-pocket, even if they had insurance. So I'm not a lawyer, but I'm wondering if that would potentially be an opportunity for the insured population and how that would work. In my mind, I don't see a difference between either a state-funded program or a manufacturer-funded program, it would still fall under that law that would have to go to the patients out-of-pocket if they had insurance.

Leta Evaskus: And I wonder if private insurers, if this was a state-led initiative if private insurers would say, okay, use the voucher through the state and then submit it, and we'll apply that towards your deductible. That would be their choice to do that.

Donna Sullivan: It's hard to say.

Mike Bonetto: Thanks, guys. But LuGina, your point that you brought up, I mean, it kind of mirrors what Kat and Jenny were talking about earlier in terms of let's just not make this either/or. Right?

LuGina Mendez-Harper: Absolutely.

Mike Bonetto: Yeah, yeah, yeah. And think about this even that short term and long term.

LuGina Mendez-Harper: Right.

Mike Bonetto: And even the way that legislation is crafted is like that. Right? So you're really focused on what's the emergency supply process, but then what is the look at a long-term cost reduction, as well?

LuGina Mendez-Harper: Yeah.

Mike Bonetto: Thank you, guys. I want to go to the -- I think we're at next steps, Mary.

Mary Fliss: Terrific. All right. Well, thank you so much. Great conversation again. Really appreciate the dialogue with this. And next slide. Great. So we are issuing our final legislative report in March of this coming up year. It is amazing to me to think that next week, a week from today, we will be in September. It will be Fall, and so, we will be continuing to take the work and the discussions that we've had. Really, again, appreciate the dialogue and the insight and come together around at the end of October and then continuing to have every other meetings until we hit March, where we'll have our March 16th meeting.

And then we'll be working on issuing the final report from there. So I see Amber. Do you want to unmute yourself and make your comment? Okay, great. Well, thank you so much for the insight. I really appreciate having the voice of those patients and family members. It's so important for us to be keeping that in mind as we go through this process. Very helpful. And then I also said that I would give an opportunity for guests who may not have had a chance to make any comment to also offer their thoughts, as well.

Leta Evaskus: This is Leta. If any of the attendees want to raise their hand. So I see Ronnie Shure. So I will unmute you.

Ronnie Shure: Hi. I would just like to emphasize the point that someone brought up about comparing the underinsured, the people that have insurance, who might benefit from a plan that works to support their price, lowering prices for insulin for those people versus the non-insured. I don't think we can ignore either one. This is a matter of life and death. We, you really should keep that in mind. But I wonder -- excuse me, there's an airplane flying through my window here. No, I wonder if the larger number of people who have insurance and are paying hundreds and hundreds of dollars each month is a burden that we should consider and that whether we cooperate or build on the California manufacturing program or the ArrayRx card for underinsured, that the more we put out there or emphasize the impact it's having on the larger number of residents in Washington, the more likely the insurance companies or manufacturers will respond. Insurance companies can lower those copays. Manufacturers can be told there's an upper limit they are going to pay. And if we offer that as a threat sorry to say -- a kind threat that we are working hard in Washington State to do a number of things, and one of them is lowering the price of insulin. The more we put that out there, I think the more likely manufacturers are, and the more likely insurance companies are to hear us. So I think we have to work on both ends of that candle. So thanks to people who have brought that up and discussed that. I think these are very important options, and we need to cover all of our bases. And people who don't have coverage, we need to realize we're talking about life and death. So thank you for all the work that you're doing to address these issues. It is a matter of life and death. So thank you.

Mary Fliss: Great. Thanks so much, Ronnie. I appreciate you're offering your insights, as well. Great. Next slide, please. Terrific. So we do have an email set up for this team. If you have any comments or suggestions, please feel free to use this email. We will also be posting this meeting as well as the documents that we

have been referring to, and you will also be receiving this. This will be emailed to the workgroup members, as well. So before we wrap up and wish everybody a great September and look forward to seeing you towards the end of October, any other questions or comments people would like to share? All righty, then. Oh, excuse me. Go ahead. Excellent. Okay. Well, thank you so much, everyone. Have a wonderful couple of months, and we look forward to bringing us back together again and continuing this important discussion. Bye-bye.

Jenny Arnold: Great. Thank you.

Mike Bonetto: Thank you, guys.

[end of audio]