MaryAnne Lindeblad: Well, good morning. I'd like to welcome you all to the January Prescription Drug Affordability Board, and I'd like to make an announcement before we get started. Many of you may be aware of this already, but effective noon today I will take over the position of the Acting Director for the Health Care Authority, and I will stress the word acting. [Cross-talk] --

Eileen Cody: [Cross-talk] It's a great [cross-talk] --

MaryAnne Lindeblad: [Cross-talk] short-term as they continue to recruit Sue Birch's replacement. So with that, I'm not able to remain on this Board, so I have to officially resign as of noon today. I do hope that I'll be able to get back on the Board when that appointment is over. Can I do that? This is not a position that I am going to, again, do for a long period of time. It's going to be probably three to six months this one we anticipate. So anyway, I am going to stick around for a little while this morning, and I will go ahead and turn the meeting over to Mike -- or if anybody has any questions or anything.

Eileen Cody: Good luck.

MaryAnne Lindeblad: Thank you. Thank you.

Mike Neuenschwander: Right, yeah. And we're very excited for you, and that's fantastic news. And yeah, once you're done with that and you're able to hop on back on board, I will definitely be glad to see you return and, hopefully, just kind of keep on going.

MaryAnne Lindeblad: Ease back in.

Mike Neuenschwander: Yep. Perfect. Perfect.

MaryAnne Lindeblad: Thanks.

Mike Neuenschwander: Um, well, great. So that was actually one of the first things on my [indistinct]. I wasn't sure if you were going to stay around here for the meeting this morning, so that's great. Next thing, just in terms of the Director's Report, just to make sure everyone knows, the dashboard that we sent out to the Advisory Group and the Board members for the list of drug reviews -- or not the drug reviews, but the list of drugs for selection with the data is on the PDAB webpage, so if anyone needs to see that or wants to look at it in the general public, they have access to it and are more than welcome to. And then also one of the things that we're doing is we're currently over the next couple meetings going to be working on looking at this dashboard for drug selection, but we're also trying to look ahead for the drug review. Again, we're kind of building this plane as we're flying it.

And so one of the things that we've been working on just on the back end are some of our data submission forms for our industry partners. So as we're going to need to collect data, we have some of that from our internal sources, which we've been using to help build the dashboard, but there's also pieces that will need to be collected from the industry partners themselves of whatever drugs that we select. So we have some data submission forms. One of the things we're wanting to do just kind of give a head's up is to set up a meeting where we can have opportunity to get feedback from industry partners on those forms, just again, some of that feedback that we've received in the past from industry partners has been really helpful in terms of helping us set up how we're doing these drug selections here thus far. So just kind of an FYI that's something is coming down the pipe, and Dharia will probably be reaching out for some help in terms of doing steps with that.

And then I also had -- I know we had some comments during our Advisory Group meeting, which happened December 10th, in terms about our process for selecting the drugs and making sure that that was a solid process, and we weren't doing anything that would be considered arbitrary. So Michael's going to give us a little chat in terms of -- in legal terms of what that all means.

Michael Tunick: Yeah, yeah. And so, again, I wasn't present, so I not, like, opining on sort of the reasonable civil process but more just sort of legally as your legal speak. When I hear arbitrary and capricious, that's a judicial standard of review generally confined to review of administrative agency action, and so I'm just going to go with arbitrary and capricious defined as the result of both willful and unreasoning disregard of the facts and circumstances. So when I read cases, then I look at the Merriam Webster's dictionary definition, they are pretty much like what you might as like a layperson think of as what is arbitrary and what is capricious fits within that sort of legal definition? And it's a highly deferential standard over one word that won't really be set aside unless, like, the review in court says they are just -- they are showing an error or there two opinions, even if the review in court might disagree with the outcome, it's not just sort of, like, oh [audio cuts out].

And I'm just going to provide some sort of examples. The first one is what I would say is one of the most famous but seemingly unreasoned judicial actions or unreasoned government actions would be -- I'll go back to thousands of years to the judgment of Solomon. So this was the Settlement of [indistinct], a child custody dispute [laughter] in which King Solomon ordered that a baby be cut in half, and so that seems -- yeah. So King Solomon was not being despotic. He was being quite wise because -- and I bring this up because a lot of times it's not so much about the outcome, but more about the reason for getting there. So here we have a very difficult situation where King Solomon didn't know who the true parent was or who the true mother was, and so he came up with a pretty ingenious way to sort of fair that out by sort of ordering that the baby be cut in half, that the true mother would reveal herself by rejecting the judgment and the false mother by accepting it. And again, so that's an example of something where it seems, again, like they are not

necessarily a reasoned outcome, but once we sort of understand the logic behind it. As we know, King Solomon was very wise.

So okay. Then other stuff I was going to say, like legend has it that Julius Caesar would settle legal disputes by a coin toss. And so nowadays we think about it, and we're like, well, that's an okay way to decide who will kick off during the Super Bowl, but we don't necessarily want all government action. But I realize that in election disputes -- note election disputes -- in election ties, a lot of states have basically games of chance as the latest to decide who the winner is, whether it's a coin toss, drawing the card on the deck. In this state, it is drawing lots, which I'm not exactly sure what that is, but I know it is some sort of a game of chance. I don't know if it's pulling straws. That's by statute. And so statutes are a little bit -- you know, the Legislature has a little more leeway [cross-talk] --

Eileen Cody: [Cross-talk] They are arbitrary and capricious.

Michael Tunick: -- going to be arbitrary and capricious, and so the Advisory Committee cannot flip coins to decide things. But just sort of bringing up that there, you know, games of chance are not ways for a judicial decision but yeah, there are circumstances where it does actually turn out to be okay. And then I was just going to say, if the government does have specific draw a line, and it's my understanding it's sort of going along [indistinct] time here, there was something about a certain number of drugs that could be reviewed, and so you have to sort of narrow down a list somehow. And again, I'm going with the statute here, but the retirement age used for Social Security is 65. Like, why not 64? Or I think it's going to go up to 67 and 70. So there has to be some line drawn. And sort of the cynic in me always thought it was, well, the retirement age in 1935, or whenever it was that they passed the Social Security Act initially was -- not the retirement age, sorry -- the life expectancy for men was about 58, women were about 62. And so I was like, well, they figured no one would live that long to get the benefits. But I guess it was actually based upon other private and public pension systems had either 65 or 70 as the retirement age, and so they looked at sort of actuarial calculations.

They thought people could pay a small tax and have a retirement based upon their life span. So what -- and then, yes. And so then, like the Medicare and Medicaid programs, they adopted the same 65. Again, that was just more administrative expediency because it was that they already had the infrastructure in place to find out who is eligible and who is not based on age. And yeah, so I guess the -- what I'm going for is that a lot of it is about the process and the reasoning, and it's not necessarily -- I mean, the outcome has to sort of match the facts, but the outcome doesn't have to be, like, preordained. So it's not necessarily whether we agree with the outcome but as long as they sort of have a reason for it. Any questions? If there were questions, I would provide more examples of -- yes, it's tough to find examples of arbitrary and capricious. I'm [indistinct] that they don't exist, but I was sort of reading the Federal Society. I think they when they said that since

somewhere like 1982 or something, the Supreme Court has upheld 92% of cases that have -- under the standard of review.

So there are recent examples where I think like, the DACA deferred action, childhood arrivals, and so it wasn't like the repeal of it wasn't -- this was something that could be supported, but because there was no explanation for the repeal, it was found arbitrary and capricious. So that is something where -- um, and I think there were a few examples like that with the last couple of presidential administrations. That's on the federal side, where they reserve undoing the prior [indistinct] administrations work, but they didn't sort of go through the effort of providing an explanation going through the process of actually the change. And so I think that is more top of minds. Like didn't the Supreme Court recently do --? And it's like, well, those were examples that sort of almost, like proved the rule. And so, again, I don't want to like say, oh, you can do whatever you want.

MaryAnne Lindeblad: We have a question.

Michael Tunick: [Cross-talk] Yeah.

Eileen Cody: [Cross-talk] Somebody's having trouble hearing.

Michael Tunick: Oh. [Cross-talk] --

Eileen Cody: [Cross-talk] You probably got to speak up.

Mike Neuenschwander: Yeah.

Michael Tunick: Oh, I'm sorry.

Mike Neuenschwander: That's fine. Yeah, just speak up [cross-talk] into the mic a little.

Michael Tunick: Um, okay. Yeah, so with -- yeah. So where agency action is found arbitrary and capricious, it tends to be that there are certain factors which need to be considered that haven't been considered. And so, an example I have is where a Growth Management Hearing Board has applied a test for substantial compliance. I think there was like a late application, and they failed to consider prejudice, where they determined that the sort of substantial compliance with the filing requirement had not been met. It was something where it was really just like the -- I think they were supposed to serve the Board and the city, but they did it in the opposite order, and in uncovering of that, procedural filing requirement had found they failed to consider their own rule, which said there is no prejudice, which there wasn't in that situation. The event substantially [indistinct], so that's where they failed to consider a factor other times thinking that considering

factors that should be considered or situations where just the decision flies in the face of the events or for them.

So I have one where the -- where is that -- the Department of [audio cuts out] what was rulemaking for [indistinct] chemical cholinesterase testing, and they opted not to do rulemaking because they had limited resources, and their priority setting was to do other things, but the evidence of the record showed that actually had been studying this and that they had some informal guidance, and so that their explanation for denying an application for rulemaking is being arbitrary and capricious because it's just sort of flew in the face of the evidence before them. And so [cross-talk] --

MaryAnne Lindeblad: [Cross-talk] I mean, thank you, Michael. This has been really thorough and really helpful. I mean, that's a term that gets thrown around a lot, so it's [cross-talk] good to have [cross-talk] --

Eileen Cody: A labor law. It should [cross-talk] --

MaryAnne Lindeblad: [Cross-talk] Yeah, absolutely. And so it's good to have sort of a refresher course in some ways [cross-talk], so thank you.

Douglas Barthold: Right.

MaryAnne Lindeblad: Are there any questions from anyone? Is anyone online? Nothing? [Cross-talk] Okay.

Mike Neuenschwander: So I think the general gist is that making sure we have methodologies that we've developed in terms of creating the drug list, in terms of how we're prioritizing the drugs. We're not going against the Legislation or our rules and that we have a reasoned decision of how we're coming to these selections.

MaryAnne Lindeblad: So a real process.

Mike Neuenschwander: Yeah.

Michael Tunick: Yeah.

MaryAnne Lindeblad: So apparently there's some difficulty with some folks hearing. They can hear part of it or nothing, so I don't know.

Ronnie Shure: You hear us better now?

Eileen Cody: Yeah.

Douglas Barthold: I can hear okay.

Eileen Cody: Okay.

MaryAnne Lindeblad: Can you hear okay? All right. It's the s- [cross-talk] --

Eileen Cody: Ronnie says yes. [Cross-talk].

Mike Neuenschwander: [Cross-talk] Ronnie says yes.

Eileen Cody: Okay.

Mike Neuenschwander: We'll project and talk with our booming voices. Okay. Um, great. So any other questions in terms of that? I think that for me helps clarify, I guess, making sure we stick to our methodologies, that we're following our processes that were creating reasoned decisions. And as long as MaryAnne isn't trying to divide any of the HCA staff in half, [laughter] I think we should be good.

MaryAnne Lindeblad: [Cross-talk] Never again.

Eileen Cody: But you never know.

MaryAnne Lindeblad: [Cross-talk] but you never know. [Laughter] --

Mike Neuenschwander: Okay. Good. Um --

MaryAnne Lindeblad: Are we on to [cross-talk] --

Mike Neuenschwander: Yeah. So then I think that takes us on to voting on our drug selection policy. And we have taken a look at this during our last meeting, and this is basically just kind of how our weights and ranks work to create the drug dashboard which we have been looking at. And so, yeah. Unless there are any questions on that, I think we can move forward.

Eileen Cody: You need a motion?

MaryAnne Lindeblad: You ready? Then okay. Yeah, the motion. [Cross-talk] --

Eileen Cody: [Cross-talk] I move that we accept the drug selection policy. We affirmed that.

MaryAnne Lindeblad: And I second that. So all in favor [cross-talk], Board? Aye.

Mike Neuenschwander: Aye.

Eileen Cody: Aye.

Douglas Barthold: Aye.

Hung Truong: Aye.

MaryAnne Lindeblad: Great. Well, it's been moved and seconded, and all votes in favor, so we have adopted that. So adopted with a fake gavel. [Laughter].

Mike Neuenschwander: Awesome.

MaryAnne Lindeblad: So at this point, I am going to head upstairs. And again, I look forward, hopefully, to join you all.

Eileen Cody: Yeah, your time. You can't get out of this completely [laughter].

MaryAnne Lindeblad: But thank you. Have a good meeting.

Mike Neuenschwander: Thank you.

MaryAnne Lindeblad: Take care, guys.

Eileen Cody: All right. See you later.

Michael Tunick: All right. I just want to say we still have a quor -- we still have four [cross-talk] and if I understand it correctly, [cross-talk] --

Eileen Cody: [Cross-talk] your [indistinct].

Michael Tunick: -- Representative Cody is now [cross-talk] --

Eileen Cody: [Cross-talk] I'm not Representative Cody anymore. [laughter]

Michael Tunick: All right, sorry. [Cross-talk] [laughter] [indistinct] Eileen-- was t Cody is now the Chair, is that -- was that right? You're [cross-talk] --

Eileen Cody: [Cross-talk] Yes.

Michael Tunick: Yeah. [Cross-talk] --

Eileen Cody: [Cross-talk] Well, I'm second, so [cross-talk] I believe, yeah.

Michael Tunick: [Cross-talk] Acting Chair.

Eileen Cody: Yep. Right. Yes.

Michael Tunick: Okay.

Eileen Cody: Unless anybody else wants to really jump in and take over, we'll stick with that.

Mike Neuenschwander: Yeah.

Eileen Cody: All right. So now we move forward to the dashboard. We're doing that data on the dashboard. Is she on? I can't tell with [indistinct] thing.

Mike Neuenschwander: You want to walk us through that again? And I think this is the time Board Members, if you have questions on functionality or features, this is a great place where they can probably answer anything you would like to know.

Kelly Wu: Yeah, sure. I can share. All right. So if you're not sure where to find the dashboard, if you go to -- sorry, this part keeps popping up -- if you go to the website, the link to the dashboard is under Policy resources, and then PDAB data dashboard. So this is what the dashboard looks like when you click on the link. So there are a bunch of tabs so you can navigate through the tabs to view the different dashboards, but I'll go through each tab just to show you what's on it. So the first tab is the dashboard overview. It gives an overview of how many drugs are in the dashboard, information about our data sources, as well as some limitations. So one of the things we'll notice in the dashboard are any prescription drugs with less than 10 people using the drug won't be on the dashboard, and then any other measures that use the number of people using the drug in the calculation will also be blank. So you can't back-calculate how many people are using the drug. And I'll show you some examples of how this would work if they are missing.

Next, is the Dashboard Information tab. So this just gives you more details on what each dashboard or each tab up here what information they each contain. And then if you wanted to see

the information for a specific dashboard, you can also filter by that and just look at that rather than scrolling through the whole thing. There is also the Data Dictionary. So this gives you the definition and data sources for the different terms and calculations used in the dashboard. And then again, you can also search and filter by a specific data field if you want to go through it really quickly.

And then getting to the data, this is an overview of the Drugs that are Eligible for Affordability Review. So we have 294 drugs, and then we have a graph here that breaks down the drugs that are eligible because of their cost of course of treatment by biologics and brands. And then here we have [audio cuts out] interactive graph, so you can sort by how many drugs you want to see, and then they are sorted by top number of people using the drug product and then top products by total paid amount. And then again for this graph that shows the top drug products by number of people using the drugs, if there is less than 10 people using the drug, it won't show up.

Next, there is a more detailed dashboard that goes into a lot of different measures for each drug that is eligible for review. So if you go to Select Label Name, you can search for whatever drug you're interested in by label name, and there's also NDC available. And then here you can see that this drug had more than 10 people using the drug, so everything is populated. But if, for example, there's a drug with less than 10 people using that drug, you'll notice that these three measures are missing. And then if the drug didn't have any claims data, then it would just be missing for -- all eight of these boxes will be missing.

We also have a dashboard that is showing the number of drugs on multiple lists, and which lists they are on. So for example, this first drug is on both the 15% increase or over and 50% increase or over list, and then it also shows whether they are specialty or not, which they all are not.

Then finally, we get to the Prioritized Lists. So we have two lists, one list of top 25 specialty drugs and one list of top 25 non-specialty drugs. So here you can filter by specialty drugs or not, and then whatever you choose will show the top 25. And then there's also a lot of data here. There is a weighted rank, which we use to select the top 25 for specialty and non-specialty, and then there's the data for the six selection measures that were used to actually make this list, so they are highlighted in gray. And then there are just more data measures to provide context, and these are also in the Drug Lookup tab. And you can also filter by Label Name if you want. So this is useful if you want to compare two drugs. So for example, you just want to see the data for two different drugs, and you can just look at two at a time or three at a time or whatever you're interested in. And this also links to the last tab, which is some visualizations.

So whatever you filter in this prioritized list, or whatever you filter in this list, they are connected to each other. It's like their filters are connected to each other, so whatever you select here, it will show up here and vice versa. So I'm just going to take off the filter for now. So this is like a visual

representation of the data in the previous tab. Yeah, it just shows you the distribution of the different measures. And then I know this Increase Over 1 or 3 Years looks kind of weird because there's one data point, but only one of the drugs on either of the top 25 lists was on the increased list. The other ones were on the course of treatment over $60,000 a year. So there's only like one data point here, but I still think it's useful because if you hover over it, you'll see like more detailed information. And then same for the other graphs. If you hover over them, you'll see more detailed information. Yeah, that's all for the dashboard. And yeah, let us know if you have any questions or feedback or concerns.

Eileen Cody: I'd say it's quite a database. That would be my reaction to all of it. Any comments or questions?

Hung Truong: And this is public data, so can anyone come in and take a look at this?

Mike Neuenschwander: Right. Yeah, it's on our website.

Hung Truong: Yeah.

Greg Gipson: Is there any way -- I know there is, like it's kind of broken up by NDC for the drugs themselves. There is no way to combine, like [cross-talk] --

Eileen Cody: [Cross-talk] All of those doses and [cross-talk] --

Greg Gipson: [Cross-talk] Yeah, and all the tablet sizes of some dose or anything like that.

Douglas Barthold: You mean within the drug product lookup tool?

Greg Gipson: Yeah.

Eileen Cody: Did you hear that question?

Mike Neuenschwander: So, Kelly, for example, putting all the Enbrels [cross-talk] together.

Greg Gipson: [Cross-talk] Yeah. Like one dosage. Yeah, like all of the Afinitor tablets or something like that.

Mike Neuenschwander: So Kelly, can they select just to see what all the Enbrels together on the 25 list?

Kelly Wu: Sorry. Are you talking about this tab and like collapsing these together? Or are you talking about collapsing the drugs in this tab?

Mike Neuenschwander: Uh, on that one you can filter, right? Go down the filter by label name, and then you can leave all of the drugs with the [cross-talk] like-drugs together, and then you can see them just lined up together.

Greg Gipson: Yeah, that would be helpful, and then I can just add them together.

Mike Neuenschwander: Yeah. And then you can see, for example, what they would look like.

Greg Gipson: Yeah.

Douglas Barthold: Yeah. I mean, I agree. So in this section what you are showing now, that would still be on separate rows, though. So if you took, say the Cabometyx 20/40/60, it would be a different row for each of those. It would be -- I mean, I guess it would helpful, especially in the Drug Product Lookup Tool, if you could consolidate by say generic name because that way you can get all of the data consolidated for all of those rather than having to switch between them and see what the figures are for each of the different formulations or dosages or whatever.

Greg Gipson: Yeah, because ultimately if we put an upper payment limit on something, it would be for the -- it wouldn't just be for a single NDC. Is that correct? It would be for products within all the Afinitor tablets or something like that.

Mike Neuenschwander: Yeah. So that was one of the things that we were talking about doing is, yeah, we pick a drug, but then we would group them together and then do the review on the group.

Greg Gipson: Yeah. So if we are trying to compare all of these somewhat equally, you know, if you have a drug with many tablet sizes or dosage forms, you are sort of -- it may not show up high on this list that we are looking at.

Eileen Cody: So, Kelly, do you [audio cuts out]? I guess the question is, can you do that? Or I guess the question for you guys is the way that she described that she could do it, does that work for you?

Mike Neuenschwander: Yeah, like [cross-talk] -- oh, go, Kelly.

Kelly Wu: So I think we might we talking about two things here. So I think one, like you were talking about whether we are going to role -- whether we should have rolled up the drugs before

we created this top 25 list, and I think that we agreed that we would just [cross-talk] go with creating this top 25 list, and then we have roll up the drugs by label name or whatever after we selected the whatever drugs we are going to review. But now we're thinking maybe we should roll it up before we create this top 25 list? Is that the thinking?

Eileen Cody: No, I don't think that's what -- is that what [cross-talk] -- ?

Multiple Speakers: [Cross-talk] That's not what you were saying.

Mike Neuenschwander: You just want the ability, for example, with all the Enbrels, I went and selected it on my screen the top 25 with five different Enbrels, and so just being able to, like for example, add the total people using it and the total paid amount together, right?

Greg Gipson: Yeah, just to kind of lump them all together. I mean, we've got a top 25. They all look like pretty good targets. Then we'll have to think about within these drugs.

Eileen Cody: Is that what meets your question, too, Doug?

Douglas Barthold: I think so, yeah. For instance, like two and six together would potentially be rolled up when we -- if we were to do an affordability review on that, so I do think in that decision. And I remember that we talked about this before when we were defining the level of drug -- our level that we would be making this list at, and I can't remember why we decided to do it at this level rather than rolling it up a little higher. Does anyone remember that conversation?

Eileen Cody: Well, I won't say my memory is great, but I think it was that we wanted to pull it all out this way and then, as you said, roll it up after we did the top ones.

Douglas Barthold: Hm.

Mike Neuenschwander: [Cross-talk] Kelly, can you go and just select the Enbrels on that list?

Hung Truong: I mean, another way is you could search by generic name of it because it doesn't make any other -- NDC is totally different.

Mike Neuenschwander: So is there a way to export this to Excel so then we could sum, basically, this stuff?

Kelly Wu: Um, this doesn't allow you to download the data. I think it's a restriction because it is a public dashboard, or I'm not sure. But Greg, I think what you're saying is you would like to see what the data looks like if we rolled it up. Is that what you're saying?

Greg Gipson: Yeah. I mean, if the Board has already decided that they want to pick the top 25 based on NDC, that's fine, but I think my decision making of the top 25, I think at some point we should factor in accumulative costs of all of these products to the patients, to the health system, total number of patients on it, and sort of get a more global picture of that. Again, it's just because I see a lot of the same drugs with different dosage forms, even not in the top 25 list, and then that makes me worry that we're not seeing a complete picture of each drug, if that makes sense.

Douglas Barthold: I agree, and it's not a simple as just summing them because so, for example, the average out-of-pocket cost, you're going to have to take the -- to calculate that for all five of those rows, you have to use the number of users, the total out-of-pocket costs, and then recalculate for the five of those rolled together.

Eileen Cody: Ronnie, what do you -- you're on the Advisory Committee. What -- I'm sure you guys talked about this.

Ronnie Shure: Well, I know in the portal presentation to us they discussed the fact that other states are aggregating or putting all of the drugs together of a particular brand in order to develop the cumulative price. I don't know if that impacts our choosing the drugs at this point. It certainly would impact what the staff does with evaluating or finalizing the review. I believe that we will aggregate all of the different formulations of the drug in coming up with a final analysis.

Mike Neuenschwander: Yeah. And in the drug review, that will be altogether. See I think maybe what we could do here -- do we have any more questions not specifically on the dashboard?

Douglas Barthold: I have a couple of other points, but they are not related to what we are talking about now.

Mike Neuenschwander: Yeah. Laura says, can we filter usage? By [cross-talk] --

Eileen Cody: [Cross-talk] diagnosis? Uh, no. [Cross-talk] --

Mike Neuenschwander: [Cross-talk] No.

Eileen Cody: [Cross-talk] I don't think --

Mike Neuenschwander: [Cross-talk] No, I don't. I don't think [cross-talk] --

Eileen Cody: [Cross-talk] I don't think we [cross-talk] --

Mike Neuenschwander: [Cross-talk] We can't. We did not [cross-talk] --

Douglas Barthold: [Cross-talk] Yeah, I think we denied that [cross-talk] --

Kelly Wu: [Cross-talk] Yeah, that's --

Douglas Barthold: [Cross-talk] -- and it was [cross-talk] --

Kelly Wu: [Cross-talk] Um, oh, go ahead.

Douglas Barthold: We weren't -- because we weren't able to see indication at the claim level, and so we weren't able to know what these drugs were being used for. Right?

Mike Neuenschwander: Yeah. And I think another point was just as we were developing this dashboard to add the indications to this at this point, technically, it was going to be a bit of a hurdle. And so behind an Excel sheet that we sent out that did have indications next to it, but we just didn't incorporate it into the dashboard.

Kelly Wu: I also wanted to add that if you highlight the rows that you're interested in and you hover over it, it will sum it for you. So that's a really crude way to do it for now, since we don't have the totals by each label name rolled up.

Eileen Cody: Could you show us how to do -- what are you talking about? Can you show it on the screen?

Kelly Wu: Sure. So let me go to a non-highlighted row. So for example, for average paid amount, if you just select off by these and then you hover, it will sum it for you.

Eileen Cody: Oh.

Kelly Wu: So yeah. Wait, did it? I have no idea.

Eileen Cody: No [cross-talk] --

Kelly Wu: Never mind. Sometimes it works when I do it.

Eileen Cody: Yeah, it does look like an average.

Greg Gipson: Can you do the total and see if it's --

Mike Neuenschwander: So what do you do? You click on it and then select and then down [cross-talk] --

Douglas Barthold: No, that's just the one cell that you're hovering over.

Kelly Wu: Um, never mind.

Eileen Cody: Oh, okay.

Kelly Wu: But I noticed sometimes it does it. But yeah, I guess since I'm presenting, it's not going to do it.

Eileen Cody: Oh great. That's always the way it works.

Douglas Barthold: Okay. So I guess we should decide if we think that the level that we have done this ranking at is not the best level, then we potentially want to go back and aggregate to a higher level. And what should that be? I definitely agree that it's -- you know, I'm out of two minds because there is I think the level that we are going to be doing the affordability review at, which we would say, whatever, if that's all the Enbrels are all everything within one generic name, that's if we're doing it with the affordability review. It would make sense to rank all of the drugs at that level. On the other hand, this is certainly easier. And then maybe we can -- it gives us a sort of a cruder sense of how the ranking falls, and then we can choose the drugs that we see. Especially if there are multiple rows for one drug. I don't know. What do you all think?

Eileen Cody: Well, I actually think this -- that we can pick it from this because of the fact that you can pull it out and see how many times it's on the list and get an idea of what the total cost is [cross-talk] --

Douglas Barthold: [Cross-talk] some would be what if the drugs that -- what if on this list there was one generic name that filled rows 26 through 50 that we are not seeing right now, but if we aggregated them, then we would actually be numbered, like, one or two or something like that. And we're missing it because it's not aggregated.

Kelly Wu: Yeah, but these are based, again, on like these data measures, so if it's not already on the list, then it's probably like, for example, not a lot of people using it or not a lot paid for it, so --

Mike Neuenschwander: Yeah. I was going to say, if it didn't make it on the list "as is", the chances of multiple [cross-talk] much smaller things aggregating something slim.

Douglas Barthold: I agree. You know, the example I made up is obviously extreme. I was just, you know, trying to sort of illustrate the point of, like, what we could be missing. Yeah.

Eileen Cody: Well, I guess I'd also say remember this is the first time and will probably want to make adjustments after we have done our first round and figure out whether there are things that would make it go smoother or what -- you know, that type of thing, too.

Mike Neuenschwander: And you know, for example, the indications, that's something that's on our list of for the next go around on the dashboard to include that, but just timing-wise be able to that in and make it all work and not distort everything else in terms of how things display or fit, it just didn't work this go around. But yeah, I think we have with the lists, kind of like Eileen was saying, I think enough that we can, we can [cross-talk] --

Douglas Barthold: [Cross-talk] I agree. Wasn't -- and is Ryan here today? I feel like Ryan had some -- like when we were defining this level of analysis, Ryan had some reason why -- it was something within the eligibility criteria that we were -- that we decided on this level. Uh, I can't -- is Ryan [cross-talk] here?

Ryan Pistoresi: [Cross-talk] Yes. Yes, that's a good point. [cross-talk] --

Douglas Barthold: Yes.

Ryan Pistoresi: So when we were building out the list, we were look NDCs because we were looking at that cost threshold. And when we went back and had to revise that list, we did run into some of those issues, so that's why the dashboard is at this individual drug product level. From the discussion that you were having today, it sounds like you really want it at that drug ingredient level because, as Hung had mentioned, you could do it at that generic name. So I think what we can look at is having it at this individual drug product level right there at the top it says the 25 prescription drug products and also try to get the top 25 drug ingredients where we can get all of the etanercept, all of the adalimumab, and all of the others and have you be able to look at it both ways. So that way you can see if you do have a lot of different rows of the same drug that are taking up lower positions but an aggregate or higher and how that compares to some of these other higher drug products.

Douglas Barthold: Thanks. That's helpful. Yeah. And that's, I think that's what, basically, I was trying to remember.

Eileen Cody: Doug, did -- you said you had some other --

Douglas Barthold: Yeah, I mean, just kind of like generally about the dashboard. You know, when I -- so this is going to be like public on the website, right?

Eileen Cody: Right.

Douglas Barthold: So I think that like somewhere on the home screen it should say like what is the point of the dashboard. And also and specifically within the flow of what the PDAB is doing, You know? Says this is the 294 prescription drug price identified as eligible for affordability review. And so, like we need to -- I think that it would be important for us -- you know, we have that, like, triangle in our slide decks that show like where the eligibility, when we decide eligibility, and then we decide an affordability review, and things like that, having some information about sort of where this where -- how this falls into that process, I think would be very helpful for the public because they are not going to know what the eligibility means or affordability review means and things like that. See, that was -- one point of feedback. Um, I don't know. And then I have another one, but I don't know if anyone has any comments on that.

Mike Neuenschwander: No, I think that's a good idea in terms of -- we can maybe do some work on our web page. So just on the web page itself maybe it explains the dashboard and again kind of where it is in that step of as we're looking through this process. So we can work on some public facing and tweaks. Yeah, just to make sure it's clear because, yeah. We know what we're talking about, but a random Mike from Spokane walks in here, he's going to not know exactly what this is.

Douglas Barthold: Yeah, thanks. And then the other thing was on the Prioritized list -- basically the last two tabs to the -- on the right. I like that you can filter by specialty. Um, but I also -- like, I would want to be able to see the list without the filter applied, so basically having both Y and N as an option. Does that make sense?

Kelly Wu: So the top 25 regardless of specialty or not?

Douglas Barthold: Yeah. Just so you can see what that ranking is if you don't apply any specialty filter.

Mike Neuenschwander: Well -- and, Kelly, correct me if I'm wrong, but I thought the top 25 list was originally just the specialty pretty much, and then we added the second one just to get a wider, hopefully, usage. [Cross-talk] at the original 25 list is [cross-talk] --

Douglas Barthold: [Cross-talk] I think you're right [cross-talk] I remember that, too. Yeah. So my thought was just that so, for instance, let's say that I want to be able to look by drug, and I'm looking at this. So I filter by label name, and I'm scrolling in there, I have to then go and alter my filter by specialty selection in order to see a different set of drugs, and so you never really get --

you never get to see the full list of drugs unless you play with these different filters. And so that's why I think it would be helpful just to have the no filter option on specialty.

Kelly Wu: So you're saying like rank and weight all the drugs regardless of specialty or not? Or are you saying you want to see specialty and non-specialty, like the top 25 for each all in the same list?

Douglas Barthold: Umm. [Cross-talk] Let's see. So [cross-talk] --

Kelly Wu: [Cross-talk] I know but [cross-talk] just make sense of that.

Hung Truong: I think the last option.

Douglas Barthold: Yeah. So basically, they'll give you, like, the list of 50.

Hung Truong: Yeah.

Kelly Wu: Okay, yeah. I'll have to think about how to do that because I put in this rank column just to show the top 25 in order. So if I show it all, then -- I don't know if this rank column is going to work, so yeah, I'll have to think about that.

Doug Barthold: Okay. Yeah, I mean, that was just like, again, my thought was like, it's helpful to see all of the, like, you know, sort of -- if we have this ranking system that we have applied -- using all these data, I think it's helpful to see everything that we have identified at the top of this list all together, and that's why I was thinking, like, you know, I wanted to have the no filter option. But, you know, if I'm the only one that thought that, then, you know, maybe that's just kind of a weird thing to look at. But yeah. Anyone else have thoughts on that?

Kelly Wu: [Cross-talk] I think you [cross-talk] --

Hung Truong: [Cross-talk] I concur. Oh, [cross-talk] I concur with you, Doug. I mean, yeah, it's got to be dominated by specialty drugs just because of the cost.

Kelly Wu: Right.

Douglas Barthold: [Cross-talk] And that [indistinct] to see.

Hung Truong: Yeah. And do I think deciding on what to review, I mean, yeah, there is criteria, but we looked at something that affects the mass, which are usually the non-specialty drugs.

Douglas Barthold: Yeah. So maybe all the non-specialties are ranked 26 through 50, but then you can see as you go down that list of the specialties and then you get to the non-specialty, you see how many more users there are, that would be informative to our decisions.

Kelly Wu: Right, but the rank is by weighted rank, not by, like [cross-talk] --

Douglas Barthold: [Cross-talk] Yeah. Okay. So the weighted rank is within -- that is determined within specialties and then within non-specialties? Hmm.

Kelly Wu: Yeah.

Eileen Cody: [Laugh].

Kelly Wu: So I was asking if you wanted like an overall list that was just so weighted rank for like just weighted rank by -- like not specific -- not separating it out and just calculating the weighted rank and having the overall top 25, like we originally had.

Douglas Barthold: Right. Yeah, and I remember that. And I appreciate that you, like, you know, did that and went to this. Um, and like I said, I didn't -- this is very good the way it is. So then if we had a weighted rank overall without that filter, it would essentially -- it wouldn't -- 26 through 50 wouldn't be non-specialty, they would probably all be specialty, too, right? Yeah, Hung is nodding, yeah.

Hung Truong: And likely just because Enbrel is listed five times, you're going to get five Enbrels on there. That takes up five spaces.

Kelly Wu: Right.

Douglas Barthold: Okay. So essentially, the only way that we could sort of have one list would be to do the separated weighted rankings and then combine them. Basically, append the non-specialty list to the specialty list, and that would sort of -- and then that would need in reflect the true ranking. Yeah. And that could be misleading, so I guess it's fine the way it is. I was just trying to think of a way to see them all together.

Kelly Wu: Yeah, and if you do the overall list, you're not going to see any new drugs. There are just going to be a combination of drugs on both lists, like Hung said.

Douglas Barthold: Okay.

Kelly Wu: [Cross-talk] going to send you information.

Douglas Barthold: All right. That's fine then. Forget it. Forget this idea. It's a habit [laughter]. Yeah.

Hung Truong: Hey, Kelly, can this be filtered by therapeutic class?

Kelly Wu: No, but would you be interested in having that filter?

Hung Truong: Well, sort of yeah. The reason I say that is, you know, just reading back some of the comments from PhRMA and then from each coalition, I think when you pick one it affects the others in the same class. And this could be formulary choices. It could be provider selection. And so when we do a review, we have to think about if there are other options of how we're viewing. Do we review the whole class, so that way it decreases the downstream affect on others. Right? You know, PhRMA has a good point that you're picking one, then that's the one that's getting looked at. How are all the rest in the same class, right? Now, granted, I was thinking disease state, but then a drug can be used in many uses for it, as someone commented. So is it the class we look at? I mean, there is just -- I'm just thinking -- trying to think differently, taking account the comments that we're seeing.

Kelly Wu: Yeah, I could add in a filter for a therapeutic list.

Mike Neuenschwander: Great. Any other questions on the dashboard?

Eileen Cody: No?

Mike Neuenschwander: Okay. Well, we can continue refining this down and there are 100 different ways to slice and dice all of this, each with its pros and cons, but we'll keep trying to add more features just to help us see and organize things a little bit better as we go. But if there are no questions on the dashboard functionality, then we can move on to the next topic, which is more discussing the actual content of the dashboard.

Eileen Cody: And the Advisory Group members are going to tell us how they came up with their list also?

Mike Neuenschwander: Yeah. So I think what we're going to do is Simon has a small slide showing some of the cross between the Advisory Group members selected things, and you can kind of go through that real quick, and then we'll open it up if the Advisory Group members want to chat about their selections and why they did so, and if the Board Members have specific questions for them, and then we can kind of move on from there.

Eileen Cody: Okay, so [cross-talk] --

Simon Borumand: [Cross-talk] It's taking a second to load up.

Eileen Cody: Oh, okay.

Simon Borumand: And then I'll share my screen.

Eileen Cody: All right. We'll take a breath. Beginning to think our technology in this room isn't the greatest. I don't understand.

Mike Neuenschwander: I have it pulled up, but it's just giving like an error message [audio cuts out] seconds, so just bare with me.

Mike Neuenschwander: Want to take a quick break while we figure our technical stuff, Simon, do you think?

Simon Borumand: Sure.

Mike Neuenschwander: Yeah.

Eileen Cody: Okay.

Mike Neuenschwander: Five.

Eileen Cody: Five minutes.

Mike Neuenschwander: Okay.

Eileen Cody: Be back in five minutes.

Mike Neuenschwander: Okay.

Eileen Cody: While we work to get our technical [cross-talk] --

Mike Neuenschwander: Okay.

Eileen Cody: -- problems arranged.

Mike Neuenschwander: Okay, sounds good. So five minutes. Sorry for the delay. Just trying to get computers to work, and then we'll be back.

[break]

Eileen Cody: Okay, we rebooted, so things are working now.

Mike Neuenschwander: Okay.

Eileen Cody: All right. So do you want -- who wants to [cross-talk] --

Mike Neuenschwander: Yeah, sure. So we're back. We got our computer issues sorted out, so now I think we can go through the Advisory Group recommendations. Simon, I will let you just walk through this real quick, and then we can open up the floor to our Advisory Group members if they thoughts and comments, and then the Board Members if they have questions.

Simon Borumand: So each of the Advisory Group members were asked to admit their top five drugs that they would recommend for review. As we just discussed, you have the broader list of drugs with the doses. But why wasn't that just simplified if two members said Enbrel, whatever the dose, I just counted it as two votes for Enbrel, and then what we've done here is just put together a simplified list of what other drugs have multiple Advisory Group members suggesting. So if at least two suggested a drug be put on this list, and then we went and just for information purposes to see if ICER had done an analysis on any of those drugs, and it turns out for these ones there are analyses available online for all of them.

Eileen Cody: How many Advisory Group members are there?

Simon Borumand: Uh, five total and four submitted recommendations because one has a conflict of interest.

Eileen Cody: I see. Okay. Just checking to see how this plays out. All right. Well, we have a couple of them. I don't even know who everybody is, but I know Ronnie and yep. [Laughter]. So does everybody on the Advisory Committee want to tell us why you chose what you did, or how and what your processes were? Go ahead, Ronnie.

Ronnie Shure: I can start. I can start. So I chose drugs that were indicated for different purposes so that we just knowing that drug prices are related to a disease state. So looking at it from the perspective, I tried to divide my group up. Most of them were for rheumatoid arthritis, but they also have combinations of conditions that are addressed. So I use that as one factor. The other factor was looking at the ICER price increases over the past few years, and that helped me choose

the five drugs that I chose. So it was a combination of past price increases, which we don't have records because we are just starting. And the conditions, the disease state that they are indicated for, because I think there are economic factors that determine prices within a disease state, so by choosing one from three different disease -- or conditions that are on our top 50 list, I thought that would give us a model to follow for future evaluations. And I did look. I found the data from the dashboard very useful to look at the number of patients and using the drug. So those were my parameters.

Eileen Cody: Tim Lynch.

Tim Lynch: Yeah. My selection criteria is really based upon I thought the staff -- the ranking provided by staff was very objective, and they used a standardized process, which I really appreciated. I also looked at the number of patients that were impacted by the drugs. I felt that would -- I really wanted to capture more patients that would be impacted by a focused effort. I also did not want to duplicate drugs that have a different dose depending on the indication, and so I try to take that into consideration. Then also the therapeutic class, what they were used for and the patients that would be impacted by that. That was the criteria I used.

Eileen Cody: And Laura Berry.

Laura Berry: Well, let me first start off by saying I wanted to discuss some of the issues that I was having. I felt that I looked at the list and say, for example, Enbrel showed up five times on the list depending on different delivery devices. And I didn't know because I don't have a medical background what the different delivery devices would be used for. For example, one that I was able to find, there was one particular delivery device that was the only one that was approved for children. So we wouldn't want to rule out that particular -- and, unfortunately, I can't find it in my notes that I took earlier, but I think it might have been Humira. One of the delivery devices approved for children would have to stay on the list if that is the only thing that approved.

But, for example, Enbrel, I had trouble because I didn't know if you change a delivery device, if it's going to change the patient compliance, and if you change the patient compliance, if you are going to end up with more people, for example, in a crisis, and that, of course, would increase your whole cost. That would remove your purpose for saving money on these drugs. So I felt that I needed more assistance from a medical standpoint in determining which of these drugs would be cost efficient and for which purpose. Enbrel could be treated for rheumatoid arthritis, or it could be ulcerative colitis. And one of these drugs may be better for one particular item -- or more cost effective for treating colitis but less cost effective for rheumatoid arthritis. So I just wanted to put that out there that that was a significant question in my mind on how to go about resolving that.

I also know that some of the Board Members had chosen based on out-of-pocket expenses, but I couldn't find anything in the spreadsheet that listed the patient assistance programs that are offered by most manufacturers. And although they are stated as offered to people to help with low income, they are really provided to everyone. I had a child on a very expensive drug program for many years of his life and was provided a drug assistance program, but no one every asked me to provide any financial information. As a matter of fact, it was just simply assumed that I would want it. And of course I took it because it was a very, very expensive drug, but I didn't have to provide any information. So whatever the drug said it costs per month, that was -- I paid a small fraction of that amount. So if that is a consideration for the Board on the patient out-of-pocket expense, I think that needs to be researched a bit more.

That being said, I made the choices based on the information that I did have, and I looked at the National Institute of Health recommendation that said that Humira treats autoimmune diseases and more cost effective basis than Enbrel. So I just made that choice there and also based on the same sort of information I recommended that Taltz be reviewed for cost savings by simply the delivery devices that -- substituting multipack is more cost effective than the single pack.

Eileen Cody: Okay.

Laura Berry: Anyone have any questions about [indistinct]?

Eileen Cody: Dharia, do you want to tell us what --

Dharia McGrew: Hi. Thank you, Board Members, for taking the input of the Advisory Committee. Dharia McGrew on behalf of PhRMA. So as was mentioned by Mike, we did not submit any recommendations for specific drugs as we -- I'm here to represent the industry at large. And I would be remiss if I didn't caveat that we do have legal concerns with the underlying statute and some of the implementations so far. Putting -- getting that out of the way, I do want to speak to there was some discussion at the Advisory Group earlier with council about the random whether it's arbitrary or not, and I think that this exercise is an example of that. The Board has gone to great length so far to calculate -- do a lot of backend calculations at the staff level on eligible drugs to create a methodology for quantifying everything that can be quantified to do the ranking exercise to get to your top 25 drugs to create the dashboard, to do everything in quite a methodical and reasoned way.

And then after getting to your top 25 list by taking input from various Board members based on whatever factors are important to that Board member, while they might be important factors to that Board member, if drugs are chosen for review based on random factors, this is where we get to the observation that it is becoming arbitrary. What is to say that a drug wouldn't be chosen by someone because they don't like the packaging or the advertisement that they see on TV, and that

is not a metric of affordability. So that's why we have cautioned that this final step in asking for input from Board members selecting drugs based on that input for the final step is not the best idea. Thanks.

Eileen Cody: So, Dharia, are you saying that you think we should just take the top however many we decide to do by the weighted rank?

Dharia McGrew: I think that the Board should have discussions about choosing based on a metric, whether that's X number or whether that is -- however it's filtered, it should be based on a quantifiable metric and be X number of drugs based on that metric decided by the Board. Yeah.

Eileen Cody: Ronnie, did you have something else to add? Or is your hand still up?

Ronnie Shure: No. I certainly -- but I don't really understand what Dharia is saying that we are using metrics. Is that not your perspective? That we're making some kind of arbitrary decisions? Is that your criticism of the process?

Dharia McGrew: Yes, up until this point, the selection up to the top 25 has been a quantifiable use of metrics, and then the Board is required to solicit input from Advisory Committee, and that is appreciated. Technical input or metrics factors that are important to Board -- to Advisory Committee members and to Board members. But if considering that the next step is to choose X number of drugs for affordability review, if those X number of drugs are chosen at random from the top 25 list, then you've undermined all of the methodology and quantifiable work that's been done up until that point.

Mike Neuenschwander: Thank you. And I think [cross-talk] Jim has his hand up, too.

Eileen Cody: Yeah.

Jim Freeburg: Thanks. I appreciate that. And I don't wade until the legal aspects of something that I'm not prepared to go into, but I think it's not at all unusual for state policy-making bodies to have official advisory entities making qualitative input for policy-making decisions. That's very common. And so I think the PDAB's really doing its due diligence to incorporate multiple factors with some precision into this decision-making process. I would kind of echo what others have said about the influences on the decisions that we made individually as Advisory Group members. Another one that I haven't heard discussed yet is how other states are including drugs for review by their PDABs. I thought that was an important consideration for us to look at how other states are doing analysis as well. So I'll just add that as an additional factor for my decision.

Mike Neuenschwander: Great. Um, and thank you very much for that feedback. You know, I really appreciate the time that the Advisory Group members put into their recommendations. We forwarded all of your specific recommendations and reasonings to the Board members to take a look at and appreciate you taking the time to talk about them a little bit more here in depth. And you know I think the Advisory Group, it's outlined in the Legislation as a requirement. We're supposed to get that feedback and input. And I think everyone coming from your different backgrounds -- you know, Laura, for example, I appreciate your thoughts and just specific lived experiences, which are reasons why this work is important to everybody in which will give us that experience and that desire to participate. So I think that's very important.

And then just with the drug list itself here, you know, we have Dharia. I appreciate you bringing it up. You know, we've worked hard to do these methodologies and create this list. At the same time, I think using all of this information that we've worked to create is part of how we then come to a reasoned decision, kind of like what Michael was talking about in terms of it isn't just Greg taking a dart and chucking it at our list of 25 and whichever one it happens to land on, that's what we go for. It's using all the information as well as the input from our Advisory Group as we're required to do, and I think as Jim rightly pointed out, it was a very standard practice across government to then combine this information to make an informed decision and a reasoned decision using the data at hand, so I appreciate that very much. Board members, do you have any other specific questions for the Advisory Group members and some of their thoughts or comments on their selections?

Eileen Cody: Well, I was just looking at -- I mean of the record who they -- who -- the drugs that they recommended, they are all in the specialty or the non-specialty in the top 5, I think. So, I guess that I'm -- well, I guess this is for Dharia. It -- like from what you said is that you're thinking -- I guess with what you're -- we would do how you describe it -- you wouldn't have the differentiation between non-specialty and specialty?

Dharia McGrew: That's a decision for the Board. The Board just voted on the policy as laid out that did differentiate specialty and non-specialty drugs, I think. That's -- I'm not saying that that's an improper or a proper way to do it, but that decision should be made by the Board using quantifiable reasoned metrics.

Ryan Pistoresi: Hi, this is Ryan. I just kind of wanted to reiterate that the reason that we did split up the list between specialty and traditional drugs was that was a request from the Board because when we had originally presented the list in November, it was dominated by the specialty drugs, and they wanted more information to see how non-specialty drugs are, given that they do impact different disease states and different populations around the state. So I think one of the reasons for having these two lists was to be able to better understand how different populations are affected by these drugs.

Mike Neuenschwander: Any other questions from the Board to our Advisory Group members? No? Okay. Well, then I think that can kind of take us into the next phase of our discussion, which is I know we talked a little bit about this last time in terms of the number of drugs that we were thinking about and then which of those drugs based on the Board Member review and the Advisory Group input. So we can kind of go dig into that a little bit more. Again, I wasn't -- my intent today isn't to say these are the -- agree that we're for sure going to choose but rather let's come up with a short list here of things that we ponder about until our March meeting, and then if we need a little bit of additional tweaking to our dashboard or some additional information, we can gather that and kind of go from there.

Eileen Cody: Well, I guess I have a question about where we're at in some ways. I know that we have this little budget problem, and that contracts are not being -- you can't move forward with contracts. And so where -- how is that going to affect us? I mean is [cross-talk] --

Mike Neuenschwander: So right now in terms of budget, I know everyone's kind of getting their belts tightened a little [cross-talk] bit over the next four or so [cross-talk] years.

Eileen Cody: Well, yeah, it kind of plays into how many we think we could actually do.

Mike Neuenschwander: Yeah. And so I can't tell you all the details of exactly how this will work out because I think there's still quite a bit of uncertainty around budget and staffing and all that.

Eileen Cody: [Cross-talk] Yes, there will be until at least April.

Mike Neuenschwander: Yeah. So until April, I don't know that I have definitive answers, but that being said, knowing that there is a level of uncertainty and that resources have a decent chance of being constrained in a number of ways, I think a more modest approach to start with until there is a little more certainty will probably be preferable from a staffing point of view.

Eileen Cody: So we might want to like come up with the top 5 and then say -- go put them in order so that if you don't have the resources to do all of it, then [cross-talk] you're cut off.

Mike Neuenschwander: Yeah. Yeah. Yeah, I would say yeah. You know, kind of have our short list in March, we can sigh for sure. Hopefully, maybe they'll be a little bit better, clearer picture of what we can and can't do during that meeting, and then yeah, we can start out and do one or two drugs at a time and see how that goes. You know? And if we aren't able to get to certain drugs, we can either put that on the docket for our follow up year or maybe the next go around and decide, hey, there's something else there that is more enticing that we want to chose right now.

Eileen Cody: Okay.

Mike Neuenschwander: And that's just kind of me thinking out loud and leave it up to the Board's discretion on what you all want to try.

Eileen Cody: [Indistinct] When's cut off?

Greg Gipson: Cut off?

Unknown female: Oh, it's so long [cross-talk] like later February that [cross-talk] --

Eileen Cody: Of course. Oh --

Simon Borumand: [Cross-talk] The first one is February 21st.

Eileen Cody: Really? That seems early to me. [Laugh] [Cross-talk] [indistinct]. Okay. Just so I was trying to figure it out for March. [Cross-talk] That's the Committee cutoff, so then the Floor cutoff isn't until, must be, it's got to be March.

Unknown female: [Indistinct] [audio cuts out) [cross-talk] It's kind of like around the 20th [cross-talk] or something like that.

Eileen Cody: That's what I would think. And Fiscal cutoff, you know that?

Unknown female: I think a week after policy. Doug's like the [cross-talk] --

Eileen Cody: Okay.

Unknown female: Yeah [indistinct].

Eileen Cody: I'm trying to, like, figure out where we'll be at, whether you'll actually know anything on that.

Mike Neuenschwander: Yeah. Well, yeah. And I mean, again, we've been -- this is all new, so all of this is kind of a figure it out as we go. So we'll keep figuring one way or the other, just sometimes it might take a little longer depending on circumstances.

Eileen Cody: So at this point we need to think about how we're going to do the cut the list down , or [cross-talk] --

Mike Neuenschwander: Yeah.

Eileen Cody: -- what list, okay? All right, guys [cross-talk]. Comments?

Mike Neuenschwander: Doug, do you have a [indistinct], a handful that you feel passionate about? Greg? And we can [cross-talk] --

Douglas Barthold: No passion, just numbers.

Multiple Speakers: [Laughter].

Mike Neuenschwander: Oh, that's right.

Douglas Barthold: But the -- well, I mean, I think this goes back to the first thing we talked about today, like Greg brought up. I want to be able to aggregate this list by generic name both -- sorry, I got both lists, the specialty and the non-specialty list. Because again, like, yeah, Enbrel looks like it's probably number one, but I want to add up what the five Enbrels on this top 25 are. I also want to add up however many Xeljanz there are on the non-specialty list and see how that compares. You know, it's not quite apples to apples yet because -- this is not the row, the rows of these lists are not the level that we're doing the affordability review at.

Greg Gipson: I totally agree. I kind of want to see the top 5 or even like top 2 or 3 probably at the start and see how stark those numbers are compared to the rest of them [cross-talk] and probably just go by numbers. I mean, [cross-talk] --

Douglas Barthold: [Cross-talk] I'm just trying to copy and paste into Excel right now. I can't do it, so um [cross-talk] --

Multiple Speakers: [Laughter].

Mike Neuenschwander: We do have that Excel list that we sent out with the Indications. I think you can filter that. Well, it's [cross-talk] --

Douglas Barthold: [Cross-talk] Do we -- oh, I ---

Kelly Wu: I also want to say if you are trying to sum, it might not always be accurate because sometimes there could be people double counted that probably used two, maybe they went between the same brand name but different doses or something like that.

Douglas Barthold: So you're saying that an annual estimate of say, we have the 10 mg row and the 20 mg row, the same dollar went into both those rows?

Kelly Wu: And I'm saying if you're trying to sum it yourself, then we might double count people because they could have been counted if they had a claim for like the 10 mg and then counted if they had a claim for the 20 mg. But if we did it on our end, we will probably only count them once if we're boxing the ingredient name together.

Douglas Barthold: Okay. That probably sounds like -- that sounds to me about what we need to do. Right? I mean, that's -- yeah, you're right. So I just pulled up the Excel sheet that you sent, and yeah, we do have some numbers here, but Kelly is warning us that it would be a bad idea.

Eileen Cody: Well, but that's -- Kelly, is it just the people-- the number of people? Is it not the money?

Kelly Wu: Yeah. The number of people, but that's also used in some of the other data measures. So, yeah, I don't want to mess that up.

Douglas Barthold: Average out-of-pocket costs can be determined by the number of users.

Mike Neuenschwander: But I mean ballpark.

Douglas Barthold: Yeah.

Mike Neuenschwander: You know, for general purposes. I mean, I don't think we should be that far off. But yeah, we can work on some summing. So I mean, maybe do we want to have -- I mean, just kind of looking at it, we can talk about our, again, maybe our top 6 to 8. We can over the next month -- come back with these summed features to either confirm or deny, maybe, assumptions that we have and then make that final decision in March.

Eileen Cody: So our goal is to make -- basically get our list done in March.

Mike Neuenschwander: Yeah, to choose the drugs that we want is [cross-talk] --

Eileen Cody: [Cross-talk] I'm just trying to like play the [cross-talk] --

Mike Neuenschwander: [Cross-talk] Yeah.

Hung Truong: I can tell you that I live in this world day-to-day, and it's consistent with the list. It's exactly what I thought it would be and, obviously, the data is showing that. So I don't think, I don't think it will be that difficult to find -- to get that six to eight.

Mike Neuenschwander: Okay. So, Hung, what do you think the six to eight is?

Hung Truong: Enbrel, Humira, Cimzia -- um, what's on that list? I mean that --

Mike Neuenschwander: Taltz, Orencia [cross-talk]. Do you want Kelly to pull up the list for the screen and we can look at it on the dashboard?

Hung Truong: Yeah. The most of it will be the anti-inflammatories because when you look at Oncology, there won't be that many people on it. There won't be -- if you're looking at total cost. Enbrel, Humira, it's used for any type of colitis or inflammation. They're prescribed left and right.

Douglas Barthold: And my thought is that I certainly trusts Hung's judgement. Like he knows, he's in it, and I would guess that his rank is going to be what our rank is after we aggregate.

Hung Truong: Yep.

Douglas Barthold: However, in this public meeting, where this is all on the record, if we go and say that we're judging off of what Hung says, he thinks is the top 5, like that's not going to -- I feel like we're going to get sued. That's not going to stand up. If we have the same top 5 that are ranked according to our objective metrics, and then that is how we arrive at the top 5, then I think we're in good shape. And so that's why I'm like reluctant to kind of like name names until we have the level that we're going to be doing the analysis at.

Hung Truong: I concur, Doug. What I'm saying is that the top 15 or 20, any of it can be in the top 6 to 8, and you won't get an argument from me based on the data. That's all. Right? And so if -- and Mike was asking, what would be my guess? While those are the top 3, and I'm sure it's up [Cross-talk] there. We saw it, [cross-talk] --

Douglas Barthold: [Cross-talk] Yeah.

Hung Truong: -- so that's all. Dharia has a good point. We can't be arbitrary picking it because I like one brand over another. I'm not -- I have no allegiance to any of this.

Mike Neuenschwander: Okay. Greg? Eileen? Thoughts?

Eileen Cody: Go ahead.

Greg Gipson: I feel the same way. Yeah, I think we need to collapse the generics within the top 25, then sort them, and then help me by my preference to just go top to bottom.

Eileen Cody: Well, I'm trying to look at when you look at the non-specialty and the specialty, I agree with Doug that it's a little hard not to have them put together. That's the one thing, so I'm kind of going back and forth between the two to see where the non-specialty would fit in. I mean, the specialty are usually more expensive, but you know, depending on -- actually, the first one, I think, would extend [audio cuts out] [indistinct] specialty or maybe the non-specialty. I think that Xtandi, yep. Is that how you pronounce it now? It would probably fit the rank. Its weighted rank is 2.46, so that would -- if we're just looking at the numbers on the rank, I think it's in the top 5, too.

Douglas Barthold: Those weighted ranks are calculated separately for specialty and for non-specialty, so that wouldn't necessarily merge in. But I totally agree with your point. So I have both lists open next to each right now, and I'm trying to --

Eileen Cody: Yeah, that's --

Douglas Barthold: -- see how they fall.

Eileen Cody: I can't do that on my iPad.

Douglas Barthold: Yeah, I know.

Eileen Cody: Yeah.

Mike Neuenschwander: Okay. So long story short then, we want to be able to sum each of these -- you know, all sum all the Enbrels and the Humiras and everything together to see how they fall within that top 25. Correct? And then from there see how they rank, and then also join the two 25 lists together and see how things compare just as basically a top 50 list but with each of the drugs summed together to make it smaller group. Correct?

Douglas Barthold: Yeah. And so it's basically making that, like Ryan talked about, rather than the drug products level, it's the drug ingredient level.

Mike Neuenschwander: Okay.

Eileen Cody: Marina?

Marina Suzuki: Yes. Moving forward to the affordability review, what I'm hearing from the Board members is that the group thing you want to see is the group that we are going to conduct affordability review and how you're going to make the final decision on the affordability and upper payment limit. So there was a discussion that came up in the past of how to group some of the NDCs. Is it just the brand name versus generic name? How about different formulations? Especially the steroids and that kind of stuff. And it says some generic drugs have different brand name, even though it's the same drug ingredient for different indications. So I think it's good to hear your thoughts how exactly you want to group some of the NDCs. That way when we move forward to the affordability review, we don't need to regroup some of the drugs. So that was my question.

Douglas Barthold: I guess, do we have -- I'm looking at our two top 25 lists -- are there any -- you know, I'm looking at the generic names, and they all -- and I'm just trying to see if there are any that if we tried to combine, we would see a -- if we refer to combining by generic name, do we end of seeing a conflict in the brand name between -- within one of those groups?

Marina Suzuki: And that I think is another question, too. Are we doing a regrouping for the whole drug list or just the top 25?

Douglas Barthold: My thought it was just the top 25. And I can see it [indistinct] comes back to the definition of eligibility that we used, which was at this NDC level.

Mike Neuenschwander: So that should probably be relatively easy, Kelly, right?

Marina Suzuki: Yeah, some of the like, strengths or formulations not on the top 25 may be grouped if it is not the current top 25.

Mike Neuenschwander: Mm.

Marina Suzuki: Yeah, if it [laugh].

Douglas Barthold: So the question is yet, would we take -- so we have 296. Is that right? 296 eligible drugs?

Kelly Wu: 294.

Douglas Barthold: Okay. Do we go back to the 294, aggregate, and then do this sorting? Or do we just take these top 25 and aggregate and sort?

Eileen Cody: It seems like just the 25 because we already know where they have fallen [cross-talk] --

Douglas Barthold: [Cross-talk] I think Marina is [cross-talk] --

Eileen Cody: [Cross-talk] We looking for a lot more drugs. Let's just put it that way. We're not going to be able to do all the [cross-talk] top 25.

Douglas Barthold: [Cross-talk] Yeah. But the question is like, so what if when we aggregate the Enbrels, what if there is another Enbrel that is ranked 27th, do the costs for the 27th one get factored in -- get added to our list here? I would [cross-talk] --

Eileen Cody: [Cross-talk] Oh, I see what you're saying.

Douglas Barthold: I would -- I think yes, but I'm not sure. Yeah.

Greg Gipson: I would vote yes on that as well.

Douglas Barthold: Yeah.

Greg Gipson: So that's going to be like total impact of our final action.

Douglas Barthold: Yeah.

Greg Gipson: We need to know that.

Douglas Barthold: And so I think like, again, going back to the whole reason we have it at the NDC level was because that's how we made our eligible drugs list, and that's from the statute. And so that's still fine to have that as how we got to the 294, but then as we prior -- as we go through this prioritization process, I think it makes sense just to move the level to the level at which the affordability review occurs. And so that's why I think [indistinct] to the generic name makes sense There is -- I'm curious to hear what a pharmacist would say about combining cross formulation. You know, like whatever, a cartridge and a syringe, do we -- are we going to aggregate those in together?

Mike Neuenschwander: Okay, Ryan, let's get your thoughts.

Ryan Pistoresi: Yeah. In would say that it should be fair because the device delivery system may be a provider preference or a patient preference. So if you are looking at whether you would want to combine a syringe and an auto-injector, I think that they would typically be considered the same

drug. It's just that some patients may prefer an insulin pen, others who grew up and were trained on a syringe and vial may be comfortable continuing on a syringe and vial. So again, it would be both an appropriate therapeutic option for them, it may just be a preference.

Douglas Barthold: All right, so that's helpful.

Mike Neuenschwander: Ronnie, you got a thought?

Ronnie Shure: You know, I think to answer your question, Doug, different doses may actually indicated for different disease states. But, to me, the question we're asking ourselves right now is where do we get started? I'm hearing a long and lot of conversation about the final solution. I think we're looking now, correct me if I'm wrong, but we're looking now at getting started and trying to provide some keys medicines, key drugs. And certainly the question about aggregating, I don't it's a question, I think that's the only way to do it, and it's certainly what other Prescription Drug Affordability Boards have done, what Medicare negotiating prices the group has done, so I think aggregating the drugs is important. I think what it seems to me is the decision right now is how do we get started on these groups? I don't think we need to be concerned about leaving something out in the long run. I think this is a marathon, not a sprint. Thanks.

Eileen Cody: I think you have that right.

Mike Neuenschwander: Any other thoughts from the Board members on next steps then?

Douglas Barthold: Well, I guess I'm just wondering, are we in agreement on this? And do Kelly and Marina understand what we're thinking?

Mike Neuenschwander: Kelly and Marina, do you understand what they are thinking?

Eileen Cody: And are you going to be able to do it?

Douglas Barthold: Yeah.

Marina Suzuki: Mike and Michael, I don't know. Is this supposed to be in the methodology policy somehow? Like [cross-talk] how exactly to group some NDCs identifying the group of medications going towards the affordability review?

Mike Neuenschwander: Yeah, we'll probably have to do some tweaking there on that, Kelly and Ryan, in terms of grouping these together to create basically a summed list of the top drugs, does that sound reasonable?

Ryan Pistoresi: I think I have an idea on how we can group these drug products together to give a summary level kind of ingredient level overview.

Mike Neuenschwander: Okay. So then we can do that here and then come back to the next Board meeting in March, basically with our summed list, which given the competitive nature of some of the drugs, it should hopefully be decently short, and then we can kind of go from there. And it sounds like the Board members have been looking at the dashboard and kind of have an idea of what they expect in terms of the top drugs to be, but we can just make sure our data confirms what our current dashboard is indicating and kind of go from there.

Eileen Cody: Okay.

Douglas Barthold: Right now, I would add just that the dashboard as it is, is great, and so like keep the product level list on here. It's good information. But I'm thinking about this as like another tab of the dashboard that we can then use to see it at the drug ingredient level rather than the drug product level.

Mike Neuenschwander: Okay. Great.

Eileen Cody: That's good you don't want him to redo the whole thing.

Douglas Barthold: Just add more stuff.

Eileen Cody: [Indistinct] Just a little more work, right?

Douglas Barthold: Yeah.

Eileen Cody: With full employment. Okay, so that wraps that up [cross-talk] --

Mike Neuenschwander: [Cross-talk] And I kind of -- I think that kind of wraps it up. Ryan, any other thoughts of things we need to talk about?

Ryan Pistoresi: Well, I thought the discussion today was very good in helping us understand how you want the data to be presented and what you are looking for in terms of evaluating these different drug products. So I think I have everything we need in order to update this list for the next meeting.

Mike Neuenschwander: Great.

Eileen Cody: Okay. Any public comment? Do we have anybody signed up for public comment?\

Simon Borumand: I see, I think it's former Director Birch here. Are you a member of the [cross-talk] --

Eileen Cody: [Cross-talk] Not yet. She's got a couple hours here.

Simon Borumand: -- in a little bit Health Care Authority.

Sue Birch: [Cross-talk] 12 noon [cross-talk] --

Simon Borumand: All right.

Sue Birch: Actually, can I sign up for public comments?

Eileen Cody: [Laughter].

Sue Birch: I'm taking executive privilege. Um, I actually just wanted to [indistinct] that I'm Sue Birch. I'm the Director of the Health Care Authority. I want to thank this Board. This is hard work. This is work that is coming before its time while there are a few other states that have this work in motion, you all continue to pioneer forward. And so I think we're going to see so much more, especially with this new federal administration coming down about drug price is really important work. I just want to thank you guys, and who knows? Maybe I'll be working from the outside to kind of accelerate your pace and [audio cuts out] [laughter]. And so thank you. Hope that I see a hand up. Dharia.

Dharia McGrew: Thank you. I wanted to add for the public comment not just about the Advisory Committee discussion, so I wanted to add on a couple other things. Dharia McGrew on behalf of PhRMA for the record. I just want to say again, I do appreciate the Board hearing input from the Advisory Committee. It is absolutely critical that the Board here from consumers and providers, and appreciate taking tech input from industry as well. So I want to make that clear. I wasn't saying that the Board shouldn't hear that input but that, ultimately, Board decisions need to be based on reasoned metrics. I want to take the opportunity to remind Board members there was some discussion about cost to the health care system, so just our standard reminder that when a lot of the metrics that go into your list, APCD data, are based on WAC data, are based on list price and not net price, so of course, you're not looking at affordability to the system because you're not looking at what payers have actually paid. So that should always be in the back of your mind and, hopefully, publicly stated in documents like the dashboard.

I think we will go back, and I will take the discussion today and the dashboard now that it is public and go back to our subject matter experts, evaluate it, and submit a letter after the meeting with

some more technical comments on that. I will have to review comments earlier in the process on whether or not to roll up drugs. At first blush, you know, I have concerns with some of the discussion of rolling up drugs based on different delivery devices That is concerning to us because often a new delivery device offers a big advancement in patient benefit. I think it was mentioned that it might be better for the patient and therefore adds a lot of value, so when you're thinking about value to the health care system, the improvements in delivery, those two drugs are not the same. Those two drugs should be considered differently because a new delivery device is often a major advancement or it could be a drug that is taken hourly becomes a drug that is taken daily becomes a drug that is taken weekly, while they all have the same drug product, those changes in drug development are major advancements and have a major impact on value in the health care system. So we will submit a letter in a couple of weeks regarding today's discussion and the dashboard. Thank you.

Eileen Cody: Anybody else that has signed up there, Simon? No? Okay. I guess that wraps the meeting up then. Thank you, everybody. And you get to think for the next two months about all of this. I'm sure we'll be hearing from Mike and Simon.

Mike Neuenschwander: Yeah, we'll try and get these improvised pieces up out to the Board sooner rather than later, so they get time to ponder it and come to the next meeting, hopefully, with some pretty set ideas of how we want to move forward.

Eileen Cody: Okay.

Simon Borumand: It looks like there are two things in the Q&A [cross-talk] --

Eileen Cody: [Cross-talk] I think that was from earlier.

Simon Borumand: Is that old stuff? [Cross-talk] --

Eileen Cody: [Cross-talk] Yeah. That's when we couldn't hear [cross-talk].

Simon Borumand: [Cross-talk] Oh.

Eileen Cody: Yep. Okay.

Simon Borumand: Thank you.

Eileen Cody: Meeting adjourned.

Douglas Barthold: Thanks, everyone. Bye!

[end of audio]