**Washington State Pharmacy and Therapeutics Committee**
**Drug Utilization Review Board**
**Meeting Transcription**
**November 13, 2024**

Mike Neuenschwander: Okay.

MaryAnne Lindeblad: I see Doug is --

Mike Neuenschwander: I believe Doug is online, and I think Hung was going to come online as well today. [ cross-talk ] --

MaryAnne Lindeblad: [ Cross-talk ] He's going to be on my [ cross-talk ]. Okay. Are we ready?

Mike Neuenschwander: Yep, [ cross-talk ] I think so.

MaryAnne Lindeblad: [ Cross-talk ] Okay, great. Well, good morning. Here we are again with our PDAB Board [audio cuts out], so, yeah, Board Meeting or maybe even more. [ cross-talk ] It feels like we get together a lot. Anyway, I want to welcome folks. And what I'd like to do first is some introductions. MaryAnne Lindeblad, I am Chair of the Board, and we could go around to the folks in the room. Um, Greg Gipson is new to us today, and we'd like Greg to maybe -- maybe, Greg, you can start out [ cross-talk ] --

Greg Gipson: [ Cross-talk ] Sure. [ cross-talk ] --

MaryAnne Lindeblad: -- with an introduction and tell us a little bit about yourself.

Greg Gipson: Yeah. So my name is Greg Gipson. I was born here in the Northwest in Portland, but we're up in Olympia, actually. So it's kind of fun to have an opportunity and an excuse to come back to the area, but I'm in Seattle now. For most of my training I went to school up in Western Washington and ended up going to pharmacy school. I came back to the area after that from California. A residency at the University of Washington Medical Center. I have since stayed. I worked as a pharmacist, kind of focused in critical care. I did some Cardiology work and some other things, but mainly in hospital pharmacy for about 10 years. And then about a year and a half ago, I switched over to a different goal within UW Medicine. Now, I'm a drug policy and utilization pharmacist there. A lot of my work now is looking at drug

costs, drug use, policies associated with all sorts of medication-related issues. Drug safety is a big aspect of my position there. I've also played a role in our pharmacy residency programs, so I do mentor a lot of learners and people going through the program, gaining skills after they've completed their formal pharmacist training. Yeah, and now I'm here to play a role in this. So I'm happy to be here, and thanks for bringing me to the Board.

MaryAnne Lindeblad: What do you do for fun?

Greg Gipson: So what do I do for fun? Yeah. Well, I've got two small children, so a lot of things involve chasing children around and to the park, monkey bars, you know, but I used to ski, and cycling was a lot of fun for me.

MaryAnne Lindeblad: Well, welcome.

Greg Gipson: Yeah. Thank you.

MaryAnne Lindeblad: Great to have our final fifth member [ cross-talk ]. Um, Eileen.

Eileen Cody: Eileen Cody. Former -- well, I'm a nurse first [laugh] --

MaryAnne Lindeblad: Nurse first.

Eileen Cody: -- nurse first and a former state representative.

MaryAnne Lindeblad: And we've got a couple of the Members who are online, Doug.

Doug Barthold: Hi everyone. Doug Barthold, Board Member. I'm a Health Economist and Research Associate Professor in the UW School of Pharmacy and the Comparative Health Outcomes Policy and Economics Institute. Thanks.

MaryAnne Lindeblad: And is Hung on? I don't see him. I think we'll have him introduce when he arrives [ cross-talk ]. And so I would like to have the staff go ahead and introduce themselves here in the room.

Mike Neuenschwander: Yeah. I'm Mike Neuenschwander, the Director for the Prescription Drug Affordability Board here with HCA.

Ryan Pistoresi: I'm Ryan Pistoresi. I'm the Assistant Chief Pharmacy Officer here at the Health Care Authority.

Michael Tunick: Michael Tunick, Assistant Attorney General, and Legal Counsel to the Board.

Simon Borumand: I'm Simon Borumand, Policy Analyst on the PDAB team.

MaryAnne Lindeblad: And then the staff that are online. And I -- little print. I can't [ cross-talk ] --

Eileen Cody: [ Cross-talk ] I know. [ laughter ] --

MaryAnne Lindeblad: Kelly, can we start with you? Well...?

Kelly Wu: Yes. Oh, can you hear me?

MaryAnne Lindeblad: Yes.

Kelly Wu: Okay. Hey, I'm Kelly, and I'm the PDAB Data Analyst. [ cross-talk ] --

Mike Neuenschwander: Um, Marina?

Marina Suzuki: Hello. This is Marina Suzuki. I am House Economics Research Manager, so I'll be helping with Affordability Review.

Multiple Speakers: [ Cross-talk ] [ laughter ] --

MaryAnne Lindeblad: [ Cross-talk ] It might make it easier to see things [ cross-talk ] a little better.

Simon Borumand: Good call, yeah. Okay, when something is [ cross-talk ]Thank you.

MaryAnne Lindeblad: Thanks.

Mike Neuenschwander: Okay, Jingping, are you on?

Jingping Xing: Yes, this is Jingping. I'm the Cost and Quality Analytics Manager in HCA in the Data team.

Mike Neuenschwander: All right, thank you. I think Donna texted me. She'll be on here a little bit later, so --

MaryAnne Lindeblad: Great.

Jingping Xing: I think Hung is also online, but he thinks he cannot speak. I don't know if he has the panelist access or not.

Mike Neuenschwander: Okay.

MaryAnne Lindeblad: Okay.

Mike Neuenschwander: Okay. I'm in here to see if we can get him on.

MaryAnne Lindeblad: [ cross-talk ] you can get him.

Eileen Cody: Look on the attendees.

Mike Neuenschwander: Oh, on attendees. Okay. Putting him in this group as a panelist.

MaryAnne Lindeblad: We'll get this.

Mike Neuenschwander: There we go.

MaryAnne Lindeblad: All right. Is he on?

Hung Truong: Yeah, hey! [ Cross-talk ] [ laughter ].

MaryAnne Lindeblad: I'll go.

Hung Truong: Hi, sorry. I was joined on the website, a Zoom link, and I didn't have one to [ cross-talk ] --

MaryAnne Lindeblad: Great. Well, why don't we go ahead and get started? So, Mike, I'm going to turn it over to you.

Mike Neuenschwander: Great. Let me pull up my list of stuff to talk about. So we had our first Advisory Board Meeting last month, where we were able to begin introducing the Advisory Board basically to the PDAB and the Legislation and their role. I know some of the Advisory Board Members have already been following our PDAB work here, so for some of them it is a little bit of a review. So our first meeting was more kind of like we did with our first Board Meeting, more administrative in nature just trying to get the foundation set up for what we will be doing. So we will talk a little bit more about the next steps for the Advisory Board here later at the end of this meeting. So that was

good to have that up and running. We have also had the opportunity to answer some questions from some of our partners in the industry and refine some of the work that we have been doing, which has been great. So with that, we are doing some updates to our draft Eligible Drug List and tweaking a few of the ways we do some of the calculations to help clarify some things. So that was -- we've had some really fruitful and useful meetings here in the past couple of weeks with that. And so with that, we'll be updating that list and some of the data in the coming days then uploading that data -- that revised data into the dashboard as well. So once we get that finalized, we'll share that with everyone. And along with the dashboard, we're very, very close to having that completed here. We're still going through, again, some final tweaking and inputting of the data as well as the final steps of the approval process to get it shared here with the Board and the Advisory Group. So -- the final version is still going through that process, but as soon as we get that done, we will share that link. Today, Kelly will be talking about -- the methodology and kind of the selection process of what's making the dashboard work, and she'll have some additional data to share in terms of the weighting and rankings and everything the Board submitted as well as how that shapes our top 25 list of drugs that we'll be able to look at. So in the coming days, very soon look for that. And then, again, I'll talk later about how we will use that and present it to the Advisory Board as well to help give us input for our next meeting here in January, in terms of looking at which drugs you want to select. And then just kind of a follow-up public comment we had. Sarah Lanford from the Policy and Advocacy Association for Clinical Oncology, asking a question, and I just want to make sure one of the public comments we followed up in terms of how we work with physician-administered drugs. So, Ryan, you want to --

Ryan Pistoresi: Sure. Yeah. So based on the statute for how the PDAB identifies eligible drugs for review, the criteria are really around how the drugs are dispensed. So if a drug is dispensed from a retail specialty or mail-order pharmacy, it is eligible to be counted under our drug list. When we think about physician-administered drugs, we typically don't think of them as being available through a pharmacy, but because a lot of these physician-administered drugs are, in fact, available through pharmacies, they are being counted for the drug list. I think a good example to think about is the long-acting injectable group are a few medications, so Sublocade and Brixadi. There is a REMS program in place that makes it a requirement for any of these providers to get these medications to make sure it never ends up in the hands of the patient. But these drugs are, in fact, available through specialty pharmacy. So

even though this medication can never be dispensed to a patient, and it has to always be administered by a physician, it does meet the eligibility because it is available through specialty pharmacies. The same thing is true for limited distribution pharmacies because these pharmacies are dispensing medications where the pharmacist is labeling it with the patient's name, and it's leaving that pharmacy, even if it's going to a physician's office for them to administer it, it still meets the statutory definition for being eligible on the drug list. So even though we don't typically think of the physician-administered drugs as drugs under the purview of this because they are available through these specialty pharmacies, they are ending up on our Eligible Drug List. So just to keep in mind that that was a comment that we had received seeking questions about why these drugs had appeared on the list. You know, this is the reason why they are still on the list.

Mike Neuenschwander: Okay.

MaryAnne Lindeblad: Thank you.

Mike Neuenschwander: Thank you. Yeah, and I just kind of want to follow up, we really do appreciate the comments -- public comment that we received. We do look at it, and it gives us an opportunity to dig in and answer some of these important questions as well as help sort of refine our process. So we greatly appreciate that, and we'll follow up with that message with a written explanation as well just to make sure we close the loop on that. So with that, I think those were my big topics for the Director Update here.

MaryAnne Lindeblad: All right. Um, so next topic. So the Board will be voting on updates to the Eligible Drug List Identification Policy and, Mike, take it away.

Mike Neuenschwander: Yeah. So we have been working on this policy over the summer. Again, we had some comments from industry which allowed us to go back and tweak some of the language, but basically this is the policy that we use to put together that initial drug list, which then we will pull from to help create our dashboard. So I know we've talked about this and looked at it in the last couple Board Meetings and some of the changes, so I think nothing really new this go around, so I think we're just we're [ cross-talk ] get ready to vote and go for it.

MaryAnne Lindeblad: Okay. So let's go ahead -- and vote -- on the Eligible Prescription Drug Policy. So [ cross-talk ] for all of those --

Eileen Cody: [ Cross-talk ] You need a motion.

MaryAnne Lindeblad: [ Cross-talk ] I need a motion. Thank you. [ laughter ] That was your legislative [ cross-talk ] --

Eileen Cody: [ Cross-talk ] that we enforce the [ cross-talk ] --

MaryAnne Lindeblad: [ Cross-talk ] Thank you.

Eileen Cody: [ Cross-talk ] policy as written.

MaryAnne Lindeblad: Do I have a second?

Greg Gipson: Second.

MaryAnne Lindeblad: Great, so it's been moved and seconded to go ahead and endorse the policy as written. All in favor.

Multiple Speakers: Aye. Aye. Aye.

MaryAnne Lindeblad: Any opposed? All right. It's been moved, seconded, voted, so policy [ cross-talk ] --

Eileen Cody: Those motions. We've had motion sickness before. [ laughter ]

MaryAnne Lindeblad: All right, go back to that. So now again turn it over to Mike, going to be reviewing the drug selection policy.

Mike Neuenschwander: Yeah. And so with this one, basically, this is going over what we've been discussing at the last meeting. This is trying to write it down and put it into a standardized written format of what we're doing, and Kelly will go through a lot more of this today during her presentation. So this is basically our first draft to take a look at it and introduction to how going over the different criteria that we talked about in terms of the six criteria that the Board wanted to look at as we're creating this dashboard to create the drug selection policy, the weighting, how the weighting works, incorporating the weighting votes or numbers or the different categories at the Board selected. And so, again, Kelly will walk through this more. So this is more just kind of the initial look. Take a look at it. Cruise through it until the next Board

Meeting, and then if you have questions or other comments or problems with it, then we can address it here. So more just the introduction to this new policy and the ranking of how we did that.

MaryAnne Lindeblad: So was the plan then to take a vote on it next time [ cross-talk ] --

Mike Neuenschwander: [ Cross-talk ] Yeah, as long as, again, everyone's happy with it. [ Cross-talk ] We all understand it and we're all good with it. And of course, if you have time for industry and anyone else to have some public comment on it, help us if they think that we've missed any news.

Eileen Cody: So --

MaryAnne Lindeblad: Any questions?

Eileen Cody: So on the ranking, I see that we had a tie on [indistinct]. Are we going to have to figure out which comes first [indistinct]?

Mike Neuenschwander: I think Kelly will walk through the how this ties all of that in at the end of the day with this ranking. It's not so much super important what is first and second, and I think the key is trying to narrow down a huge list to [ cross-talk ] a smaller list. And then as we look at the top handful of those drugs, then the Board Members can look and decide, hey, these drugs -- look like the most expensive. These ones have the most utilization. These drugs have generics, which might affect that. Additionally, Kelly has put together a list of what states -- or what drugs other states have reviewed. So if we say, Okay, well, Colorado has already looked at Enbrel. Do we want to do a review that another state has done? Yes or no. If you know -- maybe yes because we think it would add more weight to the review, or no, let's not duplicate work that someone else has already done. So that's up for the Board to decide.

Eileen Cody: But don't we have to at least review the review if we were going to do the -- I mean, we are a couple years from this, but to do the, like the price [indistinct].

Mike Neuenschwander: Yeah, the upper payment limits?

Eileen Cody: Yeah, upper payment limits.

Mike Neuenschwander: Yeah, yeah. So if you want to do an upper payment limit on a specific drug, then we need to do a drug review on it first [ cross-talk ] --

Eileen Cody: [ Cross-talk ] Even if another state has done it.

Mike Neuenschwander: Yeah.

Eileen Cody: Yeah.

Mike Neuenschwander: Yeah. And so, yeah, that's I think some of the things that the Board can consider, but Kelly will kind of walk us through all of that here in a little bit. So anyways, for your information, take a look at it, read it, and okay holes in it -- that's what it's here for here is to help us make it a better product. Okay. Any questions on that policy?

MaryAnne Lindeblad: All right. So, Mike, again [ cross-talk ] next one.

Mike Neuenschwander: Yeah. So then that takes us -- we're done with kind of the paperwork policies. Now, we're starting to get into -- we'll do the initial kind of review of the dashboards here with Kelly and Jingping or the strategy behind that. But also another conversation that we need to start having here soon is, how many drugs do we want to review? So the Legislation [ cross-talk ] outlines that we can do quite a number of drugs here on this initial go around should we so desire, but we don't have to do -- was it set to 24, I believe?

Ryan Pistoresi: I think up to 25.

Mike Neuenschwander: Yeah, or up to 25. Um, 24 or 25. [ Cross-talk ] --

Ryan Pistoresi: [ Cross-talk ] 24. Yep, 24.

Mike Neuenschwander: Okay.

Ryan Pistoresi: Okay, sorry.

Mike Neuenschwander: No worries.

Ryan Pistoresi: I was looking at something else.

Mike Neuenschwander: However, I don't know that we necessarily have the capacity at this point to do the 24, so I'm kind of opening that up to the Board maybe to -- we don't have to make a firm decision today, but I think in the next meeting or so we'll need to decide on that.

MaryAnne Lindeblad: Doug?

Mike Neuenschwander: Doug has something.

Douglas Barthold: Thanks, guys. Yeah. I just -- so just for determining the number of affordability reviews that we want to do, I think for us to have any sense of the right number we have to -- we need to know the time span over which we have to do them and how long we think it takes to do one. Because, obviously, that feasibility constraint is, I think, going to be the most important one. You know, obviously, like you said, right? I don't think we need 24, and so it can be two, it can be six, like that or not? Can we do 10? I have no idea, and so do you guys have any sense of what we do have capacity for?

Mike Neuenschwander: Well, and so with that, we do have Marina on and -- oh, hold on. There are some questions on document access, Simon. As we've never done a drug review before, a lot of this would be a little bit of guesswork, and I don't know. Marina, do you have some initial thoughts? As she's kind of leading the charge here on developing our drug review? Might have stepped away.

Marina Suzuki: Oh, sorry [indistinct]. Yes. So the plan is we are developing the stakeholder information forms, so we will collect both [indistinct] and also some data from all our stakeholders including manufacturers, patients, and also the experts of the subject matters. And hopefully, we'll be reaching out to the [indistinct] centers also. And the once we collect everything, we'll summarize the information, and we'll keep the confidential [indistinct] information for the Closed Session, but we can share pretty much everything with the Board Members. And Cost Effectiveness Analysis Budget affect on this will also be collected as well. Whatever is existing from the manufacturer site as well. Yeah. And so outline what is shared at the last Board Meeting, but we are still developing the old forms ,so we can still make tweaks if there are any additional requests. But yeah, the plan is that we collect information first from our stakeholders. We'll do an internal review, validation, and summarize, and then we'll present to the Board Members.

Hung Truong: Mike, would we be able to ask other Boards who have already done it just an estimate on how long it's taking? And then are we able to get like a preliminary list? Say, the top 24 for us to take a look at? I know the information might be difficult to get as Marina has said, but if there's a preliminary list, then we may know, like, okay, there are 10 that really stood out, and then maybe we decide on the 10. So I don't know how difficult that would be.

Mike Neuenschwander: Yeah. And we do have a preliminary list here, and Kelly, I believe, will be talking about that here in a little bit, so we can take a look at that. Again, once we get the dashboard finalized, then there will be a lot more data associated with that list, and you can kind of compare and contrast drugs, which would be really nice. But yes, we will talk about that preliminary list and, yes, we definitely should follow up with the other Boards on what's happening with them. I know some other states started and found that the drug reviews were a little more complicated than they had anticipated, so then they had to kind of stop and restart. And so, I know there have been some difficulties with some states on that. But yeah, Colorado has completed their five drug reviews, and I can follow up on the exact timing of how [ cross-talk ] long each of those took.

MaryAnne Lindeblad: Did that -- are they the one state that's completed some numbers? You know, some number?

Mike Neuenschwander: Yeah. Maryland has selected some drugs for review. I don't believe those reviews aren't done yet. Those have been out pending for a pretty decent time, right? And so, yeah, Colorado is the first one that's actually gone through and done it. And I believe Oregon has restarted some of their different reviews as well. So every state is kind of in a little bit of a different spot with that.

Doug Barthold: And just to follow up on the time span, do we have a date by which we need to be done with however many we do?

Mike Neuenschwander: So there is no -- required, like you have to do X by, you know, every single day. It says you can do up to 24 per year. As this -- you know because we're still developing the program, and we haven't finalized our methodologies with this stuff yet, this first year will be a little bit weird as we are still building the airplane as we fly it, but then in subsequent years, once, once -- so kind of my vision is, I guess, let's get through a few -- see how long, see

what it takes to do it. Start small, and then once we have a better idea of [audio cuts out], it gives us a chance to work the kinks out, and then we can go, and the following year have a whole lot better idea of, okay, this is where we had problems last time. This is the data. Here's how long it takes to collect it. You know, based on our staff capacity, we can do X, Y, Z and kind of extrapolate out from there. But as this is all very new to everybody across this country, I don't have a solid answer for some of this stuff yet.

MaryAnne Lindeblad: Mike, do we have an obligation for a report or anything for the Legislature for 2025?

Mike Neuenschwander: Yes. So we do annual reports of our updates on our program, and it is due in December of every year, and so with that we tell them what we have done and that the drug [ cross-talk ] --

MaryAnne Lindeblad: [ Cross-talk ] No specific expectations [ cross-talk ] at this point. [ cross-talk ] --

Mike Neuenschwander: [ Cross-talk ] Yeah, but there [ cross-talk ]. Yeah

Eileen Cody: But the drug has to -- I mean, if once we do the review, then it has -- the Legislature has to have a session before there would be an upper payment limit. [ Cross-talk ] So it does, it should be kind of -- I would expect that we should time it to be -- get reviews done for the year by December so that [ cross-talk ] --

Mike Neuenschwander: Yeah, and I think once we kind of get the system going, we can do that, but again, upper payment limits aren't even [ cross-talk ] --

Eileen Cody: [ Cross-talk ] Right, I know. [ cross-talk ] --

Mike Neuenschwander: [ Cross-talk ] until 2027. So it actually works out really well right now in terms of timing, giving us this time to develop the program, develop these drug reviews, and then once we kind of go a groove going, then we can set that cadence so it appropriately times out with any approvals that the Legislature has to do.

Eileen Cody: I know they will be looking for [ laughter ] [ cross-talk ] --

Greg Gipson: So I guess how important is it to set like a number right now? Can we do two of them and just kind of time it and see how it goes, and use that to reassess our process? Or can we have a pick?

Mike Neuenschwander: So there is nothing that is saying you have to do X. Um, and so I think given where we are at, you know, giving ourselves as much flexibility a possible. I'm kind of a fan of start small, and if it's a lot easier than you thought, oh, great! We can add a couple more is kind of my philosophy. But, yeah, I guess I don't, but I would recommend against is, Hey, let's try and pan out 20 this year and then realize, holy smokes, we just bit off way more than we can chew, and now we're in trouble.

Ryan Pistoresi: Yeah, and I think one of the things that we'll need to consider is that for the affordability review today is we'll be working with different drug manufacturers, and some may be quicker to respond than others, and so by having a few that run parallel to each other, we can then say we got this data back earlier. We could then start processing this affordability review, but we had question with this other manufacturer. It was the data we received from them may not be lining up with the other data that we have resources that there may be [audio cuts out] this Board conversation. So I think having a few that run parallel to each other gives us the understanding of how we work with multiple drugs at the same time.

Mike Neuenschwander: Yeah.

MaryAnne Lindeblad: So, Mike, are you open to get a firm number or just a [ cross-talk ] --

Mike Neuenschwander: [ Cross-talk ] I think for right now, it's just more of this discussion of, you know, I think Doug has some really good questions. We can go back and look at that. If there are any questions that the Board has, toss them to me know, and we can make sure we are putting all in the docket. I think this is more of the initial, let's start thinking about this and again, answering these questions that you have in terms of what our expectations? What other requirements? Do we have to pick X amount of drugs? You know? Can we switch? Can we add more later? And so I think just having this initial discussion to grease the skids and have the Board Members come back next time saying, okay, I want -- I think we, you know, based on the information that we have and based on the questions you have answered, I think I want to do X. And then you guys can decide amongst yourselves working up or down of what we think this appropriate and realistic, so [ cross-talk ] --

Marina Suzuki: Mike?

Mike Neuenschwander: Yep.

Marina Suzuki: Um, this is Marina. So for choosing the medications for review, I think it is helpful if it's a prioritized risk instead of we pick five drugs for this year, we have maybe like top 5, top 10 prioritized list and will start from number 1, and we will start reaching out and see how long it takes to get all the data and information, so that way we know which one Board Members are most interested in rather than having just a bullet point list if they have prioritized. I think it is helpful for us to know where to reach out first. Yeah.

MaryAnne Lindeblad: I mean that makes sense to me. Maybe we end up with a list of 10 and then prioritize and start from that number one and work our way down and get a sense of what that work looks like.

Mike Neuenschwander: Okay.

Douglas Barthold: I like that, too.

Mike Neuenschwander: Yeah. And then I think maybe we can kind of have that list, start with our top ones, and then depending on the time frames that we have and when the next list of drugs come out, we kind of get what we get and we can start over, and if the next list is very similar, you can use that as a starting point to help pick where we are going from there.

Eileen Cody: What we'd be really happy about is if they're in the top 10, but we didn't get to them, if they would lower their prices so they were not on the list the next time.

MaryAnne Lindeblad: They took themselves off.

Eileen Cody: That's right! [ laughter ] There's always a possibility.

Mike Neuenschwander: Yeah, yeah. [ Cross-talk ] Well, you never know, never know. We have lots of people here listening. You know? Maybe we could come to an accord. Okay. Um, any other questions? Oh, Doug.

Douglas Barthold: Yeah. Just on like sort of the prioritization. The one I really like is that approach of if we have our ranking and we start at that point or however we can do, that's great. Um, the one thing that I would be concerned about with that is like if -- you know, I'm guessing there is going to be varying degrees of difficulty with the different drugs, and so I don't want to see it hung up on like our second one is really hard to do and we can't get any data and we're waiting around forever, I don't want that to delay the third. So I don't know if we're going to be able to do that in parallel to each other and sort of start the next one as we are waiting for whatever the manufacturer from the second one to give us the data we want, or as you know, [indistinct] accumulating evidence about them. I don't know. Does that make sense? Do you think we'll be able to do that in parallel?

Mike Neuenschwander: Yeah, yeah. I think doing a couple at a time within parallel, especially to start out. Because, yeah, I think there is going to be a degree of hurry up and wait as you put out a request for data and you are waiting for someone to respond because there is some data, as Ryan was discussing during our last presentation that we can pull from A, B, C, D, or FDB, or any of our other internal sources that could help inform certain parts of where [indistinct] additionally might have data that we could use or other external partners. So with that, if there are places where we can pull data or use data that exists, that is a lot faster, but yeah, then there are going to be parts where it is the hurry up and wait. We have got to have people respond. And if there are questions, then you got to go back and forth. See I think if there is a -- I think the idea would be to have a couple [ cross-talk ] chickens in the pot, so to speak [ cross-talk ] --

Eileen Cody: [ Cross-talk ] You do a data call or like the first [ cross-talk ] several --

MaryAnne Lindeblad: [ Cross-talk ] Three or four [ cross-talk ].

Mike Neuenschwander: Yeah. And so kind of see where we go, and depending again, as Ryan was talking about on something that maybe moves a little faster, that report can get done faster, so. But again, I think that's the vision, and we'll have to kind of see how some of that plays out when we actually are doing it. It all sounds easy on paper. [ laughter ]

Marina Suzuki: Now, just to give more like realistic expectations, [indistinct] usually takes 7-9 months to give you one drug. Colorado is similar. I think with the first drug they took like nine months, so it's not like we request all the information for

this month and then we'll get everything by the next Board Meeting. So I think it will be a long process to collect everything and advise and summarize the information. So I like the idea to reach out to multiple drug companies, patient groups, in parallel and see how it goes.

Greg Gipson: Is there a time limit for how long the drug companies have to get back to us?

Mike Neuenschwander: Yeah. According to the Legislation, I want to say it was 30 days.

Ryan Pistoresi: And if they don't, then there is a fine.

Mike Neuenschwander: Yeah.

Ryan Pistoresi: There's no teeth to it.

Mike Neuenschwander: Yeah, and the fine varies depending on the reason for the delay and stuff like that.

Ryan Pistoresi: So that's all about [audio cuts out] and WAC.

Mike Neuenschwander: Yeah. And so, yeah, and that's a whole other process in of itself, which could add more time should we have to go down that route. Okay? Any other questions? Doug? Hung?

MaryAnne Lindeblad: Okay, anything?

Mike Neuenschwander: Okay.

MaryAnne Lindeblad: Okay.

Mike Neuenschwander: I think that's some good food for thought, and we'll follow up with that in some emails individually here on that, and then during our 101's we can kind of dig in a little bit more deeply on that as well. And then we can also get thoughts and comments and advice from the Advisory Board as well.

MaryAnne Lindeblad: That's a good idea, particularly on this one. [ Cross-talk ] Yeah.

Mike Neuenschwander: [ Cross-talk ] Yeah.

MaryAnne Lindeblad: So are we ready, Jingping and Kelly, to talk about the data dashboard?

Mike Neuenschwander: I think so.

MaryAnne Lindeblad: All right.

Kelly Wu: So last Board Meeting, we talked about which data measures the Board was interested in using to select prescription drugs for affordability reviews. So today, I'm going to go over how the Board uses those data measures to create a short list of 25 prescription drugs for affordability review, and I'll also be showing the list at the end. So in this presentation, I'll go over again what the Board is required to consider when selecting prescription drugs for affordability review. Then I'll review again the data measures that the Board shows to select prescription drugs for affordability review, and then I'll talk about the methodology we used to create our short list of 25 candidate drugs for affordability review. And then, finally, as always, we'll have some discussion at the end, but you don't have to hold your questions or discussion until the end. Feel free to interrupt me if you want to ask questions or discuss something or you want me to go back to another slide. So this is a reminder of where we are in the affordability review process. Right now, we're at the selecting drugs for affordability review stage. Okay. So a reminder before we jump into the proposed data measures. The bill says that we must look at three data measures, and that's the cost of prescription drugs and availability of therapeutic equivalents, input from relevant advisory groups, and the average patient's out-of-pocket cost for the drug, and then also the Board can choose up to 24 drugs a year to review. All right. So let's quickly review the data measures that the Board wanted to look at when selecting prescription drugs for affordability review. So the Board would look at those three required measures from the bill that I showed just now, which I color-coded in blue throughout the presentation, just so it's clear which data measures are from the bill, and which were proposed, and the four data measures that the Board proposed are shown in dark green, which are color-coded in dark green throughout the presentation. And then also you'll notice an icon of four of the four of the measures signifying that those are quantitative data measures or data measures that can be measured, counted, or expressed as a number, and this will become important in our process later as well as you'll see in the coming slides. And if you need a refresher on what each data measure is, the definitions are in the appendix of this presentation. Okay, with that out of the way, let's jump into how we created the short list of drugs for affordability review. So a big question is, how do you use the information in the data measures together to choose prescription drugs for

affordability review? So our methodology was to first rank and weight the four quantifiable. If you remember those four quantifiable data measures with those, the icon from the previous slide, to calculate a weighted rank for each prescription drug. Then the top 25 prescription drugs with the lowest weighted rank formed a short list of drugs -- for the Board to choose from for affordability review. And then, finally, the Board will review the weighted rank in all the data measures, both quantifiable and non-quantifiable together to select prescription drugs from that short list for affordability review. And don't worry if you did not understand a lot of this. I'll be explaining each step in detail in the coming slides. In our methodology, it was to rank in weight the four quantifiable data measures. So to do this, the Board participated in a prioritization exercise to determine how important they thought each data measure was when selecting prescription drugs for affordability review. So while the Board was doing that, on the data staff side, we sorted each data measure and descending order and assigned rankings. And I'll show an example of this later, so don't worry if you don't understand this right now. And then once we got the results back from the Board, we computed the weighted rank for each drug by summing the rank of each data measured, multiplied by its corresponding weight that was created by the prioritization exercise from the Board. And then I'll show an example later, so just hang tight if you are having trouble following at this point. Okay. So more about the prioritization exercise, and how did it result in weights being created for each data measure? So each Board Member was given 20 points, which told us to 100 points across five Board Members. The Board Members were told to allocate their 20 points between the four quantitative data measures and that the more points they allocate to a data measure, the more important it is to them. And then once they gave us the results, we summed the allocated points for each data measure to create the weight for that data measure. So this is an example of how a Board Member might use their 20 points among the four quantitative data measures. So in this example, the total number of people using the drug was most important to this example Board Member, so they assigned it 10 points. However, the other data measures are also kind of important to them, so nothing was assigned 0, but total out-of-pocket cost was the least important to them because it was only assigned 2 points. Okay. So here are the actual results of the Board's prioritization exercise, and then you'll see that I highlighted the weights that were created as a result of this at the bottom. And the weights show that the total out-of-pocket cost was the overall most important data measured to the Board when selecting prescription drugs for affordability review and will be weighed the most heavily out of the three measures. And then similarly, total

number of people using the drug was the least important to the Board by being weighed the least. And this is a visual representation of the overall distribution of points versus how each individual Board Member distributed their points. So you'll see that some Board Members got that some data measures were not, and for net all and gave them zero points, while some Board Members thought that all the data measures had some kind of importance.

Mike Neuenschwander: Doug, I know you had some questions in terms of the point allocation. Did you want to talk about some of that?

Doug Barthold: Um, yeah. Well, like, I guess -- I don't know if you want to let Kelly finish first, but I was thinking it might be helpful just for the Board Members to discuss sort of why they voted as they did, you know, so that way we can sort of understand why we care more about one or the other, and then that might help us sort of -- I don't know if we're going to end up changing these votes or not, but just to kind of justify what we're ranking, you know, this overall ranking that we're going to have.

Mike Neuenschwander: And would you prefer that now or at the end?

Kelly Wu: Um, I don't mind either way.

Mike Neuenschwander: Maybe we can walk through and then do it at the end. I just wanted to make sure, Doug, since we talked about that [ cross-talk ] --

Doug Barthold: Yeah. Appreciate that. That's fine. Doing it later is fine.

Mike Neuenschwander: Okay.

Kelly Wu: All right. So we'll go back to this later. Okay. And then, as I mentioned, while the Board was doing their prioritization exercise, I sorted each quantitative data measure in descending order and assigned rankings. So here is an example of how that was done. So, for example, we sorted the average out-of-pocket cost in descending order in the drug with the highest average out-of-pocket cost and got assigned a rank of 1. The drug with the second highest average out-of-pocket cost was assigned a rank of 2, and so on. And we did the same across the other three data measures, so unless that prescription drug topped every data measure across the board, they'll have different rankings for different data measures. So, for example, for drug A here, they

ranked first in average out-of-pocket costs but ranked in various other positions for the other three data measures. So what if there are tied rankings? Or in other words, what if two or more drugs share, say, the same total paid amount? How would the rankings be assigned then? So to break tied rankings, we use the average ranking method. So, for example, here you see that drug C and D both have a total paid amount of $12.00 and are ranked in position 3 and 4 when, really, one shouldn't be ranked higher than the other because they have the same total paid amount. So using the average ranking method to break the tie, they'll both be assigned the rank of the average of their rankings. So, here, they're ranked in positions 3 and 4, so to compute the average of their rankings, it would be 3 plus 4, which is 7, divided by 2 because there are two drugs that are tied. So that means 7 divided by 2, which is 3.5, so then they are both assigned the ranking of 3.5. Okay. So putting together the weights that we created from the Board's prioritization exercise and with the ranking of each data measure, we can calculate the weighted rank for each drug with this formula. So for each drug, the rank of each data measure will be multiplied by -- the weight of each data measure will be multiplied by their corresponding rank. And so if we put in the weights that we have so far, the weighted rank is, again, the rank of each data measure multiplied by those weights that I showed you a few slides earlier from the Board's prioritization exercise. And so if we apply this back to our previous example: so for drug A, the rank of one for the average out-of-pocket cost will be multiplied by the average out-of-pocket cost weights and the total out-of-pocket cost rank of two for that drug, it will be multiplied by the total out-of-pocket cost weight and so forth, and then you can see the rest of the multiplication that will happen here, and then the sum of all of that would be the weighted rank. So applying this to real drug data, I'll demonstrate this with Xtandi, which is a prescription drug used in the treatment of prostate cancer. So you'll see that for each of the four data measures, it has a different ranking, and it happened to rank the highest out of all of them in total out-of-pocket cost, but it had the second highest total out-of-pocket costs out of all the eligible drugs for review. So plugging these numbers into our weighted rank formula, we have that the weighted rank for this drug is 6.63, and this is also the drug that topped our list of 25, our short list. Okay. So this is our preliminary short list of the top 25 prescription drugs based on their weighted rank, which I just showed you an example in the previous slide. And so these are the 25 that would choose drugs to conduct affordability reviews on. And just to clarify the rank here that I showed is based on their position in the short list, not the weighted rank. So I don't know if we want to look at this for a second before we move on.

Hung Truong: I mean, it's all specialty drugs. All of it, except for a few [ cross-talk ]. So you're talking about 3% of the population on a health plan lives, 3% to 5% would be on these drugs. The rest would not be. So it's something to keep in mind.

MaryAnne Lindeblad: Could you just repeat that?

Eileen Cody: Yeah. What are you saying, Hung? I didn't get it.

Hung Truong: What I'm saying is when you look at this list, the majority of these are specialty drugs. And so on average if you look at a health plan, there's only about 3% to 5% of the total lives would be on these drugs. So you're looking at -- you're basically seeing that 25% of the population would be on this -- on this list.

Kelly Wu: Yeah. And also, I think it corresponds with how total number of people using the drug was also weighted the lowest, so that probably also plays into -- that's also probably why -- a reason why the drugs are this way in the list.

Ryan Pistoresi: This is Ryan. So, Hung, yeah, you're right, and I think one of the reasons why we see different Boards in different states be able to review other drugs is that our State of Washington does have the highest threshold and cost per year. So we are at $60,000 per year or higher, whereas other states like Colorado or only $30,000. So if you do look at the Eligible Drug List between US and Maryland, Colorado, and other states, they do have some more of those non-specialty traditional drugs that you see, like, with the HIV medications, diabetes medications, things like that. So that I think plays into your observation that our list is dominated by specialty drugs.

Greg Gipson: I just had a question. So the list -- just looking at the list, are we going to break these down by, it looks like, NDCs? Is that how we're going to rank them? Are we going to cluster them together for like -- and this is like per tablet size, per -- you know, Enbrel is on here like three or four times for the different administration methodologies that are set up and patented. Is there a plan to pull these together, or are we going to get them all separately?

Ryan Pistoresi: I think that's a decision for the Board to debate. And so, right now, yes, these are at the NDC level. But if you see Enbrel up there, and you know that Enbrel is on there a few different times, you could say, let's do one of Enbrel

together because that affordability review is going to be for that drug, right? So you're going to be looking at therapeutic alternatives. Well, the therapeutic alternatives for all three of those NDCs are going to be the other Cytokine and CAMs off-label uses. All right? But they're going to all have the same off-label uses. So I think that that makes sense for you to consider those together, even though that they have individual lines here on the list for when you're selecting an affordability review, you can say let's look at Enbrel altogether.

Hung Truong: I think Doug has a question.

Douglas Barthold: A comment.

Mike Neuenschwander: Yeah.

Douglas Barthold: Thanks. This is really helpful. So I just have a question for Kelly. Did I -- I'm not sure if I understood this correctly. You said this is a ranking by the short list ranking and not by the weighted rank? Did I hear that correctly?

Kelly Wu: No. The 25 is by the weighted rank. I just wanted to clarify that the rank that I am showing here on the left is not the weighted rank. I just put it like showing this is the top 25.

Douglas Barthold: Gotcha. I just want us to verify that. Um, and then, yeah, I definitely agree that pooling the NDCs by molecule or by drug makes sense, but the -- another thing that I think would be really helpful, and I guess my question is, if this will be on the dashboard, would it be if we could see indication sort of as part of this table as well as we are considering the list, just like a sort of another point of information.

MaryAnne Lindeblad: That's a great suggestion.

Ryan Pistoresi: And so, Doug, just a point of clarification, are you looking for indication as by FDA label, by compendia? You know there are many different ways to think about indication. Is there like a preference that you would want to see for us to use as a data source for identifying indications?

Douglas Barthold: Um, I guess I would like to see most common indication, I mean, or a list of all indications. The data source, I don't have a preference on that. Really for me as -- because I'm not a pharmacist, I just want to understand what these

drugs are for. You know, Hung read this list, and he knows what they all are right away and so -- but I need a little guidance to understand what the drugs are. You know? Who is using them?

Hung Truong: That makes sense, Doug, because it's oncolytics, biologics, MS drugs, so it will be nice to break it down. Kelly, would you be able to have a separate list that is non-specialty? [ Cross-talk ] Like I know a specialty list is kind of iffy because the definition of specialty drug changes often, right, twice, and -- but if you can have something that may not considered specialty? It might help us look at the list and how we decide.

Ryan Pistoresi: And Kelly, I could help you pull out the specialty versus traditional, so we do have those listed internally that we could use. And then I also have an idea for how could pull out indication based on what we use internally for drug reviews. So I think those two things we'll take back and work on.

Mike Neuenschwander: Okay.

Doug Barthold: How would you define specialty in this case?

Ryan Pistoresi: So for us on Apple Health we do have a flag on our Apple Health PDL, which is whether a drug is considered a specialty or not. We also have another data source for Uniform Medical Plan, so that is the state self-funded health plan for public and school employees, and our specialty list is determined on what is eligible through our contracted specialty pharmacy. We have two different lists that we [ cross-talk ] look at and then kind of use as a general guide to see what drugs fall into these lists. So we're going to take a look at both and propose one as kind of an option going forward.

Doug Barthold: Okay. Um, that sounds good. Yeah. I was -- I know CMS has a specialty definition as well, which is basically just based on the cost of the drug I assume. I think the Washington definition would be better for our purposes, so --

MaryAnne Lindeblad: And we've blended PEBB/SEBB retiree and non-retiree?

Ryan Pistoresi: Yes.

MaryAnne Lindeblad: So it's all [ cross-talk ] --

Ryan Pistoresi: Yeah. So it's all [ cross-talk ] through UMP, so it doesn't matter kind of covered [indistinct] and small through that. Yeah.

Mike Neuenschwander: Um, okay. So, Kelly, and Jingping, does that sound doable? And I guess internally, do we need additional approvals to add that data to the dashboard?

Kelly Wu: Yeah. I'll work with Ryan to see like where we get the indication data from and then, yeah, he can also help with identifying the specialty drugs.

Doug Barthold: I've got a question for Hung. Your motivation for separating specialty and non-specialty, is that just to understand how many people are using these drugs? Is that your main goal?

Hung Truong: Yeah. Yep, because that was my first concern, right? When I see this list, I see there's only less than 5% of the population would be on this, and so whatever we do with these lists, it's not that -- it only affects such as limited number of folks.

Doug Barthold: Yeah, and I agree. That's definitely an important, you know, consideration. That said, you know if -- this just comes back to the question of like, do you care about a medium-high cost for everybody or an exorbitant cost for a few people? And maybe we care about both. So, yeah, I guess, like, then I agree with you that having that data in front of us will be helpful.

Hung Truong: Yeah. Yeah. The other thing, too, Doug, is when you talk about criteria and out-of-pocket costs, these drugs are always going to be high out-of-pocket because the tier they are in is not first or second tier, they're in a specialty tier that in our pocket will always be high. It's either a percentage of the cost or is the highest copay you're going to see. So it just self select all of these, I guess, because -- and that's one -- that's part of our point of discussion that we need to have. When you look at out-of-pocket, it's not determined by the drug company. It's also determined by the insurer. It's what's on formulary? What's not? What's on rebate? What's not? And so it's going to change from one insurer to another depending on your out-of-pocket, so it's really hard to look at the whole when that's a criterion. Just [ cross-talk ] --

Kelly Wu: [ Cross-talk ] Yeah. [ Cross-talk ] --

Hung Truong: [ Cross-talk ] a point to think about.

Doug Barthold: Thank you. That's helpful.

Kelly Wu: And I forgot to mention that all 25 of these drugs were on the list for the course of treatment costs $60,000 or more. So, yeah, they that plays into Hung's point that these are like all drugs that cost a lot out-of-pocket.

Doug Barthold: Yeah. I mean just to reveal my motivations, that's what I care most about. I care more about the out-of-pocket costs than I care about the plan costs or -- even if the plan is Medicaid. Yeah. That's, again, I care more about the out-of-pocket costs than I care about costs to taxpayers, so yeah.

Eileen Cody: Well, I guess I'll push back, Doug, because even if the plan is paying for it, it raises your health insurance cost. So it's still going to come out of everybody's pocket.

Doug Barthold: Yeah. I think that, um, we'll just -- and I totally appreciate that point, and I agree that like total plan cost is important. But to me, it's just the out-of-pocket. You know, when I think about the burden of these costs to a consumer, to a user, the out-of-pocket captures that more for me than total plan costs. You know, there's a lot of -- the taxpayer base in a lot of cases, you know can't afford to pay higher taxes to, and the pool of insurers can afford to pay higher premiums. But a lot of these out-of-pocket costs when they're so high, I think that's what really hurts people. That's what really causes excess costs, and so that to me is my most important goal.

MaryAnne Lindeblad: So really, for you, it's the affordability to the person [ cross-talk ] --

Doug Barthold: [ Cross-talk ] Yeah.

MaryAnne Lindeblad: -- not necessarily to the system.

Doug Barthold: That's right.

Mike Neuenschwander: Any other thoughts, comments on this?

Hung Truong: Many comments, but we can go on for a long time. So they are all good points. I mean it's great food for thought.

Greg Gipson: I guess one of the -- just to wrap my head around it, is there, like the mission of this group, has anything been kind of written down or agreed upon? Or are we more focused on kind of a meld of what's best for the system as saving money overall, or are we focused more on shielding individuals from extremely high-cost drugs, or sort of just allowing the Board to express their own interests and thoughts with regards to what's most important? And is that the idea of the ranking? There is not a specific target? Yeah? Okay.

MaryAnne Lindeblad: I mean, it's really the affordability to who [ cross-talk ] --

Greg Gipson: Yeah. So, yeah, we leave that kind of into question, right?

MaryAnne Lindeblad: Yeah, right.

Doug Barthold: So on our website, on the Mission, it says affordability to Washington consumers. And I don't know, if you pull up the law, the law, I think -- actually Ryan should verify this, but it's just excess costs, right?

MaryAnne Lindeblad: [ Cross-talk ] Yes.

Ryan Pistoresi: [ Cross-talk ] Yeah. So the statute says for prescription drugs chosen for an affordability review, the Board must determine whether the prescription drug has led or will lead to excess cost to patients and excess costs as defined in statute is: 1.) The cost of appropriate utilization of a prescription drug that exceeds the therapeutic benefit relative to other alternative treatments, or B.) Costs of appropriate utilization of a prescription drug that are not sustainable to public and private healthcare systems over a 10-year time frame. So [ cross-talk ] --

MaryAnne Lindeblad: [ Cross-talk ] It's both.

Ryan Pistoresi: [ Cross-talk ] It's both.

Doug Barthold: Yeah, it sounds like both.

Ryan Pistoresi: But again, as the Board, you're able to debate and kind of pick and choose, so you may look at certain drugs that you say, wow, this out-of-pocket cost is really above the norm. Let's have that be eligible for a drug review. And for these other drugs that are not sustainable for the state and private healthcare systems, we can choose those for affordability reviews. And as

you go through those affordability reviews, you'll have a better sense of what is causing those drug prices to be where they are, what the therapeutic alternatives are, and then that's where the upper payment limit step comes in, and you get to kind of do a second review of the drugs with a better understanding of how they are used, what patient assistance there is, how it's being used in the state, and those other criteria.

Mike Neuenschwander: And one thing I'll say, too, is so, I mean, part of this is for the Board to decide where they want to focus because there are a couple different angles which we can take this. But that being said, we're doing drug reviews every year. So just because we do something this year, it doesn't mean this is forever the way it shall be, and we're only going to go down this. So maybe this year we can focus on out-of-pocket costs, next year maybe utilization can maybe be a little bit more of a priority. And I'm not saying that's the way it has to be, but all I'm saying is just because we make a decision on a number of drugs today doesn't mean you can't tweak or take a couple different routes and every year maybe switch up stuff a little bit to, like, okay, well, this is our priority next, and then this is our priority next. So maybe just don't get too lost that, oh my gosh, this is the decision we're making, and this is forever written in stone, and we can't do anything different. You know, I think there is some play where every year we get a new chance to choose, and maybe after we look at something, we can adjust our weights or our rankings a little bit. And again, this isn't policy. This isn't WAC that is a lot harder to change or Legislation that's kind of specific [ cross-talk ] --

Eileen Cody: You never know what the Legislature will do to you.

Mike Neuenschwander: Yeah. Great, so [ laughter ], yeah. I guess just kind of keep that in mind that the Board, there are some decision points to be made, but there's also a degree of flexibility in that just because we do something today doesn't mean that's the way we have to do it forever more.

Kelly Wu: All right. Well, I just have a few more slides, and then we can go back to discuss the point allocation if we want. All right. So as I mentioned before, after creating the short list, the Board will look at the weighted rank along with all of the data measures together to select prescription drugs for affordability review. And then, now that we showed the preliminary shortlist, we also looked at what other state PDABs were doing in terms of affordability review and see if anything overlapped with our short list. So only one state, Colorado, was looking at Enbrel, which overlapped with our

short list. Then I think one of the reasons is that like what Ryan mentioned, like their thresholds might be lower than ours, and then another is probably that we have our bill says that the drug must be on market for at least seven years to qualify for review, while other states may not have that. So there are also a lot of like newer drugs like Ozempic on the lists of other states. This is just a continuation of that table. All right. And then the next steps for us will be to review the data measures for the prescription drugs on the short list, but now that we had our discussion, it will be to generate another short list of the top 25 non-specialty drugs. And then, yeah, we'll select drugs for review from the shortlists, plural. And that's the end of my presentation. So do we want to go back to the points, slides, or do we want -- are there any other things you want to discuss before that?

Hung Truong: Can you go back to the last slide? I like the Oregon list. That's just taking a look at it -- so they have infusion in here, Ocrevus and Inflectra. And then there are diabetes medications, so those are non-specialty.

Ryan Pistoresi: Yeah, I know for Oregon statute, they are required to have an insulin every year on their list, which is why you see Tresiba and the Humulins on there. So that's unique to Oregon and why you don't see insulins for any of the other states.

Hung Truong: Yeah, Shingrix. Interesting.

Eileen Cody: [ Cross-talk ] Yeah. [ cross-talk ] --

Mike Neuenschwander: [ Cross-talk ] Yeah, Shingrix. [ cross-talk ] --

MaryAnne Lindeblad: [ Cross-talk ] That's another one [ cross-talk ] --

Hung Truong: So vaccine. And then the big one is the Ozempic. So people use that for weight loss, as you all know, so that's -- but I don't think that's been out for that long. Oh, okay. HIV medications.

Doug Barthold: Kelly, can you write us for the -- our short list, what were the years of data that we used to calculate those ranks?

Kelly Wu: So we used any data up to January 1, 2023.

Doug Barthold: What was the start date of the data?

Kelly Wu: So for the claims from the All Payers Claim Database, we used calendar year 2022 data.

Doug Barthold: Okay. Thanks. Just one other follow-up. The threshold, if it seems like that threshold is driving major differences in -- which drugs get on the list for each state. We can't touch that, right? That's in the law, right?

Ryan Pistoresi: Yeah. So in order to do that, we would have to go through Agency Request Legislation and go through a process in which the agency would be working with the Legislator to sponsor a bill. So probably the earliest that we would be able to do that would be the next -- not this 2025 Legislative Session but the second half of the biennium in 2026.

Doug Barthold: Okay, thanks.

Ryan Pistoresi: But I think after you go through this affordability review and you have more experience, that then gives further support to why you would be recommending changes. But again, once you have a bill that is introduced in Committee, there are going to be amendments that could always change. So that is something to keep in mind.

Doug Barthold: Yeah, I don't think -- I didn't mean to suggest that we change the threshold. I just wanted to understand like sort of what is within the realm of our current sort of capabilities for selecting drugs.

Mike Neuenschwander: Yeah. The only other way around that would be the drugs that have X percent increase over a given time frame, so that is kind of the only other option that our current Legislation has for us.

Kelly Wu: All right. Do we want to go back to discuss the points?

Doug Barthold: Yeah. I mean, I'll just note that like actually a lot of what we were talking about before is kind of what I was interested in, and I think as we were discussing the whole trade off or -- I guess not necessarily a trade off -- that the issue of affordability to patients or affordability to the system, that is kind of what I wanted to talk about, and it was very helpful to hear that we do have -- kind of have the mandate to do both. And so I definitely agree with Eileen's point that the system is also important and, obviously, it says so in the law. And so, yeah. I'll just reveal, I was Board #1 on this, and so that's

why I kind of -- and you can see my goal here is to affect patient costs, which is why I didn't give any weight to total paid amount. I think total number of people using the drug is very important, but that's captured in total out-of-pocket cost, and so I gave my points there. Um, but yeah. I don't know if anyone else had any other comments on it.

Hung Truong: Okay. I don't remember mine, but what I know is I'm just -- I'm always leery of the out-of-pocket costs and just what I said earlier. It's not just determined by the cost of the drug, it's also by insurer. And if this was all cash then, yeah, easy, out-of-pocket, but I think there's just so much more to it. That's why I'm looking at, hopefully, the total cost, and then from there somehow decrease their out-of-pocket costs because the total paid has gone down.

Doug Barthold: Do you mean cause we're not -- what do you think? If it were all cash, it would be different? But do you mean that is because we're not seeing coupons?

Hung Truong: It's my worry is say you lower a drug by $10,000. What the insurer is going to charge the patient is going to be the same copay.

Doug Barthold: Hmm.

Hung Truong: Right? So how do we get them to -- okay, let's lower the copay, then the -- it's just going -- will make it very difficult.

Doug Barthold: Yeah, that's a great point. So I thought we had it in our -- isn't in the law that like -- any savings that the plan has are supposed to be passed on to the consumer either via out-of-pocket cost or the premium? Is that true?

Ryan Pistoresi: Yes. So under the Use of Savings section in our statute, the upper payment limit that is established by the Board must be used to reduce cost to consumers, prioritizing the reduction of out-of-pocket costs for prescription drugs. So there is a requirement that if the plans are applying an upper payment limit that they have to use it entirely, must be used for reducing cost to consumers. So it could be used to apply to the out-of-pocket costs, and then from there to reduce the premiums.

Doug Barthold: Okay. And I mean I guess like -- and does that mandate have teeth? Like, what's the enforcement mechanism on that?

Ryan Pistoresi: Um, that each of the health plans that is subject to the upper payment limit has to provide a report to the Health Care Authority demonstrating how they used those savings in the previous calendar year. So yes, [ cross-talk ] --

Donna Sullivan: [ Cross-talk ] Doug, this is -- I'm sorry, Ryan, I'm going to interrupt. This is Donna Sullivan. Um, Doug, the answer to your question is, we have no enforce -- we have no ability to enforce that. It's just voluntary report or mandatory report to the Health Care Authority by the payers, but we have no authority to find them for not following the rules or any of that. The Board has no authority to do that either.

Eileen Cody: But the Insurance Commissioner's Office in rate review would be able to have some influence on that.

Donna Sullivan: I'll leave that up to the lawyers to figure it out. [ laughter ]

Eileen Cody: And rate of [ cross-talk ] their approval.

Hung Truong: [ Cross-talk ] So I guess -- I guess a [ cross-talk ] --

Eileen Cody: [ Cross-talk ] You're not [ cross-talk ] Insurance Commissioner's Office.

Michael Tunick: Yeah. Yeah. I don't represent the Insurance Commissioner there, but I could talk [ cross-talk ] to their [ cross-talk ] --

MaryAnne Lindeblad: [ Cross-talk ] That's a good question.

Michael Tunick: Yeah, [indistinct] [ cross-talk ] --

Eileen Cody: Yeah, we could [ cross-talk ] --

Ryan Pistoresi: [ Cross-talk ] There could be some, but maybe not our agency would be a separate state agency, and so that might be an opportunity for partnership with our programs.

Hung Truong: I guess if that's the case, Doug, total out-of-pocket and total paid would be equivalent, right? I mean, you're hoping that it's going to get fuel to -- and I hate to say it -- to go down Economics, so -- [ laugh ].

Multiple Speakers: [ Laughter ].

Eileen Cody: [ Cross-talk ] we see a lot of that.

Greg Gipson: [ Cross-talk ] I mean, although, I'm Board Member #5 and the last one to show up, and that was kind of my thought is that to make maximum impact out of these initiatives, it will be to reduce total cost of the system because, again, patients are somewhat shielded based on their insurance plan and their coverage. But if you got a really expensive drug that's really high share cost -- share costs, yeah, you could have a high out-of-pocket. So that's why I was thinking about most of the energy -- or most of my points into the total out-of-pocket costs and then total amount. Total paid amount would be for the health system, and we can hit these most highest burdensome cost drugs to the health system and return those savings back to the individual patients. But yeah, I agree. My sort of take on this does leap out. You know, if you have a few patients with a relatively high drug cost, those are not really captured within my thoughts.

Doug Barthold: But our threshold does capture that, Greg. I don't know if you -- so like looking at the list that we got, it ended up being quite [ cross-talk ] relatively rare drugs, I guess because of the threshold. And so I think -- I wasn't expecting that, and so that was interesting. Yeah.

Greg Gipson: Yeah. This is what we see internally if you have is, well, our high-cost drugs, are these biologics that are somewhat niche, and they cost a few patients a lot of money. They cost the health system a lot of money, and so every year we'll have a few patients that that drive a lot of costs even just a handful of patients that need costs for the system, which is really interesting.

Eileen Cody: So when we do look at into the final of trying to choose which ones we're going to do the review, besides like the indications, I guess it would be nice to also have on the spreadsheet how many, what is the out-of-pocket, you know, basically the information that you use so that we could just look at that on one spreadsheet.

Mike Neuenschwander: Yeah. And the dashboard is going to have a lot more [ cross-talk ] out there as well as the other things that you wanted. You know, do they meet multiple thresholds per the [ cross-talk ] --

Eileen Cody: [ Cross-talk ] Yeah, okay.

Mike Neuenschwander: -- Legislation [ cross-talk ] as well as the -- you know, is there a generic to it? And then, of course, as Kelly was saying, then we also can compare it to the list of drugs that other states are reviewing as well as kind of an additional criteria of, you know -- and, obviously, Enbrel was done by Colorado. I believe looking at my notes, I believe they marked it as unaffordable.

Eileen Cody: Yeah.

Mike Neuenschwander: And so I mean that's another point to consider. And again, the dashboard will show that cost data. You can compare one drug to another drug, and then also see that other stuff, like is there a generic? Or something like that, which could help drive the decision of ultimately what do we want?

Hung Truong: Hey, Mike. Can we talk a little bit about the number of people using the drug? That's interesting, right? I mean, that's the dilemma, right? Do we want to affect the mass, right? If that's saying we want to lower cost for consumers, I mean, there are so many drugs out there that affects so many more than the 3% I mentioned. Like diabetes is a perfect example. Cholesterol or whatever else. That's important, right? I mean, we're supposed to look at the whole, not just a single set, I don't know, subset of usage.

Ryan Pistoresi: Yeah, and I think the challenge really is around the criteria for what makes the Eligible Drug List. So in looking at the review for what costs $60,000 a year, there's really none of the cholesterol medication, none of the diabetes medication, so I think the challenge is having to look at -- what meets these criteria, and then from there choosing which of the drugs will have the biggest impact in improving the lives of Washingtonians.

Doug Barthold: That really interesting, There are no diabetes drugs, no cholesterol drugs, no hypertension drugs that [ cross-talk ] meet the eligibility?

Ryan Pistoresi: [ Cross-talk ] Not that costs $60,000 a year.

Doug Barthold: Okay. So I mean, that's super meaningful. I did not expect that, and that's kind of -- hm. It makes me -- you know, I specifically -- so you can see I, again, I'm person 1. I gave 7 points to average out-of-pocket cost because I wanted to make sure that we captured rare drugs that were very expensive, and then I gave 13 to total. I just wanted to capture the more widely used expensive drugs. But it sounds like nothing widely used is even eligible. I mean I --

would it be po -- I mean, I agree with how we, like, we want to see the number of users. I definitely agree with Eileen that like on the dashboard it would be super helpful to have all of the actual numbers for all of these things. Is there any chance we could see that right now? Like what is the most common drug that meets the eligibility threshold?

Mike Neuenschwander: The dashboard just isn't ready right now. [ cross-talk ] --

Doug Barthold: [ Cross-talk ] I got it.

Mike Neuenschwander: We just can't, we can't show it until we finalize all the permissions. But we will, once that -- once we got the internal [ cross-talk ] workings here done, we'll get that out, and then we can -- you'll have plenty of time to take a look at it during our next meeting. We can dig into those other ones a lot more.

Doug Barthold: And so we don't -- and even like the short list, whatever ranking we have, we don't have to use that ranking, right? Because we have all those -- the qualitative criteria that we can then use to decide where we want to do the reviews, right?

Mike Neuenschwander: Yeah. Yeah. So, I mean, it's not like the number one drug on the short list has to be the one you choose. Again, there are other things that you can look at, like, does it have a generic that goes along with it or a different alternative. So if it does, maybe there's an affordable other option. So we'd rather go down and so going on that list, you might make it down to #18 and #23 are the ones you choose. There's nothing saying we have to pick a certain thing, but these are just different ways that we are working to try and give you information on how to choose and shorten that list to -- you know, instead of looking at 100 drugs or 200 drugs, getting it down to a more manageable mouthful based on the criteria in the way that you thought was important.

Kelly Wu: Yeah, and this is just a preview of what the list will look like in the dashboard, so you'll have like all the information for those 25 drugs and then all the data measures that were used to select the drugs as well as the other data measures that people mentioned they were interested in that weren't used to select the drugs, but it will still be therefor you to look. And then, yeah, so this patient liability proportion kind of confirms what Hung said about -- yeah, the drugs are kind of niche. So, yeah, you'll have all this information to play with once the dashboard is ready.

Doug Barthold: That's great.

Eileen Cody: So, Ryan, going back I just unfortunately know too much about the MS drugs. So like the infusions, all the -mabs then are considered specialty drugs because -- or they come from a specialty pharmacy, so they're not included?

Ryan Pistoresi: They could be included. I think the reason that you're not seeing a lot of the newer -mabs is that they haven't been on the market for seven years. Some of the newer -mabs, I think.

Eileen Cody: Yeah, but I'm saying I'm just surprised because there are the three MS drugs that are on the list are all the Caps - Oral, [ cross-talk ] --

Ryan Pistoresi: Right.

Eileen Cody: I hardly use those.

Ryan Pistoresi: Yeah. Right. I mean, again, this is based on our review [ cross-talk ] --

Eileen Cody: Yeah, No, no, no, I [ cross-talk ] --

Ryan Pistoresi: [ Cross-talk ] Some of those [ cross-talk ] --

Eileen Cody: [ Cross-talk ] and so [ cross-talk ] --

Ryan Pistoresi: Yeah, yeah. And then I think some of the other ones, since they are only available through a physician-administered and are never available through a specialty pharmacy, those ones were also excluded. So, yeah, there were some of the newer ones that are being used that are not on this for that reason.

Hung Truong: Just to clarify, Ryan, infusions are not included, right?

Ryan Pistoresi: Yeah, if it's only available through an infusion and never distributed through a specialty pharmacy, those would have been excluded.

Hung Truong: Well, I mean, yeah, yeah, yeah. There's a discussion in [indistinct], right, about white bagging, brown bagging. And so you do have some of these being forced to go through a specialty pharmacy and get sent to our system to

infuse. I mean, that technically would touch a specialty pharmacy [ cross-talk ] --

MaryAnne Lindeblad: [ Cross-talk ] Right.

Ryan Pistoresi: [ Cross-talk ] Correct.

Hung Truong: -- potentially, though, but --

Ryan Pistoresi: Right.

Eileen Cody: Okay, what's white bag and [ cross-talk ] brown bag?

MaryAnne Lindeblad: Yeah.

Eileen Cody: That's the new one on me.

Hung Truong: Oh, boy, uh [ laughter ] --

Eileen Cody: I know.

Hung Truong: Well, brown bagging is, so if you're talking about a drug that needs to be, say, administered by the physician because you can't take it, brown bagging is the patient bringing in the drug for the physician to inject, which most health systems won't allow to because what if the patient has left it in his or her car at 95 [ cross-talk ] degree temperature for a few hours. Right? You can't trust that. White bagging is if it's getting directly shipped to the physician office by a pharmacy or the manufacturer, and so there's a chain of custody. The patient won't -- doesn't get to touch it, and then the physician would infuse it or give it -- give that medication. That's [ cross-talk ] --

Eileen Cody: [ Cross-talk ] Oh, you mean the nurse would infuse.

Hung Truong: Yeah, yeah, somebody from the physician's office.

Multiple Speakers: [ Laughter ].

MaryAnne Lindeblad: Thank you for clarifying [ cross-talk ] --

Eileen Cody: I just want to make a point here.

Mike Neuenschwander: So to Hung's point, between the white bagging and the brown bagging, those do relate to our statue because just says, "Is the drug available through a specialty pharmacy?" [ Cross-talk ] And if it is, then it can be included. [ cross-talk ]. Something that we'll need to keep an eye out for as we're doing future Eligible Drug List reviews, seeing how some of these drugs may change their distribution channels.

Eileen Cody: Well, yeah. I would think it may be in the future the statute may want to change just because of how many more infusing, you know, drugs are only infusion?

Ryan Pistoresi: Right, and that is another point. You know as we're seeing a shift physician-administered or provider-administered drugs. That might be something the Legislature could look at.

Doug Barthold: My only other question is, do we want to revise our votes again? I mean, I wouldn't mind changing mine a little bit. I guess I'd like to change mine a little bit, but I don't know if we're -- what stage we're at and if that's possible for us.

Mike Neuenschwander: I would say if you want to make changes, sooner rather than later is always better. You know, you guys are the Board, so you're driving the boat here. Um, but yeah.

Doug Barthold: I thought it was an airplane.

Mike Neuenschwander: [ Laughter ] Or airplane. Yeah, I'm sorry, my bad. My bad. Keep me on track here. But, yeah, we can do that. It's just a matter of then recalculating the various formulas.

Doug Barthold: Okay. I'm going to send slight changes to mine, so then, obviously everybody can do what they want.

Mike Neuenschwander: Kelly, Jingping, is that A-okay with you guys on the backend?

Kelly Wu: Yeah. It wouldn't change our -- it was just change like the input and not any of the calculations.

Mike Neuenschwander: Yeah. Okay. Anyone else [ cross-talk ]?

MaryAnne Lindeblad: [ Cross-talk ] give folks a couple weeks if they want to change or [ cross-talk ] --

Eileen Cody: [ Cross-talk ] I'd say only a week.

Mike Neuenschwander: Okay. Yeah, yeah, as -- again, sooner rather than [ cross-talk ] later just so we can [ cross-talk ] finalize this and get it out once we finish the rest of the internal work that we have to do.

Doug Barthold: Mike, do you want to set a deadline for us?

Mike Neuenschwander: Oh, yeah, sure. How about next Tuesday? Does that sound fine?

Doug Barthold: Sure.

MaryAnne Lindeblad: [Indistinct] day [ cross-talk ] sounds fine.

Mike Neuenschwander: Great.

Hung Truong: Sure. I might change mine, too.

Mike Neuenschwander: Okay.

MaryAnne Lindeblad: I can [ cross-talk ] what I did.

Mike Neuenschwander: Okay, sounds good. So, Simon, let's make a note to do that here.

Kelly Wu: All right. And just to confirm, we want two short lists, so one would be like the one we have now, which just happens to be specialty drugs. And then another short list of the non-specialty drugs. Right?

Hung Truong: Yeah, we can take a look. I'm sorry, Kelly. [ laughter ] It's more work.

Mike Neuenschwander: Well, and again, I mean I think this is part of what our review here is for is to show you as we're going along, this is what we got, so it's looking like -- and again, I think this is, especially in these early stages of setting stuff up, getting that internal feedback for the Board Members, the staff, the external feedback from our partners in industry or other interested groups. It's really important to help us so we can refine this and build a durable product. So

once we've got a foundation set and, hopefully, the rest of this should be a lot easier in the years that are coming to -- okay, we've done this in vetting this and testing it and tweaking it to get it to where we want. So, yeah, I think that's good. This is why we are here having these conversations so, thank you, Board Members.

MaryAnne Lindeblad: I thought this was a really good conversation today.

Mike Neuenschwander: Okay, so we'll get that email sent out with the deadline for the updating and adding the non-specialty drug list, and we can kind of go from there. Hold on so I can make a note to myself real quick before I forget anything. Okay. Any other thoughts or questions on our weights and the initial list and how we're doing and what things are looking like thus far?

MaryAnne Lindeblad: It doesn't look like it.

Mike Neuenschwander: Okay.

MaryAnne Lindeblad: [ Cross-talk ] I think we can go on to the next [ cross-talk ] --

Mike Neuenschwander: Okay.

MaryAnne Lindeblad: -- next item. So, Mike, this one is also yours, the Advisory Group [indistinct] of the Advisory Group.

Mike Neuenschwander: Yeah.

MaryAnne Lindeblad: I'll turn it over to you.

Mike Neuenschwander: So as I mentioned earlier, we had our meeting with our Advisory Group, and as we can see today, we're really getting into kind of the core of what we're looking at, why we're looking at it, what we want to look at it, and then, of course, the Advisory Group is going to play and important role in terms of giving us some of the that external and industry and other feedback from other groups. So I guess kind of the next steps for them and the vision was we're going to be having a meeting, I want to say December 10th, right? Is that right, Simon? -- with the Advisory Group, basically, we will introduce them to the dashboard and this content as well so they can take a look and see. And then I think really the important thing is to get their feedback on that so that way we can gather that information for the Legislation to help

the Board make decisions as well. So for the next meeting the idea is to introduce them to the dashboard because it should be ready by then, so that way they can take a look. They can start looking at this initial list of drugs, and then I'm open to ideas or suggestions, but my thought was basically task the Advisory Board Members to each using the list that we have pick a certain number of drugs that they would recommend, that they think are important to take a look at and maybe an explanation as to why and some of their thoughts in terms of the list and I guess the conversation that we've had in terms of ranking and what they feel is important. And then each of them submits their lists, so that way we can give them to the Board before the meeting to review and that you can see, I guess, what the Advisory Board thinks about the dashboard. The drugs on that list, and we'll -- kind of their direction in terms of the kinds of drugs that we should be choosing. And I don't know, I was thinking a list of maybe three to five drugs from each of the Advisory Board Members to help kinds of point the way of what they feel is important. So open to ideas or suggestions on what the Board would like to see in terms of feedback from the Advisory.

Eileen Cody: That's good. I think three to five, that's a good [ cross-talk ] --

MaryAnne Lindeblad: I'd like to see at least five.

Mike Neuenschwander: Okay.

MaryAnne Lindeblad: Yeah.

Eileen Cody: Uh, will you send us the dashboard as soon as it's done?

Mike Neuenschwander: Yes. Yep. No, no, and again, we're trying to -- there are internal workings that, you know [ cross-talk ] --

Eileen Cody: No, no, I'm just [ cross-talk ] --

Mike Neuenschwander: At the speed of government.

Eileen Cody: No, it's [audio cuts out] I guess as soon as we can see it, it would be nice.

MaryAnne Lindeblad: Yeah.

Hung Truong: Yeah.

Mike Neuenschwander: And that's the goal, is we're trying to get that out her much sooner rather than later, then we can [ cross-talk ] --

Eileen Cody: A Christmas present.

Mike Neuenschwander: Yeah. [ Laughter ] Hopefully, an early Thanksgiving.

Eileen Cody: Oh, goodness [ cross-talk ].

Mike Neuenschwander: So, yeah, that way both you and the Advisory Board can have some time to take a look at this, and then, hopefully, during our Advisory Board Meeting have a nice robust discussion as well in terms of what they think. And then, again, providing if each of the members can acquire a list of, I think you said five recommendations with reasonings, so that way the Board can take that into it as well. Then we can discuss it at our next meeting. And Doug?

Doug Barthold: Yeah, I was just wondering, that also, I totally agree about the recommending drugs. It sounds great. A question about like our role at the Advisory Board Meetings. Are we just like observers or Members of the Public? Are we expected to participate? What's the plan for that?

Mike Neuenschwander: Yeah. The general purpose of the Advisory Board is to advise you, so, again, getting some of that other outside input and then pushing it up our way. That being said, you guys are definitely welcome to attend. I believe there is not a problem for a degree of participation as well should you desire. However, the thing that we have to really watch and be careful is no making decisions as a Board because then that changes the whole when you guys start working together and making a decision or starting to do stuff, that changes the whole meeting from an Advisory Board Meeting to an Open Public Board Meeting, basically, which then we've got to have this kind of set up, and it's a whole different thing. So I think care and limited participation are important with that one. But again, that's more for the, I guess, my vision is the Advisory Group working together to get their external group perspectives and then bringing that up to you -- yeah, with how we decide, for example, this report of them giving their recommendations.

MaryAnne Lindeblad: It might be interesting, too, to listen in from their perspective [ cross-talk ] --

Mike Neuenschwander: [ Cross-talk ] Yeah.

MaryAnne Lindeblad: -- the conversation and how they see the world.

Mike Neuenschwander: Yeah, I know, and I think, definitely, that is very good listening and seeing what they have to say. And again, just careful participation in making sure that we don't cross any lines in terms of decision-making or kind of [ cross-talk ] --

MaryAnne Lindeblad: [ Cross-talk ] Because they're [ cross-talk ] --

Mike Neuenschwander: [ cross-talk ] policies outside of this meeting.

MaryAnne Lindeblad: -- but there to listen primarily. So will you send us the point with the times?

Mike Neuenschwander: Yep.

MaryAnne Lindeblad: Okay.

Mike Neuenschwander: Yep. Definitely.

MaryAnne Lindeblad: And is that in person on online?

Mike Neuenschwander: It's online. So that one is online.

MaryAnne Lindeblad: All online.

Mike Neuenschwander: Yeah, just because of the range [ cross-talk ] and how spread out [ cross-talk ] --

MaryAnne Lindeblad: [ Cross-talk ] Where they live, yeah. That makes sense.

Mike Neuenschwander: Yep, it makes it a lot more conducive for that [ cross-talk ] group.

Doug Barthold: Mike, you're talking about the PDAB Members can't talk about PDAB business outside PDAB meetings reminded me, what is that? Is it that we have three people then we can't talk about it, but if there are two people, we can? Is that the rule?

Eileen Cody: That should be right.

Mike Neuenschwander: Uh, Mr. Lawyer.

Michael Tunick: Yeah, three would make a quorum. Yeah. And then, yeah, and so the other thing, though, there is like, I think I've heard it called daisy chains, but yes. You don't want, you know, sort of, Doug talked to, you know [ cross-talk ] --

Doug Barthold: [ Cross-talk ] So in a sense if there's [ cross-talk ] --

Michael Tunick: -- talking to, you know, so, yeah. You have to be [ cross-talk ] --

Doug Barthold: [ Cross-talk ] So three of us happen to attend an Advisory Board Meeting, we basically, can't talk because all we're going to be talking about is PDAB business.

Ryan Pistoresi: Yeah. So the Open Public Meetings Act says you can't be taking any type of action, so it's best to not talk with each other because then if even if you start not talking about action as the conversation goes, it can then spill over into action. So the best advice is just to not talk about it with other outside of the open public meetings.

Eileen Cody: But we could all be on as not panelists, [ cross-talk ] whereas then [ cross-talk ] you got [ cross-talk ] --

Mike Neuenschwander: [ Cross-talk ] Yeah.

Ryan Pistoresi: [ Cross-talk ] Yeah.

Doug Barthold: [ Cross-talk ] Yeah.

Ryan Pistoresi: [ Cross-talk ] Basically, because you're not talking to the others, so then you don't have that risk of by accidentally taking action.

Michael Tunick: Yeah.

Ryan Pistoresi: So if your kids or grandkids are all in the same little league team, you know, you can attend the game [ laughter ] and talk about that, but you don't want to like then cross and start talking about PDAB business. But yeah, go to non-whatever functions together but not [ cross-talk ] --

Eileen Cody: [ Cross-talk ] Like the Governor's Ball. [ Cross-talk ] --

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

Eileen Cody: [ Cross-talk ] There you go.

Doug Barthold: I haven't seen my invite yet, but [ laughter ] --

Mike Neuenschwander: [Indistinct] Any other questions on the Advisory Group and kind of expectations or hopes from them?

MaryAnne Lindeblad: No. I think it'll be really interesting to listen to their meetings and just get a sense of what they have to say and how that might influence some of the decisions that we make here, [ cross-talk ] certainly.

Mike Neuenschwander: [ Cross-talk ] Right. Okie doke.

MaryAnne Lindeblad: So are we ready for public comment?

Mike Neuenschwander: Yeah. I was going to say, we're making fantastic [ cross-talk ] time today.

MaryAnne Lindeblad: [ Cross-talk ] Yeah, we are.

Mike Neuenschwander: [ Cross-talk ] Yeah, really.

MaryAnne Lindeblad: [ Cross-talk ] We've made a lot of progress.

Mike Neuenschwander: The weather has even cleared up, it looks like, so [ cross-talk ] --

MaryAnne Lindeblad: [ Cross-talk ] a storm.

Eileen Cody: Would you not say it?

Multiple Speakers: [ Laughter ]

MaryAnne Lindeblad: Mike, on public, anyone signed up?

Mike Neuenschwander: Yes, we have one person signed up in advance, Dharia McGrew, who is also from the Advisory Group, and then it looks like Ronnie Shure has also raised his hand, and so we can start with them, and I'll open it up and see [ cross-talk ] if anybody else raises their hand. All right. Feel free to jump in.

Dharia McGrew: My turn? Thanks. Um, confirming you can hear me.

Multiple Speakers: Yes. Yeah. Yep.

Dharia McGrew: Thank you, Chair Members. Dharia McGrew, Director of State Policy for Pharma. I really appreciate the Board and staff for the detailed discussion today, really important topics. We will submit more detailed comments after we've had a chance to fully review the materials. I want to first point out that the Board has some mandatory and some additional criteria for choosing drugs to review. And note that this preliminary subset you have not yet considered all the mandatory criteria set out in statute, so Pharma would urge you not to go too far ahead into choosing drugs for review until you have had a chance to consider all the mandatory criteria at a minimum. On a small technical note, if the Board is interested in further comparisons with other states, I would respectfully suggest that the Board staff go back and take another look at the Oregon list you have provided. Several of those drugs were subsequently found to be ineligible for review due to errors in data analysis. So this highlights the difficulty that many states are having in evaluating the data and the need to proceed in a very clear and careful manner before going forward and then having to make corrections down the road. The biggest issue that jumps out at me from the discussion today on the new policy is the reliance on -- APCD data and using the total paid amount, since it is not net of rebates. I'm sure that the Board is aware, but I think it definitely needs to be stressed and transparent, since total price paid was ranked fairly highly by the Board's point allocation. Unfortunately, prices paid in the pharmacy claims are not reflective of the net price or the actual price paid by plans and payers. Furthermore, the APCD data skews costs upwards due to hospital markups on drugs, and this may also have some bearing on the discussion today about the prevalence of specialty drugs on the preliminary list. Looking at patient out-of-pocket costs surely gives you a metric of patient affordability, and I appreciate the recognition that out-of-pocket costs are determined by the plans and the PBMs. But many of the drugs in your preliminary subset list are likely highly rebatable drug. So I recognize that the proposed framework for affordability review would look at to quantify net costs in the next step, but I ask that the Board recognize that the subset list from the ranking exercise is based on some of the criteria are artificial prices that are not reflective of the real drug cost to the payers. Thank you.

Mike Neuenschwander: [Audio cuts out] very much.

MaryAnne Lindeblad: Thank you.

Mike Neuenschwander: I had seen Ronnie. You had raised your hand. Go ahead.

Ronnie Shure: My name is Ronnie Shure. I'm a retired pharmacist, who is on the Advisory Group, and I would just support the decisions to choose drugs on the values that you put forth. There is no way we can cover all of the issues that are to determine the price by, you know, some beginning rankings like this, but looking at the cost really does address the pharmaceutical manufacturers' end of it. But considering out of patient pocket cost is more than just a patronizing comment to the public. That considers the other big factor, which is the insurance company and pharmacy benefit managers that impact the drug costs. I think Dharia would agree with us that the cost we're looking at is not just from the pharmaceutical manufacturers. So choosing these two factors is good. As we go along, I think we'll look at some of the other mandated adjustments, whether prices have increased. And Doug probably could lead us in the discussions on the other impact of the drug, whether we need to determine whether it really improves our lives, quality of life years, or there are a dozen ways of looking at life years. So hopefully, we can use those economic bases to help with that decision as we go along. But the factors you've discussed are the perfect context to begin this analysis. So, thank you.

MaryAnne Lindeblad: Thank you.

Mike Neuenschwander: Thank you very much. Any other comments?

Simon Borumand: I don't see any other hands raised on Zoom or anyone in the room.

Eileen Cody: Do we have the meeting set for [ cross-talk ] --

Mike Neuenschwander: Uh, yeah. When is our next meeting on the calendar? Is that January? [Indistinct] [ cross-talk ].

MaryAnne Lindeblad: [ Cross-talk ] I thought you sent out 25 [ cross-talk ] --

Doug Barthold: I've got 15th. Jan 15th.

Mike Neuenschwander: [ Cross-talk ] Yeah.

Eileen Cody: [ Cross-talk ] Yeah.

MaryAnne Lindeblad: [ Cross-talk ] Yeah. [ Cross-talk ] Maybe you can resend it.

Mike Neuenschwander: [ Cross-talk ] Resend it? [ cross-talk ] --

MaryAnne Lindeblad: [ Cross-talk ] I thought [ cross-talk ] --

Mike Neuenschwander: Yeah, I was going to say, maybe, yeah, we could resend out the schedule. I know we talked about it, and we planned it.

Eileen Cody: It's not on the list that came out from the Health Care Authority about that with the other ones, like with the Health Care Cost Transparency Board and their advisory groups.

Ryan Pistoresi: From the register?

Eileen Cody: Yeah, I [ cross-talk ] --

Ryan Pistoresi: Okay.

Eileen Cody: At least with the one that I got this week. [ laugh ]

Ryan Pistoresi: Okay. We've got [ cross-talk ]. Yeah, with the [ cross-talk ] --

Eileen Cody: I don't know.

MaryAnne Lindeblad: Yeah.

Eileen Cody: Who knows? So I'm on the Transparency Board, too, so maybe that's a separate one, but it [ cross-talk ] --

Ryan Pistoresi: Yeah, I mean, it could be. I mean, but they do both have to go through the Code Reviser [ cross-talk ] [indistinct], but it looks like we have them scheduled for the third Wednesday of the odd months. But yeah, we could just double-check to make sure that that was posted.

Eileen Cody: A full day, right?

Mike Neuenschwander: Yeah.

Eileen Cody: Yeah.

Mike Neuenschwander: Yeah. We need the Advisory Board input and us reviewing the dashboard the bulk of the meeting January's meeting figuring out what drugs we want to look at. It should be a fun one. Okay [ Cross-talk ] --

MaryAnne Lindeblad: [ Cross-talk ] Meeting adjourned.

Mike Neuenschwander: Okay.

MaryAnne Lindeblad: Thank you.

Mike Neuenschwander: Thank you.

Ryan Pistoresi: Thank you.

Doug Barthold: Thanks. Thanks, everyone. Have a great day.

MaryAnne Lindeblad: Good to see you all.

Doug Barthold: Bye.

[end of audio]