Total Cost of Insulin Workgroup
Meeting transcription
October 27, 2022

Mary Fliss: I'll try to make sure I get all that straight before we start. So if we could please, we are now recording. And again, if you could please state your name before you speak so we have it on the record. We will also be transcribing this. Awesome. Okay, next slide. So today we are hoping to accomplish several things. The first is this first welcome and some opening business. The next will be patient perspectives presentation on emergency supply. Donna will be kicking that off and then turning it over to Kevin. Then we will talk about the short-term emergency supply comparison grid Hayley from The Center will be able to present some of the information they have been able to gather for us. We'll take a quick break And then we'll be doing an overview and some discussion. Mike Bonetto, also from The Center, will be leading us through that. So in terms of opening business, we got the recording in place. Also, I would like to welcome Tim Lynch, is it? Is that the right name and pronunciation? Okay, terrific. So, Tim, if you wouldn't mind saying hello to the group and introducing yourself.

Tim Lynch: Yeah. Good morning, everybody. My name is Tim Lynch. I am a member of the Washington State Pharmacy Quality Assurance Commission and eager to be part of this group.

Mary Fliss: Awesome. And so, Tim, when we all introduced ourselves, we said where our dream vacation was going to be. Now, of course, you won't understand that, or you won't have that whole knowledge for everybody else, but if you would like to share what your dream vacation spot is, that will give the group a little bit more understanding and context of you as a person as we work together on this very important issue.

Tim Lynch: Ah, wow. That is a tough one. First thing that jumps to mind is maybe Budapest. I would love to go to Budapest.

Mary Fliss: Awesome. All right. Well, welcome, Tim. It's great to have you with us. And I think with that, Nonye, Leta. Oh, I think this may also be Jane Byer's first meeting. Jane, if you could please introduce yourself. Give us a chance to meet you as well.

Jane Beyer: Hi, everybody. I'm actually sitting in for Barb Jones, who is usually OIC's representative on the workgroup, but she is out of town today.

Mary Fliss: Very good. All right, Jane, would you like to share your dream destination?

Jane Beyer: Anywhere as long as I can be on my bike.

Mary Fliss: Okay, very good.

Leta Evaskus: And, Mary, I just want to say that we do not have anyone representing the Association of Washington Health Plans at this time. Our member left that association, so we are looking for a new representative.

Mary Fliss: Very good. Yes. Chris Bandoli has taken a chance for a new opportunity. And so, Leta, I have the name of the person who is now in that role, so I will make sure I get that to you. Awesome. Any other opening business? And, Nonye, you have taken role for us?

Nonye Connor: Yes.

Mary Fliss: Awesome. All right. Thank you so much. Okay. So with that, I think we are ready to move on to our first presentation of the patient perspective. So Donna, would you like to kick us off on this?

Donna Sullivan: Sure. So we wanted to make sure that we have the patient's perspective when we are working on recommendations to provide back to the Legislature. And so, we asked Kevin Wren to help us with bringing patient perspectives on the emergency supply to us. And he has prepared a series of five videos, and he's going to display those. And, Kevin, I'm just going to pass it off to you.

Kevin Wren: Thank you. Yeah. So I reached out to a number of our chapter members just to get a rounded perspective. We have Jim here. He's first. He is, I think, on Medicare. He's a little older. And I'll let him kind of give his story about why we need to have copayment caps on insulin for people are still insured. He has insurance, but he still pays the high amounts for his costs. So I'll let him tell his story.

Jim Chairs: Hello, my name is Jim Chairs, and I have had Type 1 diabetes for 26 years. I truly appreciate the opportunity to speak with you today about the rising

cost of insulin. Even with insurance, the unpredictable and increasing cost of this life saving drug is both frightening and frustrating to me as well as many others. Every 90-days, I need five vials of Novolog insulin to stay alive and healthy. My insurance copay is 30% of the list price for insulin Novolog. Because this price is unnecessarily volatile and continues to increase, I continue to see my cost increase. Here are two recent examples of me refilling this prescription. What you'll see here is in June, the list price of my Novolog was $522. I filled again in September, and the list price had jumped to $1,302. That is quite a bit. That is 150% price increase for a drug that has remained essentially clinically unchanged for the past 20 years or so. What I don't know is why other than manufacturers and PBMs enriching themselves through the veil of rebates and formularies. Now, fortunately, my copay is capped at $290 for that for that increase, but that is still a double copay for me. And for folks in high-deductible plans without such caps, insulin becomes quite unaffordable, forcing the dangerous practice of rationing for many. And this rationing can lead to expensive avoidable complications and even death. So we really need a check to balance this inequity that limits how much we are required to pay in order to simply stay alive, healthy, and thrive. Thank you very much.

Kevin Wren: Yeah. That is Jim's story. It's not unique. I mean, many of us go through the same thing. The next video is of Levi Markland. He is 10 years old. I first testified next to him a couple years ago back in 2020. Very effective testimony, the fears of a child rationing insulin. We can't choose this disease. It chooses us. So we are kind of stuck with it. And I think his words are very impactful, and I hope you listen to his story.

Levi Markland: Hello, my name is Levi Markland, and I'm 10 years old. I was diagnosed with Type 1 diabetes when I was 6.

Amber Markland: What does it feel like knowing you have a disease that has no cure?

Levi Markland: Knowing that I have a disease with no cure is hard for me because I have to deal with stuff that most people don't.

Amber Markland: How does it make you feel when you hear about other diabetics that die because they can't afford insulin?

Levi Markland: That makes me feel worried and sad because people are dying because of diabetes. And it makes me worried because I have diabetes. And if I can't afford insulin, then I'll die, too.

Amber Markland: What do you want people to know about the importance of affordable insulin?

Levi Markland: It's important because if people can afford it, more people can live and help the world.

Amber Markland: Any last words from a superhero?

Levi Markland: Just live healthy and happy.

Kevin Wren: That was Levi. I should underline that this insulin price crisis affects black, indigenous, and people of color more than white people just because of the social inequities of our healthcare system. Social determinants of health make it harder for these communities to access affordable insulin, and so we need to work to make this kind of racist system less racist and more accessible. In the next video is Amber Markland talking about our policy recommendations for this copayment cap and the necessity of it. And I'll let her tell her story.

Amber Markland: Hi, my name is Amber Markland, and my son, Levi, was diagnosed with Type 1 diabetes in 2018 when he was six years old. We live in a country where nearly 1.9 million people live every day with a disease that has no cure. On October 18, a statement was released saying that more than 1 million Americans living with disease are rationing their insulin because they can't afford it. Insulin, the sixth most expensive liquid in the world, is sold to families like mine for hundreds of dollars. This comes at a price most average Americans cannot afford. And there is more than just insulin diabetic needs to take care of themselves. Needles, lancets ketone strips, alcohol wipes, snacks for lows, pumps, monitors, meters, emergency room visits, and so much more. Type 1 diabetes is unpredictable, expensive, and cruel. But to add the financial burden to that list when we sit here knowing there is a way to improve so many lives in our state is even more absurd. We all need insulin to live. The only difference is Type 1 diabetics have to pay for theirs. Not all diabetics have the privilege to afford to pay thousands of dollars per month. Those that can't ration their insulin causing severe damage to their bodies and eventually overtime pay the ultimate price by dying. Type 1

diabetics are already burdened by a disability beyond our control. We shouldn't be forced to feed the greed of pharmaceutical manufacturers and plead with gatekeepers of unjust rules and regulations in our healthcare system. The importance of accessible and affordable insulin for all is our Maine priority.

Kevin Wren: That is Amber. And that was amazing. Her and her son provided really poignant testimony as to why we need copayment caps. They're both insured, her and him, but they still have the high cost for their insulins, which is unnecessary. There is no reason why we should pay so much for this drug that is over 100 years old now.

Mary Fliss: Hey, Kevin.

Kevin Wren: I'm sorry.

Mary Fliss: I'm sorry to interrupt you. Before we go to the next video, some people are having a hard time hearing the videos. [cross-talk] –

Jenny Arnold: So, I had this problem. And I think there is an option because it's not just your computer audio. If you click on the carrot next to your microphone and go into Audio Settings, under there is also a separate speaker volume just for Zoom and what volume Zoom is at. And so, if that volume is way down, even if your computer volume is up, it can be hard to hear. So that is another way to adjust it. At some point mine got turned way down. I don't know why, and I couldn't hear. Not on this call but previously. So I figured that out.

Mary Fliss: Okay, great. Yeah. So under Mute, click Audio Settings, and then you have your Speaker and your Microphone Volume.

Jenny Arnold: That may help, too.

Mary Fliss: Thank you.

Jenny Arnold: And then, for whoever's projecting it, they could go in there, too, and turn up their microphone volume, and that might help with projecting a louder sound also.

Nonye Connor: Okay, I'm going to try, too.

Mary Fliss: Thanks so much, Jenny. So, Kevin, thank you for giving us all a minute to find that next to your mute button. And if you want to go ahead, and we'll turn it back to you.

Kevin Wren: Awesome. Thank you. So that kind of wraps up why. I mean, we broke it into two kinds of categories, the uninsured and the insured. People with insurance are paying a whole lot of money for their insulin. So we want to make sure to cover them with a copayment cap of $35. That is kind of what Mexico and Canada pay for their insulin. So, I mean, it's reasonable. It's kind of arbitrary. It doesn't need to be $35. We can kind of choose how much. But that is that piece. The next piece is covering the uninsured. Coverage gaps can happen for so many reasons. Not having insurance. So, I mean, I just helped someone just this month who is rationing insulin down in Federal Way. I brought them a box of Lantus pens, which can cost upwards up to $500, and it would really saved their life. I also just heard from an advocate that she knows a stylist who was rationing their insulin and had to be hospitalized. So we are raising money for them via GoFundMe and Mutual Aid Diabetes. This problem is persistent. It keeps getting worse, as Jim told you. Prices keep going up. [Indistinct] keeps changing the prices, so we have to have kind of a safety net for the uninsured and for us that maybe are partially insured or rationing for whatever reason. And having a 90-day supply is kind of critical. I can't tell you how many people I've helped with rationing insulin, provide them with insulin. And it's still technically a felony. And I'm admitting to another felony. I'm doing this. So it's hard because the burden falls on patients just kind of scramble, and we really need the state to step in and provide a solution. Madison Johnson here, who leads Washington Insulin for All, can talk to that a little bit and talk about the reasoning behind why we need kind of an Alex Smith-esque Safety Net Program that allows people a 90-day supply of insulin. Yeah. I'll let her tell her story.

Donna Sullivan: So, Kevin, before we go to the video, it looks like we have a few questions. So Jennifer Perkins.

Jennifer Perkins: Yes. Hi. I'm sorry. It's just you reminded me, Kevin, of a qualitative study that I read recently, and it was specifically on GoFundMe campaigns for insulin. And what they had found was that GoFundMe is not an effective method for actually getting people the money that they need to pay for their insulin. A lot of them didn't. They were not successful, and they did not get the money that they needed. I just wanted to share that with the group here.

Kevin Wren: Thank you, Jenny. Yeah. GoFundMe is not a solution. It is a solution, but it often doesn't help people. I mean, I've been told to start a GoFundMe because a job was unpaid with the United States Senate. So this problem persists. And it kind of leaks into all of these other things. So, thank you, Jenny, for pointing that out.

Donna Sullivan: And then Jenny Arnold also had a question.

Kevin Wren: Okay.

Jennifer Perkins: Hi. I agree. This is not something we can allow to happen in our state, but I think when we think of solutions, and that is where we are trying to go. And I know we have discussed as a group is the issue uninsurance? Or is it underinsurance? Do you as you're going through and helping these folks, Kevin? I think similarly with GoFundMe doesn't help. You know, I mean, I think that finding a box of insulin for somebody to me it isn't a solution because what happens the next month and the next. Right? We want to get people either into care solutions that work and actually cover them in my mindset, whether that is insurance and access to care, or whether that is helping with copays or dropping the cost of copays. Do you have a sense of is it all across the board? Or is there a pattern that you see where it's they don't have insurance or there is a gap in their insurance, or the insurance copays are too high? Or kind of some of the cause, I guess. Like, I agree with the problem, and I'm looking forward to hearing this next video also, but I think the root cause of it I think is helpful, too.

Kevin Wren: Yeah, I mean, it's all the reasons that you can think of. I helped my brother, who is experiencing coverage gap because he was changing jobs and didn't have insurance for a month. I helped, I mean, the person that is in a coma right now, she has a full-time job, but she makes so much money that she doesn't qualify for the subsidies for Medicaid. So she's kind of on the elbow there, which a lot of people are, where it's like you have enough money so you don't qualify for Medicaid, but then the cost of insurance is just so high that it's cheaper to pay out-of-pocket costs for insulin. So there are so many reasons. I mean, not having documentation. I helped a migrant family in eastern Washington back in March. I've helped homeless people that have somehow gotten to us online. [Cross-talk] –

Jennifer Perkins: So it sounds like uninsurance and gaps in insurance seemed to be the bigger issue versus kind of the cost of copays with a lot of the folks that you specifically are helping.

Kevin Wren: Yeah.

Jennifer Perkins: That is kind of the trend that I hear just the 10,000 foot view and then the causes for the un- or underinsurance are varied.

Kevin Wren: But it's also the insured. I'm helping the insured, too. Like people with insurance that their cost is just too high this month, so they can't. They have to save up for maybe buying the insulin next month, and they're just short. But then again [cross-talk] –

Jennifer Perkins: The deductibles are also an issue for high-deductible plans.

Kevin Wren: Yeah. And just Yeah. And like when we talk about, again, those overall solutions, like expanding Medicaid to people would be a big help. And it's not directly tied to accessing insulin, but it is one of those bigger solutions that would help a lot of these people. I mean, yeah, it breaks my heart whenever I help somebody, and it happens all the time.

Jennifer Perkins: I didn't mean to get in before the video here.

Kevin Wren: That is okay.

Jennifer Perkins: I just think the causes to me are where we find the solutions, I guess, maybe. Thank you.

Kevin Wren: Yeah, for sure. Thank you.

Ronnie Johnstone: Do you want me to go ahead and play the other video, Kevin?

Madi Johnson: Alex Smith, John Wilkerson, Jada Renee Lewis, Jesse James Lutgen – these are just four people that we know out of the many who have died because of insulin rationing and lack of access to insulin. There are countless more that we don't know or who have suffered or suffering from complications from rationing their insulin. About once a month, advocates engage in mutual aid to provide rationing diabetics with insulin here in Washington State. With over one-third of Washington at risk of developing diabetes, this issue will

only continue to grow and plague us. It's only a matter of time before one of us falls through the cracks and rations into an early grave. Experiencing a coverage gap can occur for so many reasons, even here in Washington State where we have great public healthcare. Not getting coverage, finding a provider, and getting prescribed your medication takes time. Even with within a system, we need a legitimate 90-day window in order to get these things established and sorted. We need unfettered access because life can throw you curveballs when it comes to your insurance. And no one should even ever have to wonder where they're going to get their next insulin dose from.

Kevin Wren: That was Madi Johnson underlining some of the things that I said. People ration for all different types of reasons. When we look at the Alex Smith Act, I think there are aspects of it that we can improve upon here in Washington, like loosening the eligibility criteria. I think it's hard for someone who is undocumented or homeless who doesn't have an ID in order to access this program. I mean, it has still helped like 1000 people in Minnesota this last year, so there is a clear and present need for it. It's just about us making it as accessible as possible. And that means loosening all the eligibility criteria that we talked about and surveyed about. I'm sure we'll discuss it more. But, again, coverage gaps can happen for so many reasons, so we need a safety net. We need something to help the insured afford their insulin if they have high-deductibles, and we need something for the uninsured or people that that just can't access their insulin for whatever reason. And a 90-day supply is a really innovative idea, and that again improves upon the Alex Smith Act that can take weeks to get in to see a provider, months, and then get that prescription, and then get to the pharmacy, all while navigating your life and trying to afford other things. So having that bigger window is really critical. Loosening the eligibility criteria is also really critical, too, in helping these people that are that are rationing. But then I'll go into our third policy topic with Jenny. We tried, again, to take a broader view of what providing this insulin would look like for the insured and the uninsured. How would the Healthcare Authority leverage existing systems or potentially work with California, who is looking at manufacturing their own insulin or distributing or partnering with somebody to do that. So there are some pathways for us to source this insulin and find an affordable way to provide it from the state. But I'll let Jenny talk about that.

Jennifer Perkins: Hi, my name is Jennifer Perkins. I think it's really important for us to think of resiliency and incentives in our pharmaceutical system. It has been said time

and again, the three Maine companies have unethically and artificially increased their prices in lockstep with each other. Solutions involving multi-state compacts, including ArrayRX and California's public production would be a vital solution to uninterrupted and affordable supply of insulins that people use to sustain their lives. We live in an uncertain time. If something happens to just one of these companies or something happens in the supply chain, there could be devastating effects. Having more suppliers adds resiliency and incentive to lower prices in our supply chain. Lately, I've heard that people think that the older insulins are just as effective as the newer analogs. And that simply is not the case for me and for many other diabetics. I felt really scared when I had to use regular insulin. It is not approved for use in insulin pumps, which also makes it a poor option for people like me. One study I saw, published in JAMA, switched over 14,000 people to older insulins and didn't ask what that experience was like for them. They didn't follow up on the 15.7% of people who were not included in their analysis because they switched back to their normal regimen within a year. I presume they switched back because it simply was not effective for them. And a study that only includes seniors, less than 1% of people with Type 1 diabetes, doesn't really represent the population of people with diabetes here in Washington State and, therefore, it should not be generalized to us. We should not let Pharma, PBMs, insurance companies, or anybody else decide our medical treatments based off of what is most financially best for them. Which medicine we take should be based off of what is best for our health and our future. Adding ArrayRX and the California production to the table could provide a transformative solution that as a Type 1 diabetic I can get behind. We should not settle for substandard insulin. We are not even asking for the latest and greatest drug here. Many of these analogs are over 20 years old. And we all know that the US pays more for drugs than other countries do. We ought to stop letting them get over on us and oppressing people with diabetes. One in 10 people have diabetes, and 1 in 3 seniors do. It is common. Diabetes is a common variation of the human condition, and we deserve to be treated as humans, not as consumers to be capitalized on. Money saved by utilizing the methods I mentioned are one option that could be used to reimburse pharmacies that supply emergency insulin. Thank you for your time.

Kevin Wren: Ah, thank you, Jenny. And Jenny's on the call, too. So, hi, Jenny. I think her testimony is great, and it really speaks to some of the issues we have seen. Even within this group, I think we have kind of touched on is leveraging Walmart insulin and regular insulin as a solution. I know for a lot of people it

doesn't work. It doesn't work for me. So we need to have access to the medicines that work best for us. That means not limiting which insulins are provided in the supply. We need to have access to the latest and greatest short-acting insulin, which has been on the market for 30 years. I mean, I could talk about how they have rigged the system, but I think Jenny did a great job of telling us why we need access for a program and how the state can leverage ArrayRX to source this insulin. Yeah. And then my final piece, my video here is about next steps with this group and where we see it going. I think we recommend creating a department within the state to address insulin affordability and hire four full-time employees, someone to manage the group and oversee some of the recommendations that we have provided in this group. Yeah, I'll let me take it away. – To address insulin affordability, Washington needs a team within the state government and Healthcare Authority to address insulin access on a committed full-time basis. To achieve this, we recommend creating a department of insulin access with four full-time employees within the Healthcare Authority. This crisis cannot rely upon unpaid advocates to engender change alone, and this requires a full-time commitment from the state implementing copayment caps for the insured, creating a Safety Net Program offering an emergency 90-day supply of insulin for the uninsured, and sourcing insulin to mitigate high costs, all require dedicated staff. Those advocates like myself that ushered this workgroup into formation, and we recognize their state does not have the bandwidth for a dedicated response to address the insulin price crisis in Washington alone. So creating a department to focus on access is the next logical step beyond this workgroup. States must band together to address the high cost of insulin, albeit through ArrayRX or California potentially distributing a low-price generic, and our state needs the people power to make those connections and build those bridges. They can also help explore other aspects of the crisis, like accessing supplies and technology and working with advocates to determine the needs of the community as well as working with industry individuals to negotiate access. We need a perennial solution to this crisis because our diabetes isn't going anywhere. The high cost isn't either. And with our help, we can create a long-term solution that seeks to create enduring safety nets that save people's lives and prevent us from rationing our insulin. Thank you. – Yeah, and that is just kind of taking this group to the next step in our recommendation to the Legislature. What is this, and how does this all get done establishing copayment caps and overseeing a Safety Net Program? I think it takes full-time people, and I'm sure our Healthcare Authority people on the call, being divided between your work is tough. So just having a department there I think is necessary. I don't

want to have to keep doing this as an unpaid advocate. It's really nuts. It's a public failure, and we need to step in. I think covering the uninsured through a Safety Net Program like the Alex Smith Act and expanding it to 90-days is perfect. Having copayment caps is also great. It will help people afford their insulin and focus on something else. And $35 instead of $300 is a huge difference, especially for someone on a fixed income or have other payments like car payments or whatever. So I think we have discussed all the reasons why we need these programs. This is kind of fine tuning them at this point. But thank you.

Mary Fliss: Excellent. Kevin, thank you so much for the presentation. And we'll give it a minute for questions. And just a quick reminder, as you start to speak, if you could please state your name. So, again, thank you so much, Kevin.

Donna Sullivan: Hi, Mary. This is Donna Sullivan. So I have a question. You keep mentioning copay caps. And Washington State Legislature passed copay caps I think twice now. I thought it started in 2020. And it also applies to high-deductible plans. So have you seen, are you hearing people still being charged a high copay in the last year? Because that is a regulatory issue with the Office of the Insurance Commissioner. And I think maybe Jane can jump in and correct me if I'm mistaken.

Kevin Wren: I'm still hearing it from people. There was an advocate that wanted to testify about it because the insulin for her child is still super expensive. I mean, Jim pays 30% of the list price. So it's people like Jim and people with insurance are still seeing this stuff. I mean, I get asked, I think, at least once a month via Facebook or Twitter, and I have to keep reminding people that this group is making a recommendation to expand maybe those copayment caps that already exist and explore regulatory things. But I think at the end of the day there is only so much we can do as advocates. So if it is a regulatory issue, we have to create something within the Healthcare Authority to address that.

Jane Beyer: So Kevin, this is Jane, if I can jump in. And Donna, you are correct that for health plans that we regulate, that the state can regulate, which are fully-insured health plans. That cap on copays applies. But under a federal statute called the Employee Retirement Income Security Act, lovingly called ERISA, states cannot regulate self-funded group health plans. The only self-funded group health plan that the state can regulate is our own Uniform Medical Plan, because it's our plan. And based upon national estimates that we have seen, of people who get their coverage through their employer, which is

probably upwards of 4 million people in Washington State, about two-thirds of those employer-sponsored plans are self-funded. So, Kevin, it doesn't surprise me at all that you're hearing from people who have insurance, especially large employers are more likely to self-fund. So it doesn't surprise me at all that you're hearing from people who have really high-cost sharing for their employer-sponsored plan because more likely than most likely, it's a self-funded plan that we can't touch. And many of you probably remember that the Inflation Reduction Act tried to apply that $35 copay to all health plans, but the Senate Parliamentarian ruled that you couldn't do that through budget reconciliation. So it's still a real issue for folks who have self-funded health plans. [Cross-talk] –

Jenny Arnold: And so, it only ends up being about a million people that are impacted because it's also not Medicare, Medicaid-covered luckily. That is that challenge just to round out the discussions. We have had that issue and other pharmacy issues.

Jane Beyer: Yeah. Unfortunately, the Inflation Reduction Act does apply the $35 cap to Medicare. So, thank God, Medicare beneficiaries. There are about one and a half million Medicare beneficiaries in the state. There are about 1.3 million enrolled in health plans that we regulate. So there is probably close to between two and a half and three million people in the state that get their coverage through self-funded employer plans.

Kevin Wren: Thank you for that.

Donna Sullivan: And then I saw LuGina had her hand up. Do you have a comment?

LuGina Harper: Oh, yes. No, I was just going to ask. I wanted to clarify and make sure that the Federal Inflation [audio cuts out] [00:39:11] Act would impact those with Medicare. I just want to make sure and confirm that that was accurate. And I think Jane just included that in her comments. So, thank you.

Donna Sullivan: Okay. And then Laura, I noticed you had your hand up. Did you have a comment as well?

Laura Keller: No, I was just going to say basically what she said – this is Laura from the American Diabetes Association – about those ERISA plans. And we, unfortunately, don't have the ability to regulate those on the state level. And I do hope that at some point, we'll be able to make change federally to address

those things. But you're exactly right. There are a lot of ERISA plans and companies that choose high-deductible plans intentionally. And when they choose those plans, that is what happens with high-deductibles and people not being able to afford their insulin in the State of Washington. And it's unfortunate because this group can't regulate that through a copay cap [cross-talk] in the same way that you do private insurance that the state can.

Donna Sullivan: Thank you for clarifying that and reminding us of the ERISA plans. Any other discussion or conversation? Questions that we want to document or share?

Kevin Wren: Oh, and I just want to say that I've been in conversations with the White House and Senator Schumer about potentially doing a federal price cap on insulin. And that is still a ways off, so don't hold your breath for that.

Donna Sullivan: Yeah.

Mary Fliss: Great. Well, Kevin, Donna, everyone, thanks so much for the great discussion. Really appreciate having that deep understanding of the patient perspective as well as the solution-oriented approach that you're taking on this. It's very helpful. So with that, and, of course, we will be with each other for the next hour and 15 minutes, so if we think of additional questions, please feel free to put those in the in the Q&A. And we'll make sure that we capture those and are able to continue this rich conversation. But with that, let's go ahead and move on to our next Agenda topic. And Hayley, I think I'm turning it over to you.

Hayley De Carolis: Sorry, got to get off mute. Thank you, Mary. My name is Hayley De Carolis. I'm a policy analyst at The Center for Evidence-Based Policy. And today I will be presenting an overview of the state policies we found for emergency supply in some legislation that we have talked about in previous workgroup meetings. And I just want to mention that this slideshow or this presentation is focused on short-term solutions and policies, so strictly emergency supply. We are planning on future meetings covering long-term solutions. And some of these policies do include a long-term aspect, but we won't be focusing on those today. I just wanted to start off with that note. Next slide, please. These are the four different policies we'll be going over today. They all have been implemented in the last couple of years, and some have been brought up in discussions already. Next slide, please. We are going to start with the Maine Insulin Safety Net Program. Next slide. This was signed into law June 21, 2021, implemented a couple months ago, March 1 2022. So the full policy

does include an urgent need safety program and also an ongoing assistance program for the manufacturer. It is funded partially by insulin product registration fees that are levied on the manufacturers, and it requires annual reporting to the Legislature. The Urgent Need Program provides 30-day supply. So this is different than what we have heard in the workgroup related to the 90-day recommendation. Next slide, please. So I wanted to highlight some key definitions from this state program. It doesn't specify any certain type of insulin. I know that is come up in the discussion before. A manufacturer is subject to the program if they have an annual gross revenue from sales of $2 million dollars or more annually in that state, so this would be in Maine. And they classify urgent need of insulin as having less than seven days of insulin available and being in need of insulin in order to avoid the likelihood of suffering significant health consequences. So we can talk about later how that is determined. But those are the key definitions for this policy. Next slide, please. And then to be eligible for the Urgent Supply Program, the patient must be a resident of Maine, and they must be able to present documentation of this. So that is another item that is come up in the workgroup discussions as kind of limiting access. They cannot be enrolled in MaineCare, which is their Medicaid program. They cannot be enrolled in healthcare coverage that limits cost sharing to $75 or less for the 30-day supply. Their household income must be lower than 400% FPL, not eligible for federal healthcare coverage, and then some specifications around Medicare Part D in the spending on that. Next slide, please. So an important part of this program is the application process. So the Board of Pharmacy with the state must post an application online as well as how to be available in various healthcare settings. And then on the application, the patient is responsible for demonstrating all eligibility criteria, which means bringing in proof of Maine residency. They will bring this completed application to the pharmacist, and then the pharmacist is responsible for reviewing the application at the time that the patient is requesting the emergency supply. This is different than the ongoing patient assistance programs required by the manufacturer where the manufacturer is responsible for receiving and reviewing the application for the urgent need. It falls to the pharmacy, and at the time that the patient is submitting the application and requesting the insulin, the pharmacy must also supply them with an information sheet about their Health Insurance Consumer Assistance Program, which includes programs like ongoing insulin assistance programs, information on how to apply for MaineCare, information on providers that participate in prescription drug discount programs, and other assistance programs through nonprofit organizations. So they get an information sheet with all those

resources at the pharmacy. Next slide, please. In order to access the emergency supply, the patient must present the signed, dated, completed application, a valid prescription, and a Maine identification to the pharmacist. This next bullet is an important distinction between Maine's program and Minnesota's program, which we'll go over next. In Maine, if the patient does not have a valid prescription, the pharmacy may still dispense the insulin. And then one thing that is not noted on this slide but is important is, that access is limited to a one-time supply over a 12-month period. So they can only get the emergency supply once in a 12-month period which is pretty standard across the different emergency programs. Next slide, please. So moving on to program monitoring. The Safety Net Program requires annual reporting from manufacturers, which includes how many people access the insulin, how many people are participating in the ongoing assistance program, and then the value of the insulin that was dispensed. The State Pharmacy Board aggregates this data and submits it annually to the State Legislature. And then for tracking purposes, the pharmacy must retain a copy of the application form, and they also must notify the original prescriber of the dispensed insulin no later than 72 hours after. The timeline for this varies between the emergency programs, but I believe all of them do require the pharmacy to notify the prescriber at some point. Next slide, please. So for reimbursement, Maine pharmacies may charge up to a $35 copay for the 30-day supply, and that is to cover the pharmacies costs of processing and dispensing the insulin, but the manufacturer is responsible for reimbursing the pharmacy for any dispensed insulin. They can do that either with replaced supply or through an electronic claim in the value of the insulin, which is meant to cover the pharmacy's acquisition costs. So it's important to know that this is on the manufacturers to reimburse or give a replace supply. Next slide, please. So then part of the funding from this program comes from the annual licensing fee that is assessed on manufacturers that have an annual gross revenue of $2 million or more. So each manufacturer that meets that criteria must pay $75,000 annually. They're also responsible for backfilling the supply or paying the claim. Although, there is no specified timeline for reimbursement by the manufacturer. The manufacturers must also establish the ongoing patient assistance program. They are responsible for approving or denying applications for that program, and then they're also responsible for submitting data. So this is the licensing fee. The $75,000 fee is unique to Maine's program, and it gives them revenue to support the program. Next slide, please. Okay, moving on to Minnesota's Insulin Safety Net Program, which is named the Alex Smith bill, which Kevin has mentioned in this meeting. It was signed into law in April 2020, implemented July 1,

2020. It's very similar to the Maine program, although there are a couple of distinctions. So it's the same in the sense that they have an Urgent Need Program, continuing ongoing patient assistance program reports. In addition to the Maine program, they also did a program satisfaction survey for the first year because it was submitted to the Legislature last year and that it surveyed the patients, providers, pharmacies, so we'll get into that a little later, but that is a distinction. And then same as Maine, it provides a 30-day supply as the emergency supply definition. Next slide, please. So to be eligible for the program, the patient – it is very similar to Maine – must be a resident, must not be enrolled in their Medicaid program. It has the same cost-sharing limitations, same accesses restricted to one 30-day supply per 12-month period, and they must demonstrate an urgent need for insulin. Next slide, please. And this program does have the same application process. The development of the application is a little bit different, but it must be available at all the same places. The pharmacy, again, is responsible for reviewing and determining whether the patient is eligible at the time that they are requesting the emergency supply. The only difference in this one which is not related to the emergency program, but for the ongoing assistance programs, this bill specifies that the manufacturer has 10 business days to review and approve, that was not in the Maine Bill. And then like Maine, the pharmacy must also provide an information sheet with resources. Minnesota also provides trained navigators. They have an appropriation that is used to train the navigators in helping patients access different assistance programs for insulin. And so, that information for the trained navigators is included at the time of application. So another distinction from me. Next slide, please. Similarly to Maine, the patient must present the signed and dated application, a valid prescription, and then proof of Minnesota identification at the pharmacy. Unlike Maine's law, the patient is required to have a valid insulin prescription. So that is another point of distinction between the two programs that we could consider. Next slide, please. For program monitoring, again, very similar. The pharmacy must retain a copy of the application, alert the prescriber. Manufacturers are reporting the same information to the state as the Maine program. Reports are aggregated annually. And then there was a program satisfaction survey that was submitted January 15th that is not a public report, but that was another program on a train aspect of this program. Next slide, please. So next, we are going to talk about the Utah Amendments. This builds upon the Utah Insulin Access Amendments that was passed in 2020, which we have talked about a little bit in this workgroup. But this was an amendment effective in May, and we are going to get into the specifics on the amendment. But I wanted to just kind of set a

base for what this is building upon. So the Utah Insulin Access Amendments in 2020, provided an incentive for health benefit plans to reduce their copayments. And this is similar, I believe, to our discussion earlier about how there are exemptions to that, but the state-regulated plans were capped. It required a study on insulin pricing. And then it also created an Insulin Discount Program that allowed Utahans to purchase insulin at a discounted post-rebate rate. So increasing access to discounted insulin was that program and then authorizes a pharmacist to refill an expired insulin prescription. That is what we are going to be talking about today with the updated amendment. Next slide, please. So eligibility for getting an emergency supply in this program is actually prescription-specific, not based on the patient. So the patient must have an exhausted prescription, which means a prescription for insulin that the patient is currently using that is expired no earlier than six months before the request and is not expired or has no refills remaining, fully expired, I guess. A pharmacist may dispense emergency supply no more than once per exhausted prescription. So similar to the other programs, there is a cap on how many times this can be accessed. Next slide, please. So the pharmacist may dispense the emergency refill for the exhausted prescription. This is an amount up to 60 days, so this is different than the other programs that have 30-days. But before dispensing the emergency supply, the pharmacist must attempt to contact the prescriber, notify the patient of that contact, and then inform the prescriber of the insulin that was dispensed within 30-days. Another important distinct distinction of the Utah program versus the others is that the pharmacists may dispense therapeutic equivalent when filling a prescription, and they are able to dispense diabetic supplies. So I thought this was important to highlight because it is different than the other programs, and it's a concern that has come up in the workgroup. This is the only piece of legislation I have found that list the diabetic supplies outside just insulin. Next slide, please. So this program is not funded by manufacturers. So there is no requirement for manufacturers to backfill the supplies or pharmacies to bill the manufacturers for the dispensed insulin. So there is no language in the statute related to reimbursement, copays, or insurance. So it's really just an emergency access without the – working with the manufacturers to kind of fund or financing in various ways. Next slide, please. So then, finally, we are going to move on to Ohio's House Bill 37. This was implemented June 1, 2020. And this is not specific to insulin. This legislation expanded the emergency dispensing authorization to up to 30-days for all non-controlled medications. So it allows the only legislation we have highlighted that is not insulin-specific but would cover insulin. This is for all non-controlled medications and allows the

pharmacists to dispense the drug without a prescription if the pharmacy has a record of a prescription and the pharmacy is unable to obtain authorization for a refill. And the pharmacy is responsible for determining if the drug is essential to sustaining life, and the other criteria is that failure to dispense the drug would result in harm to the patient. So, again, I just wanted to highlight that there is no specific language related to insulin, but it is covered under this proclamation. Next slide, please. So all insured patients are eligible. This is not targeting the uninsured population. You're also required to have a prescription at that pharmacy. So that is another consideration for patient access. But unlike other programs that limited access to a one-time 30-day supply in a 12-month period, this legislation allows for the drug to be dispensed up to three times. After the first 30-day supply, it's two supplies of seven days only, but it is more than the other programs have in their policies. Next slide, please. So for patient access, the pharmacist must not be able to reach the prescriber, and it is on the pharmacist to determine if the patient is indeed in need of emergency supply. Coverage and copays for emergency supply are the same as when insulin is dispensed in non-emergency situations, they will be charged differently if it's an emergency or urgent need. So really, this policy program does not address the affordability of insulin but rather the emergency access piece that we have talked about in regard to the short-term solutions. Next slide, please. For program monitoring, the pharmacy must keep a record of the emergency supply for up to one year and notify the prescriber, but there is no annual report required to the Legislature like we saw in the other programs. Okay. Last slide, I think, is just a quick highlight of the four different programs. You'll notice, Minnesota's box is pretty small because it's very similar to Maine. So you can take that as those two have similar elements. I think we have some time to have a short discussion about these four if anyone. I know that this was part of the survey that you all received. And so, we got some feedback on this. But I believe we have some time for a short discussion if anyone would like to share their thoughts.

Mary Fliss: Great. Thanks so much, Hayley. And I see LuGina's hand is up. LuGina?

LuGina Harper: Good morning. Thank you, again. This is a really great overview. I appreciate how you approached the overall program and different ways that states have approached this. One question I have in the Ohio bill. And then you talked a little bit more about how pharmacists were allowed to dispense emergency supplies whether a prescription is expired or not are in various situations. I wondered since Tim and Jenny are on the phone, who are both pharmacists

in Washington, can you share with us what Washington state law currently allows pharmacists to do when facing similar situations?

Tim Lynch: So I'll tag team with Jenny. So just to be clear, in the case of a patient who needs an emergency prescription, whether or not a pharmacist could dispense that without a new prescription in hand? Is that what the question is?

LuGina Harper: That is what I was asking because I am a pharmacist, as well. I practice in other states, and I know it varies state-to-state what you can do. Like if it's a control versus a non-control and things like that. So I just wanted to see if you can help us just get a baseline understanding of what is currently allowed in Washington, help inform us of the solution.

Tim Lynch: Yeah. So if a patient shows up, it would be under the professional judgment of the pharmacist to be able to dispense an emergency prescription. Generally, they would like to have a prescription on file if it has expired, and they would reach out to the prescriber. But they can give a temporary supply to cover the patient in order to ensure that they have the medications needed for their self care.

LuGina Harper: Okay. And the temporary supply, is there a day limit? For example, I know they talked about a 30-day supply, a 90-day supply in some of these instances. Is there anything like – because I know in New Mexico where I first started practicing, we had like a 72-hour supply where you could do something to get somebody emergently over the hump, but I didn't know if there was anything like that in Washington.

Tim Lynch: Yeah. You're really testing me right now. [Cross-talk] I'll have to go back and review the law. We went through a rule rewrite recently, and I'd have to go back and look at it. I don’t know Jenny has a top of mind. I can try to do that maybe over the break and give you the details. But it would be hard to give a 72-hour supply with a vial of insulin. So I think, generally, and I would say the patient's safety and health is paramount in these situations, and so I think that would be certainly a consideration that practitioners would need to take into account in terms of providing care. I don't want to speak on behalf of the pharmacy commission. But I think as a clinician caring for the patients, the patient needs this in order to survive. So I think there would be that acknowledgment.

Mary Fliss: [Cross-talk] All right. Tim, thank you so much. [Cross-talk]

LuGina Harper: I apologize for putting you on the spot. I just wanted to see if you knew [cross-talk], so I apologize.

Tim Lynch: Yeah, I'm just thinking of the old laws and our new, and I'll have to go and do a double check. I don't know Jenny has a top of mind or if she's still on.

LuGina Harper: For emergency prescribing?

Tim Lynch: Yeah, for [cross-talk] –

Mary Fliss: Yeah. Jenny Arnold? Yeah.

Jenny Arnold: Yeah. So Jenny Arnold from the Washington State Pharmacy Association. Ours, our state law does have a provision like Utah's, where a pharmacist can refill even an expired insulin prescription as long as either they filled it or they have kind of medical proof. So a patient couldn't just walk in and say, "I need insulin" to pharmacies they've never been to. But if they go into – I fill their prescription regularly, and the prescription is now expired, I can provide them a 30-day refill of their medications. And, Tim, it was part of our rule rewrite that you led. And it was for exactly this issue because our previous state law allowed for 72-hour supply, which doesn't really work for getting you an insulin vial. And so, we rewrote the law so that it allows us flexibility to be able to do that. So that one we have got covered in Washington.

LuGina Harper: Fantastic. Thank you, Jenny. [cross-talk]

Mike Bonetto: Jenny, this is Mike. Just a quick follow up on that, though, just so I'm clear. Is there any copay provision around that? What does that look like [cross-talk] –

Jenny Arnold: We would run it through the insurance. So there is two issues when you talk prescriptions. There is the legal authority to fill a prescription, and then there is payment for the prescription. So the pharmacist can extend that prescription. So there is the legal authority to dispense that prescription, but there is a prescription there for that prescription agent or product, and then it would be run through insurance the same. So it's not a cash pay. It would be just like you refilled your prescription. Basically, the pharmacist is

extending that expired prescription for another month. So it could be run through insurance and all that.

Mike Bonetto: Thanks, Jenny – assuming they had that insurance.

Jenny Arnold: Yeah. There is payment, and then there is the prescriptive legal authority to dispense a prescription medication. So the state law allows for that legal authority to dispense that prescription that is separate from payment. But if they had insurance, it would be run through insurance and copays would apply and all that. So it's only half – part of the battle, but I think it's an important continuity piece.

Mike Bonetto: Correct. Thanks, Jenny.

Mary Fliss: Thank you. Yes. Jennifer.

Jennifer Perkins: Yes. This is Jennifer Perkins. I had two things. One, I believe my comments only get into the transcript if I state them. So, one, before I say my question, I wanted to read what I had written, since we have a moment. Imagine if you had to do all that we have to do in order to get your life-saving water, find a specialist, wait for an appointment, pay for appointment, take time off of work to go to see specialist, go to pharmacy, hope there are no issues, pay your portion, which varies and may be unreasonable for your essential water. You must get a prescription every year, even though you will need this water for the rest of your life. I was just trying to help folks to understand what this would be like. Because I think that insulin is pretty synonymous with the need for water and how we need water every single day. But I did have a question specifically. I'm not sure when exactly this 30-day emergency supply rule that you're talking about went into effect. I'm just curious how pharmacists are – if all pharmacists are aware of this? Is there some way that everybody was told and understands what they are able to do and what they're not able to do? Because I know there are so many rules that I worry that perhaps not everybody would necessarily be aware of the rules and be able to just help patients if they're not aware.

Mary Fliss: Okay. Tim and then Donna.

Tim Lynch: Yeah. Jennifer, this is what Jenny alluded to, is we went through a rule rewrites, about a two and a half year project with the pharmacy commission where we redrafted all of our rules, and those came into effect about a year

and a half ago. And at that time, there was an education campaign that was pushed out to all of our licensees so that they were aware, but there was a lot of stakeholdering as well. So a lot of involvement from clinicians and also our public members in support of that. So there was a lot of communication, and the intent of that was to simplify the rule process the rules so that it was easier for pharmacists to adhere to that. So I think there is no guarantee that every pharmacist that is currently in practice has read those rules. But I think most pharmacists through their training – and Jenny is certainly closer to this than I am currently, but most pharmacists in their training, this has been a part of our training and experience as pharmacists. Obviously, previously it was 72 hours, but making sure that patients in urgent situations had access to care. So I think I would say that most pharmacists working in a practice, I would assume are very familiar with this.

Mary Fliss: All right. Donna and then Jenny.

Donna Sullivan: Hi, this is Donna. I would disagree with you, Tim. I imagine few pharmacists are aware of this, the ability to dispense a 30-day emergency supply. The other thing is, even if the pharmacists are aware of it, the company that they work for might not let them for specific liability reasons. So it's not necessarily just the pharmacist behind the counter. It could be, if it's a large national chain, they might have policies that prohibit the pharmacies from doing so. And the reason why I think that the pharmacies it might be an educational thing with the pharmacists. You know, we even have trouble with patients that are going in and trying to get emergency contraception and the pharmacy doesn't know how to do that. So that is been a challenge. And it would be great to work with Jenny and Tim, and how can we do more education and get the pharmacists aware of these new, I guess, advanced authorities that they have within their scope of practice?

Mary Fliss: Thanks, Donna. Jenny?

Jenny Arnold: Yeah. I completely agree with both of them that we did do quite a bit of education, but it was at the height of COVID. And pharmacists – we rolled out these rules still when we were trying to scramble to dispense lock down medications for folks. I mean, it just happened to be the timing. But I think that I'm committed to re-educating. I will even just work on language that goes out today to our pharmacy community. There will still be some barriers with the chains, and I will also work with our chain policy folks to make sure we can overcome some of that, as well, because sometimes just education on

that piece can help. So I don't want us to take any more time. The rules are in place. It's not something this committee needs to do. But I absolutely hear about the barriers, and I'll work to help to overcome those.

Mary Fliss: Thank you, Jenny. And I don't see any other hands up. But I do have one question, Hayley, for you. You mentioned that manufacturers are funding the Maine and the Minnesota programs. And I didn't see the funding source for either the Utah or the Ohio programs. I'm assuming Utah is fairly small, since it is more of an access to the rebates. But was there something in the analysis that indicated funding sources for those other two programs?

Hayley De Carolis: Yeah. So when I say funding, I meant kind of indirectly as in they are responsible for either backfilling the supply or reimbursing the pharmacy. There is also state funding for FTE to manage the program in one state. But there is no there was no appropriation attached to Utah or Ohio in terms of any FTE to run the program or manufacturer registration fees.

Mary Fliss: Very good. Thank you. And Laura.

Laura Keller: Yeah, Laura, from the American Diabetes Association. I can kind of address the Utah program. So, in Utah, they set up the purchasing program, and the way that works is people can apply. It's online. They have a website. It's a very streamlined, quick process. They get a digital card, and they can go to the pharmacy. So when there is an emergency medication – so this was like the last step, this change that we did there working with the bill sponsors. It allows them to actually utilize some of the insulin for the purchasing program to get to patients. So the pharmaceuticals are not being asked to reimburse those, so the state allows people who are uninsured. So that is the genius of the Utah bill. It had a copay cap for private insurance. It had a purchasing plan for those that are in ERISA high-deductible plans, so kind of what Kevin was referencing earlier. There are still a lot of people that don't have access to affordable insulin in states, so those people in those ERISA plans and high-deductible plans can still buy into the purchasing program in Utah. And it's been extremely successful. And the state then has larger buying power, so they can buy the insulin on a larger scale to get people access in the state through the state law that was passed. The state can charge for the purchasing program just slightly a very minimal cost to keep providing for the program. But they did not have to hire an extra FTE for this program because they had streamlined it so well. There was an original appropriation, which was a very small appropriation to stand up the program. And then

after that, they did just incorporate that into the health department and running things through state current positions. But it's been incredibly successful.

Mary Fliss: Excellent. Thank you, Laura. We'll go to LuGina and then Jane.

LuGina Harper: Hi, this is LuGina. I just wanted to reiterate, I think Jenny did a really nice job when she was answering the questions is that, on this chart that we are looking at, you have kind of two issues that are commingled in this one chart. One is the ability of pharmacists to dispense an emergency supply, whether that be three times in 12 months or whatever the case may be. So that is kind of down at the bottom with Ohio, and then what we talked about just now with Washington. Whereas the Maine, Minnesota, and Utah are really addressing the payment issue and how you fund this program. So I think there might be a little distinction here between the first three rows and then the bottom row.

Mary Fliss: Sure. Thank you. Jane?

Jane Beyer: Yeah. So a suggestion and then actually a question for Laura about Utah. So in terms of suggestion, sort of keying off what LuGina just said, it looks like out across the four state programs there are a number of issues that are addressed. There is cost sharing for people who have coverage. There are people who are uninsured. There is how the programs are financed. And there is prescriptive authority. And so, for maybe improved understanding, I would ask that The Center maybe put together some sort of a table that lays out in a column each of the different elements that we have discussed and then for each state. So I would just do a checkmark or some indicator of how the state law addresses each of those elements. It just might be an easier way to sort of compare and contrast what the states are doing and consider and help think about whether that would be integrated in. And I definitely agree that addressing Mary's question about how the insulin that is dispensed is financed. And it would also be helpful on Maine to get more detail about the criteria for the patient assistance programs that the manufacturers committed to set up. I'm assuming that there was a lot of negotiation around that, and it would be interesting to see what parameters the manufacturers are putting on. And then Laura, just a question for you in Utah. So a person can "buy the insulin" or get the same pricing for the insulin at the state sort of post rebate, who is actually doing the fill on that? And so, that is the one piece I'm not understanding.

Laura Keller: Yeah. So that is a great question. So people can buy in, and they basically are buying it through the state employee plan in the sense that the state employee plan has a negotiated cost, they can purchase it at the state employee costs after rebate. And you go to the pharmacist, and there is a code that they set up, and the pharmacist bills back to the state employee plan for that. So that is how that works.

Jane Beyer: Got it. Thank you.

Laura Keller: Yeah. And because as the plan expands, and the uninsured or those who have high-deductible that are in ERISA plans can buy into this, then the more people that are in the program, the better buying power and negotiating power that the state has, and they have one in every class of insulin on it. So even some of the newer, really rapid-acting insulins are available. You cannot get it via vial. For those that need a vial, you can get an insulin pen. So they have it in several different delivery mechanisms, as well.

Jane Beyer: And Mary, can I do one follow up for Laura?

Mary Fliss: Yes.

Jane Beyer: So follow up. How does that sort of post rebate price compare to what the WAC or the list price is for the drug? I'm just curious.

Laura Keller: Yeah. So in Utah, I believe the price for a 30-day supply is about $75 the last I checked. They may have changed that based on costs, but it's about $75. So they get what the employee plan price is through their purchasing program. So it is significantly less than list price. Now, it's not as low as a $35 copay cap, but it is significantly cheaper. And a state would have the ability where another state like Washington to develop this plan, something similar to set the price where they wanted to set the price for the consumers, especially the uninsured, to access to insulin based on what their costs were and what kind of negotiation they were able to get.

Jane Beyer: Thanks. That is super helpful. Great, terrific. So if Hayley or Mike could answer Jane's other requests around getting a separate grid, and then we'll go to Tim.

Hayley De Carolis: Yeah, I can definitely work on that, and we can send it out to all the attendees after the meeting. [Cross-talk] Thanks for that suggestion, Jane. That was really helpful.

Mary Fliss: Thank you, Hayley. Tim. Tim, was your hand up from before?

Tim Lynch: I'm talking with the mute on.

Mary Fliss: Okay, [cross-talk] there you are.

Tim Lynch: I was going to say I'll post in the comments, the WAC that references our ability to dispense emergency supplies. And we are a little bit different. I'm just looking at the content here. We are up to two times a year, but once in a six-month period versus some of these which have three times or others, but I'll post the WAC in the comment section.

Mary Fliss: Excellent. Thank you so much. [Cross-talk]

Jenny Arnold: And I'll just add, on there is a separate provision for if an emergency declaration for displaced persons. There is a separate one that is a little more lenient, as well, that also is in our law. Just so you know there is that backup, too.

Mary Fliss: Very good. Thank you, Jenny Arnold. Any other thoughts or questions? I don't want to keep us too much longer before our 10-minute break here. All right. Well, let's come back at :25 to 11:00, and we will at that point turn it over to Mike Bonetto of The Center.

[break]

Mary Fliss: Back here. Thanks again. We are recording in process. And reminder before you speak, if you could please state your name so we can make sure we are capturing that for the purposes of recording. And with that, I will go ahead and turn it over to you, Mike.

Mike Bonetto: Great. Mary, thanks so much. [cross-talk] So guys, I'm going to walk. Oh [cross-talk] –

Nonye Connor: Sorry. I just saw that there is a question in here for Ronnie. I don't know Ronnie is still here.

Ronnie Johnstone: I am.

Mary Fliss: Go ahead, Ronnie.

Ronnie Johnstone: Actually, it's the other Ronnie. I'm sorry.

Nonye Connor: Oh no. It's a different Ronnie.

Mary Fliss: Ronnie Shure?

Nonye Connor: Yes. Let me give Ronnie an opportunity to talk. Okay, Ronnie. You can speak now. You just need to unmute yourself.

Ronnie Shure: Thank you. Thank you. My name is Ronnie Shure. I'm a retired pharmacist. Well, I pretty much failed at retiring. But I am the president of Healthcare For All Washington and have followed this issue and talked with many of the people here about solutions. I'm thrilled to hear the comments about developing or the fact that an educational program is needed. But to build on that, I wanted to point out a couple of issues, which is that patients really need to be educated, as well. Our Office of Insurance Commissioner has done great jobs on developing patient rights around populations like this. So it would be great to pull in your office, Jane, to help define that as part of this educational program. Educating pharmacists not just about the law but about access to insulin. Each of the programs that we reviewed in Minnesota and Utah and Maine and Ohio had educational proponents or resource components that patients could use that are available. It's so important to pull that information together. And for pharmacists, it's more than just the law. People with insurance do have trouble still getting insulin, but there are overrides that pharmacists can use and there probably needs to be override for overrides for the institutions or the large corporations that pharmacists may be working for. I think Donna pointed out that there could be policies for employment policies that won't give the pharmacist freedom to do that. I think our state is in a great position to address those issues. But I think we need to pull in a lot of these other factors. So bottom line, I'm thrilled to hear we are talking about this – an educational program. I don't think it's going to solve all of the problems, but it can pull enough of those together that we can reach out and identify the individuals that really need to get this emergency supply that really need to overcome these barriers. And it is an issue of saving people's lives. I don't want to be in a state where someone else dies

from a lack of insulin. So I'm thrilled to hear this conversation. And I hope it will move to that next higher level. Thanks for letting me jump in, Mary.

Mary Fliss: Sure. Thanks, Ronnie. Mike, back to you.

Mike Bonetto: Great. Well, Ronnie, thank you for your comments. Okay, guys. So we are going to transition to this discussion and overview of Survey #3. So much like we have done the previous two meetings where we shared the survey results, but then also have kind of this broader discussion. We want to do the same thing today. So we want to make sure that this is kind of a discussion forum much like you guys were just having to get into a little bit more detail with those survey responses. So, Ryan, if we go to the next slide. So just to give you an idea of kind of the number of respondents down a little bit from last time. So this is a little bit of a nudge. So if we do a Survey 4 or a Survey 5, we would love to see that back up to 13, so really have everybody participating. So if you didn't do that Survey #3, certainly there is an opportunity in today's discussion to weigh in. But really, I think it helped everybody see those responses side-by-side when we go through this. Okay, so next. Okay, so a lot of texts up here, we are going to kind of take this step by step. So this is the first question. When we outlined this survey, this was before we had done even additional work on Utah and Ohio. So when you see up there says "both programs," both programs referring to Maine and Minnesota for the purpose of this survey. Now, that doesn't mean the discussion right now just has to center on that. You want to bring in any additional thoughts on Utah and Ohio., fantastic. But for right now when we look at this, so both programs meaning Maine and Minnesota allow pharmacies to collect this $35 copayment to cover the pharmacy's cost, the processing, and dispensing. And then the question really is what if any aspects of how pharmacies have paid for the service would you recommend including as part of the workgroup's report? So you guys have already touched on this a little bit. Kevin went through a lot of just even that copay, and you'll see these initial responses. Everything that you see in bold was just our take of trying to kind of highlight some of the key pieces, and that was just us trying to do that. So if you wanted to highlight other elements. If you guys were the authors of any of these statements and you want to highlight it anything else, please feel free. But you'll see here, copayments should be de minimis. Then there is this comment of why the limit is set at $35. It seems arbitrary. And I do think it's worth some discussion on that even right now. Jane brought up the comment earlier on that is tied really to a Medicare provision on that $35. And then you have a lot of states looking to align with

that policy. It doesn't mean you have to, but I think you're also trying to understand potential consequences of not having that alignment. And what would that look like if it was below? So as long as pharmacy is made whole, including dispensing fee. And then next, just a continuation of this, and then we'll get into some discussion. Importance of supporting more than just dispensing a generic insulin, ensure the supplies and time release insulin are available. You guys have talked about that several times in prior meetings. The emergency copay should be zero when $35 is a lot. Any PBM and manufacturer rebates. A comment here – a notification to prescribers is an additional burden for the pharmacy filling the prescription. Would not recommend that. And pharmacies need to be supported by the manufacturer through replacement stock or reimbursement. So, again, when you think about it, let's just talk about this copay side. So what we have seen with Maine and Minnesota, the $35. I would like for some others to weigh in. What are your initial thoughts knowing that we kind of have that alignment with what those states are looking at is having that alignment with Medicare?

Jennifer Perkins: Hi, this is Jennifer. So I work part time as a nurse at Community Healthcare in Tacoma. And we work with people who sometimes are very low income. And, luckily the other day we had a donated supply of glucometers. But there was an individual who could not afford their $10 portion of their payment for their glucometer. And so, I just know that while I think for somebody that is on insurance and has the means to $35, I mean, that is what it is. But for somebody who is really struggling. When I grew up, I spent the first 20 years of my life in poverty, and $35 is potentially a lot of money. So I think if we can lower that, it is worth doing.

Mike Bonetto: Thanks, Jennifer. Others?

Kevin Wren: I just want to reiterate Jenny's comments too. I mean, having to ration insulin, $35 can be a lot, especially when you're juggling other costs like your supplies that maybe aren't covered by your insurance. So $35 doesn't seem like a lot, and all the other states are doing it. But, again, this is like an added burden on already a chronic illness. So if we can lower it, it will mean a world of difference for people.

Mike Bonetto: Hey Kevin, have you guys thought about it being tiered in any way that it would be a different emergency copay for somebody who was uninsured versus somebody who did have insurance.

Jennifer Perkins: I hadn't really thought about that. I think that is an option. And I don't know if that would make things more cumbersome than just having a number straight across the Board. But I do like that idea so that potentially somebody who does need it to be zero, it could be zero.

Kevin Wren: Yeah, having a progressive structure would really be helpful. I mean, I think the crux of affording your insulin for the insured it's – I mean, middle income people that are just again on that elbow, where they don't quite have enough. So having a progressive structure would probably be helpful. But I mean, again, lowering that cost as much as possible should be our – is my task anyway.

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

Tim Lynch: Yeah, this is Tim Lynch. I think having a progressive copay certainly is great. Just so long as the pharmacy that is delivering the service is made whole in total. So if there is a progressive rate that is charged based upon income, I think, one, we don't want to add complexity to the process. So if the copay is a burden, I think, so long as there is a way for the pharmacy to get recoupment of that. Because this is not just a standard situation as the patient walks in. They don't have an active prescription. Maybe they have a bottle in hand. There is going to be additional screening that the pharmacist has to do in order to ensure that the patient is appropriate. There is the documentation that has been mentioned in the other law. So there is a lot of work that goes into these cases, and the pharmacies need to be made whole for that. I think the pharmacies want to deliver the service but so long as there is a way to make sure that they are made whole in this process, I would advocate for that.

Mike Bonetto: Thanks, Tim. Janice, I saw you had your hand raised.

Janice: So Mike, a couple of thoughts. First, if you're going to think about tiering, then I think you pretty much need to use an attestation process because we should not be asking pharmacists to ask people to show like their pay stub.

Mike Bonetto: Right.

Janice: That is crazy making. So if people are comfortable with an attestation, then I don't know that there's any other way that is feasible to do kind of a tiered cost-sharing structure. Because if I were a pharmacist, I sure as hell wouldn't

want to be put in the position of having to do that evaluation of somebody's income.

Mike Bonetto: Right.

Jan: I'm trying to fit the jigsaw puzzle pieces together, and this is why I asked for that table earlier. When we are talking about $35, first of all, I'm thinking at some point, we are going to have a discussion about whether we are talking 30-day, 60-day, 90-day. And so, what I don't understand is when we are talking about reimbursing the pharmacist's costs, there is sort of the administrative cost. What's the administrative cost for a 30-day supply as opposed to a 90-day supply? Right? If it's the pharmacist just having to do one dispensing, but instead of dispensing 30, you're dispensing 90. How does that factor in? Because $35 for a 30-day supply and $35 for 90-day supply is pretty different. So like I said, it's fitting the jigsaw puzzle pieces together. Sometimes it's hard to discuss each of the elements in isolation and maybe at the end sort of going back and revisiting. Okay, where are we and what does the puzzle look like when you put the pieces together?

Mike Bonetto: Thanks, Jan. I would welcome others to weigh in on that on the pharmacist side. Yeah, Donna?

Donna Sullivan: Yeah. I mean, from a cost of dispensing perspective as a plan and a payer, if there is a dispensing fee, we would pay the same dispensing fee for a 30-day supply as we would for a 90-day supply. If we are talking about cost-sharing, that is a different story. So, Jan, if I wasn't sure if you were talking about the dispensing fee that the pharmacy receives for the overhead cost of actually dispensing the medication versus the coinsurance.

Jan: So I think what I was referencing was – and Mike, can you go back a slide? Or is that doable? Dispensing and processing fees – right. So if the idea is to use the copay that the individual is paying to cover the dispensing and processing fees for the emergency insulin, then it seems like having the discussion about whether we are talking a 30, 60, or a 90-day supply is important. Does that make sense, Donna?

Donna Sullivan: Um, I think so. And Jenny, I think, had her hand up, and she can probably chime in, too. I mean, I don't want to put words in the mouths of the pharmacists. But I can't imagine the cost of dispensing being more for a 90-day supply than it is a 30-day supply other than counting. You might have to

check three boxes to make sure you have the right product instead of one. So it would just be the amount of time it would take to check the additional quantity to make sure it's the appropriate product that is being dispensed. And I can't imagine that being a significant amount of time, at least not in my experience.

Mike Bonetto: Let's go to Tim and then Jenny.

Tim Lynch: I think Jenny might have been first. But I would agree with Donna. The difference between a 30-day and a 90-day dispense, the same administrative work that is required would be the same. So I would see that as same and same.

Jenny Arnold: The biggest factor that would be different would be just the taxes paid on the product, so it would be three times more. And that is not an insignificant amount. It's about a half percent per of the cost that is charged to the pharmacy. So it's not insignificant, but that would be the biggest variable between doing a 30 and a 90-day of checking three vials of insulin versus one is, yeah, that is not significant. Three labels versus one is minor, as well. But it's the taxes, I think, would be the biggest difference on that.

Mike Bonetto: Thanks, Jenny. And Jenny, you would consider the taxes part of this processing cost. Yes?

Jenny Arnold: It's generally factored into the cost of dispensing. Yes. [cross-talk].

Mike Bonetto: Yeah.

Jenny Arnold: And I think we could factor that into an overall cost of dispensing that would work, but I think a 90-day solution versus a 30-day is a logical place to go on this and I think even more significant for tearing down barriers. This may be jumping three steps ahead, but it seems to me like we put in place kind of a dummy VIN number for this for processing through a system through the state where we fund it somehow and come up with the insulin somehow and be able to manage it. So the pharmacy basically runs it through a state program the same as they would if they were billing Medicaid or an insurance company. And then where the administrative burden would be then on the state for managing and coming up with the payment for that program, potentially. That seems the easiest. Then you can be able to track which patient used it, how often they used it, then the state would be able to

own that eligibility process versus the individual pharmacists, which would not be well equipped to do that.

Mike Bonetto: Thanks, Jenny. Yeah, Tim.

Tim Lynch: Yeah. I just want to make sure we are clear. To dispense a 90-day supply, it would have to be an act of prescription that is valid currently. And it wouldn't address the emergency provisions that we talked about before. So that is limited by WAC as a 30-day supply currently. So we just would have to factor that into the conversation if the intent is to go 90 days versus 30-days, emergency versus you got an active prescription.

Mike Bonetto: Okay, so let me – I want to keep poking on this then. So to Jane's point, let's say this $35 is there, and it can cover this processing dispensing. But if it was for 90, then Kevin, that then gets broken down to almost like a under a $12 copay per month.

Kevin Wren: Yeah. That was going to be my next question is if it's we are talking about $35, and everybody else is doing $35, but they're at a 30-day supply, whereas we are talking about a 90-day supply. So would we. I mean, how are we going to recoup that? That difference? Because it seems like yeah, again, that is like $12 per month as opposed to $35. So I just wanted to be really clear on how much the patient is spending; $35 for a 90-day supply is great, but that is a lot to cover for the pharmacy.

Jenny Arnold: I mean, either way it's not covering the cost of the insulin. That has to come somewhere else. Right?

Mike Bonetto: Yep. Thanks, Kevin. Yep. Other thoughts or comments here? We are going to hit on this again. The 90-day needs brought up again, so we are not done with this just yet.

Jenny Arnold: I mean, I think that the 30 versus the 90 is probably too far into the weeds because we haven't even set up what the program is. who we are impacting, what the solution is we are trying to solve. On previous calls, we said we were going to – we kind of needed to – we saw two different buckets of helping the uninsured versus helping the insured, and those are two different to me because there are two different solutions that you need to address. I think we selected as a group that we were going to help the uninsured. I just feel like we are going around in circles in talking in high levels. And maybe

it's if we bucket them, then we can decide is it a copay assistance program versus is this truly insulin for uninsured individuals or those lacking, maybe under and uninsured? And maybe include those who have high-deductible copays. But what does this program look like? What is the problem we are solving, I think maybe makes sense, versus getting into the nuances of 30 versus 90 or 35 versus 30 or [cross-talk] –

Mike Bonetto: [Cross-talk] Oh, go ahead, Kevin.

Kevin Wren: Sorry. I just thought we had already decided to prioritize the uninsured but that our recommendation was going to be for both the uninsured and the insured. We are not doing either/or. We are doing both.

Jenny Arnold: I think it's a start and then a second was more maybe where I was. Come up with the solution for one, and then we can work on the solution for the second was kind of where I had it. But I think that kind of sounds the same.

Kevin Wren: Perfect. Yeah.

Mike Bonetto: And the one thing that I would just kind of bring us back to is what you guys are tasked to do kind of within the legislation. So and this is kind of specific to say, you guys were tasked to review and make recommendation on the 30-day. And so, you really are talking about the emergency supply as a short-term, and then you're also looking at the long-term. Like what are we doing for the long-term cost savings? So those are the – Jane, when you talk about the two buckets. Those are the two buckets that we are actually trying to address. So you're really trying to analyze, okay, what are your recommendations to the Legislature for revamping or implementing an Emergency Supply Program?

Jenny Arnold: Thank you.

Mike Bonetto: So we are kind of does that make sense? Yeah. So within that you're right. You kind of get into different populations and what that could look like. And so what you guys almost immediately started to weigh in on was, hey, I'm not sure that 30-day feels right. Right? It almost needs to be longer than that. So again, that could be a recommendation that you guys would put forward to the Legislature. Right? We have got you asked us to analyze the 30-day. We are not certain that feels right. We may want to push that up more. But that is going to be again, kind of that group discussion.

Nonye Connor: And Ronnie has a question. Ronnie, go ahead and unmute yourself.

Ronnie Shure: It was really just a comment that [cross-talk] we are talking about life and death here. We have made public health emergencies for COVID in order to ensure that patients pick up their antivirals to prevent COVID or to prevent the spread or delay, prevent death, as is this another public health emergency would an issue that this group can work on is funding this copayment rather than struggling with $35 versus a separate copay for a 90-day supply. I think the bottom issue is life and death here. I just wanted to add that comment. Thank you.

Mike Bonetto: Ronnie, thanks for that. Before we move on to the next one, I did want to hit the second to last comment. The notification to prescribers is an additional burden. I would love some additional thoughts on that because that was a provision that was called out in one of the states, and I just wanted to get your sense of that. Is that something that you would recommend or not?

Donna Sullivan: Hi, Mike. This is Donna. I think I'm the one that made that comment. And Jenny had to drop off. But what is the purpose of notifying the prescriber of the dispensing? You are also going to be requesting the prescriber if it was an expired prescription, you would be notifying the prescriber requesting a new prescription and renewing that prescription. So I'm not sure what the purpose of having to notify the provider does. I don't know its purpose. So, Tim, go ahead.

Tim Lynch: This is Tim Lynch. Donna, I think you and I probably had the same exact comment. I was the same. I didn't. One of the things that bothered me about the other state's laws was creating artificial burdens for pharmacists to provide this service. And unless there is a real strong reason for collecting certain data elements, and a justification for what that is going to do to support the program or enhance the program. I found a number of things within the rules that other states had put forward that just seem to be an artificial barrier to providing the care that I think everybody wants to do. And I would caution us against having similar language.

Mike Bonetto: Got it. Thanks, Tim. LuGina.

LuGina Harper: Hi, this is LuGina. I just wanted to ask a clarifying question. The notification of prescribers – and I don't remember it from the chart a couple of slides

earlier – but in Maine and Minnesota, is it when the pharmacists dispense an emergency supply to help the patient not have a disruption in therapy, is it after the fact they have already dispensed it, and it's like, "FYI, Dr. So-and-so. We dispensed this over the weekend for your patient." Is that the burden? Or is that what we are talking about?

Mike Bonetto: Yeah.

Donna Sullivan: Yeah. That is I think what this provision basically does because if the notification is after the fact in both of those laws.

LuGina Harper: Okay. And I'm just trying to figure out. I mean, generally, I think that those provisions – I served on a Board of Pharmacy, as well, in my previous profession a couple years ago – but I think it's more of a continuity of care issue. And I think if you look at the language that Tim shared with us on the new rules for pharmacists, there is the element that it looks like provision E, where the pharmacist has to communicate to the prescriber within a certain amount of time after doing an emergency fill. So I always figured this was – I always looked at this as, yes, it's a burden, but it's also to make sure there is continuity of care. The provider knows that the pharmacist has done this in an emergency or urgent situation. And you can also reach out, if you need to, to get that new prescription for the next time.

Mike Bonetto: Yeah. Thanks, LuGina. Yeah, Tim.

Tim Lynch: Yeah. I was just going to say if the patient is already on a prescription that the pharmacist is providing an emergency supply of because they can't pay for it or whatever, then the notification just – again, I go back to I think in the case of the emergency prescription, the refill, these are refills that are no longer active. So I think that goes to the continuity of care to make sure that it dispenses a prescription that no longer had any refills and, therefore, I'm going to dispense it again to ensure that the patient is covered versus this where this is an act of therapy that the patient's on. So I just would say to the extent possible, insulin is generally not something that people are going to abuse and, therefore, I would argue that lowering those barriers for pharmacies can certainly – I think we just need to do that as much as possible.

LuGina Harper: Yep. Thank you so much. I didn't appreciate that nuance of as having creating a requirement for the pharmacist to inform the physician of generally just

refilling a prescription on an emergency basis. So I really appreciate you explaining that nuance.

Mike Bonetto: Thanks [cross-talk].

Donna Sullivan: Mike, this is Donna. I want to jump in. And the emergency might be that they can't afford their prescription. It might not be that their prescription is expired or they're out of refills. And so, you're notifying the prescriber that they had to use this patient assistance program this month to afford their medication rather than going through their normal insurance company. And so, that is a slight nuance, as well.

Mike Bonetto: Great. Great discussion, guys. Thank you. Ronnie, let's go to the next. So next question. Again, looking at Maine and Minnesota. Both bills allow patient access to the emergency 30-days supply to once in a 12-month period based on a completed application. The question, what, if any, aspects about the verification process would you recommend including as part of your recommendation to the Legislature? So you'll see a number of comments here. Just understanding, so what is this process? We talked about it earlier. Hayley walked through that application submittal. And then you guys weighed in. I don't think it should be limited to state residence with ID, available for undocumented, use ArrayRX to the extent possible. Next slide. It has been brought up, obviously, ensure patients get ongoing supplies, minimal verification process, notified of other health insurance programs, like we heard earlier. But I also wanted to go back to Kevin. Kevin, in your opening comments as you went through patient perspective, and you talked about your recommendations, you talked about loosening eligibility criteria. Can you talk more about that in terms of what this looks like to you? I mean, what does that mean, the loosening of, if you had your [cross-talk] ?

Kevin Wren: Yeah. Yeah, so I think in my comment – I have a couple comments in there, but I mean, I've tried to help people who are from out-of-state. And they get here, and their insulin vial breaks, and now they're stuck. I mean, if they were going to try to access this program, they wouldn't be eligible because they are out-of-state. I mean, I've helped a homeless person get insulin. They don't have ID. The process for them to get an ID takes a while. So as many barriers to entry as there are, we have to look to mitigate those. And, for me, what that looks like is you go to the pharmacy. You fill out an application. You don't need to show ID. And you can use this program numerous times. I mean, I can foresee breaking a insulin vial more than once a year. I'm a

clumsy person. I could easily drop it, and then I'm stuck if it's a Friday. So, I mean, there are so many reasons, again, why we stated why people have coverage gaps or why they don't have insurance to begin with, why they can't afford their insulin when they have insurance. There are so many reasons. So loosening the eligibility criteria I think what that means to me is someone puts down their name. There is an indicated urgency of need. I think, that is built into some of the other programs where the pharmacist can assess whether or not this person needs it. Again, I don't think anybody's going to be abusing insulin, and this is a clear you need it. And then we track how many times this person uses it, why they need this, so we can have some survey data as to the root causes of this. And then, potentially, also include education materials to sign up for other programs. Like if they are undocumented, how can we get them documented? If they're homeless, can we provide them with those services. So I think there are a lot of points of entry right there where you can have them access some of these social programs that we've talked about so that we can get them covered so that they don't have to rely on these programs. But, yeah.

Mike Bonetto: Got it. Thanks, Kevin. Jennifer.

Jennifer Perkins: Yeah, I think it was Jane who brought up the attestation earlier. And I think that it seems reasonable. You want to try to make sure you're tracking for financial reasons or whatever, and I know that is going to be done in some format. And so, I think it's reasonable to ask for an ID, but maybe not have it be required. And, at that point, if somebody, "Oh, I don't have my ID," or "I left it," or whatever, then maybe some type of attestation could be done.

Mike Bonetto: Thanks, Jennifer. And, Hayley, I'm just thinking of Jane's earlier comments. I think this is going to be one, too, that would be helpful we'll see on the grid. We can kind of see that side-by-side comparison from the states, and then we can have a better understanding of what is going to be potentially the best fit for Washington.

Hayley De Carolis: Okay.

Mike Bonetto: Other thoughts here on eligibility criteria? Okay, let's go to next. So Hayley highlighted Maine. And the way that they were looking at funding this was through this manufacturer of payment – so those who sell or distribute more than 500,000 or more units – pay this $75,000 annual registration fee, which is funding that full-time FTE. So we are curious on your thoughts around

when you think about getting a program like this up and running. What are your thoughts around funding it in this way? And you'll see what those initial responses were from the survey. Possibly some post-enactment challenges. Obviously, $75,000 could pale in comparison of what the manufacturer's profits are. [Indistinct] manufacturers can have a negative connotation if they are actually paying for this. Is that seen in negative better than using state funds? And yep. Thanks, Ronnie. LuGina Harper, I saw you had your hand raised.

LuGina Harper: Thank you. This is LuGina. Mike, I just had a real quick question. The $75,000 annual registration fee and the Maine program is one element of the financial support. And then there's also the requirement that the manufacturers replace the insulin that is dispensed. Is that correct?

Mike Bonetto: I'll look to Hayley. But my understanding is that is absolutely correct. Yes.

LuGina Harper: Okay. Thank you. I just want to make sure.

Mike Bonetto: Hayley, you would confirm that. Correct?

Hayley De Carolis: Yes, that is correct.

Mike Bonetto: Yeah. And, again, you could be having, obviously, more than one manufacturer making that payment of $75K. Jane.

Jane Beyer: So I think, Hayley, it would be really interesting, and Mike, to go back and talk to the folks in Maine. There was obviously a deal cut. Right? The use of the Patient Assistance Program, $75,000 annual registration, replace the pharmacist supply. I'm trying to figure out how the patient assistance piece fits in. Is this so the manufacturers could do a tax write off and call it a charitable donation? It just seems like if this is the path that the group wants to go in its recommendations, it would be really helpful to have an understanding of what the political dynamic was in Maine when this was being discussed.

Mike Bonetto: No, Jane, I think it's a good call out because I think I saw the same thing. When you see that 500,000, that's a number. Right? That is a target. And if it's funding one full-time, you can start doing the math of how many manufacturers that is going to apply to. Right? So I'm sure there was some deal cut. So I think that it's a fair follow up on our end. William.

William Hayes: Yeah. I completely agree with what Jane indicated. We have to be careful with building these programs and obtaining the money from the manufacturers. But as a representative from an entity that participates in a program that works with the manufacturer where we built an agreement to obtain medications at a lower price and runs a program that is completely government funded, I think we need to find ways to limit the use of state funds to pay for this. And if we can be creative and find ways to get money from those entities that are creating this challenge for our patients, in the end, it would be nice to be able to seek funding from them. So I'm interested in finding out more information, as well.

Mike Bonetto: Thanks, William. We'll do. Other thoughts/comments on this? Great. Thanks, guys. Okay, Ronnie, let's go.

Jennifer Perkins: I'm sorry. I do have a comment because I think anytime that you are taking money from somebody, there is going to be, like Jane mentioned, it's a deal. And so, I don't want somebody from the pharmaceutical company being the person in charge of this program.

Mary Fliss: Thank you, Jennifer Perkins.

Jennifer Perkins: Thank you.

Mike Bonetto: Thanks, Jennifer. Okay, so next one. Both bills again, Maine and Minnesota require manufacturers to reimburse pharmacies with backfilled supply of the emergency dispensed or reimburse monetarily for the dispensed insulin equal to the pharmacy's acquisition costs. What, if any, aspects of this reimbursement or replenishment model would you recommend including as part of the report to the Legislature? You'll see what we have down here. Again, now many of you might not have responded. So whether you did or didn't, again, I would love to hear people weigh in on this. Reimburse pharmacies with backfilled supply of the emergency insulin. There should be an accounting of the supplies in effort. Leave it up to the pharmacies. Manufacturer paying pharmacy acquisition costs or to replace the supply is a good option. Support a monetary reimbursement model so long as it is timely. Remuneration is included for the pharmacy and a dispensing fee. Pharmacies which should be paying the copay fee, too. Thanks, Ronnie. Can you go back just the next slide so they can see – yeah. Thanks. So initial

thoughts/comments here around how this should be set up with manufacturers reimbursing and backfilling.

Mary Fliss: William Hayes has his hand up.

Mike Bonetto: I know. William, was that from last time?

William Hayes: Yeah, actually it was. But I will comment as well. I think any model where we can utilize the manufacturer is great. So whether it's direct funding or replacement or rebates, I think I would support anything that works well for us. But, again, we have to understand where the political ramifications and the deal-making is transparent. From my role in ArrayRX as well as with DOC, we want to make sure that everything is clear and open to those that are involved in all of this. So we want to make sure it's a good process. And in the end, we are ensuring the people of the State of Washington, in particular, our patients are the ones that are getting the best care from what we are doing here. So I'm glad I had my hand up so I could speak. I liked all of these ideas, but I think we, as the workgroup, need to find what works best for us.

Mike Bonetto: Got it. Thanks, William. Tim.

Tim Lynch: Hi. This is Tim Lynch. I would say I don't think we need to pick one option. I think we could use a menu of options and let the pharmacies opt into what is best for them. I think, again, lowering the burden for the pharmacies to be able to provide this service and letting them pick if they want reimbursement or they want to use their existing wholesalers to supply it and get monetarily reimbursed, whatever that looks like. I think coming up with different menus or rebates as someone mentioned, I think that would be the ideal state for me so that we are not trying to fit everybody into a single solution. A large retail chain may have an entirely different infrastructure available to them to be able to facilitate something that is easy for them versus a small, rural community pharmacy that has one person who is the pharmacist and also the buyer and the purchaser who has to do all the paperwork behind the scenes. So I think leaving it up to the pharmacies to determine what's best would be a good solution.

Mike Bonetto: Okay. Thanks, Tim. Yep. Mary.

Mary Fliss: Yeah. Mary Fliss. So I would just add that we should be aware of the nuance of other manufacturers that may come to the market. So if we have the

opportunity to buy from the State of California, say, and they are offering insulin at a significantly reduced price, I think we need to be careful about how we would consider participating in that sort of a program and in the context of this.

Mike Bonetto: Got it. Thanks, Mary. Other thoughts/comments from pharmacists out there? Okay. Ronnie. [Cross-talk] –

Mary Fliss: Mike, do you see Leah's hand up?

Mike Bonetto: Oh no, I didn't. Sorry. Leah.

Leah Lindahl: No worries at all. Thank you. Leah Lindahl with the Healthcare Distribution Alliance. Just for reference, I think we would agree with Tim. I think the devil is in the details as far as how the legislation would look or the language and probably best to leave it up to the pharmacies and how their individual contracts work. But I just wanted to reiterate what Tim had said. Perfect. Thanks, Leah. Appreciate it. Next one. So final thought if you think about Maine and Minnesota. And, again, I would open this up for Utah and Ohio as you think about what you have heard today from Hayley's overview related to insulin any other recommendations. And I guess I also want to frame this knowing that we'll come back at Meeting #4 and I think take Jane's recommendations to heart with a more maybe detailed grid, where you can start to see side-by-side and almost have a placeholder for Washington of really what you guys would want to see populated. Then that could start to frame up what you could potentially have in that report. So anything else that you see here that you'd like to add on for group discussion today?

Mary Fliss: LuGina, I see your hand is up.

Mike Bonetto: Yeah, LuGina. Thanks.

LuGina Harper: Hi there. This is LuGina. I was just wondering if we could add – you talked about the additional detailed document that is going to be put together. I'm just wondering, can we segment out the patient out-of-pocket costs for each of the programs when they are using it versus the pharmacy dispensing fee? I'm a little confused about the Maine element, and I need to read it a little bit more closely. But there was the $35, but is that the dispensing fee for the pharmacies? Or is that the patient copayments or cost-sharing? So I just want to make sure that we are comparing apples to apples.

Mike Bonetto: Agreed. And, Hayley, I don't know if you have thoughts on that. But yeah, do you know I think that's a fair call out that we would include that in that grid? Hayley, did you want to weigh in?

Hayley De Carolis: I was trying to pull it up the specific bill language, and I don't have it yet. I believe the $35 in Maine was specific to – hold on just a second. I'm almost there. In order to cover the pharmacy's costs of processing and dispensing insulin. That is the language in the bill. I am not an expert on copayments and how pharmacy dispensing fees work. But that is the language if that is helpful at all. And then the manufacturer was responsible for refilling or reimbursing for the acquisition, the cost of getting the drugs. So that's kind of how it's divided in the bill language.

Mike Bonetto: Thanks, Hayley. Ronnie, can we just go through – oh, Jane, go ahead.

Jane Beyer: So just one quick thought, Mike, in terms of structuring this options kind of menu with that via the table. I'm thinking we've been talking about emergency, but the Utah program isn't an emergency program. The Utah program could be ongoing in terms of somebody's choosing to take advantage of the pricing that is available through the Utah program. And so trying to make that distinction. And the only other question that I think would take maybe even some legal research is that Tim referred to, well, if you're going to do 90 days, that is inconsistent with the rule, the pharmacy quality assurance commission rule that caps the emergency prescribing to 30 days. So a question is would you need some sort of statutory authorization if you were going to go to a 90-day [cross-talk] concept? So just to take a look at that.

Mike Bonetto: Yeah. Hayley, Jane just mentioned Utah. I just want to make sure we are clear on Utah. It's two separate provisions though.

Jane Beyer: Right. I was going to say. Yeah. So I want to make clear that the piece of Utah presented today was just supposed to be the emergency authorization, which is a separate statute than the discount program. We are thinking of the Utah discount program as a long-term solution. So it would be grouped with the ongoing patient assistance programs in Maine and Minnesota and then the ArrayRX solutions that we talked about in a previous meeting. But we can put together a similar table for long-term solutions. That's why we didn't really dig into that portion today.

Kevin Wren: Kevin Wren. Just a quick question on top of that grid. Would you be able to include maybe a detail of how many full-time employees the state has to address this?

Donna Sullivan: This is Donna. What would that tell you?

Kevin Wren: And then I'm just curious about the state's commitment to it as far as a long-term solution. Because when we looked at it, we were thinking something like four full-time employees and an actual department for our recommendation. But I'm just curious. I guess I'll just do that research.

Donna Sullivan: Well, I guess my question is I might be able to answer your question, but I'm not sure what you're asking. Are you asking how many employees are in the State of Washington? Or how many employees are dedicated to this work?

Kevin Wren: How many are dedicated within Utah and then also Minnesota to address this because I'm just wondering about the government footprint as opposed to our recommendation of four full-time employees or whatever that might look like.

Donna Sullivan: I think in Utah it was zero. This is Donna. [Cross-talk] Go ahead.

Mary Fliss: Yeah, Kevin, this is Mary. I think it's a really interesting question. And I sort of thought when you made that proposal, you sort of lined out what you would ask the staff to do. And I'm not sure the expectations you lined out. We would have to match that also for comparison purposes to another state. And I'm not sure that what you described is what we've heard as in place in any of the other states. It sounds actually that Maine put it on the manufacturers to create that sort of patient outreach and assistance program.

Kevin Wren: Yeah. I'm curious as to know what other states are doing. And that is something that I'll look into and try to figure out.

Mike Bonetto: Thanks, Kevin. And we'll do the same. And, obviously, we'd want to match that with population size and all that so we get a better understanding. Yeah. Donna, did you have your hand raised before or no?

Donna Sullivan: I did. This is Donna. I was responding to Jane's comment about legislation I think we'll need legislation on. I know we have the emergency supply

already. But if there's going to be a specific emergency supply of insulin, whether it be 30 days, 90 days, whatever number of days, I think the Legislature is going to have to pass a rule and fund it somehow.

Mike Bonetto: Thanks, Donna. Ronnie, can you hit the next few because I think these are just a continuation. [Cross-talk] Oh –

Ronnie Johnstone: Leah had a comment.

Mike Bonetto: Sorry, Leah. Go ahead.

Leah Lindahl: No worries. I just put it in the chat. Again, Leah Lindahl with the Healthcare Distribution Alliance. Just saying that usually in a state legislation, you can look up the FTE total in their fiscal notes. So that's an easy resource [cross-talk] to find the question that Kevin had.

Mike Bonetto: Thanks, Leah. We'll definitely check that out and include that. Okay, so just a few more comments here from this question, kind of overall. A 90-day supply. Access more than once a year. Pharmacy should not have to notify prescriber in 90-day. Things that you had touched on next. Greater flexibility more than once a year. Greater flexibility for patients under 18. Repayment to pharmacies occur within 10 business days. Not include rules requiring pharmacies to retain copies of patient applications, much like you guys had talked about before. Anything else that anybody want to add on there? You guys had covered a lot of this. Okay. And I think we just have one more, Ronnie. Any additional feedback? So, yep. You guys have been talking about inequality for a while. That is why we are all here. Right? And having an easy process for consumers. So great. So a lot of feedback. This is great. I wanted to frame up again what we talked about earlier. You guys did talk about different populations, uninsured, underinsured, versus insured. And I think again, we were trying to stay clear with the legislation of you guys being tasked to look at how could or should the state look at a 30-day emergency supply, which is getting into this discussion. And then also, what's the longer-term cost savings path, which we had talked about at the prior meeting, looking at some of the other states, whether it's California looking at, certainly ArrayRX and its capabilities. So we want to start even narrowing that down over the upcoming meetings. We've got two more laid out. I think again, Jane, great idea with this grid, I think the grid is going to help you guys get your head around that emergency policy options and then starting to package that together with what's going to again be the best fit for

Washington. And I think, Hayley, you mentioned it. I think we can start to think about something similar on the long-term side, as well. So you can start to see kind of that side-by-side comparison and, again, start to pick out what's going to be the best path for Washington. So again, this has been great, great feedback today. I think that is it on our end. Mary, we want to switch back over?

Mary Fliss: Sounds good. Any other questions or comments? Thank you, again, for all of those who participated in the survey. And I think we are now moving to our Poll Everywhere.

Mike Bonetto: Thanks for the reminder. We do have the Poll Everywhere. So we do want to follow up. So it's always nice to be able to quantify a few things after a discussion like this so we've got some good feedback and some subjective comments. But we want to see what we can do to get a little bit more of some numbers behind this. So like we've done before, we've got this Poll Everywhere. In fact, can we put that in there? Ronnie's ahead of me. In the chat, she put the link in there. So PollEv.com forward slash CEVP OHSU 300. And again, you can put yourself down or not you can be anonymous. Your call. So I'll give everybody just a second to do that. Okay, so let's go to the next. So this will be the first question. So just on a scale to 5 with 5 being strongly support, how strongly would you support a copayment not to exceed $35 for an emergency supply of insulin? We have 100% right now for strongly support. Give it 1, 2, 3, 4, 5. Yeah, Ronnie, go ahead and you can lock that. I think we are pretty clear. Awesome. Thanks, guys. Let's go to the next. On a scale of 1 to 5 with 5 being strongly support. How strongly would you support eligibility criteria that includes being a Washington resident to access an emergency supply of insulin? Okay. We're a little more split. Well, that's [cross-talk] folks a little bit here. This keeps moving on us.

Jenny Arnold: A point of clarification. Are we talking a legal resident of Washington or resident of Washington?

Mike Bonetto: Resident of Washington.

Jenny Arnold: So it would cover undocumented?

Mike Bonetto: Correct.

Jenny Arnold: Oh, okay. That might have shifted my thinking on that vote.

Unknown Speaker: I wanted to mention in the comment, I think Tim wrote that he wasn't able to access the poll. So I'm not sure if everyone was able to access the poll for the first question. I don't know [cross-talk] –

Mike Bonetto: We can go back. Sorry, Tim.

Donna Sullivan: I had trouble using Chrome, so [cross-talk] –

Mary Fliss: [Cross-talk] Yeah, it took me a minute to get on, too. [Cross-talk]

Donna Sullivan: Yeah. So I missed the first question.

Mary Fliss: Yeah.

Mike Bonetto: We can go back and open it up, too.

Tim Lynch: Oh, yeah. I'm still trying to log in here, so I'm super slow. Sorry. No worries. Okay, let's go to the – can we keep going? We'll keep going to the next. Let's just keep that open right now, Ronnie, and we won't have to lock anything.

Ronnie Johnstone: Ready for the next one?

Mike Bonetto: Yeah. Let's –

Tim Lynch: Just a sec. I apologize.

Mike Bonetto: Okay, no problem.

Tim Lynch: Join call says its survey. Never mind. Go ahead. I'm technology challenged. I just cannot get on it.

Mike Bonetto: Are you doing it through your phone right now?

Tim Lynch: I tried to do it on my work computer, and they're blocking it. So I'm trying to do it on my phone, and it's taking me to some funky website that is not the right website.

Jenny Arnold: To me, the easiest thing on your phone is to just go download the Poll Everywhere app.

Tim Lynch: Okay.

Jenny Arnold: And then you just type in that CEB, and it's way easier.

Tim Lynch: Okay. Go ahead and move on.

Mike Bonetto: All right. All right, Tim. Well, if you have time, we can always go back. It's truly no problem. Okay, everybody. Let's hit the next one. On a scale of 1 to 5 with 5 being strong support, how strongly would you support requiring manufacturers to pay an annual registration fee if they sell or distribute a certain volume of insulin in Washington? A little more mixed. Okay. With all the caveats that you guys put forward before, I think that is helpful to know. And folks, just another few seconds here. And, okay, Ronnie. Let's go to the next. We don't need to lock that yet. We'll just let – yeah, thanks. Tim, how's it going? So the last one we have here is open. So what other key takeaways do you have from the reviewed state legislation that the workgroup should consider? So, again, a lot of discussion today, I think very fruitful, very needed. But anything else that stands out that you want to even call out here? The requirement of manufacture reporting. So whoever wrote that, I just want to clarify it. So you're saying that is a good thing?

Mary Fliss: Yes. This is Mary. I think that was a good thing. And particularly given the discussion we had around not notifying providers and wanting to make sure it's not a huge burden to the pharmacists. But there is something about making sure that we are monitoring and tracking how the program is working, and so it's not coming from the pharmacies or from other if we don't – we need to have a source of information in order to make sure we are managing the program.

Mike Bonetto: Yep, yep. Got it. Thanks, Mary. Two buckets? Yep. And I think we will start to frame that up. So thanks. Who said that? Yep. Easy to use. Consumer, pharmacy, state, and insurance. Yep. Great point. Hayley, that is something to think about, even with that grid, too. Right? Almost like an ease of use category. Like how we want to define that. Anything else guys? We started looking at long-term solutions, not just these short-term ones like the copays of emergency supply. Yes. And we're going to get back to those long-term solutions, as well, in our next meeting, but this this meeting really was done. dedicated just to this emergency supply issue. Yep, have to create marketing educational campaign for healthcare providers and patients alike. Yep. Tim,

did you get in? No. Okay. All right. All right. I'll stop. I'll stop bugging you. Anything else? Great comments, guys.

Donna Sullivan: Does Tim have anything to add over the phone [cross-talk] that somebody else can type in?

Mike Bonetto: We can. Yeah. Fair, fair.

Tim Lynch: No, I'm good. Thank you very much.

Donna Sullivan: Okay.

Tim Lynch: I appreciate it, Donna.

Mike Bonetto: Okay. There should be a standard easy-to-use registration system that is selected to be used as part of this program. Yep. Everybody have their comments in? Okay. Great job, guys. Ronnie, I think we can go to the next slide. And now, Mary, I think I'll turn this over to you. Thanks.

Mary Fliss: All right. So next steps. Thank you so much, everyone, for participating in today's meeting. We will take the comments and the feedback that we received, create a summary as we know also that this presentation will be made available as well as the transcript. And that usually takes us a little while to pull all that together, so appreciate your patience with that. We'll be continuing to work with The Center for developing the next phase of our meetings and really making sure we have information to create our report out to the Legislature. And our next meeting is again, three hours. It's on Tuesday, December 6th. And then after that, we should have as Mike mentioned, this was really focused on that 30-day emergency supply, looking at how other states have solved for that problem. The next we'll be looking at more of the long-term solutions, and then we'll be working on drafting the legislative report. And we'll have another meeting then in the Spring of next year, and we will be turning in our report on March 31st. And so, we are setting expectations appropriately. The review cycle for a legislative report has many pieces to it. We make sure that we have subject matter experts looking at it. We have our communications folks looking at it. We have our leadership and our policy people looking at it. So we like to build in time to make sure that we have a very polished product for the Legislature. So, of course, this team will be the brains behind that report. But even though it's due on the 31st, we are not able to take all of your edits up to the 30th. This is

this is something that will be laying out a timeline for the report and making sure everybody has very clear expectations. And we do take a considerable amount of time to make sure we have it all righter than rain before we send it on to the Legislature. Donna, anything else that you would think we should add? Mike? Others? Anything else for the good of the order here?

Donna Sullivan: I don't. I thank you, Kevin, for putting together the videos. Thank you, Jennifer, for sharing in your video. And thanks to everyone on the phone for participating. I think it's a great conversation. Really appreciate the collaboration.

Mary Fliss: Yes, agreed. And thank you, Jane, for filling in. And, Tim, welcome again to the group. And we look forward to seeing you on the 6th. Take good care.

Tim Lynch: Thanks, guys.

Ronnie Johnstone: Thank you.

Donna Sullivan: Thanks. Bye.

Laura Keller: Bye.

Mary Fliss: Bye.

[end of audio]