Total cost of Insulin Workgroup
Meeting 5 transcription
March 16, 2023

Donna Sullivan: We might wait just another minute. I think are waiting on one other member. Okay. Good morning, everyone. It looks like we have everyone here. I'm Donna Sullivan, I'm the Chief Privacy Officer at the Healthcare Authority. I'm going to lead the meeting today, Mary Fliss is no longer with the Agency, and so replacing her today is Ryan Pistoresi. And we will be going through the Agenda in just a minute. So we have a workgroup activity to date that we are going to summarize. The Center staff will be going through that. Ryan will then be giving us a Legislative Update around some legislation related to insulin that has been introduced. Also some other things are going on. We'll look at the Voucher Program and the Discount Card overview. Leta will be giving us a brief overview of that. And then we are going to go through the draft final report that is due to the Legislature in June. And Hayley will be reviewing those slides for us. We'll take a short 10-minute break, and then we will have an open discussion about anything that might be missing on the report or if we need to make any edits to the report. And then we'll wrap up with some next steps.

Mike Bonetto: Awesome. Donna, do you want me to jump in here?

Donna Sullivan: Sure, please do.

Mike Bonetto: Hey. Good morning, guys. Mike Bonetto here, with The Center. So As Donna mentioned, we just wanted to make sure we put this up there, so we have a little grounding of where we have been and just to highlight that this is Meeting 5 of 5 Meetings. So again, thank everybody for all of your work over the last many months. But I think as you just look at this chart, just making sure that we are clear where we have been starting back in July of getting some a foundation of what this group was tasked to do. And then moving through those subsequent meetings of really getting a better understanding of what those possible policy options were for both the emergency supply as well as the long-term and starting to craft those out based on the surveys that you guys did over those many, many meetings. So you'll see those surveys 1, 2, and 3. That really helped shape where we are today. Brought in Utah and started to look at other states and other models, both on the emergency supply and the long-term. And then you obviously spent more

time in December crafting those proposals as policy proposals. And that's where we are going to get into more today. Right? And whatever is discussed today, and key themes will also go into that final report. So it's not that I don't want you think about this final report as being completed today. Still some of the key findings or input would get put into there. And then from there, that'll go through some further edits within HCA, and then that will get handed off to the Legislature. Donna, I believe that's a July 1 deliverable for you guys, but I think we are on course. And, you know we haven't met since December, so I just wanted to make sure you guys saw this and understand the process that we have been through and then where we are going after this. So, Donna, thanks for that. Any questions, thoughts on this? Everybody tracking?

Donna Sullivan: Great. Thank you. So next up, we have an update on the Legislative Session. So Ryan, I'm going to hand the mic over to you.

Ryan Pistoresi: Great. Thank you, Donna. So I'm Ryan Pistoresi. I'm the Assistant Chief Privacy Officer here at Healthcare Authority, and I'm helping fill in for Mary Fliss today. So just a quick overview of the current legislative session. So we are at the start of a new biennium, which is a two-year process for the Legislature. So we operate in two-year increments, so this is just the beginning of the session. It started on January 9 of this year. The first major milestone just passed earlier last week, which was on March 8th. That is the day that the bill that is introduced in the House has to pass out of the House and go into the opposite chamber. So bills that are introduced in the House must go to the Senate by that date, and those that are in the Senate must go to the House. There is a shorter turnaround for it to get passed out of the opposite House. That is the next major milestone. That is on April 12th. And then the last day of the regular session, when everything needs to be wrapped up, is scheduled for April 23rd. So we are right after the first major milestones, and so we do have some updates on some insulin-related bills to share with you today. So this year only two bills were introduced that are related to insulin. The first one is House Bill 1725, and that was proposed to create an insulin access program for Washingtonians under the age of 21. And the other one was introduced in the Senate. That is Senate Bill 5729, and this was to remove the expiration date related to cost-sharing cap for insulin. So we'll start with the House Bill first. So this was a bill that proposed establishing a bulk purchasing and distribution program for insulin specific to those who were under the age of 21. This would be similar to a bill that was passed in 2021, Senate Bill 5195, which created a naloxone bulk

purchasing and distribution program at HCA. Naloxone is an opioid overdose reversal medication. So they had seen that that bill passed in 2021, and they were looking to expand it for insulin for those under the age of 21. After some discussion at a public hearing, it was amended to a Substitute version, which changed it from a Bulk-Purchasing Program to a Copay Offset Program. And so this program was structurally very different in that it looked to receive funds from different health carriers and health plans in-state that could then be used to help offset the cost-share of insulin. And this would be a program that would have gone up by January 1, 2025. So this bill did pass out of the House Committee on Healthcare and Wellness on February 15th that did have a 15:1 vote, but it never passed after that. So even though it was eligible to go to rules or to the floor, it did not get a subsequent hearing and has since failed to meet that cut off. So that bill is considered dead until the next Legislative session. The next half of the biennium starts in 2024. The other bill, this one was related to the insulin cost-share cap in Washington State. So 2020 was the first year that the Legislature looked at a cost-share cap for insulin. And at the time that it passed in 2020, it was effective in 2021, and the insulin cost-share cap was capped at $100 for a 30-day supply. In 2022, the Legislature reduced that cap further, making it a $35 maximum cost-share, and that would be into effect until January 1, 2024. So given that this statute was expiring, a bill was introduced that would have changed the expiration date to January 1, 2025. But a substitute version was later introduced that just removes that expiration date altogether. So this also passed out. I do realize that there is an error. So this actually passed out at the Senate Committee on Health and Long-Term Care on February 16th, with a 9:1 vote. And it did get scheduled for the Senate Floor, and the floor did pass it out of the Senate. And it had a pretty much unanimous 47:0 vote. So it does seem that there is a lot of bipartisan support for this legislation. Earlier this week, it had its first public hearing in the House Committee on Healthcare and Wellness. And it is actually scheduled for an Executive Session tomorrow, so it could be voted on and moved out of Committee as early as tomorrow. So any questions at all on this year's Legislature or Legislative Session? All right. I don't hear any questions, so I guess I can hand it back over to you, Mike [cross-talk] --

Jenny Arnold: Mike, this is Jenny. I'll chime in a bit. For the first insulin bill, it came back to me that this group had -- it was a suggestion from this group. And so there were a lot of reasons it was not a suggestion from the group, the House Bill 1725. And so I'm sure that you all had a lot of work to do to counter detail on that. And I guess I appreciate it. It was surprising or frustrating from my

standpoint to hear that somebody had introduced a bill and said it was based on the work of this group when it hadn't been. So, yeah. Anyway, just comment more than anything.

Mike Bonetto: All right. Thanks for that, Jenny. Yeah, and as you know from our workgroup, we are working on a few recommendations that we are hoping that the Legislature will then be able to consider as early as the 2024 Session.

Donna Sullivan: Great. Thanks. I think the next step on the Agenda is Leta with the Overview of the Voucher and Discount Card.

Leta Evaskus: Thanks, Donna. I'm Leta Evaskus. I'm the ArrayRx Operations Manager at HCA. And I wanted to go over the difference between the Voucher Program and the Discount Card one more time to clear up any confusion. So the Discount Card is currently available. It's an existing program. All Washington state residents qualify to sign up for free. There is no age or income restriction or membership fees. All FDA-approved prescription drugs are eligible for a discount. There is no formulary. And there are even discounts on some over-the-counter medications without prescriptions, and this includes diabetes test supplies. And the Discount Card users get the same negotiated discounts as the other ArrayRx participating programs. Next slide, please. So the way it works is today, you can go to ArrayRxcard.com and enroll online. You will automatically receive a digital card. If you need a paper card, you can request to have one mailed to you. We have online tools where you can find participating pharmacies near you. You enter your zip code, and it will populate with the pharmacies near you, and examples are Safeway, QFC, Fred Meyer, Walgreens, and in rural areas. There are also lesser known pharmacies names that I don't know off the top of my head. And will also give you the price at each pharmacy. So pharmacy prices can differ a little bit depending on where you shop. You will take your card and present it to the pharmacist at the point of sale, and you would get rung up for the discounted price. You can save up to 80% on generic drugs and up to 20% on brand name drugs. But the Discount Card cannot be used with insurance. It can't be used to pay the copay for your insurance. And purchases on the Discount Card don't apply to your insurance deductible. So, for example, if you have a high-deductible health plan, you could choose to use the Discount Card instead of your insurance if you know you're not going to meet the deductible by the end of the year. Next, slide. Thanks. These are some examples of prices of four insulins. This was on March 1st. Prices can change. I also noted the Eli Lilly drug, Lispro. Eli Lilly announced that it will

reduce insulin prices by 70%. So this could change. And we are waiting to see how they are going to roll that out. The Voucher Program differs in that it's a customizable pharmacy program, and it's used by facilities to ensure continuity of care when a patient is discharged. It can also be used by public sector entities to set up a program for eligible populations with a controlled pharmacy benefit. Next slide. Thanks. So, just like the Discount Card, a voucher would be written for a patient, and they would take it to a participating pharmacy and have their medication filled at no cost if it's being covered by the sponsoring facility or Agency or for a predetermined copay. Next slide. So how the Voucher Program could work for insulin is the Healthcare Authority could release a request for proposals for discounted insulin prices. Drug manufacturers would bid, and the winning drug manufacturer's brand of insulin would be used for the Voucher Program. So then, the patient would sign up online, and like the Discount Card, receive a digital card or request a paper card, show the card at a participating pharmacy, and they would be charged the HCA-negotiated price. The downside would be that patients who prefer a different insulin than the winning manufacturer's would not be able to use the Voucher Program. They could still receive a discount through the Discount Card, though. Next slide. For the 30-day emergency supply of insulin, we are looking at two ways that could happen. So like Minnesota's law that directed manufacturers to have a $35 copay for emergency supplies, the Washington Legislature could enact a similar law directing manufacturers to provide either a free or a minimal copay for an emergency supply. If the Voucher Program was used, during the request for proposal it can be included that we are requiring the winning manufacturer to provide a 30-day emergency supply. Next slide. So the way that could work for the Voucher Program is that the card could be programmed with a one-time 30-day supply of insulin for each calendar year. The patient would go to the pharmacy and tell them that they want to use that emergency supply, and it would be filled at no cost. Either way, the manufacturer would be paying for the emergency supply if the Legislature enacted a law or if we use the Voucher Program. Next slide. So are there any outstanding questions on the Discount Card or Voucher Program?

Mike Bonetto: [Cross-talk] And Leta, this is Mike. Oh. Jane, go ahead.

Jane Beyer: Thanks, Mike. So, Leta, question in terms of if there was a competitive procurement. It sounds like the statement is that there would only be one successful bidder. But given the variety of insulin products that are out there, I mean, could you design the RFP to say that you wanted to have three

different types of insulin available and that you could have a successful bidder for each of the types?

Leta Evaskus: Yeah, if HCA put out an RFP, we could design it any way we want. If we have more than one manufacture, we probably won't get as big of a discount as if there was only one winner because then you're ensuring [cross-talk] --

Jane Beyer: It's a greater volume.

Leta Evaskus: Yeah. The volume, exactly.

Jane Beyer: Okay, thanks.

Donna Sullivan: And, Jane, just to add on to that, what we would probably do would be to try to pick one manufacturer for each category of insulin. So if there was a category where one of the manufacturers doesn't have a product in that, we might select a single manufacturer for that particular category of insulin where they are not competing. And then I think we could get better discounts. And then I do see that we have another question. Lumi.

Lumi Nodit: Yeah. I was thinking of the same type of question. You should work though because if you are picking one winner but offer a matching opportunity through the RFP, I just don't know how that could be implemented in practice. But if someone really could benefit and a manufacturer would like to participate, offer them a chance to have access to provide that type of insulin if that's really the option that works better. So while you are the winner, I understand the discount is what matters, but at the end, they pay for it if it's part of it. So that's my suggestion to consider some type of consideration for a manufacturer that would be willing to pay and participate in the program, even though it's not a winner. I don't know how it could be implemented, but that's my thinking here.

Donna Sullivan: And we might not have summarized how the this really works. We wouldn't exclude a manufacturer just because -- we would choose the best option. It's just our experience that a manufacturer will give you a better discount if they are not competing against other products within their -- what they'll call a market basket. That's just our experience. By any means, if manufacturers come in at the same price and are willing to compete against one another, we would definitely, absolutely choose as many manufacturers as we could. So I

think we were speaking more to one of our experiences rather than a real strategy.

Lumi Nodit: Yeah. And I'm sorry because I missed the last meeting, but I was just trying to understand this bidding part. You know? If the manufacturer pays for as part of the program, I mean --

Donna Sullivan: I think you cut out. Lumi, we can't hear you.

Lumi Nodit: So my only comment here was just because that's how business works now, why can't you implement a program that facilitates giving choices priority? For example, if someone needs insulin, they really have to pick a different product because that's the only product that is provided versus make it the other way around. If the manufacturer would pay, I understand. But it's new legislation, so it's a new implementation of something that prioritizes what the consumer would need versus -- I understand the word "preference" is there, but that's my thinking. And maybe in practice you will think that getting more volume, but not having that option for whoever needs it is more important to me than facilitating around a program that they will have to pay. And it's not like an incredible amount of volume. So that's my thinking.

Leta Evaskus: So are you more interested then in the Legislature enacting a law that has all manufacturers of insulin lower prices?

Lumi Nodit: Well, I mean, the process is great. You will facilitate giving access through this emergency type of need, and you will give them priority whoever wants to participate. But facilitating the idea that, again, the highest bidder and bidding and the volume and the game that is already at play, it seems a little bit more like doing the same thing, just call it something else versus trying to offer an opportunity for who else wants to participate in this program? I understand that if they want to provide more discount that they will be referred in some way, but I don't necessarily want to call it out like pick one winner. So that's my only reservation.

Leta Evaskus: Okay. And Jennifer.

Jennifer Perkins: Good morning. This is Jennifer Perkins. Just when I was listening to her speak about that, it just reminded me of that term called non-medical switching, which occurs sometimes when your formulary, your insurance, or whoever, maybe ArrayRx, picks that one winner, and it is not your insulin. You may be

then forced to switch your insulin, which the thing that worries me about that is that's also a potential point where people could have to deal with, like having to get a new prescription from their provider, which is an added cost, and it's just like an unnecessary obstacle for people. And so I just wanted to say that there are multiple reasons why I understand the business side of it, and why there is potential, like, power for mass purchasing. But there is also that's the downside that I see from it as well is that some people are then going to have to be forced to do that non-medical switching to get the discount [cross-talk] --

Leta Evaskus: Right. I see what you're saying. And we could definitely put out an RFP asking for multiple manufacturers, saying that multiple manufacturers will win. But what if they don't bid?

Jennifer Perkins: Yeah, yeah. Well, it's just something to think about, I guess [cross-talk] --

Leta Evaskus: Yeah.

Jennifer Perkins: -- and try to do the best that we can with what we got. Thank you.

Jenny Arnold: A follow-up question just to clarify something that was said. When you say, "could one manufacturer." The assumption, though, would be that you would have a fast-acting insulin as well as a long-acting insulin and the different insulins in the different class. So I'm not trying to downplay insulin switching and non-medical switching and the challenge that not all insulins are created equal, but at least it's not that you would have to be everybody switching to regular and that would be it. You would have an insulin in each classification for lack of a better word of insulin. Correct? And I see nodding [cross-talk]. Thank you.

Leta Evaskus: [Cross-talk] Yeah, that would be. And these examples were very generalized because we don't have direction yet as to what we are going to do. So it's just examples of scenarios and how it could work. But yeah, all the details would be fleshed out.

Ryan Pistoresi: And just looking over at Utah, I can see that they have a few different manufacturers for their Utah insulin savings programs. So at least if we are looking at how another state has approached this, they do have several different types including long-acting, short-acting NPH, so they have a wide variety.

Laura Keller: This is for Laura Keller with the ADA. So in Utah, what they did was they went with the least to start the program. They contracted a better contract with their employee plans insurance for an insulin provider. So they leveraged who they were currently already had an account with, which was the Novo Nordisk products [indistinct] in had to your point, all three different levels. They had the fast-acting, the long-acting, all of that. They have [indistinct] that's what they did. They used the contracts that they already had to get up in front [indistinct] from their employee [indistinct].

Donna Sullivan: Laura, you were really hard to hear. I'm not quite sure I understood what you were trying to say.

Laura Keller: -- that's any better. Is that better?

Donna Sullivan: Much better.

Laura Keller: Okay. Sorry about that. Been having a little of internet issues today. So in Utah, they use the provider of insulin that they had with their employer plan. So for their state employees, they had already negotiated a contract with, at the time it was Novo Nordisk. And they used that to leverage to get better coverage for their insulin for the purchasing program, so they leveraged the state employee plan. Does that make sense?

Leta Evaskus: Donna, you're on mute.

Donna Sullivan: Sorry. They have a different program as well. Their employee plan, I should say, subsidizes or floats the rebate spread [cross-talk] where the employee plan is getting charged and paying for the insulin for those that are not part of the employee -- they are not necessarily a Utah State employee. They are paying for that insulin up front and then waiting for the rebate, I believe, on the back end. And we don't really have the authority to do something similar at this point in time. I see, Ryan, you have your hand up.

Ryan Pistoresi: Yeah. I just wanted to say Utah was an example of having different manufacturers bid and that they have multiple. It wasn't saying that we should go into the details of it. I was just trying to provide a bit of context. So I didn't want us to necessarily go down the rabbit hole.

Mike Bonetto: Donna, thanks. I just wanted to chime in one more time. Just any other questions, thoughts? This difference that Leta just went through with this, the Voucher Program versus a discount because it's going to be important as we talk about the future policy options as Hayley walks through in the next stage. I just want to make sure everybody understands that because it's going to be a bigger part of the next discussion. I want to make sure people are aware of that. Okay. With that, we'll keep moving, and we can turn things over to Hayley. Sounds great. Hayley, thank you for being here and walking us through the draft on reports.

Hayley De Carolis: Yeah. Thanks, Mike. I'm Hayley De Carolis. I'm a Policy Analyst at The Center. So like we said at the beginning of the meeting, we are just going to walk through the final report that is due July 1st, so it's still a draft. And then we'll save some time at the end to get feedback. But as we go through, if there are questions, I will also try to pause at the different sections. But feel free to raise your hand or come off mute or put it in the chat because it is a lot of information, so I don't want to have everyone have to wait until the end. So if there are questions, please feel free to ask along the way. Let me get back to the slideshow. So the organization for the final report starts with an executive summary then goes into a background which is about insulin affordability and the state legislation that prompted this workgroup. Then we get into the process overview, the different steps that we took as the as a workgroup to come up with the recommendations. Then we get into the first chunk of new content, which is the legislative requirement for #1, which is to design a long-term strategy for affordable insulin access legislation. Legislative requirement number two was the 30-day emergency supply, so we talk about what the workgroup discussed around that. Then we include other legislative recommendations that we see across the nation, which is evolving right now, as everyone probably knows, and so we talked about some other options that were not directly included in the workgroup scope, but that came up in the process. And then we will finally conclude the report. So that's the outline, and how this presentation will flow. So starting with the Executive summary, this final report is due July 1st. And one important feature of the report is that it must include any statutory changes necessary to implement the strategies. So we have included that in the policy grids that you all have seen before. We added another element to talk about where statute might be required or where this could be implemented without any statute changes. And then I just wanted to highlight that the two tasks that the workgroup was assigned was to design strategies to reduce the cost of and total expenditures on insulin in the state, which is what we are thinking

of the long-term policy and then to provide a once yearly 30-day supply of insulin to individuals on an emergency basis. So just wanted to ground everyone, and those were the two requirements in the specific scope that this report refers to and that we have referred to along the way as the workgroup. So then there is a section in the report that outlines the process that the workgroup took. I summarized all of our steps into six steps. And we will walk through each of these. So we'll start by reviewing the Cost Analysis for Insulin. So if you remember, this was in, I believe, meeting #1. We presented the work that HCA and The Center did to conduct data analysis related to insulin costs using the All Payers Claims Database in Washington. And as part of the report, there is, I think, a 30-page deep dive into this cost analysis. And so I would encourage everyone to take a look at that in the Appendix. I have summarized some of the main findings, which was that just how complicated the insulin and market is and how the price paid by many individuals depend on things like coverage, patient condition, treatment regimen, etc. And so reporting the average cost does not always accurately describe the range of the minimums or maximums that people pay. And that was a major finding in the report. But like I said, it's in Appendix B, and I would encourage people to take a look at that. I do see some chats. Oh, Kevin. Yeah. I'll let someone else handle that one, and I'll keep going with the next step that we did, which was to review relevant prior work by HCA. So I think worker meeting #2 presented the work that was done from the 2021 Senate Bill 5203, which was named Producing, Distributing, and Purchasing generic prescription drugs. So as part of that work, we presented four best practices or other state initiatives that came from similar state legislation, and those were California's Manufacturing Act, ArrayRx, which we have heard about today, Civica RX, and then also that Utah Insulin Savings Program. So we went over those in that meeting. And then we also spent some time on the Washington-specific insulin policy recommendation, which came out of that work, which was to use competitive solicitation to secure a preferred price for insulin and then use the existing ArrayRx Discount Card to pass that lower price to the consumer. So that was a previous recommendation that we went through. And then we also talked about other tools and considerations that we considered for both purchasing and distribution and then the different pros and cons to each of those alternative solutions. And then, step three was conducting survey of nationwide policy options. So this started after the second workgroup survey and really stemmed from the strong support around discussing Minnesota's legislation. And so through that research at HCA and The Center found four examples that we were going to do a deeper dive into, which was Maine, Minnesota, Utah, and then Ohio

House Bill 37. We reviewed the following elements of the policies, which stems or ranges from an application to the eligibility to patient access, and we highlighted that Maine and Minnesota both require manufacturers to reimburse pharmacies directly, which is a strategy we had not looked at in the previous work. Then we looked at how Utah offers insulin through a single-benefit health plan, and we talked about that a little bit earlier today. And the full presentation of all these options can be found online on the workgroup webpage, which has all of the recorded workgroup meetings and other resources, too. So after that meeting, we got great feedback from Jane about creating the policy grids to summarize this information in an easier way. So that was the next step that we took. We worked with refining the policy grids and having a long-term option and an emergency option. We reached out to other states and tried to talk to them about the decision making for their policies. And then we were able to have a representative from Utah attend Workgroup Meeting #4 for a brief Q&A session. And then here is the example grid that we presented several months ago with the differences by each policy highlighted and bucketed into easier-to-digest pieces. So this was the original iteration of the policy grids. And then we moved on to reviewing the policy grids. And so in the 4th Workgroup Meeting, we held a Poll everywhere. I highlighted this result, just as one example where we got feedback on the level of support for each of the policy elements of each of the strategies. And then step six is compiling the final report, which we have been working on from December to March. And then this final meeting, the hope is that we can review the report and have an open discussion with any feedback or questions. I don't see any other questions in the chat, so we'll just keep going. So Legislative Requirement #1 we have been calling the long-term strategy, this is a summary of the long-term policy. We have recommended a three-pronged approach including a Manufacturer Assistance Program, a Prescription Drug Voucher Program through our ArrayRx and then ArrayRx Discount Card Program. And the reason why there are three options is that it's a way to target different individual needs, potentially different income levels depending on the eligibility criteria. And each of these options is in a varying stage of implementation. So the Manufacturer Assistant Program would actually be a mandated Manufacturer Prescription Assistance Program, where the Washington State Legislature would mandate that manufacturers produce and are selling over a certain volume of insulin in the state every year be required to offer a patient assistance program. So this is separate from any existing generic manufacturer assistance programs. This would be specific to the State of Washington. And this is how Maine and Minnesota do theirs.

These programs typically have an income requirement. In Maine and Minnesota, it's 400% FPL. So that is a consideration, but not everyone would be eligible for this option. The other two options have less eligibility requirements, but they would probably have a higher cost. The Prescription Drug Voucher Program like Leta went over is something that exists. There is not an insulin specific policy or insulin specific program, so that would need to be created. But the goal would be that the negotiated price would be lower than the Discount Card Program. And that program is a current program existing. No income requirements. Anyone can access it right now. That is just an overview. Let me see. There is a chat up. Thanks, Mike. So then just getting into a little bit of the operational details of each of these prongs. Let's see if the animation works. There we go. For the manufacturer Assistance Program, the individual would apply directly with the manufacturer. The manufacturers, like I said, would be mandated to participate if they sell over a certain volume of insulin. In other states, manufacturers and how their programs are designed is that manufacturers determine the eligibility and are also responsible for approving or declining applicants. But there is a state oversight for appeals. So that's the process we have outlined here. And drug manufacturers would be responsible for reimbursing pharmacies directly. And in this option, there is like a mail pharmacy option, too, for people just want to deal with that. And then the Prescription Drug Voucher Program through ArrayRx. We have talked a lot about this already, how HCA would put out an RFP for a discounted insulin price. And then the brand or brands, as we spoke about earlier, would be used for the Voucher Program, and then the consumer would pay for insulin at the discounted price. On a Discount Card Program is something that already exists. You can apply online and get an electronic card or a paper card, take it to the pharmacy, and then the consumer would access insulin at the current negotiated price, which the hope or the assumption is that it would be a higher price than the Drug Voucher Program. That's a distinction I wanted to highlight. So then here on that note is a quick summary of why there are three options and who is targeted in each one. So each one would have different eligibility considerations. Some would be within HCA and ArrayRx purview. So like HCA could already have the authority to create the eligibility criteria for the Insulin Voucher Program if that is the way it goes. The mandated Manufacturer Assistance Program typically has income eligibility requirements, so that would be different. And then the Discount Card has none, although I should say to state residency, but we talked about what that means for people in different housing situations. And then implementation status. The first one, the mandated Manufacturer Assistance Program would

need to be created and would require state legislation. The Voucher Program is something that exists but not specifically for insulin, so that will need to be created. And then the Discount Card is fully operational. So those are the three different prongs of the long-term approach. Yeah. Kevin, do you have a question?

Kevin Wren: Sorry. I was just reading the report again, and I'm just wondering, I mean, you can answer this now or in an email. But if there is any basis on the education assistance, like how that might be disseminated, if it's being modeled after anything that the state is already doing as far as to educate pharmacists and doctors and the general public?

Hayley De Carolis: Great question. I can speak to the report, and then HCA staff, if you want to speak to the Washington part, please jump in. I think originally, that's something that Maine and Minnesota did. So there are examples and even funding levels for something like that. So that's what is included in the report. I don't know if there are any other Washington programs. If HCA staff can comment on that piece.

Ryan Pistoresi: Hi. This is Ryan. I can speak about a few other programs that we have done. When we implemented an opioid policy in late 2017-2018, we did a lot of webinars and printed a lot of materials, had printouts and other information that were for providers, for pharmacies, and for patients. And so we could look at an education program like that. I know that more recently, we have been doing naloxone education. So we have been partnering with the Department of Health and our Department of the Division of Behavioral Health and Recovery to do webinars more specific around like hospital billing, around naloxone disbursement at [indistinct] and things like that. So we do have some experience of providing education to different types of stakeholders in the community. And I think we would have something similar to those programs but specific to insulin.

Kevin Wren: Thank you. I was just thinking, because I remember the Utah person saying that they were underutilizing the program. And I was wondering if they might have like some things that they learned about introducing something like this. Thank you.

Hayley De Carolis: Yeah. That's a great point. I think one distinction I can think of is there. They were not given any additional resources actually for the effort. And then in May, I think Minnesota was given $250,000 for a public awareness campaign

as well as training peer navigators. So I think that probably goes down. Like, that could be a great point is that if state legislation includes resources for something like that, it probably would be more successful than what we heard from Utah. Great question. Okay. Moving on then. This is just an example that I wanted to show everyone what is in their report. It is a slightly different version than the policy grids we went over in the fall. So this one was created specifically to meet the requirements of the report to highlight any statute changes. And then we also included any appropriations that would be necessary to implement as well as administrative considerations around things like new contracts or FTE or anything like that. So this is not filled out, obviously. Those are the elements of the policy on the left that we highlighted, and this can be found as Table 3 in the report. And then the next couple of slides highlight some major points that I wanted to bring to everyone's attention between the feedback we got from the workgroup and then what is in the report. So eligibility criteria was a big topic that we talked about. There was strong support to utilize ArrayRx current eligibility requirements, which is that you just need to be a state resident, no age or income restrictions, and it doesn't require an ID or documentation of residence. So this is something that we wanted to highlight for establishing the Voucher Program eligibility and how strong the support was to keep it similar to the Discount Card. So I just wanted to highlight that piece. And then the next piece was also reimbursement, that there was strong support for manufacturers to reimburse for the patient assistance programs and for the pharmacies for any dispensed insulin. And then here's back to Kevin's question about educational assistance. This was something that was a workgroup suggestion to create a program for pharmacists and patients to help overcome any identified barriers. We think this would require a statute change. For example, Minnesota received $250,000 through their legislation to do something like this. I think this was highlighted just as an example of the magnitude of resources it might require and also showing through the Poll Everywhere results from a previous meeting how strong the support was around providing something like this. And then also included after Table 3, Table 4, which is we included legislation language examples from Minnesota, just as an assistance. Like, if the Legislature wanted to do something like this, here is example language specific to Minnesota, obviously, but that is also listed in the report. And then at the end of the section for Legislative requirement #1 is the summary of workgroup recommendations. So we wanted to include this to highlight any major contributions of the workgroup that maybe didn't fit directly within the scope. This is more of a point with the emergency supply, but anything that

didn't neatly fit into the preceding sections. And we also want to highlight that all of the comments and feedback to the surveys, unedited feedback, are in Appendix C of the report, and a lot of that is also online, too. But the two major recommendations related to the long-term policy were transparent financial disclosures. So we do think that something like this would require legislative changes to require the financial disclosures be reported by manufacturers to HCA. This is currently not allowed under the Washington State Drug Price Transparency Program. So if that is something that needs to be changed, then that would probably require a stakeholder engagement process and staff resources to implement. And then we also heard a lot of positive feedback for integrated data to publish total diabetes impacts and improved outcomes. And I think this was related to that discussion around price transparency in the initial report we went over and how it's really hard to see what is going on across all areas of insulin policy. So that is the end of the section for Legislative Requirement #1, which is the long-term policy, I'll pause to see if there are any questions or comments. We also will, like I said, at the end of this, we'll have a break and then time for more feedback and pointed questions. But if anyone has anything. Oh, yep, Jennifer.

Jennifer Perkins: Yes. Good morning. Thank you. This is Jennifer Perkins. I like that we are going to have some appendix at the end that doesn't have everything that's going to be captured in the beginning portions. And I'm going to send some commentary back after I read through the whole recommendations myself. It would be really nice to make it explicit somewhere just even one question nod to the fact that these, while I think they are good solutions that are going to have a positive impact, that they are imperfect solutions, and I don't know, maybe I'll put this in the end in the comments. But we do have an ableist healthcare system in our country that thinks that people with chronic health conditions and disabilities should be at a lower class in our society. And so we charge people with chronic health conditions more money. And so I don't think this is a perfect solution. I think it's a good solution. But I would like to make a nod to that I would like to support other additional manufacturers that jump on board. I think that that is incredibly important. I feel strongly that even one sentence saying that we would support other manufacturers jumping on board because this one doesn't say anything about supporting another manufacturer. Thank you.

Hayley De Carolis: Yeah, that's a great point. Thanks, Jennifer. We did highlight Civica Rx, which I think is at the end of the report, they are planning on manufacturing and distributing insulin at a much lower cost. So we do highlight it, but you're

right. It's not in this section of recommendations. So thanks for pointing that out.

Jenny Arnold: Maybe. [Cross-talk] --

Hayley De Carolis: Yep.

Jenny Arnold: I can wait my turn. Sorry.

Hayley De Carolis: Okay. LuGina.

LuGina Harper: Good morning. I wanted to ask you -- and I'm not sure -- please tell me to stop if this isn't the right time to do it. But on this slide -- you're talking about transparency -- and I had a question on page 23 of the report, where we talked about financial transparency and then drug price transparency. It seems to be the same thing, but I wanted to just get a better understanding of that. And if this is something that's better addressed later, I'm fine waiting.

Hayley De Carolis: I think it's a great question. I will try to take a stab at it. But then, Ryan, specifically, if you want to jump in. I think the language when we said drug price transparency might be specific to the Washington State Program. And then the financial disclosures, which is general feedback from the workgroup. Ryan, do you mind confirming that or adding any extra context? Or anyone from HCA?

Ryan Pistoresi: Yeah, that seems appropriate. I was just going to pull up the draft report that we sent out. You said it was on Page 23? [Cross-talk] --

LuGina Harper: [Cross-talk] 23. Yeah.

Ryan Pistoresi: 23.

LuGina Harper: And both of them, again, the concept of transparency was not the issue that I'm pushing back on. I just was trying to understand. There is financial transparency, and then there is drug price transparency, and they both talk about information that's reported to the Washington Drug Price Transparency Program. And so I just wanted to understand if they are different or if that can be consolidated into one thing. So that was my question.

Ryan Pistoresi: Yeah. No, that's a good question. And I think the clarification around drug price transparency is more around the use and utilization of it, whereas the financial transparency would be more around the actual costs that go into it. But I'm trying to pull up the report and having a little bit of difficulty in getting to that page. [Cross-talk] But I can take a look and hopefully clarify it in just a minute.

LuGina Harper: Oh. No worries. And, Ryan, the reason that I'm asking is that it sounds like the drug price transparency information that we are wanting to be reported is what is being reported to the Drug Price Transparency Program already by manufacturers, plans, PBMs. So I just wanted to understand if we are asking for different sets of data or just access to the same data.

Mike Bonetto: LuGina, we'll put a pin on that, and we'll come back to it. I think it's a great point. I was looking at the same piece. So yeah [cross-talk]

Nonye Connor: Ryan, I just emailed it to you.

Mike Bonetto: That's right.

Ryan Pistoresi: Thanks. I have it up. I'm just rereading it.

Mike Bonetto: Jenny, do you want to go?

Jenny Arnold: Yeah. It was just a brief follow-up on that previous point of maybe we list that we support dynamic or innovative contracting models, something that doesn't pin us to one but some process in that.

Mike Bonetto: Got it. And Hayley was saying, too. I mean, if you guys have thoughts on again, language, anything like that, welcome your feedback. I mean, this is the whole point of this. So yeah, this is great.

Ryan Pistoresi: Okay. And I did have a chance to re-read that section. So to answer your question, it would be financial transparency that is reported to the Drug Price Transparency Program. But right now, the Drug Price Transparency Program is not able to report on individual prices, individual drugs, individual manufacturers. And the idea is that if it could be modified, we could take that existing data and disclose it out to provide more detailed information about what is going on with insulin. So it would be all types, not only just the financial data, but also costs and utilization around the different

insulin in the state through that program. So it would be our current Drug Price Transparency Program, but it would be allowing it to report those individual details.

Multiple Speakers: Do I -- [cross-talk] ?

LuGina Harper: Okay. I'm sorry. You want me to -- can I keep going? Or do you want to go to Lumi and Jane?

Hayley De Carolis: Did you have a response to Ryan's?

LuGina Harper: I did, Ryan. And I just wanted to just talk a little bit more. The Drug Price Transparency Reporting, there is a very purposeful reason why data is aggregated because it's important that when we are going out -- even in the case of insulin -- when we are going out to get discounts or rebates from the insulin manufacturers, we are asking them to compete against each other. And if there is disclosure of what Sanofi, for example, is offering, then Eli Lilly -- we are trying to get the best discount, and if you have information in the public domain that discloses like, well, this is what Sanofi is giving, and this is what Eli Lilly is giving, that could undermine our efforts to get the best their best proposal for a discount or a rebate. So that's my only concern about trying to have drug-specific information. And that's really why that aggregation concept exists in the Drug Price Transparency Program.

Ryan Pistoresi: Right. And that's a good point. I mean, there is a reason why we currently can't disclose that type of information today. I mean, when we have tried to report prices in the past for our P&T Committee, we use a relative cost. And so we have a price set to 1.0, and then we have different costs relative to that. So we have done that in the past. But I think this group is interested in better understanding exactly what are all of the finances related to insulin? And I think that's just one of the recommendations that the Legislature could ultimately act on or not act on.

LuGina Harper: Right. And I just want to be clear, my issue is not the transparency concept. It's just making sure that we don't have -- we don't unintentionally undermine getting the best discounts that we can by doing this in a way that releases competitive information. So anyhow, thank you. I appreciate the response.

Hayley De Carolis: Yeah. Thank you. How about Lumi, and then Jane.

Lumi Nodit: So I'm sorry. I'm trying to follow what the discussion points are here on transparency, and I was trying to understand. I understand the aggregation of the points behind it, but in terms of transparency, there is all this big debate on using some mechanism to increase prices and whether we will facilitate that in a way. And I just want to cautious some type of recommendation from this group to make more harm in other areas, for example. You know? Like we want to make sure the information we are getting does not impact the competitive impact of these companies and how they compete with each other, but at the same time not cause more price increases, otherwise. That's one point. And another comment I had about this use of the word "brand," which specifically eliminate other competitors that may have a generic version of insulin. not that that would be preferred or not or whether they will have satisfied the rest of the requirements to have volume in the state or whatever else I may have seen somewhere else. But those are some comments I had.

Hayley De Carolis: Okay, great. Thank you, Lumi. I did want to point out that because the report is so directed at the two legislative requirements, this section of the report the intent is to summarize other discussions the workgroup has, but we are not proposing any specific policies to encourage transparent financial disclosures. We are not recommending any specific policies, it's just like we were tasked with regrouping these two things, and that led to other conversations or other ideas. Mike, did [cross-talk] --

Mike Bonetto: [Cross-talk] Yeah. I know. And, Hayley, just to echo that, we were trying to channel your thoughts. I mean, so this is trying to a compilation of what you guys were talking about to trying to highlight that in a way that makes sense. So again, all of this as a lot of what you guys have been discussing.

Hayley De Carolis: Yeah, Jane. Do you have a question or comment?

Jane Beyer: Yeah. I guess the only thing I would know is we have state laws specific to not just transparency around prescription drug reporting but a whole bunch of other healthcare costs issues where we exempt information from public disclosure. But now there has been so much activity on the federal side around transparency, for example, with the prescription drug reporting requirements that were in the Consolidated Appropriations Act back in 2020. So I always wonder whether if there is any discussion about state law on transparency, there can at least be some discussion about what comparable

federal policy is. In other words, are the Feds being more transparent than the state? And is there data that's not available from the state, but that could potentially be available via federal reporting? Because it's, if you want to get the whole picture, it just seems like we need to talk about the federal transparency efforts that if there are any directly related to prescription drugs, that would be an analogy to this. And maybe Ryan and Donna in the HCA team have more affiliate familiarity with the federal stuff than I do at this point. It's one of my interim projects.

Hayley De Carolis: Thanks, Jane. That's a great consideration. Are there any other feedback or comments for the long-term policy before we move on to the emergency side? Okay, great. Let's keep going. So then Legislative Requirement #2 was to design a strategy to provide a once yearly 30-day supply of insulin to individuals on an emergency basis. The summary of the policy for the emergency supply is a once yearly 30-day emergency supply would be made available, and the legislation needed would need to direct manufacturers to reimburse pharmacies for the dispensed insulin. And how this would work operationally is that the individual would apply online or through forums at healthcare sites. The pharmacy would be responsible for reviewing those applications, determining eligibility, and then dispensing the 30-day supply. And then the pharmacy would submit an electronic claim to the drug manufacturer for reimbursement or for a replaced supply of the dispensed insulin. So this is how it would work. Again, this was directed to be a 30-day emergency supply, so that is the summary of the policy in the report, but we will highlight the other feedback around different options beyond 30 days a little bit later in this section. So again, this is just to highlight where this table is in the report and to mention that we altered it slightly to include the statute change and other considerations required from the legislation. So this is similar to the long-term policy. The next several slides highlight areas of workgroup support and how those might align or not align with the recommended policy. So to meet legislative intent, the policy grid does show the 30-day supply option. But we wanted to document if there was significant strong feedback from the workgroup for a 90-day supply rather than 30 days, so this is where we are where we do that. And then also, the legislation directed the workgroup to consider a once yearly supply. But again, a lot of workgroup members were more supportive to allow access multiple times during a 12-month period. So we wanted to highlight this because it was outside the scope of the legislative requirement for a 30-day policy option, but there was strong support among the workgroup members. And then, for the policy element of Emergency Prescription Authority, this is talking about

how it would be on the pharmacy to receive the completed application and determine eligibility. So this was strongly supported by the workgroup members. And I just wanted to highlight that other states' processes for the application, the patient must attest that they have not received an emergency supply within the previous 12 months, and that's on the application. It's not on the pharmacy to determine that. Obviously, if they've come to that pharmacy before, that's something they can check. But if someone had accessed the emergency supply from another pharmacy, that's not something they can check. And manufacturers are still required to reimburse, so they follow this patient attestation process for enforcing the once yearly supply. So that's something I wanted to highlight. And then prescriber reporting requirements, Maine and Minnesota and other states that have emergency prescription laws outside of insulin or not specific to insulin, do most of the time require the pharmacy to report to the prescriber that they dispensed the emergency supply. The workgroup members mostly supported not requiring prescriber reporting. I think a lot we heard feedback that that would be an additional administrative burden with unclear value. And so that is something that is a little bit different than the other policies in Maine and Minnesota. And other policies not specific to insulin is that this workgroup did not think that that should be included in the recommendation. And then for reimbursement process, there was generally strong support for requiring manufacturers to reimburse pharmacies directly. But along with that, we did receive feedback to include to recommend including a timeline for reimbursement such as 10 days and then also allowing pharmacies to choose whether they wanted to be reimbursed during via replaced stock or the electronic claims process. I did look at the manufacturer portals for Maine and Minnesota, and it does seem like they differ with the manufacturer. Some manufacturers allow for the replacement stock, and other manufacturers require electronic claim. So that is something that implementation night need to be figured out during implementation, but we wanted to document the strong support for allowing the pharmacies to choose. [Cross-talk] --

Donna Sullivan: Hayley, it looks like Jane has her hand up. I'm not sure if she has a question or if it's been up.

Hayley De Carolis: Oh, thanks, Donna.

Jane Beyer: Sorry, I didn't lower my hand. My apology.

Donna Sullivan: Okay. Sorry about that.

Hayley De Carolis: Thanks, Donna.

Donna Sullivan: Go ahead, Hayley.

Hayley De Carolis: And then this table is just like the long-term policy. We have included example legislative language from Minnesota's legislation around all of the policy elements, just as an example. And then, so getting back to that point we just went over for the long-term policy, there is a section of this policy recommendation for documenting worker recommendations that either were outside the scope of the legislative requirement or came up during conversations of the policy. So we did hear significant consistent feedback that a once yearly 30-day supply was not enough and that the worker, obviously understood that was the directive but instead would be leaning more towards recommending something around 90 days and allowing individuals to access this more than once a year. And even there should be no limit to the amount of times an individual can access emergency supply. So we did want to document that even though it was outside the scope. And again, all of the responses to the survey, I think there were several opportunities for you all to write written responses related to these. All of those are in the appendices of the report. So this is not the only place where your feedback is. This is just a summary. And then this is an alternate approach to the recommended policy. I think there is a decision that the Legislature could make to either direct health plans or the state to fund the Emergency Insulin Program instead of manufacturers. We don't see this in other states. And it's not something that the workgroup obviously is recommending. It's just something in a discussion that came up, and we did find examples where states were expected. Those are not the states that we highlighted in the policy grids. But if the Legislature did decide to direct HCA to provide the emergency supply insulin, we do think the state would need additional resources to work with the ArrayRx Program on creating the emergency supply. And the state would need an appropriation to cover the cost of supplying the emergency insulin. And the difference would be instead of billing manufacturers directly for the replaced supply or electronic claim, the pharmacies would go through ArrayRx and the Voucher Program. And so this is definitely not a comprehensive overview of the operations of what that would look like, but it is something we wanted to include since other states do have something like this. Kevin, do you have a question?

Kevin Wren: Yeah. I just have a question follow up to that. I don't know if we are going to talk about cost for the emergency supply, but I imagine the Eli Lilly and Novo Nordisk news from this last week would change the landscape for how ArrayRx might do this and if the state could cover the cost of this, so I imagine we'll get to it later, but I just wanted to bring up the point of cost and how much this might cost a consumer or someone needing insulin.

Hayley De Carolis: Yeah. [Cross-talk] --

Ryan Pistoresi: [Cross-talk] Oh. Go ahead, Hayley.

Hayley De Carolis: Oh, no, Ryan. You can take it.

Ryan Pistoresi: Yeah, we did see that there was the announcement by Lilly about the Insulin Value Program, and so we have been looking at it. About your statement that the state may be able to help with it. In the fine print on it, it does say that the offer is invalid for patients with a state-patient or Pharmaceutical Assistance Program. So just given the details of that, it can't be used with any Medicaid, Medicare, Medicare Part D, Medigap, DOD, any of those, but it does specifically say any State Patient Assistance Program, which I think this would be a part of. But thanks for bringing that up. You know, that was big news that we wanted to make sure that we did speak about here at this workgroup meeting.

Kevin Wren: And I saw that it was in the conclusion. So I imagine we'll get there. So thank you.

Hayley De Carolis: Yeah, late breaking Well, I think the conclusion is even outdated from last week, so we'll be updating that definitely still. So then moving on to the next section, which is Other Legislative Recommendations. So these were things that were brought up in workgroup discussions that maybe didn't fit directly into the Legislative Directives of the two policies. So they emerge from workgroup discussions, and the two that we highlighted were copayment limits on insulin products and then requiring insurance coverage for equipment and supplies. So we did look at copay caps around the nation, and 19 states and DC have enacted legislation to cap copayments. Utah and Minnesota are examples, not exemptions. They are examples where a copay cap also applies to the uninsured population. Thought that was important to highlight, so there are only two out of 20 that we could find that does apply to uninsured. The legislation typically applies to state-regulated plans, which

we have talked about, and does not include all of the plants that are offered in Washington State or at the federal level. So that is an important distinction. And then some states also cap copays on insulin-related supplies, which we found an example in Connecticut of $100 per 30-day supply of devices and supplies, which I think a theme in the Workgroup Meetings have been always talking about the supplies related and not just the insulin. So there are some examples, but this is just an overview. Table 7 lays out the specific state policies. It was on Page 34 of the report. We probably need to update these numbers. But if you ever needed to see the scan of the different states and what they offer. And then coverage of equipment supplies. Most Medicaid programs, including Washington, do provide coverage for CGMs. And then this is just a brief table that talks about any policy that we found related to supplies. But as you can see, we didn't find much. So these are just two other policies that were not directly included in the workgroup tasks, but we wanted to include in the final report. And then getting to the conclusion, this is just outlining how the report flowed, what it was showing. And then we did add a section talking about the national landscape and how it's currently evolving. This is even outdated. But we talked about Civica Rx a little bit and then the manufacturer announcements, and just recommend that the Legislature know that there is an evolving landscape and take those considerations. And at the time that this was written, this was the most recent information, but that is constantly changing. So the recommendations might change related to any other news. But we just want to include that as a consideration. Yeah, Mike.

Mike Bonetto: Hey, Hayley. I was just looking at James' comment in the chat. And I think Jane, yes, is spot on. I think that's what Ryan was referencing earlier today. And I think depending on how 5729 moves, that would be absolutely part of this report in that conclusion. I think that's going to be an important piece. Yeah. Good point.

Hayley De Carolis: Yeah, so with that, that's the full report. We are scheduled to have a break, and then we are hoping to have some discussion with some questions related to the report and feedback. But if anyone has any questions about what has been presented, so far, I'll pause it and let anyone jump in, or we could get to the break. Okay, it sounds like -- that was a lot of information, but it looks like there weren't too many surprises. And so, yeah. I think the next thing on the Agenda is a 10-minute break and then an open discussion. So it looks like it's 10:20. Do we want to meet back at 10:30?

Leta Evaskus: That sounds good.

Mike Bonetto: Sounds great.

Leta Evaskus: [Cross-talk] everyone.

[break]

Mike Bonetto: Okay, thanks, guys. We are at 10:30. Hopefully people are getting back online here. We'll give folks another minute here. All right. Thanks, Jennifer. Yeah, I was just trying to figure out the best way to make sure that people are here. If you want to give a thumbs up or you want to let us know you're back, we'll get going. Great. Thanks, Tim. Thanks, William. Okay. I think we've got folks coming back. Thanks, Laura. Donna. All right. So we have some time carved out for a deeper dive discussion on some feedback. We've got, I think we had 75 minutes on the Agenda. If it takes a little longer, we can. If it takes shorter, we can do that as well. So I think we've only got about five or six questions that we really wanted to lay out there just to tee up some initial conversations. There may be some key themes that maybe you haven't seen. If you hear from your colleagues, we wanted them to have that open discussion after you see some of the feedback that you guys are putting down. Before I do that, I just wanted to as we're going through this discussion -- I wanted to call out Hayley for her work. So Hayley has been behind the scenes coordinating not only the draft report for this presentation, so just Kudos, Hayley. I think you did a fantastic job. If I could give a virtual standing ovation, we would do that right now. So I think you've done a super job. You really have, so many thanks for getting this here.

Hayley De Carolis: [Cross-talk] Yeah, thank you.

Mike Bonetto: Absolutely. Okay, so you guys have done this before with us. So if we can go to the next slide. When we do Poll Everywhere, you can do this on your phone, or you can do this on your screen in front of you. But if you go to Pollev.com/cebpohsu300. That should take you to this site. And again, always your choice, you can put your name, you can be anonymous, it doesn't matter. We'll give everybody just a few minutes to get there. And I forgot, Hayley and Ronnie, usually we do -- I forgot. We didn't put a test question in there, but that's okay.

Kevin Wren: I'm sorry. Can you drop the links in the chat?

Mike Bonetto: Yeah, yeah, yeah. Great call.

Kevin Wren: Thank you. Thanks, Hayley. Everybody have that now? Great. Give you guys just another second to get teed up. Anybody having issues? Assuming that everybody is on. Checking all good. Okay. Can we go to the first one? So overarching first question. Anything presented today that was a surprise to you or that you did not hear in workgroup discussions? Okay. So I know whoever put that down on legislative recommendation on Page 34, I'd love to come back to you. Okay. Well this is good, meaning we're not surprising anybody. Okay. Supplies and equipment. Great. So we'll circle back through these in just a second. Good. Okay. Well, good. I think we are starting to feel like we hit the mark for the most part. Hayley, can you scroll on that? Or Ronnie? Yeah. Whoever put that in, are there any other highlights there on legislative recommendations on page 34?

LuGina Harper: Hi. That's me. That's LuGina.

Mike Bonetto: LuGina? Yeah, yeah, yeah. Thanks.

LuGina Harper: So, the copay limits on insulin products. Certainly, we discussed that, and I know that we have updates on the legislation that's currently going through the Legislature now, but I don't recall us having a discussion about mandating insurance coverage for equipment and supplies. And my concern is I think this group has been very intentional and purposeful. Like, let's study and look at the -- you know, you guys have such great access to data to be able to see, well, is there an issue with insurance not covering equipment and supplies, such that it would support having a mandate for coverage? So I just didn't recall there being a discussion of that. So please correct me if I'm wrong. So that's why I was just taking a [cross-talk].

Mike Bonetto: LuGina, I think that's fair. There was another comment there that said equipment and supplies. So Kevin, I know you have your hand raised. And LuGina, I don't know if there was consensus, but I would say there was certainly discussion on that and the concerns around it not being covered. So Kevin, did you want to add on?

Kevin Wren: Yeah. I think it was like the first and/or second meeting. We discussed it, and I remember, I came back to Nonye and you all, and it wasn't within the purview of the group itself, but it still is a recommendation that we discussed

in covering supplies and technology. I provided some links. There are studies that show that the discrimination and access to technology specific diabetes technology and for people of lower income. So there is evidence there. We discussed it. I don't know why it's a surprise.

LuGina Harper So I guess I'm thinking the requiring versus like further looking into it, certainly, I think is appropriate. I just don't know that we got to the "we need to require [cross-talk] coverage."

Mike Bonetto: So, LuGina, your concern is like being perceived around a consensus around a mandate.

LuGina Harper: Right.

Mike Bonetto: [Cross-talk] saying there was discussion and some favored recommendation of moving that forward.

LuGina Harper: Sure. And I mean, I think that the question is a valid question to look into. Like, if there are challenges getting equipment or supplies, let's look into that. I have no problem with that. But this sounds like it's more of a consensus that there was a consensus [cross-talk] recommended. Exactly as you said.

Mike Bonetto: Got it. Okay. Okay. Okay. That's helpful. Jennifer?

Jennifer Perkins: Yeah, thank you. This is Jenny Perkins again. Yeah. I think we did talk about it just a little bit. But I'm not sure if I brought this up last time. I just want to point out that, yes, there definitely are disparities by race, which is likely linked to the disparities and outcomes. And so this is also a health disparity issue. And I know that there are young people that are probably dying because they don't have access to some of this stuff or they're having worse health outcomes. And so it's definitely worth putting at least somewhere in the report, even if it -- I don't know where we're going to put it, but because if we want to end health disparities, then people just need to have access to this stuff.

Mike Bonetto: Great. Thanks, Jennifer. Oh, Laura Keller.

Laura Keller: Yeah. So a lot of that, Kevin and Jennifer, are exactly right. There are access issues. But the reality is the access issues primarily are in the Medicaid and getting Medicaid programs to cover diabetes technologies. So Washington

State has a state law that mandates insurance plans to cover diabetes supplies and medications. The issue that I recall, though, was that we're talking about copays specifically. Like what's your copay in your insurance plan versus whether it covers those things. So private insurance is already mandated to cover diabetes supplies, including pumps and CGMs. Medicaid doesn't always cover those things, and it's an access issue. Kevin is right about making sure that the physicians that are in Medicaid and things are even prescribing those to their patients, and that's diabetes education. So that's a huge issue. It may not be something we can -- that would have to be done legislatively to get Medicaid to cover those things, most likely. And obviously, there's a lot of community outreach that needs to go there. But a lot of it is every time you have a diabetes supply, there's a copay attached or coinsurance. Right? And all of those things add up and multiply. And that was part of our original discussion, was that the cost multiplier of each thing.

Mike Bonetto: Got it. Laura, thanks. That's helpful. Hayley, I saw you had your hand raised for a second, but I just wanted to circle back with you, too, that this dialogue is making sense that we'd be able to incorporate those changes.

Hayley De Carolis: Yeah. Thank you. That's what I wanted to check on because I just wanted to first make clear that the title of this section is Other Legislative Recommendations, and we do mention that they came out of workgroup discussions. But while I was hoping that that would present as just a national scan of what people are doing for devices and supplies, and so I wanted to check if the recommendation is to get rid of the word the workgroup recommended these if that's too strong. And I don't know if that's something we need to get written feedback from members on or if that's something we can talk about now, but the intent was that these were not related to the specific work of the workgroup, but more came out of discussions, and then we listed state examples. I just want to make that clear. And if that's not clear [cross-talk] --

Mike Bonetto: No. [cross-talk] Hayley, I think that's right. So it's almost you could list it as additional policy considerations or options, something like that as well.

Hayley De Carolis: Yeah. And if that would help LuGina's [cross-talk] other [cross-talk] --

LuGina Harper: Yeah. [Cross-talk] Oh sorry. Yeah. I think that is what kind of threw me off. It was like these specific recommendations emerged and are important. And again, I think Mike hit it on the head. When I read it, it sounded like we were

as a group supporting a mandate. And again, I want to be very clear. I think that it's valid and a good use of time to look at insurance coverage disparities and all of the things that were raised, but I just feel like the way that it's worded, it's much strongly, "We recommend a mandate."

Hayley De Carolis: Yeah. I totally see that. We can soften that, LuGina. I think that's a valid point.

Mike Bonetto: Great. Good feedback. Anybody on the HCA side? Thoughts, comments here? Are we tracking? Okay. Well, guys. Great. Thank you for that. That's an overarching one. So can we go to our next question? So specifically to the first piece, the long-term, anything missing in the final policy presentation for the long-term strategy? Anything else that you guys have been thinking about that may not have gotten in? So, Hayley, when I see a lot of Nos like that, I think, again, you have summarized their responses well, kind of looking at that three part approach. Right? With manufacturer's voucher discount. Great. Okay. I will be honest. I don't know if we were expecting all of those Nos, but that's good. It means captured this well. Jenny, can you speak more to that piece if you don't mind? I want to better understand that if I can.

Jenny Arnold: Yeah. No problem. I just see that if -- like I said, I don't think that our -- we're not -- what we are supporting is going to have a -- it's going to benefit our community. But it's not a perfect solution, and I don't think that -- we're not going to be able to -- like the perfect solution would be access for everybody regardless no matter what and free, but we're not giving a perfect solution. And the reason why I really feel strongly about just nodding to supporting manufacturers like a different manufacturer is because I think that we have -- there's a couple reasons. One is we have limited manufacturers, which I think is the reason why we're in this situation that there was a price issue because they were able to utilize the limited manufacturers, that power to exploit people financially. And so I think that's one piece why more manufacturers are important, but then also like we've seen with issues with distribution. Like with the baby formula shortage, and then there was the egg shortage recently and fall out with that, and there may be more shortages in the future with our global economy and stuff like that. So I just worry that if something -- some unforeseen thing was to happen that caused one of these manufacturers to have some serious issues, that there's only three. And I worry that another manufacturer -- if there was another manufacturer -- that we would be more resilient to those type of potential harms or potential problems that could occur in the supply chain, that if we only have to two or

three manufacturers, then when something hits the fan, then it could have a catastrophic effect.

Mike Bonetto: Thanks, Jenny. So even something to put into those other considerations like what we just talked about. So, Jenny, I think that's an important piece so not to lose. I hear you on that. That's helpful. Okay.

Jenny Arnold: Thank you.

Mike Bonetto: Yeah. LuGina, I saw you had your hand raised. Oh, yeah. I was just going to make the same suggestion that you had, is that maybe in the other legislative recommendations we add something about looking at the biosimilars. I know that we already mentioned Civica in here, but then we know Lilly and things are changing throughout the market. So maybe what another legislative recommendation would be is to keep an eye on all the different ways that hopefully are driving down the cost of insulin so that it increases access. So I thought that was a good idea.

Mike Bonetto: Yeah. Yeah. I agree. Hayley, any thoughts from you? I mean, you're tracking on that as well where we put that?

Hayley De Carolis: Yeah, definitely. I have captured all of that and think they are great suggestions we can add.

Mike Bonetto: It seems like it would be helpful to have an alternative process to online application for individuals who don't have ready internet access. Yes. I maybe even look to Leta on that one, as well, because I would imagine which with ArrayRx that is in place today, but I want to make sure that I'm clear.

Leta Evaskus: Hi. Let's see. So people who don't have internet access could go to the library. Or if they're at a clinic, the person at the clinic could sign them up online. We have gone to all online enrollment for the discount card due to modernizing it. A person at the pharmacy would be ideal. Yeah, if the person at the pharmacy has time to do it is the thing.

Mike Bonetto: Right.

Leta Evaskus: I think people at clinics, if you were at a health clinic and you're getting the prescription, if you could ask to be signed up.

Mike Bonetto: Could I ask whoever just put that in, it seems like it would be helpful to have an alternative process to online application. Thoughts on what that process might look like? Whoever submitted that.

Sheri OIC: Hi. This is Sheri with the Office of the Insurance Commissioner. Yes, I just would want to -- it's something to think about. I hadn't thought of a specific strategy for that. But just something that comes up regularly in the things we're looking at is ensuring equity in access. So just making sure. I mean, that's something that if people are having telehealth visits, for example, they might not be in the clinic and if they're doing -- like we have audio only telehealth visits available right now. So again just trying to think about the people who don't have that ready internet access. I mean, yes, sometimes people can go to the library, but if people are out in, for example, some of the rural areas where it's sometimes difficult to get internet coverage, going into the doctor's office or going into a library also isn't always something that's really easily available either.

Mike Bonetto: Yep. Sheri, thank you for that. That's helpful. Just even to have that context. So we'll make sure that gets highlighted as well.

Sheri OIC: You're welcome.

Mike Bonetto: That's helpful.

Sheri OIC: Yeah.

Mike Bonetto: Other thoughts/comments here? Really helpful. Okay. If we can go to the next. Thanks, Ronnie. Sorry. There we go. Anything missing on the 30-day emergency supply overview? Do you guys have anything else in mind from other states or anything else that you guys were looking at that we didn't highlight? Okay. The other thing that was my big takeaway, too, was what Hayley highlighted in the other considerations where you guys, I think, landed time and time again, on the 90-day. Right? I just want to make sure we will obviously call that out because I think you guys felt like you guys were put in a box on the 30-day, even though that's the Legislative task but really looking at something longer than that. As we mentioned, addressing cost for this would be helpful. Could I ask for some additional clarification, whoever put that in?

Sheri OIC: Hi. Sorry, this is Sheri, again. Someone had just mentioned earlier just addressing what the costs of this 30-day emergency supply might be if there would be costs associated with it or [cross-talk] --

Mike Bonetto: [Cross-talk] Like any infrastructure setup or anything like that, Sheri. Is that what you're talking about?

Sheri OIC: I'm sorry?

Mike Bonetto: Like any infrastructure setup within HCA or just like the overall administration of the program?

Sheri OIC: Yeah, I guess, if we were thinking about a particular cost component with the 30-day emergency supply or how that would be if that was anything to think of for an additional consideration or something like that.

Mike Bonetto: Yep. Yep. And, Hayley, I don't know if you wanted to comment on that. When I just think about the grid and what you had in terms of statute change and budgetary impact. Anything there you want to highlight?

Hayley De Carolis: Yeah. Thanks, Mike. And I think -- HCA team, please jump in if I get any of this wrong -- but I think the assumption is if the Emergency Supply Program is designed in the legislation to be similar to Maine and Minnesota, it wouldn't require any costs or resources unless they were to do a larger public awareness campaign because the manufacturers would be responsible for all reimbursement. It's only if the Legislature decided for some reason that instead of having the manufacturers pay that they wanted to state to run the program, that we assumed costs. And all that to say that, I mean, I want to caveat that it's if the program was designed like made in Minnesota, but if it was different, there would be considerations. But I just want to make sure that's clear that the reimbursement would be on the manufacturers.

Mike Bonetto: Thanks, Hayley. And to Hayley's earlier point, any HCA comments? Everybody tracking?

Ryan Pistoresi: This is Ryan. Yeah. That is correct.

Mike Bonetto: Great. Thanks, Ryan. Great. I'm just checking. comments here. I think again, good support. Hayley, I think you captured everything so well. But again, before we move, any other thoughts/comments here?

Tim Lynch: Just a quick comment and question as I'm looking at -- this is Tim Lynch --

Mike Bonetto: Yeah.

Tim Lynch: As I'm looking at the policy, I just want to make sure we're including the reimbursement for the insulin but also the dispensing of it, too. Is that part of the final policy, as well?

Hayley De Carolis: Yeah. Thanks, Tim. That's a great point. I think our final policy recommendation on that was that we were going to allow the pharmacy to charge for the dispensing up to $15, I think is what we -- I'm checking the report.

Tim Lynch: I'm looking at it. I'm looking -- I think it's on Page 24. Right?

Hayley De Carolis: Um --

Mike Bonetto: I have it here, too.

Tim Lynch: I just -- maybe it's [cross-talk] --

Hayley De Carolis: Yeah. In Minnesota, it says the pharmacy may collect a copayment from the individual to cover the pharmacies costs for processing and the dispensing in an amount not to exceed $50 for a 90-day supply. I think that's a great highlight. Sorry, Mike, were you going to say something?

Tim Lynch: Oh, it looks like it's on page 26. Is that it? It says a $15 copay is for dispensing the drug. The rest of the reimbursement would need to come from the manufacturer first.

Hayley De Carolis: Yeah. Thanks, Tim. That's correct. And that's following the designs of Maine and Minnesota. So I'm not sure. I don't know that that was a recommendation as much as a here are the programs that we are designing these recommendations off of and this is how they're doing it. I think that's a great point to highlight if there's any other discussion on that.

Tim Lynch: Yes. So for clarity, what's in the report is what's happening at other locations. It says potential Washington. So the $15 is under the potential? Right? On page 26. Is that -- it is [cross-talk] --

Mike Bonetto: That's the way I'm looking at that, Tim. Right. Right. Right.

Tim Lynch: Okay. Okay. Thank you.

Mike Bonetto: Tim, when you look at it, is there anything else you think needs to be changed on that? Or is that as you read through those, is that okay as is? Do you want to make any change?

Tim Lynch: The only thing I would say is, it says copayment of $15. Copayment to me implies that the patient is sharing in that, but we're really talking about a dispensing fee payment. So I don't know, this copayment. Who is the "co" in the payment part of that? Does that make sense?

Hayley De Carolis: Yeah, totally.

Mike Bonetto: Yes.

Hayley De Carolis: Yes. Um, in other states, I believe it is the patient so it wouldn't be completely free access to the emergency supply. I believe it is the patient's responsibility to cover the dispensing fee. But I think that is a great point of [cross-talk] clarification.

Mike Bonetto: But that's what we had discussed before, Tim. I'm pretty sure. But, again, that's yeah.

Tim Lynch: And so if the patient doesn't have $15, then the pharmacy can waive that, or they can just not dispense it.

Mike Bonetto: That's my understanding. Yep.

Tim Lynch: Okay. That's, I don't know. It strikes me as a little bit of a concern given the intent of this is to provide insulin to patients, but I might have missed that prior discussion.

Mike Bonetto: Right. Yeah, I think we were looking at this as a way to compensate the pharmacies for their time in dispensing the medication.

Tim Lynch: Mm-hmm. No, I totally agree with the cost of doing this work. I'm just wondering who pays for it. But I couldn't be alone on that. Jenny, you're

much closer to sort of the community pharmacy aspect of this. I'd love to hear your thoughts.

Jenny Arnold: Hi. I will full on admit, I was dealing with a kid who has a stomach bug for a moment there. Can you repeat the question?

Tim Lynch: Sure, Jenny. It's on page 26. And it was related to the last question concerning, and it's really about the copay. There's a copay portion on page 26 of the final policy that says. It really isn't I believe is what I've heard is it's intended to be that the patient is paying that $15, and I'm just concerned for patients. That could be a barrier. The $15 could be a barrier to a patient getting it, and I was wondering what our community pharmacist how they would interpret that if a patient couldn't come up with the $15?

Hayley De Carolis: Yeah. I mean, I think that there's a couple different ways. I mean, clearly $15 can be a barrier for some patients. And I think that some pharmacies are in a position to be able to absorb that. And it probably depends on the relationship with the patient and things like that. I think most of us would gladly chip in out of our own pockets even in that circumstance. So something that we see done with -- and it's really to cover the pharmacist's time, energy, labels, refrigeration, keeping that on the shelf. Some of those costs are the dispensing fee. So something we could do is like you see with the Vaccines for Children Program is allow the pharmacist to waive that and give the pharmacist flexibility to waive that if they -- under their judgment.

Tim Lynch: [Cross-talk] Or refuse the insulin if they don't want to cover that cost.

Hayley De Carolis: I mean, that could be the other flip side of it is that they could refuse that insulin. I mean I'd like to think that most people are not going to turn patients who cannot afford their insulin away for $15. But, you know, it probably has a hit and miss implementation there.

Tim Lynch: And I agree with you. I would hope most would not, but I just hate creating artificial barriers for a life-saving drug in this case. But I guess that's true of a lot of drugs. So thank you for that feedback.

Mike Bonetto: Yeah. Thank you, guys. And I'm also tracking just the chat. Lori, I saw your comment earlier, so we'll make sure that gets included. Jennifer Seeley, thanks. And Dan, yep, we'll make sure that gets included as well. Okay. Great. Any other pieces here? Okay, so we got a couple next questions on the

implementation side. So it's one thing to talk about the overall policy. The next thing is more on the administrative, the implementation side, and this gets even to the HCA side. So what concerns you most about the potential implementation of the long-term policy that we just reviewed? And Leah, I saw you had your hand raised.

Leah Lindahl: Thanks, Mike. Just a brief note. I wasn't sure when to call this out. But this is reflected in Minnesota, and then some of the state laws that have passed in Washington as well. When you look at some of the definitions of manufacturer, sometimes due to FDA guidelines on how entities that touch the product, would have to follow like good manufacturing practices, etc. Sometimes those definitions can be broader than the actual manufacturer of the product. So like in the Minnesota Alex Smith law, they kind of redefine manufactured insurance just targeting those specific entities. So just a legislative recommendation if it was going into the proposal to make sure it's a specific definition that points to those targeted entities.

Mike Bonetto: That's great. That's good. Thanks, Leah. Yeah, Hayley, I think that may be worth a note, as well.

Hayley De Carolis: Definitely. Thank you.

Mike Bonetto: Great. Okay, so we got a few things here. I think that the copay is small enough and perhaps may be paid by taxpayers for the long-term staffing resources. Yep. Anything else? Anybody want to add on for whoever put in staffing resources? Thoughts on that?

Donna Sullivan: Oh, that was me, Mike.

Mike Bonetto: That's okay.

Donna Sullivan: No, I know this is going to fall in my lap.

Mike Bonetto: That's okay.

Donna Sullivan: Just that the Legislature staff gives us the funding that's necessary to support the program if it's something that we have to manage internally or contract out.

Mike Bonetto: Yep, yep. Okay. No, I think that's going to be an important piece as is the piece above that, where we put in the education components fully funded. And I don't know if folks have thoughts on what Hayley was highlighting Minnesota versus others. I mean when you think about funding an education campaign on the provider side, on the patient side, what that could or should look like if you guys have really good examples of where this worked well. Thoughts/comments?

Tim Lynch: Yeah. That was my comment. I think the education component is so vital because, I mean, just hearing from Utah and that the emergency program was utilized at 50% or something like that, and they probably applied some of the same thinking that we're doing right here about reaching some of the uninsured or reaching providers or things like that. So just knowing that this process hasn't been done before specifically about like emergency insulin stuff. So whether that's educating the general public about what insulin is or making sure that it's a fine tuned campaign that reaches specific organizations and individuals. That's just my concern because [cross-talk] I mean, we've seen some similar laws pass, and we don't know the extent of the problem if it's not fully addressed. So, thank you.

Mike Bonetto: Yep. Thanks, Kevin. It just makes me think, Hayley, I'm trying to find the section that you had. I don't know if we -- did we highlight any of the that concerned lessons learned from Utah?

Hayley De Carolis: Yeah, but that is a great point. We didn't really talk about lessons learned. I'm trying to think if there is a place. We could, I think, at the beginning of the report we do talk about presenting previous work. And we could highlight it there. I'm trying to scan the report in my brain, and I don't know if it comes up in any other place but [cross-talk] --

Mike Bonetto: But maybe just for us to go back and put a placeholder because I think that's an important piece what Kevin highlighted, just even some of the takeaways from Utah that we wouldn't want to make those same mistakes [cross-talk] if we can have a better educational platform. Yeah, great. Lumi.

Lumi Nodit: I don't know if implementation here envision the operations and how the RFP process is, but as I raised before, I share the same concern of making, putting some type of limits of whether just the brand company can participate in the process. Should you include manufacturer of biosimilar or the ones that maybe are not as well known now. So that would be like an

overall concern of limits on the RFP and who can participate, and what type of brand versus generic or [cross-talk] --

Mike Bonetto: Yep. Now, Lumi, that's great. I know that you -- I appreciate you highlighting that earlier, as well. So it's almost that just how that RFP is framed. And looking at, I think Donna referred to it just at the number of those categories that is more of a holistic approach. But that is a concern in terms of just -- and then, Leta, I think you brought it up, too, in terms of just how many manufacturers would submit and would respond to the RFP? It could be another concern. Great. Anything else here, guys? Same as previous, non-medical switching creates a barrier to continuity of care. So, Jenny, yeah. I think that's an important one that kind of gets to this piece on choice. Right? And it's just that balance of choice versus -- and then driving a discounted price with volume. And then how do you make that? How do you create that balance? Yeah, Lumi.

Lumi Nodit: Oh, I had another thought. So let's say you have the manufacturer are putting this program of patient assistance, and there is some exclusion and it becomes kind of confusing for people whether they -- in terms of the education piece? Are they applying for this program that the manufacturer is potentially advertising? Or is this other that the state does? How at some point, you know you wish that they will be so good the manufacturer will offer such programs that will be advantageous and will compete with whatever this will end up. But, yeah, just that piece of how you differentiate through education and also how you leverage to take advantage of the programs that the manufacturer may offer because there's this push to make it more affordable to include. And then to that extent, how you actually addressed the limitation that the manufacturer imposed like state employees who are not necessarily taking place. Like, there are some limitations. Someone read the small print, and I just didn't pay that much attention, but those type of limitations and how this program the 30-day emergency would try to cover any future potential limitation in other programs a manufacturer may offer or some type of caveat language to include those categories.

Mike Bonetto: Got it. Got it. Thanks, Lumi. Good points. Has anything else? A concerned patient confused on eligibility solution would be to make it extremely simple and clear in education materials and online applications. Can I ask whoever submitted that? I just want to make sure I'm clear we're talking about patient confusion on eligibility. What does that -- how are you seeing that?

Jennie Seeley: Hi. This is Jennie Seeley. Just with programs like this, sometimes it's confusing, not only to healthcare organizations but also to patients whether or not they are eligible. And so I really just feel like it's important for us to make the eligibility criteria very clear and simple so that as a healthcare provider or an insurance coverage, we can help the member, the patient, find the right programs that will work for them. And oftentimes, that's not always clear in a state-run program. No offense but [cross-talk] --

Mike Bonetto: [Cross-talk] No, no, no. [Cross-talk] --

Jennie Seeley: [Cross-talk] it just needs to be really simple and clear for patients so they know what's available.

Mike Bonetto: And, Jennie, I think that kind of links even to Kevin's piece, just on the education piece. Right? I mean, that's going to be the kind of [cross-talk] --

Jennie Seeley: Absolutely.

Mike Bonetto: Good. Yeah, yeah, yeah. Good point. Donna, I saw your hand raised.

Donna Sullivan: Yeah. I mean, that raises a good point. Oftentimes, the state programs we're lucky if we're funded to get resources to run it, but resources for an educational campaign or even a marketing campaign, we would never get money to do that. And so making sure that we're able to advertise that this is a program that's available to people would also be important, I think.

Mike Bonetto: Yeah. Great. Jenny Arnold.

Jenny Arnold: I completely agree. We've had numerous examples of you can't just assume you will build it and they will come. And you know pharmacies, you can't expect them to say, "Hey, come here for your free insulin!" You know? Like they're not going to also be able to put their marketing dollars towards that. And if people aren't even willing to walk into the pharmacy and talk about that, I mean, clearly, if they are there and can't afford their insulin, their insurance ran out, the pharmacy can offer it. But even educating the pharmacists about this program. Just because it exists doesn't mean that they will know either about it. So I think both, too, primary care providers could have both providers as well as patients to be able to educate on this is important. And we all share the word for me from the association standpoint, but I think a multimodal approach is essential.

Mike Bonetto: Great feedback. Yeah, Hayley. I like that in terms of even building out that education piece with some of these comments. That's helpful.

Hayley De Carolis: Yeah. Thank you.

Mike Bonetto: I saw another one here. [Indistinct] rule is this would be for other high-cost medications, and I think that's a great point. I don't know who put that in, but I don't know if somebody had some thoughts. Kevin, you had thoughts on that.

Kevin Wren: Yeah. I put that comment in. I was just thinking like, we're working with a lot of different coalitions. And insulin is a very high-cost drug, but there are so many other drugs. And if this could serve as a model for the state to approach other drugs, whether that's in conjunction with the Prescription Drug Affordability Board or I don't know. I feel like we set some precedents here in the way that we've gathered this information from our members and then like members of the public and the patients. I don't know. I like to see this process in other things, especially patient representation. I think that was something that we really had to fight for you just to get one person from the public on this. And then to get four more, we had to fight even harder. So I think baking that into future legislation that tackles drug affordability. Like, we need to be at the table, and we need to have a collective voice. We need to have more than just one perspective because we can't just be tokens. Yeah. Thank you.

Mike Bonetto: Yeah, yeah. Thanks, Kevin. Okay. It's an interesting piece for this group to be thinking about how this could serve as a model for others. And I think that's another piece, Hayley, to consider we talked about other considerations, right. If this is done well, that's helpful. Jenny, I saw your hand raised, but maybe that's still up from prior. Okay, great.

Jenny Arnold: Yep. Thank you.

Mike Bonetto: No problem. And then I just saw the last comment here. Insulin is essential, but over long-term, patients need access to care and screenings as well. Perhaps this can be expressed in the background. Yeah. Whoever put that in maybe just a little bit more context.

Jenny Arnold: Yeah, that was me.

Mike Bonetto: Thank you. Okay.

Jenny Arnold: I was kind of reading it through different lenses. So it occurred to me that I didn't see that in there. But that was a, something I felt like was regularly brought up that patients don't just need insulin to really control their diabetes well, they need access to a provider. So as we talked about needing access to supplies, access to primary care, eye screenings, foot screenings, or you know, foot checks, all of that if you're really thinking long-term, how do we best help patients? That's important. And I agree with Kevin there are a lot of meds that people need to manage chronic illnesses and that the opportunity to scale this. I just want to look backward to that comment. And I also agree with that.

Mike Bonetto: Yeah. Thanks, Jenny. So really just focusing that this is just a piece it -- of the access to the insulin, but there is so much other in terms of wraparound and services that these patients need. So yeah, Hayley, again, I'm looking at you in terms of just how that can get potentially woven in, whether it's background or even other considerations.

Hayley De Carolis: Yeah, that sounds good. Thank you for sharing.

Mike Bonetto: That's great. Anything else here? Great. Feedback. All right. Let's go to the next. Same. Uh, did I just miss one there? I apologize. Can we hit this one though? What concerns you most about the implementation of the 30-day emergency supply policy? Unintended barriers at the pharmacy, nonmedical switching requiring a new Rx and, thus, a doctor appointment. Yep. Yep. And I kind of like this, Hayley, as we get this in. This would be nice to weave. We'll weave this in, as well, on those other considerations. This is helpful. Yep. There is pharmacy awareness understanding, especially in independent pharmacy. So getting back to the education piece. I'm afraid of vagueness and how one applies. I want for anyone to be able to access this program as many times as possible, but I'm unsure of how the legislation would treat enforcement. Anybody want to add on to that? The vagueness of how one applies. So we obviously have an application process eligibility as well. And then this is an issue you guys have talked about at length in terms of one time per 12 months versus multiple? Anybody want to add on who just wrote that one?

Kevin Wren: Yeah. I wrote that.

Mike Bonetto: Okay. Thanks, Kevin.

Kevin Wren: I mean, I want anybody to access this program as many times as possible because we're always in need, and you shouldn't have to be forced to ration because you've already used this program. People straddle the poverty line for whatever reason, and I think we should make the process open and available to anyone and everyone and how they can apply. But I'm worried about some legislator picking it apart because there's some issue with vagueness or enforcement or something about limiting the extent of this program. Because I can see that there are some unintended consequences. Like someone could easily use this program and lie and deceive the system and get free insulin all year, which is not its intent, but it's still a possibility if the system itself is based on these personal reporting requirements. And the receiving from pharmacies is I think we've talked about a pen and paper system or how they would report. There are issues around that. Mike, I want this thing to be used, but I also want a recommendation to be clear about why we think this eligibility criteria should be open because people drop their insulin or for whatever reason, but it's explicit about why we think these requirements should be looser than fine tuned.

Mike Bonetto: Yeah. Thanks, Kevin. Anybody on the HCA side have thoughts on that? I mean, part of that could be when I was thinking about that. How specific any legislative language is versus giving that flexibility to administrative rule in terms of just how the program has actually developed. Ryan, Donna, any thoughts?

Leta Evaskus: This is Leta. One issue I see as a barrier is if pharmacies aren't going to get paid for the insulin. So whatever program is set up, it has to ensure that the pharmacies are paid the full rate for the insulin.

Ryan Pistoresi: Yeah. And I would just say, Mike, your comment about the rule. Rule would be a little bit easier to change than statute just given that there's only a certain time of the year that the Legislature meets, and it has to go through that entire process. If the statute is created, and it's more broad and there's rule that can be created, that rule can be created at any time during the year as part of the Agency's work and is a little bit more flexible. But it still has to be within the framework created by that statute.

Mike Bonetto: Thanks, Ryan. Yeah, great points. Kevin, thanks for that. Just seeing these other comments here. Make it easy. Yep. Potential complexity of the program might create barriers for pharmacies. So I think you guys have really hit this hard on the simplification, education. All of that I think are going to be big components. Other thoughts? Comments?

Jennifer Perkins: I have a comment. This is Jenny Perkins.

Mike Bonetto: [Cross-talk] Yeah.

Jennifer Perkins: [Cross-talk] Well, I know that some folks could, like Kevin was saying, tear it apart for the potential for abuse. I just wanted to point out that I think that it's unlikely to be abused because it actually would be a pain in the butt to go to like 12 different pharmacies and use this and apply at 12 different pharmacies. So although it is possible, I just don't think that that's going to be common or likely.

Mike Bonetto: Thanks, Jenny. That's helpful. Okay. Guys, why don't we move? We've got one more question for you. Thanks, Ronnie. So last one. Are there any other potential legislative options you'd like to include in the report? Anything else that I think you guys have been highlighting? We've hit a lot of the key things that you guys have been talking about, but anything else that you guys had in mind that should be included. Compensated members of the workgroup. Fair enough. And whoever wrote that, maybe facetiously, or when you think about future workgroups of this, I mean, that is something to be considered. Kevin, was that you?

Kevin Wren: Yeah, that was me. That's something that we've been talking about [cross-talk] --

Mike Bonetto: Yeah.

Kevin Wren: -- at the federal level. I mean, we're not compensated for our time and energy, and members of the public and myself, we're not paid advocates. We have regular jobs and things so. And we also don't come from the industry, which you all -- I'm not going to shy away -- you guys make a lot of money and a lot of money off the system. Whereas we are doing this just for basic rights for ourselves. So it's a little different. And I think that we should be compensated for our time because I put in a lot of energy into this, and I don't expect anything out of it, but I want there to be realistic change and

making people -- like Jenny -- Jenny is a full-time student and has kids. And this is three hours out of her morning. So I know families -- but we're not paid to do this work. We're doing this like -- I should amend that -- compensating members of the public. Not [cross-talk] members of the [cross-talk] workgroup [cross-talk] --

Mike Bonetto: Yeah, I got it. Okay.

Kevin Wren: Yeah.

Mike Bonetto: No, Kevin, thanks. And I saw a second there as well on that. So that's helpful. Somebody put in broad legislation with rulemaking authority for the last mile of limitation. So we just talked about that, but whoever wrote that need any further clarification? It's [cross-talk] --

Kevin Wren: No. I just wanted to memorialize that because I think the devil is in the details of this stuff.

Mike Bonetto: Yep.

Tim Lynch: I think creating flexible rules that can make it as permissive as possible is going to make it easier for implementation and adoption by pharmacies because pharmacies right now are losing money. It's tough for them to stay open. So a heavy burden on them, and it's just going to create the unwillingness to participate. And we don't want to create barriers for patients either, so I think we just got to make sure that whatever we implement is super easy and that the pharmacies are paid for the services that are provided because they are -- Jenny can speak to this. Community pharmacies are truly struggling.

Mike Bonetto: Yeah. Well, Tim, thanks. Thanks for actually putting it more or less like you said. I think that it's a great piece to call out. I don't know if anybody else on the HCA side has anything to add on that one. Leah, I saw your hand raised.

Leah Lindahl: I'm just falling on Tim's comment. I wonder if there would be some type of Legislative Review where within two years of implementation they could come back and see how this has gone and any kind of fixes or issues that could be addressed to help the longevity or for the [indistinct].

Mike Bonetto: Leah, almost like a report back to the Legislature as well. Right? Or something like that.

Leah Lindahl: Due to the effectiveness, some things need to change in the future. [cross-talk]

Mike Bonetto: Good point. I like that. Okay. Another commenter. HCA should implement not a standalone DOH Agency. Anybody want to add onto that?

Jenny Arnold: That was my comment. And the thought was we've seen Healthcare Authority is used to standing up programs like this and supporting it, making sure that the appropriate max and contracts are in place. And when we've also seen times where like around Prep Program, where it was an isolated group that was doing this, isn't used to working in this space, and it doesn't go as well. And so I have all the confidence in our pharmacy Health Care Authority folks, and I think that they are the best ones to implement this versus a separate workgroup just on insulin.

Mike Bonetto: I see. I see. And it gets to the question we were just talking about, or the issue we were talking about before, and like how can you replicate this with others. Right? And if you could do this well. Yeah, absolutely. I didn't want to lose that. Oh, thanks, Ronnie. This one is saying in a disability saying, "There is nothing about us without us," And bragging about our workgroup having patients' community members would be good. And then suggesting future workgroups also include patient members to provide depth. I think that's a great comment and one to include. I think that is a key takeaway because I think -- I mean, the report that we've put together is all based on your input and feedback, which has been invaluable. So, yeah. That's a great point. I think we had another one that just came in above that. Perhaps we should consider creating a small Board to support this work that can create policies under rules where we can do PDSA along the way. Anybody want to add on to that?

Tim Lynch: Yeah. This is my comment. And I'm just trying to think about rulemaking is very -- its an 18-month to two-year process. So I'm just trying to think of how we -- some creative ways that we could make this work nimble so that if there are barriers that are identified, a Board or Committee or whatever -- I don't know how it might be constructed under legislation -- would be empowered to continuously monitor the program and help make changes along the way so that we're not stuck with a program that's going to require

additional legislation or rulemaking, which as everybody knows, can be very, very lengthy. And then the program withers on the vine.

Mike Bonetto: Yeah. Thanks, Tim. Again, looking at HCA folks. Thoughts on this? I'm guessing you guys traditionally have like rules, Advisory Committees, or something like that, but this may be a little bit even beyond that with what Tim was highlighting.

Tim Lynch: Yeah. I mean, we do have a draft rule go out for public comment, and we do have hearings, and so there is a lot of opportunity for people, not only on this workgroup, but the public in general, to review, comment, provide feedback in that timeframe. I think that's also why it takes a little while is that we do need to make sure that we are getting a lot of feedback from the public on that.

Mike Bonetto: [Cross-talk] But to add onto that [cross-talk] -- oh, go ahead, Tim.

Tim Lynch: Oh, I was just going to say I'm pretty familiar with the CR 101, 102, 103 process, and it can be extremely lengthy. And I know there is intentionality around rulemaking. I'm just trying to think if we want to make this program something that is adaptable to the market, adaptable to our patients, and I don't know the solutions, and I don't know what's permissible under legislation to do so. But perhaps thinking of in any legislative recommendation that they be given some sort of way to make small changes to the program under policy rather than rule or legislation so that it can address barriers that come up along the way. Because as much as we want to anticipate or mirror other states, until we actually manage and run the program, I don't think we're going to actually understand what the potential barriers or things or issues that get in the way. And so I'm just trying to think of a creative way that we could do this so that the program is successful.

Ryan Pistoresi: Okay. So I better understand your question now. So yeah, we can definitely write rule so that it can let the program be flexible. I mean, if you think about our current Apple Health Pharmacy Program, we have new drugs come to market pretty much every day or at least every week, and we're able to change preferred and add generics or things like that. So that I think we can design this type of insulin program with the flexibility needed to be able to adapt to let's say Civica coming out or California brand insulin coming out, or if there is a shortage like that another workgroup member mentioned earlier, that way we can build in that flexibility in the rulemaking process so that way

we don't necessarily need to go back through rulemaking to be current with the current market.

Tim Lynch: Yeah. And I'm thinking just that and the application process, the copay, some of the other features that we've built in that we may have to evolve over time, but we don't want to have to rely on the rulemaking process to do it. If it's something that -- again, I'm just trying to think of long-term success of this program and how we might make it more flexible.

Mike Bonetto: Thanks, Tim. This is kind of piggybacking on what Kevin just wrote in there. Whether it's the workgroups, some advisory committee, or something like that, that could be responsive to and kind of work with HCA even during that kind of rural development process.

Jenny Arnold: And promotion, too, and ideas of where and how to promote it.

Mike Bonetto: Mm-hmm, mm-hmm. Thanks, Jenny. Yeah. That's a great point. Anything else, guys? Wow. Great feedback. And thank you. So again, all of this -- there will be some consolidation and get into the final report. Donna, do you want to walk through the next steps? Do you want me to? What do you want to do?

Donna Sullivan: I can definitely walk through next steps. Sorry about that. I think the next step really is for us to massage the comments and the feedback that we got today and any written edits or comments that you provided to us via email, incorporate them into a draft report. And Nonye and Ryan, I forget if it's coming back to the workgroup for one final review. I don't think so.

Mike Bonetto: I don't think so.

Donna Sullivan: I think we were going to just massage the comments that we picked up today and through email and then go through our -- the HCA has a process for submitting Legislative Reports, so we'll have to finish that process, which is why we are completing this work so early, even though the report is not due until July. It's a several month process to get it through the channels that we have to get it approved before we can actually submit it to the Legislature.

Mike Bonetto: Hey, Donna. One question I had, and this is for Hayley, as well. I saw some feedback already from workgroup members on edits to the report, which is great. Hayley, do we have a timeframe when we would have final edits in from folks? Is that like next Friday or something? Or do we have a timeline?

Hayley De Carolis: I don't know that we have established a timeline, but next Friday sounds good to me [cross-talk]. Yeah. Or we can send out in the follow-up some dates, but I don't have a timeline yet.

Mike Bonetto: I was just going through our calendar of when we have to do our internal review edits and then get back over to HCA. So I would put that out there. If you guys are okay with having next Friday as a deadline of doing your own internal review and then get feedback and edits back to us, that would be fantastic.

Donna Sullivan: That would be great. And Nonye, maybe you can send out a reminder to the group with that due date, that would be wonderful. I would like to thank all of you for participating in the workgroup. It's been really, really informative. I've learned a lot. Changed some perspectives by listening to your feedback. So I really do appreciate having patients here at the table with us as well as other stakeholders. Mike and Hayley, thank you for all the work that you've done for us. It's been amazing working with The Center, as usual. And the other workgroup members, thank you so much for your participation. I really appreciate it.

Mike Bonetto: Awesome. All right. Are we signing off?

Donna Sullivan: I think so.

Mike Bonetto: I think we are. Well, thank you guys, again. What a ride. I look forward to seeing next steps from here for sure.

Donna Sullivan: Okay. Great. Thank you. Mike [cross-talk] --

Mike Bonetto: Thank you, guys.

[end of audio]