

**Washington State
Prescription Drug Affordability Board Meeting
Transcription - March 18, 2026**

Doug Barthold: Good morning, everyone.

MaryAnne Lindeblad: Good morning.

Mike Neuenschwander: Morning, Doug.

Doug Barthold: Can you guys hear me okay?

Mike Neuenschwander: Yep.

Doug Barthold: Great.

Mike Neuenschwander: We're still waiting on a few people here, so we will give it a little bit and might start a couple minutes after, so [cross-talk] --

Doug Barthold: [Cross-talk] Yeah, sounds good. I just figured that I was going to have, you know, probably 5 minutes of technical difficulties, so, but it just worked. It worked on the first try. I couldn't believe it. [laughter]

MaryAnne Lindeblad: Excellent. So let's go ahead. Renee. [Long pause]. Okay. Well, I think we're ready. So let's go ahead and get started. Welcome to those of you that are here in the room and those online to our Prescription Drug Affordability Board Meeting. I just want to welcome you all here today. Let's go ahead and start with the introductions of the Board members. MaryAnne Lindeblad, Chair.

Hung Truong Hung Truong, Board Member.

MaryAnne Lindeblad: And online? We got Doug I can see.

Greg Gipson: Greg Gipson.

MaryAnne Lindeblad: Greg. Doug?

Doug Barthold: Doug Barthold, Board Member.

MaryAnne Lindeblad: And we'll perhaps have Eileen Cody joining us at some point in time. She is enjoying her time in Mexico right now, so we'll wish her well. And then just go ahead and go around the room first here and then staff that are online. So, Ryan, do you want to start?

Ryan Pistorosi: Sure. I'm Ryan Pistorosi, the Assistant Chief Pharmacy Officer here at HCA.

Mike Neuenschwander: I'm Mike Neuenschwander, the Manager for the Prescription Drug Affordability Board.

Michael Tunick: Assistant Attorney General, Michael Tunick. I am Legal Counsel for the Board.

Simon Borumand: Simon Borumand. I'm the Policy Analyst for the Board.

MaryAnne Lindeblad: And then staff online.

Kelly Wu: I'm Kelly, and I'm the PDAB Data Analyst.

Marina Suzuki: And this is Marina Suzuki. I'm the Health Economics Research Manager.

Mike Neuenschwander: Great. Anyone else?

Jingping Xing: I'm Jingping Xing. I'm the Cost and Quality Analytics Manager for the HCA.

MaryAnne Lindeblad: Great. [Cross-talk] --

Mike Neuenschwander: Great. [Cross-talk] --

MaryAnne Lindeblad: So thanks to all, and to all those attending. And we'll go ahead with the PDAB Director's Report. We've got a full agenda today, so we'll want to get moving.

Mike Neuenschwander: Yep.

MaryAnne Lindeblad: Thanks, Mike.

Mike Neuenschwander: Okay. So, yeah. I want to thanks everyone for coming out today. I always appreciate having the time to chat and work with you all. So our big thing that we've been working on here for the last little bit is trying to gather data and prep for our drug reviews that we are putting together. So really, the big things that we've been doing or working on collecting data from a variety of sources and manufactures, handing out surveys for people to review, getting reports from the Advisory Group members, and then also pulling internal data to try and fill in pieces that we have available through that type of data. And so we will be chatting more about our drug reviews here today. We'll have a closed session for a little while to go over some of our -- you know, where we're at in our first draft and what we have, what we're still working on. So we'll take a little time, I'm guessing probably an hour, to meet with the Board on that, show them what we got, and see what questions that they have. So for that piece, the Board members will go to a separate online meeting, and then we'll just ask people to clear out of the room temporarily while we're doing that. After that, we have a few other presentations around our new drug list that we're developing as well as for the next year of eligible drugs as well as beginning discussion on upper payment limits. That will be, I think, very interesting. In terms of kind of some other interesting things that are going on in other states. So Maryland is also working on UPLs and how to implement those. And they're beginning some new reviews on other drugs. And they have gotten a little bit of legislation to expand the Board's authority to cover all payers statewide. So, that will be interesting to see if that works. Colorado, as we know, last fall, set their first UPL on Enbrel, which was effective January 2027. The original Amgen lawsuit was dropped, that they have started a new one basically with a lot of the same constitutional arguments but appealing on the UPLs causing harm to them. So other drugs that Colorado has done some reviews on four other drugs. And if you guys want a little bit more information on the lawsuit, the Colorado Sun has a good article in explaining that. Oregon has completed reviews on some of their drugs and determined Cosentyx, Trulicity, and Vraylar to have affordability challenges. And then they did get a little bit of a change in their legislation. They were required to review insurance products, at least one has one product. They got the legislation changed to say that they "may review insulin products" so that way they are -- that gives them a little more flexibility in terms of how they're able to work with their drugs. And a

broader report is going to be forthcoming with drugs reviewed -- that were reviewed in 2025 and what the Board recommendations on those. Minnesota has a relatively new PDAB Director for their state, Vernon Rowan. So he's beginning to stand up their PDAB. New Hampshire's PDAB, due to budget difficulties, was actually eliminated. So that is something happening over there. And so really, timeline that we're trying to work on here, generally speaking, in reviewing our initial drug draft drug review today, hoping to have things kind of finalized and filled out more for our May meeting. Then, in June, for the Legislation, we are required to give a new list of eligible drugs for us to begin thinking about that could be removed, so working to get ready for that. And then also, again, UPLs for us will come into effect 2027. But in order to get ready for that, we need to start crafting and working on the WAC language now, so that way it can be ready for the 2027 calendar year. And then, of course, those new rules won't come into effect until after the 2027 Legislative Session, according to the policy note we had. So a lot of things starting to happen here. And then just dates for upcoming Board meetings: May 20th, July 15th, September 16th, and November 18th. And so we'll adjust as needed if we need to. But that is what we've tentatively got on the schedule right now. So questions, thoughts, or comments on that?

MaryAnne Lindeblad:

Mike, is there any other states considering setting up PDABs?

Mike Neuenschwander:

So I know there have been a few other states that have had some legislation in the works. Ryan, do you remember off the top of your head who that -- if there are any new ones besides the ones we've been working with recently?

Ryan Pistorosi:

Yes. I believe that there are some, and I believe that they may be looking at a different kind of model legislation that may tie more into the Medicare price -- negotiated price -- using that as kind of some of the language embedded in the statute. But I don't know which states may have [cross-talk] --

MaryAnne Lindeblad:

[Cross-talk] That's okay, just curious.

Ryan Pistorosi:

I thought Virginia might be one, [cross-talk] but I can do a quick check.

- Mike Neuenschwander: And I think Maine. I remember someone saying something about Maine potentially, I think, doing that as well.
- Ryan Pistorosi: Yep.
- Mike Neuenschwander: The ones that we kind of coordinate with and we -- meet with very regularly are Maryland, Colorado, Oregon, and Minnesota. And so those are, those are the ones. There are some differences again with all the states and how their PDABs work and what rules and restrictions they have in terms of reviewing drugs. For example, Oregon doesn't have UPL authority. But yeah, those are the ones that we probably collaborate [indistinct] --.
- MaryAnne Lindeblad: And looks like Eileen has joined us. Welcome.
- Eileen Cody: Good morning.
- Mike Neuenschwander: Good morning. Glad you could make it.
- MaryAnne Lindeblad: We're just all jealous.
- Eileen Cody: It's pretty nice out here.
- MaryAnne Lindeblad: It's pretty rainy here.
- Eileen Cody: And it snowed right after we left, so I'm glad I got out of there.
- Mike Neuenschwander: Okay. Any other questions?
- MaryAnne Lindeblad: All right. We're ready to go on. Were you going to change up the [cross-talk]?
- Mike Neuenschwander: [Cross-talk] Yeah. So I think we were going to switch up our schedule just a smidge. So we will go with Kelly's presentation first on just -- again, a reminder of, you know, how our eligible drug list is created. You know, going over how we're waiting and ranking those to create a list of drugs that we can choose from. And so just kind of a refresher on that so everyone is up to date and prepared for it as we're starting to come into June, which isn't too far away, and we're going to have a new eligible list of drugs that we can choose from and then some new

drugs that you can select drug reviews for there next year. Kelly, I will let you take it away.

Kelly Wu: Um, it's thinking. Okay. Can you see my slides?

Mike Neuenschwander: Yep.

Kelly Wu: Do you see my notes?

Mike Neuenschwander: Not your notes.

Kelly Wu: Okay, great. So it's been a while since we pulled our initial list of eligible drugs for Affordability Reviews. So we thought it would be helpful to briefly go through the methodologies we used because I'm not until -- I had to review my own notes when I created this presentation because it has been so long. So some of these slides might look familiar because I just collated the slides from previous presentations. So I'm not going to get into great detail about the methodologies we use since this is going to be a refresher, and there's a lot to cover in this presentation. So, if you do need a more in-depth refresher, you can go back to the presentations from our previous Board meetings. Okay. So I'm going to go over the methodology for including [audio cuts out] --

Mike Neuenschwander: Kelly, are you there?

Doug Barthold: I can't hear anything.

Greg Gipson: Yeah, I can't hear it. Kelly? Kelly, we can't hear you.

Doug Barthold: I don't know if she can hear us. Kelly.

Multiple Speakers: [Laughter]

Mike Neuenschwander: Uh, let me reach out and see if we can find where she went. Is she going to call in?

Kelly Wu: So sorry about that. My audio loves to drop out at important moments. So I'll just - so like, when -- did I drop out like when I was talking about this slide or when I went to this slide?

Mike Neuenschwander: I think you were just transitioning to the second slide, so.

Kelly Wu: Okay. Thank you. Okay, so I'll just go over this slide again. So I'm going to go over the methodology for including prescription drugs on the eligibility list. and then I'm going to go section by section of the bill and talk about how we're interpreting and calculating these thresholds. And then I'll go over the methodology for creating the prioritized shortlist, which should be more fresh in everyone's head since we just did this. And then feel free to interrupt me if you have any questions or want to see anything again, but we will also have time at the end for discussion and questions. Okay. So let's get into reviewing the methodologies for how we included the drugs on the Eligibility List for Affordability Review. So this would be the first part of the review process which is identifying eligible drugs for affordability review. So just a reminder, this is a part of the bill that states the different ways a drug can make the list. And I'm not going to read it all because I'll be going over it section by section, but it is here for reference. And then our data sources for pulling the data will be First Databank and Medi-Span, which are two commercial drug pricing databases. So the first way a drug can make this eligibility list is to be a brand or biologic drug that has a WAC of \$60,000 or more per year or course of treatment lasting less than one year. So if you remember, our data source for this is specifically the dosing modules from FDB, which contains dosing data for drugs by age category. And then these are the terms that I'll be referring to when I talk about our course of treatment calculations. So as you remember, we're using the high dose, which is the dose will be -- that we'll be using in our formulas. And then, so for example, if someone is described as dose of 5 mg of a drug, but it can also be prescribed as high as 10 mg a day for certain scenarios, then the high dose would be like 10 mg in this example, and that is what we would use in our calculations. And that is what we would use in our calculations. And then the high duration of therapy means the high end in days of the recommended amount of time that the drug should be taken. So if like most people take it for like 10 days, but it can also be taken for as high as 21 days for certain conditions, we'll be using that 21 days for our formula. And then sometimes you might see like [audio cuts out] --

Mike Neuenschwander: We lost you, again, Kelly.

- Kelly Wu: Darn it. There's like So I had there's like an AI notetaker that's waiting in the lobby. Are we supposed to, like, admit them or not?
- Mike Neuenschwander: Uh, no.
- Simon Borumand: Yeah, they keep [indistinct], so I just ignore it.
- Mike Neuenschwander: Yeah. No, we'll leave AI notetakers alone.
- Kelly Wu: Okay. Um, yeah. So there could -- sometimes the hydration of therapy in days can show up as zero in the data. But that just means it's a chronic medication, or there's no data available, but more likely as a chronic medication. And then disease duration refers to the duration of the disease or health-related condition associated with that NDC. So that can be acute or chronic or both acute and chronic. And then finally, there's like maintenance and single dose, so those are types of drug doses. So the maintenance dose is the amount of dose you need to take to achieve a steady concentration of the drug in your system. And the single dose is like one-time dose you would take if it's not something you take regularly. And we're excluding vaccines and non-drug products from our course of treatment calculations, so these will not be making the eligibility list via the course of treatment threshold. So if you remember, we're using the generic name indicator from the FTB to identify brand name drugs. And as the name suggests, the GNI will use the drug's name to identify whether the drug is a brand name drug or not. And then we'll be using the FDA Purple Book, which is the database maintained by the FDA that contains information on all FDA-approved biological products to identify biologics. And this is a brief overview of the methodology that we will use to calculate the course of treatment. So first we will deduplicate the data so that each NDC only has one dosing data record because an NDC could have multiple dosing data for different age groups or different indications. And then once we get that one record per NDC, we will multiply that by the NDC's high dose -- multiply the NDC's high dose by the high duration of therapy in days to get the number of units used in a year. And then we'll also do any unit conversions in this stuff if the high dose is in a different unit than the strength of the NDC. Like the high dose could be in milligrams, and the NDC is in grams, so we need to convert them to the same unit. And then after we do that, we multiply it by the

NDC's WAC price to get the cost of course of treatment for one year. And then as I mentioned before, NDCs can have multiple records for, like, different age ranges and different indications, so we need to do this deduplication. We choose one dose per NDC to use. So that means we're going to choose the dosing data for the highest age range since adults will have a higher dose recommended than children. And we'll choose the chronic and maintenance dosing data if available since that's a dose people will most likely be taking if they're using the drug for a year. And so I've shown this before, and this is an example of what dosing data would look like for a drug. So this is for an antibiotic Bactrim. So you can see there's, like, multiple dosing data for different ages and different dose types. And then after deduplication, we would only be keeping the record I highlighted here since it's the dose for the highest age group, which is adults 18 to 110 years, and it's also the maintenance dose. So to put it into, like, a more visual way, the formula that we're using to calculate the course of treatment is high dose per day, converting that, if necessary, to the same units as the NDC strength, and then we divide that by the strength of the NDC, so we know like how much of the drug the person is taking per day. So if like the high dose is 10 mg and the NDC for this is 5 mg, we know that the person is taking 2 units of the NDC per day. And then, next, we multiply that by the days they should be taking the drug, and then we multiply that by the WAC unit price, and then we get the cost of the course of treatment. Okay. So this is an example of how we -- you would calculate the course of treatment. And this is for Erleada. This is new data that wasn't shown in previous presentations, and this is a brand name drug, and it's used to treat prostate cancer. It came onto the market in 2018, so it wouldn't have been eligible for when we did our when we pulled our list in 2023 because it wasn't on the market for seven years -- yet at that point. So the most recent price for this drug at the time I made this presentation was \$127.50 per unit set in January 2025. And I already deduplicated this dosage data, so our only rogue data we're going to use for this NDC is what's shown here and this is the maintenance dose for people aged 18 to 110 years old, and the high dose is 240 mg a day, and each tablet of this drug is 60 mg, so we don't need to do a unit conversion here. And then we see that the high duration of therapy in days indicates how the drug is taken daily. So plugging this into our formula, we have that high dose per day as 240 mg. The drug comes in 60 mg tablets, so $240 \div 60 = 4$ no unit conversion needed, so the conversion factor is just 1. Then we

multiply that by the high duration of therapy in days, which is 365, and multiply that by the WAC price. Plug all those in, we get cost of the course of treatment for a year for Erleada is \$186,000 -- \$186,115. So that's definitely over the cost threshold of \$60,000, and this drug would be on our 2026 list for Eligible Drugs for Affordability Review. All right. So again, feel free to stop me if you want me to go back or explain something again. So the next way a drug can make it onto our eligibility list, so we're getting into, like, the increases and stuff, is to have price increases that are 15% or more in a 12-month period or over 50% over 3 years. So for a drug to be included in the list in this section, I just mentioned before that they need to have that increase, and then that 12-month period that we're looking at where they need to have an increase is January 1, 2025 to January 1, 2026. And then we're going to look at their prices as of January 1, 2026, so we're not going to, like, look at, like, what their price was like yesterday. So we're just setting that we're going to look at all the prices as of January 1, 2026 and not after that. Yeah. So they need to have a recent increase in that calendar year that I mentioned to make our list. And then in our last list we pulled in 2023 in that time period was they needed to have an increase between January 1, 2022 and January 1, 2023. So, like now the window has moved forward, like 3 years -- or 2 years -- 3 years. Okay. And then I'll be using the term current WAC to refer to the NDC's WAC unit Price from that most recent price increase between January 1, 2025 and January 1, 2026. And for lack of better terminology, I'll use the term one-year WAC to refer to the NDC's earliest WAC price in the immediately preceding 12-month period from the date the current WAC was set. And this next part might be a bit confusing because we haven't heard it in a while, but I'll be showing an example that will hopefully make this more clear and like jog your memory. The 12-month period will depend on the date of the NDC's current WAC, so if the current WAC is in like July 2025, then we'll look at what the NDC's price 12 months prior to that was like as of July 2024. So if there were like one or more price increases before the most current one between that period, we would use the earliest increase, so the increase closest to July 2024. And if there are no price changes in that period, we would just use the NDC's price as of July 2024. So NDC's will have different 12-month periods we're looking at depending on when their current WAC was set, but that increase must happen between January 1, 2025 and January 1, 2026. So this is the formula for the one-year price increase, and it's just the current unit

price minus the one-year unit price divided by the one-year unit price. And this is, once again, an actual example of the newest data that we're going to use. And so this is data for Clomid, which is a drug used to treat infertility. And it's been on the market since 1999, so it's definitely been on the market for at least seven years. And the current WAC unit price is from August 2025, and it's \$11.50. So this meets our criteria of having that increase between January 1, 2025 and January 1, 2026. And so now we look back 12 months from August 1, 2025 to August 1, 2024, and there happened to be no increases in that time period. So we'll take its price as of August 1, 2024, and then that price, which is our one-year WAC unit price is \$7.86, which was set on July 3, 2024. And so plugging in these four numbers into the formula, we get that the one-year price increase for Clomid is 46.31%, and that's way over that 16% or more thresholds. So Clomid would definitely make our list of eligible drugs this year, and it's also going to be a new addition to our eligibility list because it didn't have an increase in the time period we were looking at last time when we pulled our list. So yeah. Oops. Okay. And then moving on to the three-year increase. So very similar, except we're now looking back 36 months instead of 12, so same idea. And then similar formula to the one-year increase, it's just we're now plugging in that three-year WAC price instead of the one-year. And so this is an example for the three-year, and this is also new data that I'm showing. So this is for Demerol, and this is a synthetic opioid medication. It came out to the market in 1990, so it's also been on the market for at least seven years. It did have a price increase on January 1, 2026, so it barely made it on our, and that was to a WAC unit price of \$21.85. So going back 36 months from the date of its price increase, which was on January 1, 2026, we go back January 1, 2023. And then, what do you know? It happened to have a price increase on that very day. So we get that the price set on January 1, 2023 is \$3.13, and that'll be our three-year WAC unit price. And then plug in those numbers, we have that Demerol's price increased by 598% in a three-year period, which is also well over the increased threshold of 50% or more stated in the bill. And this would also be -- this drug would also be a new addition to our eligible list because its price increase -- it didn't increase in price enough to meet the threshold when we last pulled our list. Okay. So another way the drug -- a drug can make it onto our list is if they are biosimilar product that has an initial WAC cost that is not at least 15% lower than the reference biological product. And so we use FDB documentation to

identify reference biologics in their biosimilars. And we'll calculate the increase in price using the price of the biosimilar's earliest listed WAC unit price, which I'll call that initial biosimilar WAC, and comparing it to the price of the reference biologic at the time of the biosimilar earliest listed WAC unit price, and I'll call this the reference biologic WAC. And I keep saying earliest listed WAC unit price because Medi-Span only contains like 12 price histories per NDC, so if the NDC has had more price changes than that, then the earliest one won't be like it's actual initial price. So the formula used to calculate the increase is very similar to the ones I showed before. It's just that we would be using like the biosimilar and biologic prices instead of like the one-year or three-year WAC unit prices. Okay. So this is also new data, and this is how we calculate the increase for a biosimilar. So this is data for Yuflyma, which is a biosimilar to Humira. And these drugs are used to treat certain types of arthritis, and this drug entered the market in March 2002, but it's -- yeah, it's eligible for review because it's been on the market for more than seven years. And then you see here that the initial WAC price was \$6576.50 [indistinct] on -- I think I wrote the -- I made a typo on this slide. The -- it should have come into the market in March 2024, not the 2002. But it's still eligible for review because it's referenced biologic has been on the market for at least seven years. So that initial WAC price was set in April 2024, one month after it came onto the market, and that \$6500 about dollars was the initial WAC price. And then at the time the reference biologics WAC price was \$3461.31. So then if we plug that into our formula, we have Yuflyma initial WAC price was 90% higher than its reference biologics price, so it was definitely not like 15% or more lower, so it would definitely make our list for this year. And then finally, a drug can make the eligibility list by being a generic drug with a wholesale -- with a WAC of \$100 or more for a 30-day supply or less that has increased by 200% or more -- in the past 12 months. So I showed this before. We are using the generic name indicator to identify generic drugs as well since you can tell from their name that they are generics. And then if the generic is like newer than seven years, but the brand that it's based on has been on the market for at least seven years, they will also be included on our list. And so we're using a very similar deduplication algorithm to get the one record for NDC for the high dose to use for our calculations, so I'm not going to go over that again. But where this differs slightly, we're also going to calculate the increase, so kind of we're mixing the previous two methodologies. So

we're calculating the what it costs for like a course of treatment but then also the increase because it needs to meet both. And for the 200% or more increase, we're using the same method as like the one-year increase, but now like the threshold is 200% and not 15. And so the formula is very similar to that. And then to calculate how much a 30-day supply costs, we're going to be looking at the high duration of therapy in days. So if the high duration of therapy in days is greater than or equal to 30 days, we're going to multiply the number of units used per day by 30 days. And then if the hydration of therapy in days is less than 30 days, we'll use the exact number of days that it is. So we're accounting for the cost of the 30-day supply that may be taken daily, but then we're also accounting for stuff like antibiotics that might not be taking chronically. And then this is just a visual representation of the formulas for each kind of calculation. So if the hydration of therapy in days is greater than or equal to 30, we multiply by 30, which is in purple. And then if it's less than 30 days, then we multiply by the exact amount of hydration of therapy in days. And this is an example from our -- this is an example from our 2023 Data Cycle, so you've seen this before. Also, this NDC is from a repackager, so it would not be on our list because we're supposed to exclude NDC from repackagers, but it will still be good to go over an example with numbers. So this is for primidone, and it didn't have an increase in the time period that we're -- in our like new time period that we're looking at, so it wouldn't be on our list. But it wouldn't be on our list anyway because it's from a repackager. But just for the sake of an example, this drug had an increase between January 1, 2022 and January 1, 2023, so it would have been on our list if it weren't a repackager from last year. And then that newest price when I pulled it in 2023 was \$0.24 and then also in 2022, and then it didn't have any price changes for a really long time. So it's like the last price change was in 2010, which is \$0.08. This happened to be an exactly 200% increase, so it meets that first part of having a big enough increase to meet the threshold. And then multiplying the dose by the 30-day sup -- by the number of hydration of therapy in days to get the cost of the 30-day supply, we see that it is \$288. So it increased by 200% over a 12-month period, and it also costs more than \$100 for a 30-day supply, so it would be eligible for Affordability Review if it were not a repackaged NDC. But that would be like how we would calculate other data for other NDCs. Okay. Next, I'm going to go into

like how we created the shortlist for Affordability Review. So we just did this. So hopefully I can go kind of fast. [Cross-talk] --

Mike Neuenschwander: [Cross-talk] Kelly.

Kelly Wu: Oh, go ahead.

Mike Neuenschwander: Yes. Board Members, any questions on that first part? I know it's a review, but, uh -- Okay. Okay. I just wanted to make sure before we jumped off the next cliff that we had the first one figured out. So, okay, go ahead, Kelly. Sorry.

Kelly Wu: No worries. All right, um. Okay, yeah. So when we create the short list for Affordability Review, this would be like the second part of our Affordability Review process, where we're selecting drugs for Affordability Review. And then this is a part of the bill that says that the -- what the Board shall consider, and then the Board can -- and has also come up with other measures they want to look at. And the Board can choose up to 24 drugs per year. And these are the data sources that we're using for our Affordability Review. So we have the All Payers Claim Database. We have manufacturer data, (PBM) prescription benefit manager data and then, once again, our commercial price drug pricing database data. So as the bill mentions, when choosing prescription drugs for Affordability Review, the Board will look at those three required measures from the bill, which I color-coded in blue. And then the brown measures are the ones that are -- that were proposed by the Board. And then I also have a little graph icon for the measures, and those signify that those are quantitative data measures or data measures that can be measured, counted, or expressed as a number. And they will also be the data measures using our ranking and weighting methodology, which I'll go over really quickly in our next slides. And then this is our methodology that we use to create the 2025 shortlist. But going forward with the 2026 list, based on our discussion from the last -- or was it the last? In the November Board meeting, we will be changing our methodology slightly, and I'll mention this in our upcoming slides. So this is more of a of a refresher on what we did for this cycle, but going forward it might be slightly different. Okay, so first what we did was we separated the eligible NDCs into specialty and non-specialty drugs. So prescription drugs that are biologics and biosimilars, except for those

reclassified as biologics under the Biologics Price Competition and Innovation Act, were considered specialty. That means they require special storage, handling, administration, or monitoring. And brands and generics were considered non-specialty. And then after we separated our drugs by specialty and non-specialty, we aggregated their data by labeler code and generic name. And the goal of this was to aggregate drugs with the same ingredients from the same manufacturer or distributor. But in our November Board meeting, there was discussion that we -- going forward we want to aggregate the drugs by generic name only when creating our shortlist. So this is what we plan on doing in this upcoming data cycle. We're going to aggregate by generic name regardless of manufacturer. So after I do that, the next step is to rank and weight the data and calculate -- the weighted rank for each labeler code and generic name. So we do that so we can create our shortlist. So to rank the data, we sorted each quantitative data measure in descending order and assigned rankings. So, for example, here we sorted each quantitative measure in descending order and assigned a rank. And usually like a labeler code and generic name might not have the highest like ranks across the board for everything, so it might rank highly in one measure and not as high in another, and that is what is happening here in this ranked data. And then in cases where our rankings are tied, we use the average ranking method to break the ties. So, for example, in these two circled labeler code and generic names, they both had a total paid amount of 12, but they're ranked in positions 3 and 4, which is not correct since they have the same total paid amounts. So if we use the average ranking method to break the ties, the final total paid amount rank is the average of the rankings. That would be the sum of the rankings 3 and 4, which is 7, divided by the number of type, labeler code, and generic names, which is just in our case. So 7 divided by 2 is 3.5. So if we use that average ranking tiebreaker method here, both of these labeler code and generic names would have a ranking of 3.5. So that is what we used if there are any ties in the rankings. And we also had weights, which were created when the Board members did an exercise to like assign points to the quantitative data measures based on how important they thought the measure was. So these are the results from that exercise, and what I circled here are the weights that resulted from that. And so this is a form -- the formula used to calculate the weighted rank for each labeler code and generic name. And then after we did this calculation, the top 25 lowest weighted

ranks -- the top 25 NDCs with the lowest-weighted ranks for specialty and non-specialty labeler -- sorry, not NDCs -- the top 25 labeler code and generic names with the lowest-weighted rank for specialty and non-specialty made up the two shortlists. So the weighted-rank is basically the sum of the rank of the data measures multiplied by their respective weights. And then this is the same formula, but it has the actual weights plugged in. And then this is an example from my previous presentation in 2023 -- or it's using 2023 data, so it's not new data but, nonetheless, we can see how like the data is actually plugged in here. So this is for the drug fingolimod hydrochloride for labeler code 00078, and so plug in the formulas, plugging the numbers into the formula, we can see that we plug in the different -- the ranks -- the respective ranks for each data measure, and we can see that this drug has pretty like varied ranks, so some are lower and some are higher. But nonetheless, you plug it in and then you multiply that by the weight, and then you get -- the weighted rank for this drug is 7.17. And then basically, we do this for like every labeler code and generic name, and then we rank the weighted ranks if you will. And then once we do that, we can select the top 25 specialty and non-specialty labeler code and generic names with the lowest-weighted ranks, and then like those turn into our two shortlists. And then once we create the shortlists, the Board will look at the weighted rank as well as all the data measures, both quantitative and non-quantitative, to select the drugs they want to review. Okay. And these are some limitations for our methodologies in general, so this is like going back to the first part of my presentation, but I still think it's important to point out. So we are doing like the WAC, tackling like the increases with the WAC cost. We're not making any adjustments for price inflation. And then also our data sources, as I mentioned before, might not contain the complete price history for NDCs, as they like change too many times. And then, finally, we're using the high-dose data to calculate the course of treatment, and this might not reflect the dosing data that most people are prescribed. So our next steps will be to pull the 2026 eligibility drug list and then create the Affordability Review shortlist from that list. Okay. I know that was like a lot and super fast so, um, yeah. Any questions? Or you want me to go -- want me to go back to anything, let me know.

Doug Barthold:

I think that all looks really good. Thanks, Kelly. Appreciate the summary.

- MaryAnne Lindeblad: There doesn't appear to be any questions here in Olympia, so [cross-talk] --
- Mike Neuenschwander: [Cross-talk] Okay, yeah. So I think, again, just something to -- as a refresher here for what's coming up in June, so that way when we have the drug list, again, we know how it got here, what we're looking at, how the selection criteria was made, and then so I think some of the other questions around this that we were chatting about over earlier that we should start thinking about. Or maybe we could discuss it a little bit if you want is we selected two drugs this last go around. Start thinking or any thoughts on how many drugs that we want for the next go around, and then I know we also had selected two additional ones that we just didn't get to. So do we want to push those forward? Or, you know, I know, Doug, you had thoughts of hey, let's just start with a fresh list and fresh data and kind of pick from the top from there. So I think it's just things to ponder as we prep for this upcoming new list. And I think for us starting small has served well with just figuring out the kinks and figuring out the data, I think, was a good strategy to help us not be overwhelmed as we were trying to put together all the pieces of the puzzle for the first time. So, yeah, those are just other points of consideration that as we are coming up on this June drug list, things for us to consider as we are getting ready for that. So thoughts? Questions? Yeah.
- Doug Barthold: Yeah. I'll just add I agree with -- excuse me -- like, summarized it well there. But I think that the information that we're going to get from the new eligibility list is going to be more up-to-date and at least they reflect a more accurate picture -- depict a more accurate picture of what we -- of the current situation in Washington with regard to affordability of these drugs. And so I'm in favor of using the most up-to-date data as possible and in all of our subsequent decisions.
- MaryAnne Lindeblad: And that certainly seems reasonable. I see Eileen shaking her head yes.
- Eileen Cody: Yes, I would agree. I think that, you know, we want to look at what's egregious this year, not what's egregious from the years past.
- Doug Barthold: Yeah.

Mike Neuenschwander: Okay. Okie doke.

MaryAnne Lindeblad: Ready to go on?

Mike Neuenschwander: Yeah. So I think that we're ready for our Executive Closed Session. So we can maybe put this on pause here, Simon, and uh --

Simon Borumand: Well, couldn't we do that -- can the Chair just sort of read the purpose of the Executive Session and then also the time when we [cross-talk] back.

MaryAnne Lindeblad: [Cross-talk] Do I count that?

Simon Borumand: You know, if we need extra time, we can come back to the Public Session to tell the public [cross-talk] --

MaryAnne Lindeblad: [Cross-talk] Is there something here in --

Simon Borumand: If not, I will.

MaryAnne Lindeblad: I can certainly come over there and [cross-talk] --

Simon Borumand: Okay. Yeah, it's that [cross-talk] --

MaryAnne Lindeblad: I think it's easier. [Cross-talk] Oh, my. [Cross-talk] Okay.

Simon Borumand: [Cross-talk] could be in pursuant -- sorry. This is [cross-talk] pursuant to --

MaryAnne Lindeblad: [Cross-talk] All right. [Cross-talk] How much do you want me to read?

Simon Borumand: Well, just, yeah, say so pursuant to RCW 42.30.110, um, [cross-talk] --

MaryAnne Lindeblad: [Cross-talk] When are we going to start?

Simon Borumand: And then [cross-talk] we'll be [cross-talk] --

- MaryAnne Lindeblad: [Cross-talk] just hearing what [cross-talk] okay. [cross-talk] --
- Simon Borumand: [Cross-talk] we'll be going into Executive Session for [cross-talk] --
- MaryAnne Lindeblad: [Cross-talk] Sorry.
- Simon Borumand: Yeah, just highlighted what part you guys are sort of showing your obligation to say the reason for the session and I will return to Public Session [cross-talk] --
- MaryAnne Lindeblad: [Cross-talk] [laugh] Okay.
- Simon Borumand: But yeah, just [cross-talk] --
- MaryAnne Lindeblad: So the reason for us to go into the Executive Session is to consider proprietary or confidential data collected or analyzed pursuant to Chapter 7405 RCW, um, before convening in Executive Session, the providing officer of a governing body to publicly announce for the purpose of excluding the public from the meeting place and the time when the Executive Session will be concluded.
- Simon Borumand: Okay. And so what is the time when you're anticipating [indistinct] [cross-talk] and so the public knows when to come [cross-talk] back.
- MaryAnne Lindeblad: [Cross-talk] half an hour?
- Mike Neuenschwander: [Cross-talk] Um.
- MaryAnne Lindeblad: [Cross-talk] Okay.
- Simon Borumand: And we can always come back to the Public Session [cross-talk] --
- Mike Neuenschwander: [Cross-talk] Okay.
- Simon Borumand: -- to say, hey, we need more time.
- Mike Neuenschwander: [Cross-talk] Okay.
- Simon Borumand: We'll be back at, you know --

Mike Neuenschwander: Maybe let's start with a half hour [cross-talk] --

MaryAnne Lindeblad: [Cross-talk] Okay.

Mike Neuenschwander: -- and then we can [cross-talk] --

Simon Borumand: [Cross-talk] 10:00, maybe?

MaryAnne Lindeblad: [Cross-talk] We'll start.

Mike Neuenschwander: Yeah, 10:00.

MaryAnne Lindeblad: Yeah, the same.

Mike Neuenschwander: And try to [cross-talk] --

MaryAnne Lindeblad: We'll run until 10:00 and then regroup.

Simon Borumand: Okay.

MaryAnne Lindeblad: And we'll have to ask for more time [cross-talk] --

Simon Borumand: [Cross-talk] Yeah.

MaryAnne Lindeblad: -- if needed.

Simon Borumand: Yeah.

Mike Neuenschwander: Okay.

MaryAnne Lindeblad: Does that sound reasonable?

Simon Borumand: Yeah. Okay.

Mike Neuenschwander: All right.

MaryAnne Lindeblad: Thank you.

Simon Borumand: Thank you, both.

MaryAnne Lindeblad: Thank you.

Simon Borumand: We'll come get you [cross-talk] --

Multiple Speakers: [Cross-talk] --

Simon Borumand: When we get in the lobby [cross-talk] --

MaryAnne Lindeblad: [Cross-talk] Yeah.

Simon Borumand: When we get in the lobby? Okay. Thank you.

Mike Neuenschwander: Okay.

MaryAnne Lindeblad: Right.

Simon Borumand: So let's go to [cross-talk] [indistinct] Executive Session, yeah. So --

Doug Barthold: [Cross-talk] So are we supposed to [cross-talk] --

Kelly Wu: [Cross-talk] Are we ready to hop onto the other meeting [indistinct] room?

Simon Borumand: Okay, and we'll jump. Thanks.

Kelly Wu: Okay.

[Executive Session]

MaryAnne Lindeblad: Let me know when we're ready. Do we got it? Okay. So those folks that are online, we are going to have to extend our Executive Session for at least another half an hour, so we will be regrouping at 10:30. Thank you for your patience.

[Executive Session]

MaryAnne Lindeblad: Okay. Well, I want to take the opportunity to meet -- to have you meet Ryan Moran, and Ryan just started in the middle of August as the new Health Care Authority Director, so I'm going to invite him today.

Ryan Moran:

Yeah. I am so grateful to be here. Thank you, Chair the Blad, and I just will say like a very public way super grateful for MaryAnne for her service, obviously, long before me coming in Drug Director last year where she served for the State but also the enormous help she was in the transition and process for me personally. So it's a treat to have you back on the Board when I had to take a step away. And now you're back in the Chair steep. We're really happy to have you. And I think -- and I also want to thank the staff and the team, Simon, Mike, Ryan, for your work on getting the PDAB started. I really reached out since joining in August to say real interested in this body of work and this group's work. I'm thrilled that this is part of the purview of the Health Care Authority and there are a few reasons I'm hoping to demonstrate that in very real tangible ways about the direction of the Health Care Authority and the overall thinking of the challenges that we face in healthcare and just how important this work is in that [indistinct]. I'll just say a little bit about me. I've had opportunity to meet a lot of people who are on the Board. I see Ronnie. I see Eileen Cody, who I have had the chance to interact with as well. But my background is coming from the State of Maryland, where I was the State of Maryland's Medicaid Director. And in that realm, one of the states that I know that the Board looks to in terms of learnings and best practices or things to share ideas with is the State of Maryland. So the Medicaid program that was there we did not if you will have direct purview over the Prescription Drug Affordability that the Health Care Authority has, but we were obviously because of Medicaid a [indistinct] partner in the work that they were doing, and so I worked very closely with colleagues there in Maryland to support that work, really centering affordability around for individuals across the state. So I come from that perspective of really being interested, curious, and a partner in this particular work. And I'm thrilled that this is part of the body of the Health Care Authority. There are two things I want to say to the Board and sort of an introduce and also the next direction where I think there is a sync here. The first is per the Authority as we navigate the complexities that we have for our healthcare environment thinking about the three pillars that we have, Medicaid, PEBB, and SEBB, vision of behavioral health recovery, and then opportunities to support those particular who work with PDAB with the Cost Board with our value-based purchasing work with rural transformation. Our focus is really on three propriety areas for the future that you will hear me and other members of our leadership talk

about, but that is the first and foremost in this time. How could we as an agency be responsive to the needs of Washingtonians? And there are four key areas of focus in that bucket, and that is #1, coverage, coverage, coverage. We know that the Authority and the programs that it operates have significant challenges, changes to federal programs that threaten the continuity of coverage, particularly in the Medicaid but also our federal financing program in any area across the Health Care Authority and across the state, so coverage, coverage, coverage. Coverage, coverage, coverage means also sustainability of our delivery system. And so we at the State play a very important role of designing the programs and policies that, yes, the folks from the federal government will have to go through, but we can play an important [audio cuts out] trying to ensure that coverage is as mitigated as much as possible. And then that obviously leads to the delivery system being sustained as much as possible as they can in this environment. The third area in that bucket is partner accountability. And so the Authority is home to some of the State's largest contracts community care organizations, carriers on the PEBB and SEBB side, contractors on our behavioral health mission to recovery. I take very strongly the responsibility of state government to be the health strategist that hold those partners accountable to ensure that we are centering the lives of the people that we serve. And the last, which is the direct correlation of the work of the Prescription Drug Affordability Board is cost and affordability. Over the last 6-8 months, really since the discussion around H.R.1, the National Debate in Healthcare is all around cost and affordability. That increased in its elevation with the sunset of the enhanced premium tax credits for folks seeking coverage on the individual market, which has a direct connection with our Work Authority as well. But we know that the other pressures that exist in the healthcare environment continue to put a significant pressure on cost. And how the impact Washingtonians specifically at their particular level is of utmost importance for us to begin thinking about how we use the assets that we have, like the Prescription Drug Affordability to impact that on a daily basis. The other two areas I will focus less on, but just to give you a sense is the other two focus, the second one would be closing gaps to help disparities and advancing health equity. So some things that are very important for us, and as the Authority moves forward in the future is advancing investments in primary care, continuing Washington's work in the integration of behavioral health and

physical care, and investing in our behavioral health, specifically our community behavioral health system delivery of care, internal child health. We have a unique opportunity in our state with a rural transformation grant to advance rural health. And so our teams across the Department of Health and the Department of Social Services are working on that opportunity. And then the final area of focus for us is strengthening the agency operations at the Health Care Authority. And you might say from an agency head. "That's really odd because that's your job." That's the person who is overseeing the agency. But we call it out as a priority because today's environment in case of the dynamic around us, it's all about the basics. It's all about your eligibility systems, it's all about can providers get a hold of you to register to become a provider within your PEBB and SEBB or your Medicaid networks? Even the discussion around fraud, waste, and abuse is centered in the national debate right now. Program integrity isn't new for federal financing for programs. We have always cared about program integrity from state service respective. In fact, there are very strict federal guidelines that guide us in these regards and thinking about the use and stewardship of public dollars. But those operations for an agency like ours are really important so we can get the basics right in terms of what we navigate toward. So we are very focused on people processing systems at the agency at the moment. Plus, we can't do this work alone at the Authority. We have to work across all of our state agencies and be in side-busting work with DSHS, with the Department of Health, with the Benefit Exchange, with the Department of Children, Youth, and Families, and I'm fortunate and have the pleasure to work with those colleagues and agencies to be able to do that in my work. So that leads me to sort of a combination and then a summary. If that is the vision and direction of the strategy, this particular work, as you can see and as I have outlined, really plays [indistinct]. I know I've talked to Mike and Ryan and Simon about wanting to as you move into the Board's authorities and what you're talking about in terms of upper payment limit for 2027 and the tools you have been assessing for the past couple of years since the Board's inception, is elevating this particular work as we center healthcare cost and affordability. So that's a key priority and area of focus for us. And the last thing that I would mention is I see some direct connections between this Board's work of prescription drug affordability and the overall work that the Cost Board and Cost Transparency Board is doing at the Authority as well. Their three

areas of focus, which are very much in alignment with some of our priorities include best medication and thinking about strategies of investment into primary care or strategies to improve healthcare access into the future. You know primary care plays an important role of trying to reduce the cost of care. Second is looking at expenditures. The Cost Board is looking at healthcare expenditures, which has been traditionally their particular role over the last few years. This year, the Cost Board is electing, which has come up in the data calls from carriers in the past of the increasing cost of pharmaceuticals. So obviously, that's a direct connection with this Board's particular work, and so we will need to work collaboratively with -- together. And then secondly and thirdly, market oversight and mergers, acquisitions, and consolidation. What does that do to the overall [audio cuts out] dollar [indistinct] spent within the State of Washington? So if that's their three priorities, I very much do and want to ensure that this particular group culminates with their work so that as we move into the next biennium you will begin to think about decisions of the Board [audio cuts out] around discernments with the work of cost and affordability for every Washingtonian is centered in that. I am grateful for your service, the Board, for Board members who are serving and for being on the forefront nationally of getting one of the first PDABs up and running. And I know we have Chair Eileen Cody to thank for that from her time in the Legislature. And I'm looking forward to staying in tune and really partnering with you to advance and elevate this work in the future. So I thank you for letting the Chair crash this meeting [laughter]. I wanted to come and talk, but I really do want to come and talk and genuinely say this body of work has renewed focus for the agency in terms of our vision and direction as we [indistinct]. Do you have any questions?

MaryAnne Lindeblad: [Cross-talk] Yeah. Folks here at the Board, any questions? [Indistinct]. Any comments, questions?

Greg Gipson: Great to meet you. And thanks for coming here and sharing your philosophy and your guidance. I think that is really helpful for us as we kind of form decisions in the Board as well, so thanks.

Doug Barthold: Yeah, same. No questions from me, but it's nice to meet you and appreciate the introduction.

MaryAnne Lindeblad: Eileen, anything?

Mike Neuenschwander: Eileen?

MaryAnne Lindeblad: I see Eileen.

Simon Borumand: [Indistinct] executive.

Mike Neuenschwander: Yeah. [laughter].

Multiple Speakers: [Laughter].

Ryan Pistorosi: [Audio cuts out] Mexico, so --

MaryAnne Lindeblad: Yeah.

Ryan Pistorosi: Enjoyed vacation.

MaryAnne Lindeblad: Any questions from staff?

Mike Neuenschwander: Oh, I appreciate taking the time to come down here, and we're always looking at ways to try and do things better and collaborate. Know we're -- as this is all new, we're kind of figuring it out as we go. And then, yeah, we have some other partners in other states, which is definitely helpful. I recommend as much as we can also call upon the resources and things we have here internally and have access to, I think that will also be good.

MaryAnne Lindeblad: Well, we really appreciate Ryan coming and hope that you'll stop in when we have [cross-talk] --

Ryan Moran: [Cross-talk] Yes.

MaryAnne Lindeblad: -- our meeting so we get him on the calendar for future meetings.

Ryan Moran: That's my plan.

MaryAnne Lindeblad: Great.

Man: Thanks, man.

Ryan Moran: Yeah.

MaryAnne Lindeblad: Anything else? Okay. Great.

Ryan Moran: I'll let you get back to work.

Multiple Speakers: [Laughter]

MaryAnne Lindeblad: [Cross-talk] We'll let you get back to work.

Ryan Moran: It is mutual.

MaryAnne Lindeblad: Take care.

Ryan Moran: Uh huh. Thank you.

MaryAnne Lindeblad: So what are you [cross-talk]. Let's see. Where we want to go next? We want to -- ?

Mike Neuenschwander: So I think just to kind of have some continuity of operations here, maybe we can go to the Upper Payment Limit presentation. We still have a little bit more to discuss in our closed session with the Board, but we can kind of put that last piece of that, maybe, towards the end of the meeting just so people aren't waiting around on us for too long. So Eileen, is that -- I mean, MaryAnne, does that sound, uh [cross-talk] --

MaryAnne Lindeblad: [Cross-talk] No, perfect.

Mike Neuenschwander: -- good? Okay.

MaryAnne Lindeblad: Turn it over to Simon.

Simon Borumand: Sounds good to me. I just want to see if we can get Eileen on before I start. I sent over another link, but maybe we just give it a few minutes to see if we can get her on.

MaryAnne Lindeblad: I [indistinct] do want to [cross-talk] --

Doug Barthold: Well, while we're waiting, can I just clarify where we are on the agenda? I think we've kind of jumped around on the one that I received. [Cross-talk] --

Woman: [Cross-talk] Hi. Can I have your attention? [cross-talk] --

Doug Barthold: [Cross-talk] I mean what do we still have left? [Cross-talk] --

MaryAnne Lindeblad: [Cross-talk] I just checked, so [cross-talk]. So go ahead, Mike.

Mike Neuenschwander: So we got our UPL presentation we have to do, and then we got Public Comment, and then we just need to finish our Executive Session

MaryAnne Lindeblad: Yeah.

Mike Neuenschwander: So I think if we can do the UPL here -- and then do [cross-talk] --

MaryAnne Lindeblad: [Cross-talk] We can do public comments?

Mike Neuenschwander: -- we want to have public comment?

MaryAnne Lindeblad: Do public comment, and then we can go back to the Executive [cross-talk] Session.

Mike Neuenschwander: [Cross-talk] Okay. Is that okay?

MaryAnne Lindeblad: Folks want to [cross-talk] comment, they don't have to wait.

Michael Tunick: Yeah, yeah, yeah.

MaryAnne Lindeblad: Does that work okay, Michael?

Michael Tunick: Yeah. Okay.

MaryAnne Lindeblad: Okay.

Michael Tunick: Yeah. It sounds silly at the time after we sort of close up the public session we are still gaveled [cross-talk] back in at the end [cross-talk] of the Executive Session [cross-talk] expectation that [audio cuts

out] assume for [audio cuts out] a physical room just to say "adjourned."

- MaryAnne Lindeblad: Well, I adjourn the meeting in the [indistinct] backup.
- Michael Tunick: Okay. [Cross-talk] yeah --
- MaryAnne Lindeblad: [Cross-talk] That way it sounds [cross-talk] --
- Michael Tunick: [Cross-talk] Yeah, yeah.
- MaryAnne Lindeblad: [Cross-talk] Okay. All right. [Cross-talk] Well, then let's go ahead with Simon. [sneeze]
- Simon Borumand: Wait. Is Eileen able to join, or just [cross-talk] --
- MaryAnne Lindeblad: [Cross-talk] Why don't we just go ahead and start?
- Simon Borumand: Okay.
- MaryAnne Lindeblad: Hopefully, she will hop in. [Indistinct].
- Mike Neuenschwander: [Indistinct], I found Eileen real quick. Just a second. Hey, Eileen, with the HCA Director that popped in, we moved back into our regular meeting. Can you get back into that meeting? You can't get in? You're sound -- give me one second here. Sorry, what was that?
- Eileen Cody: [Audio cuts out] I can't get in. It cuts it [audio cuts out].
- Mike Neuenschwander: Hmm.
- Eileen Cody: Thank you.
- Mike Neuenschwander: Um.
- Ryan Pistorosi: Did the other -- I just sent a couple more emails. Did she [cross-talk] -

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- Mike Neuenschwander: [Cross-talk] Ryan just sent another email or two. See if those work. Okay. Yeah, we'll wait for you over there. Joys of technology. Okay. Maybe she can do that. Just leave her on this one and --
- Ryan Pistorosi: Eventually, [cross-talk] --
- MaryAnne Lindeblad: [Cross-talk] Can't we -- ? Yeah, we can [cross-talk] --
- Mike Neuenschwander: Okay.
- MaryAnne Lindeblad: -- get, yeah. [Cross-talk] She can listen [cross-talk]. She can hear us.
- Ryan Pistorosi: [Cross-talk] [indistinct] --
- Mike Neuenschwander: That is a backup.
- Ryan Pistorosi: Yeah. [Indistinct].
- Simon Borumand: She just emailed me. The same, same problem. She'll wait for the Executive Session, she said.
- Mike Neuenschwander: Okay. Well, I'll just -- I'll try this, and we'll see if there is a history of echoes. Tell her to go back on the other link that she -- Eileen? Hear me? Okay. Well, let's get started, and I'll see if I can [cross-talk] --
- MaryAnne Lindeblad: [Cross-talk] If we can pull her in?
- Mike Neuenschwander: If we can figure out on this end what's going on.
- Eileen Cody: That's makes no sense.
- Simon Borumand: Well, it's Simon. I'll be presenting on instead an Introduction to Upper Payment Limit methodologies and intention of putting this in context as we are doing the affordability review. At the end, one of the options is to put an upper payment limit on the drugs that are deemed to have -- be leading excess cost. But the way that you implement an upper payment limit, there are a lot of different approaches that you can take to getting to that final number. And for us, what we will want to do is make a decision of how we write our administrative codes, the WAC, to be able to reflect whatever methodology we choose. At the

same time retain some flexibility so that we can use the right metrics and the right approach for each drug. So in this presentation, I will go over what is laid out in the legislation in terms of what we need to do for an upper payment limit and how we are restricted. And then I will go into the timing of how this will all work and then, finally, lay out just a high level of different methodologies that are out there for setting an upper payment limit. Then we can dive deeper into those in future meetings and I think through those at a deeper level later. So, background -- and a lot of this will be familiar just from the legislation and from our conversations. What I wanted to do was to pull the relevant sections of the legislation into this PowerPoint so that you have just one reference point and then organize it just so it makes it more systematic. So each year we can set an upper payment limit on up to 12 drugs. Obviously, we will be starting lower and [audio cuts out] way up. There are certain types of requirements that we have to do and certain prohibitions on what we can't do when we set this methodology. And as I said before, we set an upper payment limit. For instance, Colorado, they set a certain price for a certain drug. We'll want a methodology of how we get to that price. Something that's defensible and it follows a certain logic. In terms of legislative requirements, there are certain things that we must take into consideration so the cost of administering the drug, the cost of delivering the drug to patients, the status of the drug on a drug shortage list, and then other relevant administrative drugs -- or administrative costs delays the [indistinct] delivery of the drug. Process-wise, we'll need to post notice of it. And then down the road we'll need to monitor the supply of drugs and say it. So that's an important bullet because a lot of the comments we receive are, you know, "Will this make it tough for patients to access the drug?" And that's just something to flag down the road that will be monitored right. In the prohibitions, limitations on how we can put together the UPL. Not use all the adjusted life here standard that takes into account the patient's age for disparity of illness or the disability and when we identified subpopulations. And so it's just some of the methodologies that are out there in corporate qualities in different ways, and we'll just want to thread that needle of how we're using that. We cannot put in place a UPL before January 1st. And then here's where we get in. I've got a chart later that makes this, I think, hopefully makes a little more sense. But there are some funny dates. We can't establish it before January 1, 2027. It can't go into effect until at least 90 days

after the next regular Legislative Session, and then the effective date must be at least six months after we adopt the UPL. Doug, I see your [cross-talk] --

Doug Barthold: [Cross-talk] Quick question.

Simon Borumand: Yeah

Doug Barthold: Yep. Um, so we -- these are qualities -- these are the first bullet there, is that referring to the determination of -- an affordability, or the determination of the UPL level? For both.

Simon Borumand: So in this instance, it's referring to the UPL. This pulled out of the part of the legislation regarding the UPL. I'd have to go back and check if it also applies to those [cross-talk] --

Doug Barthold: Yeah, I guess I was just trying to remember if this also applied for the determination of affordability.

Kelly Wu: Yeah, I think that's correct. We can determine the affordability before this, but the UP -- this is specifically for setting up the UPL.

Simon Borumand: Secure. It's small -- smallish print, but I tried to just call out what those last three bullets were saying around the timing. And so we can announce the UPL sometime after January 1, 2027. Ideally, we'll announce it before the start of the Legislative Session in 2027, so that's -- I believe the Legislative Session begins on the 11th of January. And so from the 1st through the 10th we can announce, and that way we can potentially have a UPL in effect with -- in 2027, and it would be at least six months after we announced, so starting on July 10th at the latest and then 90 days after the Legislative Session ends, so July 27th -- or July 25th. So really if we [indistinct] early so we can put in place a UPL, that goes and has an effective date in 2027 would be announcing very early January and having it effective in late July. Does that make sense? Any questions? The caveat here is that the UPL goes into effect for purchases, contracts, and plans that are issued on or renewed after the effective date. And so while it may go into effect July 25, 2027, it'll really be subject -- you know, those plans that will be subject to the UPL will be the ones that are issued or renewed on or after that date.

- MaryAnne Lindeblad: And I'm assuming that we are, um, well, it's that they'll actually get out of town on time, the Legislature. So will it get pushed out?
- Simon Borumand: [Cross-talk] That's just -- yeah.
- MaryAnne Lindeblad: If they -- yeah, it just [cross-talk] --
- Ryan Pistorosi: [Cross-talk] I think it says regular session, so if [cross-talk] --
- MaryAnne Lindeblad: [Cross-talk] Okay. So we can [cross-talk] --
- Ryan Pistorosi: [cross-talk] there is an extended session, [cross-talk] --
- MaryAnne Lindeblad; [Cross-talk] Okay.
- Ryan Pistorosi: [Cross-talk] that wouldn't impact [cross-talk] that. [cross-talk] --
- MaryAnne Lindeblad: [Cross-talk] Okay.
- Greg Gipson: Just a quick question. How often are these contracts renewed? Are they annually? Or just depends?
- Mike Neuenschwander: Yeah. So, that was something that we had discussed that probably a whole lot of plans that the renewal date will be January 1st, but there will be some that will be a year. And so, realistically, our assumption is that many of the plans that would be subject to the UPL wouldn't feel an impact. If we were to announce it in January of 2027, they wouldn't feel an impact until January of 2028.
- MaryAnne Lindeblad: The next [indistinct].
- Simon Borumand: But this timeline is important to know just because if we miss that window in January, then we fall another year later. And we've discussed this before in terms of what entities are covered. Again, it's some technicalities here, but it's all purchases of the drug reimbursements that were claimed for the drug for health carriers or health plan for under Chapter 41.05 RCW. And it's really those plans that are covered by the Office of the Insurance Commissioner in certain plans. And then the kind of national ERISA plans can opt in if they like to. And then also the new federal plans aren't subject,

obviously, for a few reasons. I won't go into too much detail here, but I did want to put it in the slideshow just so that people have all of these rules in one place. But once we do announce the UPL and it goes into effect, there are processes for manufacturers to appeal that decision, and we can cross that bridge once we get there. That's the first half, and I'll just take a quick pause for questions before moving into some of the outline of the different methodologies we used for a UPL. Seeing none, I'll charge ahead. So as I mentioned, there are different ways that you can move together methodology for how to institute a UPL, and a lot of this is drawn from a white paper that portal put out, and I've shared with all of you. And I would dive into that if you want further details or examples that they do a really good job. We also looked and just tried to see if there are other methods out there, but really, the portal did a good job of relating everything into one spot. The three big categories are reference pricing, and there are few subcategories there which we'll dive into. Looking at the net price and then setting a UPL based off of certain budgetary thresholds. So reference-based pricing, there are a few different approaches. One is to do a therapeutic reference price, and so that's taking the drug and trying to describe a price of value based off how it compares to alternatives in the market. And then the other approach is external reference pricing and so benchmarking against the national prices for other state or against federal prices like the Medicare and Maximum Fair Prices we discussed, or the VA's Federal Supply Schedule, which has a formula that they use, diving into each of those, therapeutic reference pricing. Like I said, what you wanted -- what you essentially do is you take the drug and you look at the therapeutic alternatives, and you compare based off the cost and the efficacy where you think this should be. Is the price too high for its efficacy? Is the price too low? So it's -- the strengths are it's kind of reflective of its market values and it's therapeutic value. And if you have the data, it's a fairly straightforward analysis. Limitations. One, it's -- if you have all of the alternatives of high prices, then everything is just going to be inflated. If it's difficult to identify therapeutic alternatives for the drug, and it may be tough finding the data on those drugs as well may be tough, and that there may also be implications for where the drug goes on the formulary placement. But those are decisions that are made by the entities for them to [indistinct] [audio cuts out]. In terms of external reference prices, one approach is looking at international prices. So we compared our country's. [Indistinct] looking at OECD data. What

are the other developed countries doing? And then you set a price that's either the lowest price of the most favorite nation, or an average or a weighted average or those countries rose. Obvious it leverages lower international prices, and it's a very simple analysis. The cons: One is that they may be using metrics that were barred using in their analyses, and two, there may be information that is confidential and what they're getting that we won't be able to access. Another external reference price that we could use is the Medicare Maximum Fair Price, and this is the one that, as I'll mention later, the other states have really been relying on. And, as you know, they set a ceiling on the drug price based off of the weighted average net price of the drug under Part D or a percentage of the non-federal average manufacturer price. It's -- the pros of this leverages our Medicare. It's pretty understandable and has a formula, and it has been used by the other states as well, and so we will be able to see what challenges they face from the manufacturers. The cons: There may be differences in what drugs we are reviewing versus what Medicare is negotiating, and I think as our list of drugs expands, that is going to be a bigger issue. And then, finally, in terms of reference pricing, using the VA or Federal Supply Schedule pricing, this is calculated similarly. They used the nonfederal average manufacturer price, but they have a slightly different formula. Again, it uses this price negotiation regimen that the federal government is using and have a much simpler analysis that trying to derive one our own. But we may face confidentiality issues and, again, the drugs may be different lists. So the second and third approach are, you know, have less bullets, and so it will be a little bit quicker. But a second approach is to use a net price. And we were just discussing some elements and the difficulties of this. But setting a UPL based on the drug's average net price after rebates and discounts. It ensures that rebates and discounts are reflected in the patient out-of-pocket costs, and so that's big. And so obviously, those are big determinations of how a drug is priced in the market. However, the con is something that we have discussed, I think, in a lot of meetings, and it's tough to find that information or get access to it. It may be restricted or confidential. Then the final approach is using a budgetary approach. So it's setting a budgetary threshold and then trying to meet that. One version of that is used premium growth threshold and so trying to determine the impact of a drug's price on the insurance premium and then use a UPL to limit that premium growth. It's nice because you can tie the savings directly to the patient

premium reductions. And one of our goals is to tie the savings directly back to the patients. The con, though, is it is a [indistinct] analysis to try and tease out what one drug's impact is broader premiums. And then just comparing it to the other states. And so Colorado, as Mike mentioned, they announced their UPL on Enbrel. And that's anchored to the Medicare Maximum Fair Price. Maryland is working on their methodologies and what they are putting into their policies is really like a broad-based approach where they can use the methodology for each drug. But in the first few, also they are setting up for Jardiance and Farxiga. They are using the Medicare Maximum Fair Price. So that's just a data point to have in mind. And then a simple slide. But our recommendation is to follow along with what Maryland has done, which is to really try and have a methodology that is broad enough that we can tailor it for each drug and it cannot be tied to one approach. Logistically, how that would work is the next step is working on writing the Washington Administrative Code, and we work with our team and work with Michael Tunick on the actual language, have it specific enough that it matches everything that we need to do with the Legislature and the legislation and then have it outline some potential options for methodologies that we can use. And then once we have selected a drug for UPL and we want it put in place, a specific UPL with that one we would put in place of policy drawing on that WAC and specify which methodology we'll use. That's the initial recommendation but open to conversation.

MaryAnne Lindeblad: Any questions? [cross-talk] --

Doug Barthold: [Cross-talk] examine those? Yeah, that's helpful. And I just want to say I agree with the recommendation that you gave.

Mike Neuenschwander: Any questions from the Board members?

Greg Gipson: Sorry. Can you just go back to the premium growth? I just didn't quite understand it. Maybe you could explain it a little. So the idea is -- I'm sorry. Can you just run through this one more time? I just don't think I caught it.

Simon Borumand: Yeah. So the idea would be to look. And I think in our case, identifying a certain population or a certain group of plans and say for these plans that we have the data on, how -- what is the impact of this drug

spent on patient premiums? And if we were to set the UPL at a certain cost, would that bring down the premiums by a certain --

Ryan Pistoresi: Right. So I think in this we would be using like a budget impact model in order to look at where the costs are and where the utilization is, and other reimbursement rebates, things like that, and then be able to determine if the Board wants to address the excess cost because it is unaffordable to the healthcare system over a 10-year period, this approach #3 tends to address costs -- excess costs that are attributable to that, and you can say we feel that this upper payment limit should be set at a price such that it controls the premiums and, therefore, ensure a sustainable healthcare system for public and private payers.

MaryAnne Lindeblad: [Cross-talk].

Greg Gipson: [Cross-talk]. Oh. Go ahead.

MaryAnne Lindeblad: I was just going to ask, are you looking across all of the like PEBB, SEBB, Medicaid, or [cross-talk] --

Ryan Pistoresi: [Cross-talk] Not Medicaid [cross-talk] --

MaryAnne Lindeblad: [Cross-talk] well, or not [cross-talk] not Medicaid. Are you just going to do PEBB/SEBB?

Ryan Pistoresi: Yeah. We do have SEBB and other public.

MaryAnne Lindeblad: Any other public [indistinct] asks us to.

Ryan Pistoresi: [Cross-talk] That private payers and ERISA plans that choose to want to participate. I imagine some ERISA plans would want to.

Greg Gipson: Okay, thanks.

MaryAnne Lindeblad: Any questions?

Doug Barthold: Yeah. Which one other thing I wanted to mention about the recommendation regarding flexibility. I think that, like I said, I agree with it. Yeah, we should do the best we can for each drug given that

we're going to have different data inputs to each drug's UPL decision, so I definitely agree with that. But I also think the flexible approach could also be interpreted as arbitrary, you know, or sort of just picking and choosing arbitrarily. And so we need to be careful about, you know, clearly justifying the choice that we make for each drug before it's summoned. And I guess we would use the language in the statute at the end. But I just wanted to note that [indistinct] it can't look arbitrary.

Mike Neuenschwander: Yeah. And on that, you know, the Board would be able to discuss it and be able to vote and agree to consensus on which type of these approaches may be appropriate for different drugs. But given that, you're looking at Brands, biologics, generics. You're looking at many different disease states and very different costs and budget impacts. It makes sense to be able to have different tools instead of just one tool to address [cross-talk] every issue that comes up.

Doug Barthold: Well, it's like what Maryland did with, you know, it's like some drugs you have the Medicare NFP, which is an incredible resource. Like, they've done all that research, and they had -- and that they have incredible resources to arrive at that number that we don't have. It's like if we have that information, then that would be, could be, I think it would be pushed to not use it, but we don't always have that information. So I think we need to be flexible in that respect.

Hung Truong: Simon, are you saying that these methods, that whatever we decide, and it sounds like if we could do the flexibility, then it needs to be written into ruled laws. Is it okay?

Mike Neuenschwander: Yeah.

Hung Truong: And it's not currently. We just -- okay.

Mike Neuenschwander: Yeah. So that's one of the things that is actually in the legislation outlining that we need to create the rules around upper payment. So that's kind of -- because the rulemaking process takes so long, we need to start now. So even though it's like, okay, we have 2027 until we can set upper payment limits and then, obviously, it's Simon's timeline that it will actually become effective until six months later. We need to start looking at these things now in terms of how we're

going to create these rules. How are we going to set up these methodol- [audio cuts out] these policies. So one of our goals here is for our next meeting in May to come back with some proposed language for the rule. Here are some ways that we're thinking that we could flush the methodologies below some of these, look at, you know, establishing those policies. This is kind of the introduction to here are some of our possibilities. Do you like them? And if so, let's go forth and start seeing what we can do to standardize it to -- into a policy.

MaryAnne Lindeblad: Any questions, comments? All right. Well, I think it's time for us to go ahead and move into public comment.

Mike Neuenschwander: Sure.

MaryAnne Lindeblad: It looks like -- oh, Dharia. Dharia, go ahead.

Doug Barthold: We can't hear you.

Dharia McGrew: Thank you. Sorry. Switching between Zoom and Teams, my microphone is always on the wrong microphone. Thank you, Board, and Chair and Board members. For the record, Dharia McGrew on behalf of PhRMA. Thank you for the discussion today and the review of the methods from last year and starting the process of your UPL regs. We have not had a time to prepare a written letter for these meeting materials, but we will follow up with additional comments on all of this. Appreciate the lead time that the Board is taking to set this up. There is a large amount of work involved in this. As you note in the slide deck, there are a lot of pros and cons for each of the potential methods you have touched on. We will provide additional thoughts on each of those. Setting that aside, I want to flag that setting a price threshold is just one tiny step in a UPL that doesn't scratch the surface of how a state could actually operationalize a UPL. I urge the Board and HCA, in this process, to also consider how any such approach could possibly be implemented at the state level. You must consider how different markets operate in significantly different ways. For example, -- the MFP rate that you mentioned is specific to Medicare, with the goal of saving money for the federal government. MFP does not reduce patient out-of-pocket costs, and it is being operationalized through a retrospective rebate. This only works because CMS is both the payer and the regulator. They have the data. They are paying a

large amount of money to a TPA to analyze the data and determine how much the manufacturer pays in rebate on the back end. And it is unclear how any state could implement that in the commercial market given the differences between state regulators and CMS. One additional resource you could consider looking at as Board members is the Oregon UPL study that was done a year or two ago that discusses it quite in detail much of the complexity involved in each of these methods. And the Oregon UPL paper does go into additional state data needed and additional rulemaking authority that would be needed for each of these various methods. So, as I said, we will continue to engage throughout this year as you move forward and provide additional comments on your process. Thank you for your time.

MaryAnne Lindeblad: Thank you. Any other comments?

Mike Neuenschwander: Give notice beforehand? I mean, once [indistinct] limit speak, but I don't see -- So we did get a couple of letters forwarded to the Board, and one of those was from Tiffany. So we can take a look and Wednesday through that as well as all of the [indistinct] because they also discussed some of the same or similar concerns around UPLs and our [indistinct] expressed. Let me see if maybe I upgrade to make you a panelist. That allows her to speak, but --

Ryan Pistorosi: [Indistinct].

Mike Neuenschwander: That's fine. -- there, Tiffany? Okay.

Tiffany Westrich-Robertson: I am.

Mike Neuenschwander: Well, that's it [cross-talk] --

Tiffany Westrich-Robertson: [Cross-talk] Right [cross-talk] ?

Mike Neuenschwander: -- for [cross-talk] the main presentations [cross-talk] that we had now. Is she there?

Tiffany Westrich-Robertson: I'm here.

Mike Neuenschwander: Okay.

Tiffany Westrich-Robertson: Okay. All right. Great. Thank you so much for the opportunity. My name is Tiffany Westrich-Robertson, and I am speaking today on behalf of the Ensuring Access Through Collaborative Health and coordinating Patient Inclusion Council or the PIC. I'm also a person living with autoimmune disease treated by a couple of the drugs under review here this year. And I wanted to actually talk -- it's a little different than what we submitted for the coalition letter, and that is specifically to talk about as the PDAB begins its initial reviews that making sure that the patient facing data collection and the concerns that our coalition, me included, have been raising in respect to a need to revise what's currently out in the patient surveys as published. They do not reflect meaningful incorporation of public comments. They will -- so for those reasons, we would like to see those adjusted. This does matter because proper question design is essential for usable analysis. This is not theoretical. Our coalition, including myself, who has a strong background in research, have been working on Prescription Drug Affordability Review surveys based on -- since 2023, when the Colorado PDAB survey showed that poor question design prevented fully truthful responses from patients and resulted in misleading analysis. Our coalition has worked for the last 18 months to identify the right questions to ask in a multi-phase research project, which I have shared the pilot with this PDAB in August of last year. I did -- I was told by the staff that we would be referred to as collaborators when it was time to write the patient survey, which we were not. I did, however, participate in the September 18th request of a public review and submitted substantial revisions only to have one minor suggestion adopted. When I asked staff, "Why?" I was told that the survey was based on what the Board and the sta- and the stakeholder council wanted. But respectfully, I, as an expert, took 10 minutes to look at that survey that's published now, and I've identified over a dozen critical issues that if shared -- that I shared with the staff last month, who did tell me they were excellent and that they would be consi -- they would refer those to the Board and the stakeholder council. I don't know if that has happened. But I have sat here today, and I've listened to all the hard work, all the hard, hard work and effort that you all are doing to get robust and usable data for the reviews. But I must ask, why is the patient facing data collection so minimal and not as important moving forward as all of the other aspects of these reviews? It makes me question who these reviews are

really about and who the benefactor is. It's not too late to create right surveys. And I, as an expert, our coalition, we stand by you to help you make sure that the patient surveys and the data you collect can be usable in your reviews. Thank you.

Mike Neuenschwander: -- much.

MaryAnne Lindeblad: Okay, yeah.

Mike Neuenschwander: Okay. Any other questions or comments, rather? Okay.

MaryAnne Lindeblad: I think we can go ahead and close this meeting out.

Simon Borumand: And we'll be back into Executive [cross-talk] --

MaryAnne Lindeblad: [Cross-talk] And we'll be going. Right. I was going to say, and then we'll be going back into Executive Session, but we're closing this meeting now.

Mike Neuenschwander: Okay, great.

MaryAnne Lindeblad: Thank you.

Mike Neuenschwander: Thanks, everyone.

MaryAnne Lindeblad: Thanks to all.

Mike Neuenschwander: And Board, yeah, we'll reconvene here for another, I don't know, until noon, huh?

MaryAnne Lindeblad: Yeah.

Mike Neuenschwander: [Cross-talk] Okay.

MaryAnne Lindeblad [Cross-talk] As soon as [cross-talk] --

Mike Neuenschwander: So Board members, please hop back on the other Executive Session Team link.

Michael Tunick: Until noon, okay.

Mike Neuenschwander: Until noon, yep.

MaryAnne Lindeblad: We hope.

Mike Neuenschwander: Yep. We will extend as needed. Okay. Eileen, we're [audio cuts out] --

[end of audio]