

**Washington State Health Care Authority
Prescription Drug Affordability Board
Meeting Transcription
November 19, 2025**

Mike Neuenschwander: Uh, just waiting on Doug and MaryAnne at this point.

MaryAnne Lindeblad: So Simon, hi. This is MaryAnne. I made it.

Mike Neuenschwander: Hm. That's awesome. Sorry about [cross-talk] that.

MaryAnne Lindeblad: [Cross-talk] Thank you. That's okay. [cross-talk] --

Mike Neuenschwander: [Cross-talk] I'm glad it finally worked. I think we're just waiting on Doug, and then we [cross-talk] --

Doug Barthold: [Cross-talk] I'm here.

Mike Neuenschwander: Oh, Doug, you're here. Okay, perfect.

Doug Barthold: Yeah, that linked worked.

Mike Neuenschwander: Awesome. Um, in that case, we can get going, and I'll share the Agenda. Okay. And Eileen, I think you're still in charge. Do you want to kick us off here?

Eileen Cody: I do.

Mike Neuenschwander: Oh, I can't hear you. Oh, still can't hear you. Don't worry. You need to switch devices or something? Okay. Give her one minute. It's always got to be, uh, something here, you know, to kick off every meeting, so [cross-talk] --

Dharia McGrew: [Cross-talk] Test, test, test.

Mike Neuenschwander: Oh, I hear you, Dharia.

Dharia McGrew: Oh, okay. All right. I am here. Apologies for, uh, being late.

Mike Neuenschwander: Oh, no worries. As I said, we're still -- we're still working out some technical kinks here.

Dharia McGrew: Right. When you switch from one virtual platform to another virtual platform, it changes all your settings, and you have to -- [laugh] [cross-talk] --

Mike Neuenschwander: Yeah. [cross-talk] --

Dharia McGrew: [Cross-talk] -- figure out which microphone you're using.

Mike Neuenschwander: Okay. Eileen, you there? I still can't hear you if you are. Oh, I heard something soft.

Eileen Cody: Can you hear me?

Mike Neuenschwander: Uh, it's very faint.

Eileen Cody: Oh, there's nothing [indistinct].

Mike Neuenschwander: Can you get the microphone a little closer perhaps?

Eileen Cody: Does that help if I move?

Mike Neuenschwander: Um, that's still pretty quiet.

Eileen Cody: I do not understand. I think Microsoft [audio cuts out] [laugh] --

Mike Neuenschwander: [Laugh] Okay. I can see you and we can hear you. It's a little quiet, but we can -- I think we can make that work.

Eileen Cody: Well then why don't we just go ahead and get started?

Mike Neuenschwander: Oh.

Eileen Cody: And why don't they introduce themselves?

Mike Neuenschwander: Okay. Sounds good. So Board members, why don't we just run through our Board members real quick since we do have some returning faces here. Um, so, Eileen, you want to go first?

Eileen Cody: Eileen Cody [audio cuts out] on the staff for about a [audio cuts out] come.

Mike Neuenschwander: Yeah, thank you. Yeah, that was a little a little choppy, but, uh, we caught some of that. Um, Hung? You want to go next?

Hung Truong: Hey, good morning. Hung Truong, Board member.

Mike Neuenschwander: Great. Let's see, Doug?

Doug Barthold: Hi. Doug Barthold, Board member.

Mike Neuenschwander: Great. MaryAnne? Oh, you're on mute.

MaryAnne Lindeblad: MaryAnne Lindeblad, returning Board member.

Mike Neuenschwander: Great, thank you so much. Um, and then Greg, I think, had some sort of -- he's -- I think he's sick or not feeling well today, so, um, he pinged us this morning. He won't be in. So, um -- and then I'm Mike Neuenschwander, the Director for the Prescription Drug Affordability Board. Um, and then, uh, we have, uh, some of our team members on here, um, as well today. Uh, Simon, do you want to introduce yourself?

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

Mike Neuenschwander: Great. Ryan?

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

Mike Neuenschwander: Great. Jingping?

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

Mike Neuenschwander: Great. Sumaya?

Sumaya Sabeeh: Good morning, everyone. I am Sumaya Sabeeh. I'm the Data Analytics and Research Manager here in Cost and Quality Analytics Team.

Mike Neuenschwander: Okay. Arsheena?

Arsheena Hussein: Good morning, Arsheena Hussein. I'm the Drug Price Transparency Data Analyst.

Mike Neuenschwander: Okay, great. And I think, uh, Kelly Wu, who is also one of our data analysts was on, but, um, is just restarting her computer, so she should be back here shortly. Um, great. So I'll take us in here to our next spot with the PDAB Director's Report. Um, so a number of exciting things going on around the country. So I'll give some brief updates of what's happening in other states, then I'll give a little bit of a kind of timeline of how I'm seeing things here going for the next, you know, six to seven months, um, and then we'll chat a little bit about, um, some of the next year's meeting dates that we have tentatively on the schedule. So, um, probably first and most exciting is Colorado, as per usual. Um, they always have a lot of stuff going on it seems, and, uh, they're, I don't know, maybe a year, year and a half kind of ahead of the curve of where most other states are. So, um, I guess first thing they have it -- they do have a newer director. She's not new, but, uh, from a few months back, uh, Sophie Thomas, uh, who joined their team. Um, and then most recently, uh, they set an upper payment limit for Enbrel going into effect in 2027. Uh, the upper payment limit is approximately, uh, \$31,000 per year, I believe, and um, it was determined based on the Medicare maximum fair price, um, that, uh, manufacturing negotiated at the federal level. Uh, so they, as most of you probably know, they previously had a lawsuit after their first drug review on Enbrel, um, and that was dismissed as it was a rule and they didn't have standing, and there weren't damages. Um, now Amgen has refiled that lawsuit, uh, under the -- some of the things that they're, they're claiming in the lawsuit is, uh, violates the Constitutional Supremacy Clause, Commerce Clause, Due Process Protections of the 14th Amendment, and, uh, conflicts with federal patent authority, um, and that the PDAB's decisions lacked meaningful standards, making it arbitrary. Um, and there's a really great article in the Colorado Sun explaining all of this, uh, so I, uh, you know, if you want to kind of get more in depth and detail on that, uh, just Google Colorado Sun, Colorado PDAB, um, and you'll probably find that at the top of the Google search. So I believe the first hearings for that will be in January. Um, and other drugs that Colorado has conducted reviews are Genvoya. They deemed it affordable. Uh, Stelara, uh, was deemed unaffordable and eligible for UPL. Cosentyx was deemed unaffordable and

eligible for UPL. And Trikafta was deemed affordable. So, um, that's Colorado right there. Um, going on to the next state here, uh, we have Oregon, uh, just to the south of us. And they do have a brand new director, I think she started just a couple weeks ago, named Sarah Young. Um, and so they're in the process of conducting affordability reviews on 23 different products. Um, and so in January 2026, I believe, the Board will vote to narrow down this, uh, list of reviewed drugs, uh, for the spring, um, that Oregon will present to their legislature. I believe, uh, nine drugs and one insulin product, uh, I think is their goal, um, to present to that. Um, and those reviews because of the amount, I believe, are probably not as in-depth as like the Colorado reviews are a little bit shorter higher-level reviews. Um, Maryland, uh, over on the East Coast, uh, is presenting, um, some affordability reviews on Ozempic and Trulicity, or I think they - - rather they presented on November 17th, um, and so the Board, uh, -- their Board is discussing some potential paths to implement the UPL, um, and I think they've done some drug reviews on two other drugs and have info requests out for two more. And I think they are also looking at like the Medicare maximum fair price as a reference price for their UPLs. Um, and finally, Minnesota just hired a brand new PDAB Director, Vernon Rowen, and so they are in the kind of very early stages of where we were at about two years ago of just trying to start up their PDAB program from the ground up. So, uh, that's kind of, uh, what some of the other states are doing. Um, so yeah. Everyone is more or less in the process of drug reviews like we are and then starting to look towards upper payment limits. So any questions from the Board on any of those updates? And I don't have tons of -- like in-depth specifics of the how's and why's of exactly how that all happened in the other states, but what we do contact -- keep in contact with them regularly, so, you know, have general, you know, updates on what's going on there. Okay? Great. Um, so let's see, next part for the director's report, just kind of looking at our timeline here. Um, and so Board members, I know in our one-on-ones we've kind of chatted a little bit about where we are, where we're headed, um, so, uh, this fall here has really been our data collection time. You know, we selected our drugs, uh, in July, worked on trying to refine and hone the forms there in the -- at the end of summer, sent out data requests as well. Um, and so, uh, then we started getting some information back. So, uh, some of our deadlines that we had in terms of getting information back were for the PBMs were, I believe, October 16th, payers were September 30th, um, and then we do have manufacturers, um, who both requested extensions, um, so we will be, uh, looking for data from them in the

middle of December and January. And we have also been in contact with them regularly as well for questions that they've had as, you know, trying to clarify, "What is [audio cuts out] does this mean?" Or, you know, "How do we fill out these forms?" So we have been having some meetings with them as well, trying to work to complete those requests. Um, and then also just internally, we've been pulling, you know, the data we have access to from like APCD to help fill out, uh, our portions of the report for what -- we can see. And so with all of that also working to finalize just going through some internal processes for the surveys as well to get those approved so we can put those out. So the goal is planning to, um, skip our January meeting, as we're still kind of collecting data from the manufacturers but then have our first versions or drafts of the drug reviews ready for March and reviewing them in May as well. So other things that we're looking on doing throughout the winter is also because Colorado and Maryland have been working on their upper payment limit policies and working to implement those. Uh, we'll be looking at those as well, so we can also begin discussing, you know, our own upper payment limit initial methodologies, um, in the spring and work on those throughout the summer. Um, come June 30th, uh, we will also, uh, work on updating our, uh, drug list, uh, with a new list of eligible drugs, uh, and then as we're finishing up our drug reviews in the spring able to start transitioning back to selecting some new drugs for July, once that drug list comes out, and then upper payment limits can begin starting, uh, in January 2027. So that's kind of the general gist of finishing up our data collection here in the winter, doing our drug reviews in the spring, new list of drugs and selecting new drugs next summer. And then in terms of just Board meetings that we have coming up, again I mentioned we're going to be canceling the January 1, but we have March 18th for next year, March 20th, July -- or not March 20th -- March 18th, May 20th, uh, July 15th, September 16th, and November 18th. So we're just trying to plan those ahead a little bit to get those on our calendars and make sure we do reservations for the room. So Board members, if you have any specific conflicts with any of those, tell us, and we can work to make any tweaks or adjustments sooner rather than later. So in terms of a director's report, I think that's where we are at.

Mike Neuenschwander: So any other questions from the Board on any of that? Okay. Wonderful. So then I -- oh, Dharia?

- Dharia McGrew: Uh, sorry, just flagging. Um, you probably already know, but just to make sure, those dates do conflict with the Oregon PDAB meetings, so stakeholders that are engaging with both, um, multistate PDABs do have difficulty when they -- when they conflict.
- Mike Neuenschwander: Okay. Yeah. Well, we try and deconflict, uh, where possible. But, uh, yeah, the there are enough PDABs around the country and other meetings, it does get a little hard to fit everyone's calendar. Okay. But yeah, where possible, we'll try and take a look at that. Okay. Uh, let's see. So now we can go to -- now that MaryAnne's back, um, I think we, uh, had some, uh, discussions in terms of, uh, -- I know Eileen, was the Vice Chair and had taken over the Chair duties, uh, while MaryAnne was, uh, acting with the HCA. So I think, uh, we were going to, uh, discuss reorganizing our chairmanship again back to the way it was. So Eileen, do you want to take that over?
- Eileen Cody: I [audio cuts out] hopefully in time to be able to [audio cuts out] but we do need to take a vote [cross-talk] --
- Doug Barthold: [Cross-talk] I can't hear anything. I'm sorry.
- Mike Neuenschwander: Yeah, it's cutting out like every, every other word.
- Doug Barthold: It's just really faint.
- Eileen Cody: Again, uh, hasn't somebody made the motion so we [audio cuts out] pass this on [audio cuts out].
- Mike Neuenschwander: Okay. All right. I think she was saying somebody make a motion so we can motion for MaryAnne to resume the chairmanship. We can have Eileen as Vice Chair, and then we can vote on that. Does that sound -- is that correct? Okay. So moved.
- Hung Truong: Second.
- Eileen Cody: Okay then, all in favor --
- Doug Barthold: Aye.
- Hung Truong: Aye.

Greg Gipson: Aye.

Eileen Cody: Aye. MaryAnne, take over!

MaryAnne Lindeblad: I'm back!

Mike Neuenschwander: [Laugh]

MaryAnne Lindeblad: And thank you [indistinct] appreciative to Eileen to step in while I was at HCA [indistinct] for eight months, and nice to be back, so I'm looking forward to working with you all again.

Mike Neuenschwander: Yeah, we really appreciate you, uh, coming back, MaryAnne. It's, uh -- actually, it fits in really well because, you know, you already know what's going on, so, uh, [cross-talk] you know, there's not a -- there's not a steep learning curve, um, so, uh, yeah, we really appreciate you coming back.

MaryAnne Lindeblad: Thank you, Mike. So time to take over. So I guess were ready for the next - - I got to put my glasses on here. So, um, [indistinct] --

Mike Neuenschwander: Well, and I think [cross-talk] Ryan [cross-talk] --

MaryAnne Lindeblad: Or did you have something else, Mike, you wanted to raise?

Mike Neuenschwander: Yeah, I think Ryan, uh, Pistorosi has a conflict here later at the end of the meeting, [cross-talk] so if we could -- if we could bump his up first before Kelly's, um [cross-talk] --

MaryAnne Lindeblad: [Cross-talk] Sure.

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

MaryAnne Lindeblad: [Cross-talk] And then go [cross-talk] --

Mike Neuenschwander: [Cross-talk] -- the agenda as normal.

MaryAnne Lindeblad: [Cross-talk] Okay. And then go back to Kelly. Okay, great. [cross-talk] --

Mike Neuenschwander: [Cross-talk] Yep.

MaryAnne Lindeblad: So, Ryan, [cross-talk] thank you.

Ryan Pistoresi: Great. All right. So for this one, um, this is related to how we were aggregating drugs on the eligible drug list. So as you recall, one of the first steps that we did in looking at what drugs would be eligible for the affordability reviews is we presented the different dashboards and the different data around the different drugs. You know, since we did that, there were some, uh, thank you. Uh, since we did that, there have been some discussions around different ideas on how the drugs may be grouped together and how that may, uh, change some of the different data metrics on the um, you know, on the different dashboards that we have. So for here the background is that again, you know, we need to put together the list of drugs that would be eligible for an affordability review. With the one approach that we did this year was that we aggregated the drugs by the ingredient and by the labeler. But as I mentioned, there had been some discussion and thoughts around a second approach here at the bottom of the slide, which would be to, uh, compile the list solely by the drug ingredient, um, which would include multiple manufacturers rather than, uh, by individual manufacturers. And so the purpose of this presentation and this discussion today is just to highlight, uh, this alternative approach and see if this is the direction that we should move in for, uh, future years of developing the eligible drug list. Um, so the current drug list is done by the ingredient and the labeler. So that means that if there are multiple manufacturers making the same drug. So you can think about this as a brand name drug and a generic of that, or a reference biologic and a biosimilar, or even two different generic manufacturers or two different, you know, biosimilar manufacturers, those would be, uh, separated because they are made by a different manufacturer. Um, so in doing it this way, we were able to really separate out the different manufacturers because each manufacturer sets their own price, and that may impact whether drugs are eligible for the list or not. As you know, brand name drugs have certain criteria, biologics have different criteria, and generic drugs have a third criteria. So if we are thinking about how we approach that this year, we can take a, you know, drug ingredient, drug Alpha, and if drug Alpha was made by three different manufacturers, manufacturer A, manufacturer B and Manufacturer C, they would each have their own, you know, individual drug products. And so the way that you would have seen that on the drug dashboard is that you would have seen the individual Product 1, Product

2, and Product 3, rather than the aggregated drug ingredient, Alpha. So this could make the overall cost and overall utilization of that entire drug ingredient, Alpha, less than some of the others because its costs and utilization is broken out by three different items. You can think about this if they were compared to a drug ingredient, Beta, who only had one manufacturer and one product. This drug, Beta, may seem more than the Alpha products because the Alpha products, again, are split up between these three different manufacturers. And if this is getting confusing, please stop and let me know since I know that these are a lot of different names for the different types of drugs, manufacturers, and ingredients, but um, trying to help illustrate it, you know, kind of through this example on this slide. Okay. So on the next slide goes into this visual example, and so this is just a theoretical example of looking at what was presented in the upper table, um, versus, you know, kind of what is actually happening with that drug ingredient there at the bottom. And you can see that the drug total from the top, uh, matches exactly with that drug ingredient, so you get the same type of information, but it's not split out between kind of these three different drug products. Okay. So the -- there is a proposal that for the next year when we are developing this drug list that we, um, do it, uh, at a separate point. So in the development of the list, we'll continue to look at the individual ingredients and labelers because that is necessary for us to determine whether they meet the statute, uh, statutory criteria in 70.405.030, so continuing to make sure that we are looking at brand products a specific way, biologics a specific way, biosimilars, you know, and generics their own way. But once we have that list with all of the different ingredients and products at the manufacturer level would be to aggregate it to be at a drug ingredient level, so if there were multiple manufacturers whose products met the criteria, they would now be grouped into one item together rather than how they were presented this year where they were separate. And so this would change how the information is presented to the Board, but we want to see what the Board's, um, you know, their willingness to go forward with this new approach and whether you liked it in its original format where it was at the labeler level or if you would want to aggregate it more at the drug ingredient level.

Doug Barthold:

So I'm happy to add [cross-talk], oh [cross-talk] --

Ryan Pistorosi:

[Cross-talk] Let me see if there's one more slide. [cross-talk] I think it just might be the question slide. Yep, questions. Okay. So Doug, it's yours.

Doug Barthold: Yeah. I was just going to kind of summarize my feelings on this. I'm in favor of the switch. Ryan, that was a great summary. Thank you. Um, you know, as you noted, it's necessary to have it at the ingredient labeler level when we are determining eligibility for the list, eligibility for affordability for affordability review. But then when we're determining among the eligible products, which we want to do the affordability review on, I think it's important that we aggregate to the ingredient level. And the reason I think that's the case is because we don't -- if a single ingredient has multiple manufacturers, you know, like in the example you gave there if there's three, and so those costs get split out between three manufacturers, and those used and the number of users get split out between the three manufacturers. That doesn't make it less unaffordable. Let's just assume that it's unaffordable. It doesn't make it less unaffordable to the people of Washington. You know, if 5000 people use the version from manufacturer A and 5000 use the manufacturer B, and another 5000 use manufacturer C, there are 15,000 users of this ingredient. And I think that, to me when we were determining which drugs we want to do an affordability review for, it's the 15,000 users of that ingredient. That's what matters to me in making that decision, so that's kind of why I -- think this is a good idea. But yeah, I'm curious to hear what others think. So I, you know [cross-talk] --

Mike Neuenschwander: [Cross-talk] And maybe Ryan, can you kind of give just a quick like pros and cons of the two, you know, what this -- what we're doing versus what the switch would mean.

Ryan Pistorosi: Yeah. So the pros for the current state are that you are able to see a bit more granular detail around the different types of manufacturers that may be, you know, having a different level of impact than some of the other manufacturers. And so the way that it -- yeah. So if we were to continue this, and if we had an example in which the same drug by two different manufacturers, you would be able to see that detail a little easier on the dashboard, whereas the con for the current way is exactly what Doug said, is that you're not getting the actual impact of that drug because it may be spread among different manufacturers, and you may select a drug that has a lower overall impact than that kind of drug ingredient, um, for that affordability review. And the pros are pretty much the opposite of that. I mean, if we were to go forward with this proposal, you would see some of these, uh, more impactful drugs, but it

could be that it's because this drug is made by several manufacturers. And if you're interested in just a, you know, a single drug by a single manufacturer, you know, it may not be, um, as high on the list, so it's really just a method of how this -- the same type of information. I mean, it's going to be the same underlying information. It's just how is this displayed for the Board when doing the considerations for which drugs to select for the affordability review.

Mike Neuenschwander: And so, so with this new approach, if we select an ingredient, we would in effect basically have to do a drug review on multiple manufacturers if it was spread across multiple manufacturers. Correct, Ryan? Like we do [cross-talk] --

Ryan Pistorosi: [Cross-talk] Yes. I mean this -- if we were to do it then that way, then yes. Um, but I don't think that there's anything that would have prohibited us from doing that this year. It's just that, um, you know, since the statute around selecting the drugs for the affordability review is really kind of at that ingredient level rather than what we were doing is, you know, the ingredient manufacturer level because that's how we were looking at the eligible drug list.

Mike Neuenschwander: Okay. Thanks. Thanks. And yeah, I think, you know, this is just something that's up for consideration and want to. Yeah, I think Doug has an interesting idea here of, you know, some different ways we can look at this. And one of the reasons why I wanted to bring this to this Board meeting was just because if we are going to make a change, I want us to have time to think about it and then time to change our process, so when we're coming around for like I was talking about our timeline next summer, you know, we can make those appropriate changes. But Doug, you have your hand up.

Doug Barthold: Yeah, thanks. Um, I just wanted to -- so I think it's important to note that, that this, this change, this change would only make a difference in pretty rare cases because it would have to be a drug with multiple manufacturers. And so all of the drugs we chose this year for affordability review only have one manufacturer, and so it wouldn't make any difference for any of those. Um, this is only the -- this is -- when we have eligibility for a generic, then there could be multiple manufacturers, but all these ones who have eligibility through the brand criteria are not going to have this, uh, this isn't going to make a difference because they

only have one manufacturer. So um, it's a pretty rare distinction, but I think it, um, we -- again, I like it because I think it, you know, it gives us a strong, uh, sort of theoretical justification for the choices that we make when we rank the drugs in terms of what we -- how important we think they are for affordability review. And then the other thing I wanted to note was just that, like if we -- so Ryan, when you were talking about when we display them on the dashboard, the level of granularity would be different. But at the affordability review stage, we would still get that level of granularity, right? Even if we did an affordability review for you in this new -- in this proposed new system, we'd have, uh, you know, it would be for multiple manufacturers of the one ingredient. We would then get the granularity at that stage to see -- oh, well, maybe this manufacturer has a high price and this one has a low price, so we would see that then, right?

Ryan Pistorosi: Correct. Yes. You would get that. It would just be at a kind of a different step in the process.

Doug Barthold: Okay, thanks.

Mike Neuenschwander: Yeah. I would say, I think that if we did have a drug that had multiple manufacturers, again, the aid is the -- to collect the data, it's just that it's that much more work so that, you know, it's like doing multiple drug reviews in one, um, and so I think we'd have to consider how many other drugs we would review, you know, depending on how many manufacturers and stuff we'd be trying to coordinate with and gather data from. So, um, something, something to keep in mind. Uh, Hung?

Hung Truong: Oh, thanks, Mike. Um, I concur with Doug. My question would be when we're looking at the ingredient, we're also looking at [cross-talk] biosimilars. Is that correct? So it's not just a generic for that drug because the biosimilars, the ingredient plus notations to show a biosimilar, right, but it typically is the same ingredient? Why I was checking [cross-talk] --

Ryan Pistorosi: [Cross-talk] So I need [indistinct] the question. What was that about the biologics?

Hung Truong: So when we're talking about looking at it as a whole or just the -- at the ingredient, we're not, we're not talking about the brand generic, but we're including the biosimilars to looking at it in Doug's point that because as

the biosimilars are coming out, right, you're diluting the brand and the generic usage.

Doug Barthold: [Cross-talk] I think you're right, Hung.

Ryan Pistorosi: [Cross-talk] Yes, and so [cross-talk] Yeah.

Hung Truong: Okay.

Doug Barthold: If there's -- there are the three criteria with which you can be eligible for affordability review. There is -- one for brands, there's one for biosimilars, and one's for -- and one for generics. And this change would only apply to then how we rank the biosimilars and generics.

Ryan Pistorosi: Correct.

Mike Neuenschwander: All right. Uh, Dharia? Or I guess Hung first. Did you have any other questions? Was that good?

Hung Truong: Um, not right now, so [cross-talk] --

Mike Neuenschwander: [Cross-talk] Okay.

Hung Truong: -- I'm good.

Mike Neuenschwander: Great. Dharia?

Dharia McGrew: Thanks. Um, yeah, we will take this back to manufacturers and get their -- get their thoughts on that. But first my high-level initial thoughts just are that this proposal would definitely prioritize system costs, uh, and I don't see any consideration in this or discussion yet on patient affordability costs and how this would affect that if, you know, how, how this would look at that in this picture if you did have a situation where you had a brand and a generic or a biologic and a biosimilar, you know, one would presume that they have very different formulary. They, you know, they're competing for formulary placement, and they could have very different patient out-of-pocket costs because of that competition, and so those differences might get blended, diluted in in your data if you're combining those things. So encourage you to consider that as you advance this proposal.

Mike Neuenschwander: Okay, Eileen?

Eileen Cody: My question is just I assume this is now in statute.

Mike Neuenschwander: No, this wouldn't be a statute change. This is a kind of a policy after we create the initial drug list of how we're going to go about selecting stuff.

Eileen Cody: Just checking.

Mike Neuenschwander: Great. Okay. Um, any other thoughts or questions from the Board on that?

Doug Barthold: I guess I would just note in response to Dharia, I think it does take into account patient out-of-pocket costs better when you aggregate to the ingredient level just because then you're looking at total number of users. And we would also when -- one of our criteria is out-of-pocket costs, or I guess out-of-pocket costs per user, but then the total number of users is going to -- I think we're going to better capture that when we include all the manufacturers prior to this ranking. Um, so I take your point that it's. It's not going to have that granularity on the dashboard, but I think we'll see that better in our affordability reviews.

Greg Gipson: This is Greg. Can I ask one other question real quick?

Mike Neuenschwander: [Cross-talk] About what, Greg?

Greg Gipson: So I guess if we're getting multiple labelers, uh, and if -- what if some of those don't meet the statutory requirements for being reviewed? Do we just did not review those and review the others? In that sense, the upper payment limits would only apply to some of those products that kind of have this will play out potentially?

Ryan Pistorosi: Yes. Yeah. So that is correct. So we would do the review first and make sure that all of the drugs on the eligible drug list meet the statutory criteria in 70.405.030. And then once we have that list, then we can aggregate those ingredients together when creating that dashboard. So, you know, to Eileen's question, you know, we aren't changing any of the statute. We still are following all of the requirements in that. But then once we have that list created, we can present that list to you in a number of different ways. And so the proposal, you know, on the table today is to

change how you would see that data and that drug list. Now the individual drug products, you know, would still be there. And if you did want to see it at that granular level you could just do that when we are looking at the dashboard and presenting the different metrics to you, it would just be done at that drug ingredient level.

Greg Gipson: Got you. Okay. That's very helpful. Thanks.

Hung Truong: [Cross-talk] But Greg, -- going back to that question, it's how is going to apply? Is it -- if we need it -- if it's decided that the ingredient at the ingredient level that there is an upper limit so that's needed [cross-talk] that's going to apply to all [cross-talk] about someone's generic and brand that is associated with that. Um, and then there must be a difference between all three or what that upper limit would be. Is that -- is that at the -- is that the intent at the end of the day?

Ryan Pistoresi: So that's a good question, and I don't think that we've gotten to the upper payment limit methodology yet. I think that may be a question for when the Board is setting forth, you know, kind of that that methodology for setting up our payment limits. And I [cross-talk] like others [cross-talk] --

Ryan Pistoresi: [Cross-talk] My guess is that it would have to be that the upper payment limit would only apply to eligible products, and so we still wouldn't -- I mean, and again, I'm just guessing here, but -- so it wouldn't if there was a something that had that ingredient that but didn't merit inclusion in the eligible products list, the upper payment limit would not apply to those NDCs. That's just sort of my, my first stab at it.

Ryan Pistoresi: Yeah, and I agree with that.

Doug Barthold: Okay.

Mike Neuenschwander: Yeah. And like I was mentioning before, um, we're going to start pulling together some data on upper payment limits based on what the other states have been doing, um, here over the holiday and, and early winter. Um, and so, yeah, I think we can start looking at these discussions of, um, you know, since upper payment limits will be coming in 2027. So throughout 2026, you know, what does this potentially look like? Um, what do we think? And I think kind of timing wise, uh, this, uh, you know,

we're actually sitting in a good spot, um, where there are upper payment limit questions being asked in the court, um, currently, um, so we can kind of see what's going on with that as well to help inform us throughout the, the next year, um, on things that we need to do so, uh, yeah. So I think we still have a few questions around that stuff that we definitely need to iron out, but, um, that's all good conversation. Um, so with that, I think my initial goal today was just to have this discussion to get this idea out in front of us. Um, and so we can think about it and mull it over here a little bit. Um, and so if, uh, any Board members have other questions or thoughts or concerns. Um, uh, again, I think there's some advantages in terms of, uh, being able to look at data a little bit different way, um, but it's not going to be, you know, like a game changing apply to a ton -- of different things, so I think it'll be applicable in unique cases or specific cases rather. So, uh, so yeah, I think let's -- we can. Are there any other questions here before I kind of close this one out? Okay, Uh, so yeah, so Board members think about this, uh, advisory group members as well, especially, um, think about this if you have thoughts, ideas, questions, or concerns. Um, you know, chat with us here over the, the, the next couple of months and then we can, uh, bring this back up here at our next Board meeting, uh, because this will take a little bit of work in terms of, uh, reconfiguring our dashboards and, you know, how we're looking at things. Uh, so that'll give us a couple of months for our data team to be able to do that once we decide on it, um, so that way, again, come summertime as we're looking to select new drugs and do a new round of drug reviews, this can be ready for that. So great. Onto our next thing. MaryAnne, you're on mute.

MaryAnne Lindeblad: Thank you. Getting back used to this, you know? So I want to thank Ryan. And it looks like we're ready to go on to Kelly's presentation.

Kelly Wu: Are you able to see my presentation?

MaryAnne Lindeblad: Yes.

Kelly Wu: Okay, great. Is it just the presentation? Or you also see like notes?

MaryAnne Lindeblad: I don't see your notes.

Kelly Wu: Okay.

MaryAnne Lindeblad: They might be handy.

Kelly Wu: Okay So um, today, I'm going to give a high-level overview of the affordability review data collection process and where we're at. And if you have any questions along the way, just feel free to stop me, and we'll also have time at the end for questions and discussion. So I'll be starting off with an overview of the affordability review process and where we are in the process, and then I'll go over the data sources we'll be using for our affordability review. And I'll also touch on available data and potential challenges, and then, finally, I'll go over the next steps and then we'll have time for Q&A and further discussion. So this chart has been in a lot of my past presentations showing where we are in the affordability review process. And at the last Board meeting we selected drugs for affordability review, so now we've finally moved on to the next part of the process, which is conducting the affordability review. And so in order to conduct affordability reviews, we need to collect data on the drugs that were chosen. So I'll start with this high-level overview of our data collection process, and then I'll go over in the next slides why we need to also pull data from the All Payer Claims Database, the APCD, as well as First Data Bank, or FDB, and Medi-Span. But basically everybody we ask for data from, except manufacturers, are invited to submit data but not required. So as our data collection process plays out, we are also concurrently pulling data from these three data sources to supplement the data we may or may not get from the optional data submitters. So the data collection process involves requesting data from data submitters, which are our manufacturers, payers, wholesalers, and pharmacy benefit managers, or PBMs, receiving that data, validating the data, which involves things like making sure that data is in the format we ask for. For example, NDC has 11 digits and as well as logic checks, like are there more people who submitted claims than people that are part of the plan? And then the validation and receiving part may be iterative if we have questions or any clarifications or corrections from the data submitters. And then once the data is validated, we will process and clean the submitted data. So I'll explain more in the coming slides about what cleaning involves. And then after that, our data will be ready to ingest into our database, and then the data will be ready for analysis. So right now, we have received data from payers and PBMs, and we're at the iterative phase of validation and going back and forth with the -- or going back to submitters with questions and requests for clarification. And I've also worked with Marina to pull supplemental data from these three data

sources that I mentioned. And right now, I'm organizing that supplemental data into a format that Marina and other users can review. And so, as I just mentioned, in addition to requesting data, we're also pulling data from those three supplementary data sources, so I'll talk a little bit more about those. So as I mentioned before, only one data submitter, which is the manufacturers', is required by law to submit data while the others are invited to participate. And then we'll also be pulling data from the APCD, FDB, and Medi-Span to supplement the data we're requesting from the submitters since we know we're not going to have 100% participation from the submitters that were invited to submit. Um, so specifically, we will be using the APCD data to supplement the payer PDM and PDM and wholesaler data, and we're also using it to supplement some drug price data -- sorry -- APCD data, We will be using the FDB and Medi-Span to supplement drug price data, some of which is optional for manufacturers like the wholesale acquisition cost or WAC. And the national average drug acquisition cost or ending, or NADAC. And yeah, we will be trying to pull those from the FDB and Medi-Span, and we'll also be using the FDB and Medi-Span to validate the data that we receive. All right. And then with that, I'll go over the available data and potential challenges that we're facing. Um, so based on the scope of the Board's authority, the Board can only require manufacturers to submit data, so while we invite the other submitters to submit data, we will not end up having complete data for those submitters. And since we can't get the exact same data we're asking for, we're going to pull from our supplemental data sources, as I mentioned, and there are some challenges that come with that. So the first challenge is the supplemental data sources that we're using does not contain certain data fields that we asked for from the data estimators invited to participate. Like for example, the APCD is not as granular as the data we are requesting from payers and PBMs. So for example, we're requesting plan level information, so like plan name, insurance premiums, out-of-pocket maximums, and that kind of thing. But the APCD does not collect that kind of information. They only collect like the market type that the plan is in, so whether the plan is Medicare, Medicaid, or commercial. So then, obviously, we won't get any stuff on like what the insurance premium was or the out-of-pocket maximum. And so here is a more detailed table of examples of data that we are requesting from our data sources and then what we have. So like I just mentioned, we're requesting plan level data from the submitters, but the APCD only has market type data. We also even though FDB and Medi-Span has some pricing data like the WAC

and NADAC that I mentioned, it does not have like average wholesale unit price, which we're asking from wholesalers, which we did not get any submissions from. But the FDB does have suggested wholesale price, so maybe that could be an alternative that we could use. And then in terms of data cleaning and potential challenges, if you want to do any analysis on the data that we collect and we want to, for example, pull all the data for a certain plan, we'll need to make sure that the data for this plan is actually all categorized under this plan. So like all of the plans need to be spelled and formatted the same, which will involve data cleaning. So for example, this is not from the old data we have collected, but for example, say Kaiser Permanente is entered as KT or just Kaiser instead of Kaiser Permanente, if this happens, then we need to correct these two to say Kaiser Permanente so then when we pull the data by Kaiser Permanente, we also get these two cases. And then since this plan is asked in many templates, this may involve a lot of cleaning depending on like how much clean -- like how much corrections we need to do. And then we also plan on cleaning up the FDA indications data field so that we can pull the data by drug indication in the future. Um, oh, sorry, I forgot the second bullet. Um, so another potential challenge we could face is technical difficulties in processing and ingesting data. So our IT team helped us set up a database for our data, but we have to upload the data ourselves because we don't have like a dedicated IT person like some other programs. And I've done some like test uploads just to confirm that things are working. But once we start uploading more data sets and bigger data sets, I don't know if there's going to be any issues, or we may need to seek assistance from IT. And then another thing that I'll add that's not here because I created these slides a few weeks ago, are there are some things that might come up in the data -- that will happen like after I actually like clean up and do all that because I'm not a subject matter expert like Ryan or Marina, and then once they look at the data, they may notice some things that I missed. Like I can check if there's like missing data or the number of people the claim is greater than the number of people in the plan, but I don't have the subject matter knowledge to know, for example, like the quantity dispense, or the drug looks weird, or the number of claims for the drug looks really low, so it's going to be a team effort to address and identify data issues. And then once -- if that happens, then we could enter more back and forth with the data submitter for clarification and corrections. Um, and since we're pulling data from the APCD, um, we're not going to -- um, because we know that we're not going to get complete data submissions from every single payer, PBM, and wholesaler, we're

going to analyze the data that we collect from the data submitters that did submit separately from the APCD data instead of just like aggregating the APCD data at the market type level and combining it. This is also because the APCD data already contains data from those data submitters since they're required by law to submit. So this wouldn't be an accurate way to analyze data anyways because we would end up double counting. All right. And so the next steps for us are to continue the process of validating submitted data, continue organizing the data from supplemental data sources, and then once the validation process is over, we'll move on to cleaning and processing data from peers and PBMS. And as Mike mentioned, we don't have any data from manufacturers -- yet, so once we get that data, we would start this process over for the manufacturer data. And this is my last slide. So yeah, feel free to ask any questions, or if you want me to go back to a certain slide, we can go over something again.

MaryAnne Lindeblad: Thanks, Kelly. Any questions for Kelly? All right, thank you. That was a great presentation [cross-talk] --

Greg Gipson: [cross-talk] I have a question. Okay?

MaryAnne Lindeblad: Oh. One second. I [indistinct].

Hung Truong: I -- you mentioned that there's no requirement for PBM or insurance to provide data. Is there a way we can force the issue or change that they have to submit the data? Or is that too late?

Mike Neuenschwander: That would probably have to be done with legislation. Um, cause the [cross-talk] is the legislation specifically sites manufacturers have to submit the data, and if not, you know, we can't -- we have the author -- the legislation to find them. Uh, we're not, you know, giving us the data. Um, but yeah, for everyone else it -- that is not specified. Um, so yeah, that would -- and I kind of have a running list of items if we were to propose, you know, agency-sponsored legislation of ways that we could maybe tweak or improve things, um, and so we could potentially add that to the list. But yeah, it's currently not in there right now.

MaryAnne Lindeblad: All right. Any other questions for Kelly? All right. Again, thank you. So go on to Simon.

Simon Borumand: Uh, thanks, Kelly and thanks everyone. Uh, so my section is, uh, fairly short, just opening up, uh, a bit of a discussion. So we gave a preview to the Board members [indistinct] once, uh, about this, but really as we're entering the affordability reviews. Once we get to a stage where we have more data in for running analysis on the drugs, one important piece of information will be feedback from the advisory group. And so what we'd like to do is discuss how as Board members we'd like to receive information from the advisory group. Um, and just as a reminder, we have the core advisory group, which sits over multiple drug reviews, and then we have supplemental advisory group with the newer members who have specific expertise in the drugs currently under review [indistinct]. And so I wanted to -- I want to open it up to the Board to discuss it if you thought about ways that you want to receive information or format that you want to receive information from the advisory group. And if you don't have any specific ideas or goals, then we can all lay out our proposal and talk through that.

Mike Neuenschwander: Any thoughts, Board members, just start off? Oh, Doug.

Doug Barthold: Yeah, thanks. Um, the first thing that comes to my mind is just that it would be helpful in the same way that we have our meeting agenda and like, you know, a series of things like that we need to decide on. I guess it - - I think it'd be, you know, like, if we have a slide deck about whatever the eligible drug list, however -- you know, we talked about it with Ryan, the ranking thing. If the advisory boards sort of formatted their, uh, advice on those topics in line with the agenda -- with the meeting agendas, I think that that would be, hopefully, take us to sort of to compartmentalize each of their elements of advice for each of the decisions that we have to make. Um, so maybe like a couple -- if they wanted like a slide deck related to each decision point. Even if you like pre-vote and end-vote, I think would be helpful.

Mike Neuenschwander: That's helpful. Thanks, Doug. Um, and we can help the HCA staff help the advisory group members. You know, they have the thoughts, and they submit it to us, and we can help them in preparing the slide deck. So [indistinct] an advisory group member. Um, anyone else on the on the Board, thoughts? If not, I can just kind of present for the public what we're thinking, which is, uh, at the moment, something along the lines of a report. Within the report, different sections based on the expertise of the different advisory group members. Um, we would come up, you know,

[indistinct] of the report and come up with any questions to pose to them and they would respond filling out a page, page and a half or so with their thoughts on their specific area of expertise. And then, um, as Doug mentioned, we can take the information from that and we can put it into a presentation. I'm going to share it with the Board and share it with the public just as part of the discussions. And as a next step, we can take a stab at grafting that outline of the support, share it with the Board, um, and then post it online. And then, kind of, once we have a rule from the Board that leads to the questions that you want to ask, we can send it out to the advisory group members.

Doug Barthold: I think that sounds pretty good. I was also thinking it might be helpful to have some of that info in the when we do the one on ones as well just to kind of prepare us for the meetings.

Mike Neuenschwander: Sounds good.

MaryAnne Lindeblad: Anything else for Simon?

Mike Neuenschwander: And, uh, I, I guess I, I would just say, you know, advisory group members, um, as well, if you have specific ways that you think, uh, you would want to participate or ways that you can help. Um, I know I've had some individual conversations one-on-one with a number of people, um, and those have always been, uh, you know, very enlightening to do, without always feel free as we start getting this data here together more. Yeah, I think coming into the New Year there's going to be a lot more stuff for, uh, people to take a look at and give initial impressions on, uh, what we're doing and, and how we can, uh, format, especially this first drug review this we're looking forward as well. So, uh, yeah.

MaryAnne Lindeblad: Sounds good. Any other comments, questions? Okay. Is that it?

Mike Neuenschwander: Yeah, this was, this was going to be, uh, a pretty short and sweet meeting, which is why we opted to go for the, uh, you know, all online version here. So, um.

MaryAnne Lindeblad: Any comp -- so time for public comment?

Mike Neuenschwander: Or Hung? You [cross-talk] have a quick question?

Hung Truong: [Cross-talk] Just -- I'm sorry. It just took me a while to get to that. Um, Mike, can you kind of look into what [indistinct] might affect any of this or comment or summarize when you get a chance to look into it as we get into 2026? I know there's a lot going on. And I think you mentioned in Colorado they were looking into the -- three or four drugs that are going to be affected. Um, I think there's a lot of information out there, there's a lot of, uh, confusion, and so it'll be interesting to see how our work and, um, it's going to affect vice versa, uh, the [indistinct] affecting our work.

Mike Neuenschwander: Yeah, yeah, I think, I think there are a quite a few. Well -- so we just had some NASHP meetings as well as just kind of our weekly interstate, you know, director's meetings. I think there's a lot of interesting things happening from a policy -- national policy perspective and exactly what that all means. Yeah, I don't think anybody knows for sure. But yeah, there's a number of things that we're trying to kind of keep our eye on and see, yeah, what, you know, with tariffs and, uh, all, you know, TrumpRx and all these other things coming out, uh, you know, what is this, uh, all going to look like, um, so it's -- yeah, we're -- I don't think we have a ton of answers yet on a number of things. But yeah, there are a few things that definitely could be affecting us as we move into the future.

Hung Truong: Yeah, just like my initial thoughts. I mean, this is going to affect the Medicare Part D programs, right, for some of the drugs like Stelara, Enbrel, it's already on there. Um, it's not going to apply to the commercial plan. So from the state perspective from us, we can put this in to try to influence the commercial market, whereas why it is not applying to the Medicare market. And -- if a lot of companies follow suit with Medicare, which is the case for a lot of things, then it makes us looking at those drugs meet. Right? Then we can select something else to work on. So I mean just -- that's just some of my initial thoughts as we are approaching end of the year and our business coming up. [Cross-talk] that's some of the questions.

Mike Neuenschwander: [Cross-talk] Yeah. No, thank you very much, Hung. Yeah, I know. I think that that's very great. Good question considered.

MaryAnne Lindeblad: And like maybe that's a question or something that we could talk a little more about in the March meeting [cross-talk] just have more information at that point.

Mike Neuenschwander: Yeah. Okay. Anything else?

MaryAnne Lindeblad: All right. No other comments, questions? All right. Well, he said it was going to be a short meeting.

Mike Neuenschwander: Uh, uh, Simon, did we have anyone on the public comment?

MaryAnne Lindeblad: Oh, yeah. Thank you.

Simon Borumand: There were two folks that least [indistinct] email and had said they wanted to speak. Um, so raise your hand, and I can let you in.

MaryAnne Lindeblad: It looks like -- is it Tiffany? I see one hand raised.

Simon Borumand: All right. I think, Tiffany, I made it so you can speak. Uh, give it a shot. [cross-talk] --

Tiffany Robertson: [Cross-talk] Yes. Can you hear me?

Mike Neuenschwander: [Cross-talk] Yes.

MaryAnne Lindeblad: [Cross-talk] Yes.

Tiffany Robertson: Okay, great. Thank you, everyone. And thank you to the Board for all that you're doing to help lower -- address affordability for the people who live in Washington. It's a very important initiative for you to do. My name is Tiffany Westwood Robertson. I am the founder of Ensuring Access Through Collaborative Health, which is a national coalition of patient organizations and allied groups addressing drug affordability policies that benefit patients first. And we have a novel Patient Inclusion Council, or PIC, which was designed specifically because of the new era of patient engagement where we need more diverse voices to come to the table. I am also a patient living with axial spondyloarthritis, and that is treated by Enbrel and Humira, two of the drugs under your review. I just wanted to take the opportunity first because there are so many PDABs with different things that they focus on and that we're also cited today to remind the Washington PDAB that unlike some others, like Maryland or Oregon, for example, your task is to make sure that the prescription drug is viewed as affordable or unaffordable to Washington consumers, not to the healthcare system or to the state. That is really important as you

move forward, in particular, because Maryland, for example, ruled Trulicity and Ozempic considering unaffordable just earlier this week, however, they did not rule it unaffordable for patients. That's the one criterion that was not deemed unaffordable. Matter of fact, 90% of the patient reports from the manufacturer showed that they pay \$0 to \$50 because of copay. So I just want to make sure that while you're reviewing these that you're remembering that the unaffordability needs to be patient centric. Second, I did want to just point out respectfully that not everybody is excited about the Colorado Enbrel UPL. So, in particular, any patient with a diagnosis that is treated by Enbrel but was on any of the therapeutic alternatives, Simponi, Humira, Cimzia, Remicade, any of the biosimilars, are not so much excited because if the UPL does end up working -- meaning the PBM decides it will make enough profit to keep it on the preferred lowest cost option -- that means every other patient that's on a healthcare plan that puts Enbrel as the preferred drug will get non-medically switched to it. It is very hard for autoimmune patients to find the therapies that work. We don't want to be non-medically switched. So that is a very real unintended consequence that happens from the UPL. Colorado did acknowledge that that would happen, and their solution was they did advise our patient advocacy groups to go now and lobby for non-medical switching legislature to try to combat that unintended consequence, which frankly, we don't have the person power to be able to do that. And I'm also happy to talk about this with anybody here or afterwards if you wanted more information. And then just lastly, again, I appreciate all that you're doing. We appreciate all that you are doing, especially by asking more patients to be on extended stakeholder councils. It's so vital to get the patient voice. And I do think that Washington PDAP is stepping up and showing you do truly care about patient affordability. We're here to help you in any way you can. We are here to advocate with you, for you, and help you to achieve these goals. Thank you.

Mike Neuenschwander: All right, thanks very much.

MaryAnne Lindeblad: Yeah. Thank you, Tiffany. It's really very helpful. Okay, Mike, anything else from your side?

Mike Neuenschwander: Uh. I think we have one more person, Simon.

MaryAnne Lindeblad: [Cross-talk] Is there another?

- Simon Borumand: [Cross-talk] Yep, uh, Primo Castro. I just um, uh, I just allowed your mic to try unmuting.
- Primo Castro: Great, thank you very much. Hopefully, everybody is able to hear me. Just like -- just like others, I've had also issues, uh, you know, from the, you know, from the change -- switching from the other platforms, but, uh -- so my name is Primo Castro state government affairs, uh, for the western region for bio -- the Biotechnology Innovation Organization. Thank you, Chair and Members of the Board. BIO has consistently raised concerns about the premise behind establishing a drug review process. We believe this approach is fundamentally flawed and risk creating unintended consequences for patients in the broader ecosystem. The current data submission process overburdens manufacturers, while payers, PBMs, and others are not mandated but rather invited to participate. This process is duplicative of existing state and federal reporting requirements and imposes unnecessary administrative costs without clear evidence that these reviews improve affordability. Continuing affordability reviews will not achieve the intended goals and may harm patients in the long run. We urge the Board to suspend further reviews and instead focus on collaborative solutions that strengthen existing affordability programs and promote transparency without jeopardizing innovation or patient care. Thank you.
- MaryAnne Lindeblad: Thank you for your comments. All right, anything else? I don't see any others. Simon, anyone else?
- Simon Borumand: I'm not seeing anyone else.
- MaryAnne Lindeblad: Mike, any last closing comments?
- Mike Neuenschwander: I just want to thank everyone for coming out, um, and appreciate, uh, the Board members and advisory group members for your, uh, time. And MaryAnne, we're super happy to have you back, uh, uh, on the team here. And um, yeah, uh, we'll have a little bit of a break but, um, come spring, I think there's going to be a whole lot of good stuff to do. So again, if anyone has questions, always feel free to reach out, um, and we'll keep on keeping on.

MaryAnne Lindeblad: Any final comments from Board members? Eileen, it looks like you're saying some -- want to say something.

Eileen Cody: I said Happy Holidays!

MaryAnne Lindeblad: Oh, happy holidays! I can barely hear you. Yes, happy holidays. Look forward to seeing, you know, in March. But feel free to reach out to any of us if you have any questions or concerns.

Mike Neuenschwander: Okay.

Simon Borumand: Thanks.

MaryAnne Lindeblad: Thanks so much.

Mike Neuenschwander: Thank you.

Doug Barthold: Thanks everyone. Bye.

Hung Truong: Bye-bye.

MaryAnne Lindeblad: Bye-bye.

Greg Gipson: Thanks.

[end of audio]