Oregon Prescription Drug Affordability Board

Oregon Prescription Drug Affordability Board (PDAB) Meeting
Wednesday, August 23, 2023
Minutes
Approved as amended by the board on Sept. 20, 2023
See amended section in red below

Chair Akil Patterson called the meeting to order at 9:32 am and asked for the roll call.
Board members present: Chair Akil Patterson, Vice Chair Shelley Bailey, Dr. Richard Bruno, Dr. Daniel Hartung, Robert Judge (alternate), John Murray (alternate)
Board members absent: Dr. Amy Burns and Dr. Rebecca Spain, excused
Vice Chair Bailey appointed John Murray and Robert Judge to vote in today's meeting due to board member absences.

Chair Patterson asked if board members had any changes to the July 19, 2023, minutes on Pages 3-5 in the agenda packet: https://dfr.oregon.gov/pdab/Documents/20230823-PDAB-document-package.pdf and there were none. **John Murray** moved to approve and **Robert Judge** provided a second.
MOTION by John Murray to approve the July 19, 2023 minutes.
Board Vote:
Yea: Richard Bruno, Daniel Hartung, Robert Judge, John Murray, Vice Chair Shelley Bailey, Chair Akil Patterson
Nay: None.
Motion passed.

Program update: Executive Director Ralph Magrish said Senate Bill 192 was signed into law by the governor, incorporating many of the board's inaugural recommendations. It takes effect in late September. Alternate members will pivot directly to full appointees and all will vote at the October meeting. Staff will keep the board apprised of their work on a stakeholder engagement plan and analytics needed to implement Sec (3) of the bill on developing a plan to implement Upper Payment Limits (UPLs). The board will deliver a plan for establishing UPLs for drugs subject to affordability reviews to the Legislature in September 2024.

Ralph attended the National Academy of State Health Policy (NASHP) conference in Boston on August 15 and 16 and spent time with people involved in drug affordability work. Staff will send board members a request for policy recommendation ideas and ask that forms be returned by September 15. The Oregon Secretary of State released its audit report, Oregon Health Authority Pharmacy Benefit Managers-Poor Accountability and Transparency Harm Medicaid Patients and Independent Pharmacies, with these highlights: Oregon's regulation of PBMs is limited and fragmented; pharmacy reimbursements vary significantly depending on the drugs, pharmacy type, and PBM; Oregon Health Authority does not ensure sufficient transparency and compliance from PBMs. He encouraged members to read the audit and see if the board may want to make recommendations to the Legislature. He disclosed upcoming stakeholder meetings with the American Diabetes Association, PhRMA, Oregon Primary Care Association (OPCA), and Oregon Public Interest Research Group or (OSPIRG). He said DCBS will issue the carrier data call request on August 28 to get additional information to inform drug selection and affordability reviews. That information will be due back to DCBS on Sept. 29. He spoke at Senator Ron Wyden's press conference August 22 about how the board and Drug Price Transparency (DPT) program's work aligns with provisions of the Inflation Reduction Act. He shared a prerecorded message to the board from Sen. Wyden, chair of the Senate Finance Committee.

Policy Updates: **Cortnee Whitlock**, policy analyst, reviewed the amended policies on Pages 6-27 of the agenda packet. The board will vote on the policies at the September meeting. **Shelley Bailey** asked about adding a ninth member to the board to resolve the issue of a tie vote resulting in a failed motion. Ralph Magrish said it would need to be introduced into a bill to change the board's enabling legislation but could possibly be one of the board recommendations to the Legislature. **Robert Judge** asked if the recordings could be downloaded and staff said yes, with a YouTube subscription. **John Murray** asked about potential conflict of interest in Section 13, whether a pharmacist could be excluded from having to declare a potential conflict of interest. **Chair Akil Patterson** said it would be good to get guidance from Oregon Department of Justice. **Daniel Hartung** asked about the place on the PDAB website where declared conflict of interests are posted and staff said it will be added to the website soon.

Board review of DPT quarterly reports and drugs for affordability review rule: **Ralph Magrish** said the board will review the data and narrow the list of potential drugs to prioritize for the affordability review. **Cortnee Whitlock** reviewed the data on Pages 28-80, which is also located on the PDAB website. **Dan Hartung** said on the DPT carrier data – top drugs to review, the most highly-prescribed drugs include many low-cost drugs. How does that interplay with drugs that have a year-to-year price increase and does one trump the other to make it to this top-end list? **Amanda Claycomb,** research analyst**,** said if the drug was on the most costly list, it has been listed with the top 25, even if it did not show on another list. For the other classifications, if it appeared on two or more lists, it was also included. **Robert Judge** said he appreciates the way the data is presented, especially having the number of people being prescribed these drugs related to prescription volume. He wondered if Column I "List type" would be useful. **Cortnee Whitlock** said DPT carrier data - top drugs to review provides a quick snapshot, a summary list from the other sheets. **John Murray** said reviewing 80 pages of data and extensive tables for today's meeting was a little overwhelming. He understands the four criteria the board is looking at: the greatest increase; most costly; most expensive; and most prescribed. To regain his focus and not get lost in the numbers, he reviewed the purpose of the Prescription Drug Affordability Board and realized the key criteria is "most costly drug." His perspective is from the people who walk in the door of the pharmacy and get prescriptions. How do board decisions affect those people? **Ralph Magrish** said DCBS soliciting information from the carriers about rebates will illuminate the impact on members' out of pocket expense at the pharmacy counter. **Shelley Bailey** recommended filtering by the number of enrollees and prescriptions, then by total annual spend and year-over-year increase. She said seeking additional information such as the PBM percentage of the spend of these drugs would help the board get a better idea of how plan design is driving affordability. **Richard Bruno** agreed and also appreciates the DPT carrier data - top drugs to review. He sees a lot of medications on the list that are very difficult for his patients in primary care to access, many requiring prior authorizations due to high cost. He spends a lot of time trying to get his patients access to these medications. He said some drugs on this list are very much standouts and pain points for folks in primary care. **Akil Patterson** said the board needs to think about the following: data availability and integrity, whether the information is useable; how drug prices are determined within the data sets; how they are negotiated with the carriers and the pharmaceutical companies; drug price impact on different regions of the state; how the carrier data represents different socioeconomic statuses and demographics; impact on patients and trends in out-of-pocket expenses related to prescription drugs; drug price effect on choice of medications, adherence to treatments, and selection of insurance plans in relation to drug care, coverage, and costs; reaching out to health care providers, including on the board, to offer guidance about relationship between pharmacies, providers, and insurers on overall drug prices; impact on Medicare and Medicare costs; and long-term effects on quality of care from the medications the board will be reviewing. **Dan Hartung** asked if the DPT carrier data reflects net costs, net spending, including rebates and discounts and staff said yes. He said gross changes from year to year are a combination of price increase and increased utilization. The board could ask if the increases are due to drug acquisition costs or increased utilization. He said it is hard to compare these products because some are administered once every six months, some once every month. For example, Ocrevus on Page 31 is $31,000 per prescription but administered

only twice a year. Perhaps a cost per enrollee might be a more appropriate and comparable metric. **Ralph Magrish** said staff would add dosing patterns to the spreadsheet for the next board meeting.

Dr. Ben Rome, a health policy research with PORTAL and Harvard primary care doctor who is on contract with PDAB, said the board has many drugs to pick from and to get down to nine is challenging. It would be great to have every data point on every drug, but that would be overwhelming. There are many ways to go about this – pick a few drugs from each list or lean on one list this year to focus on. He agrees with Dan Hartung's comment about cost per prescription in DPT carrier data – top drugs to review. The board could take Column E and divide it by Column D for the total spend per enrollee of a prescription. He agreed with board members that out-of-pocket cost data is important. He said the manufacturer data has a lot of missing information. The carrier data is a lot easier for the board to manipulate and make those judgments. The New Specialty Drug Filings for 2022 is a more diverse list with many generic products that are coming to market in the future. The board may want staff to separate out new generic specialty drugs from new branded products to make it more manageable. There are challenges in looking at that list, partly because products are new and the board would not have data. The board would have to review primary literature, including how the FDA made a decision on the approval, what the market expectations are, and how many patients are likely to take it.

Robert Judge said the board has a concise, clean-looking workbook in the DPT carrier data. He asked if Ben Rome recommended the board focus on the carrier data, followed by the manufacturer data to help fulfill the board mission of ultimately selecting nine drugs. **Ben Rome** said the board should consider resource constraint. The list that will take the most resources to clean is the manufacturer price increase list, followed by new specialty drugs, followed by the carrier list, which is cleaner and ready to go. The board could decide to look at the carrier data this year and make decisions around how to sort it and select nine drugs from there. **Ralph Magrish** said there is no statutory requirement that the board select from both of the DPT lists. **Robert Judge** said for recommendations presented to the Legislature in December, he suggested porting over data elements from the manufacturer list into the carrier view, including biosimilars and therapeutic equivalents. **Akil Patterson** asked if the data is complete and **Ralph Magrish** said information from the carrier data request would be added.

Shelley Bailey suggested showing the cost per enrollee (total annual spend divided by the number of enrollees). **Ben Rome** agreed and said he likes total spend because it incorporates both use and price. **Shelley Bailey** asked if the board would remove drugs with orphan designation and Ralph Magrish said yes. **Dan Hartung** asked if the board would get insight into patient out-of-pocket costs. **Ralph Magrish** said it will come from the carrier data request. **Robert Judge** said most people think Humira should be on the list because it is the biggest driver of cost. But it also has a biosimilar coming to market that is going to attenuate that cost over time. It might not be worthwhile to look in depth at it. How would the board get that type of information to provide insight into this carrier list, for a drug that has a biosimilar option available or a therapeutic equivalent. **Shelley Bailey** said she would like to ask the carriers for the bin, PCN and group number for their PBM partner. If the information showed 40 percent of the drugs are through one PBM and 30 percent another, for example, it would help the board see plan design challenges that are impacting affordability. Group number may be associated with the group or employer and may be too granular, she said.

Robert Judge said to the extent that the PBM element would be helpful, it would make sense. But it is probably secondary, because the board is looking at WAC and whether the WAC increases, cost per person, per prescription, which are driven at the top. **Ralph Magrish** said the information from carriers must be aggregated and de-identifiable. He suggested talking with counsel to see if bin, PCN, group number would produce anything meaningful if the information is aggregated. **Shelley Bailey** said she believes PBMs are an important part of plan design related to affordability, especially in light of the Secretary of State's recent report.

Shelley Bailey asked the board if they would like to focus on the DPT carrier data. **Robert Judge** said he would not know where to begin with the manufacturer data. The carrier data workbook is not the best, but gives the board a really good starting place. **Chair Akil Patterson** said the board should focus on the carrier data. They could come back to the manufacturing data if it gets cleaned up. **Shelley Bailey** asked if the board was open to two motions, one for excluding Humira due to market forces and one for focusing on the carrier data. **Robert Judge** said he cautions against excluding any drugs yet until the board gets to the point of starting the culling process. **Akil Patterson** recommended having two motions and two votes. **Shelley Bailey** said based on the information from Mr. Judge, she only has one motion to make.

Vice Chair Shelley Bailey made a motion for the board to focus analysis on the carrier data for the affordability reviews but rely on the other data to the extent that the board determines it helpful. **Ralph Magrish** asked if she could add that staff use the information for the DCBS carrier data call. The **Vice Chair Bailey** amended the motion accordingly. **John Murray** provided a second.

MOTION by Shelley Bailey for the board and staff to focus on the carrier data as primary data for analysis but rely on the other data if helpful.
Board Vote:
Yea: Akil Patterson, Shelley Bailey, Robert Judge, John Murray, Daniel Hartung
Nay: Richard Bruno.
Motion passed 5-1.

Beginning of amended section

This section of the minutes was amended by the board on Sept. 20, 2023 during the minutes agenda item.

Chair Akil Patterson made a motion to amend the minutes to clarify Vice Chair Bailey's motion from the Aug. 23 meeting that the board is not excluding any data sets at this time. The board will look at all data sets given to it as long as the data is relevant to what the board is reviewing. Vice Chair Shelley Bailey provided a second. Amy Burns said she would abstain because she was not at the Aug. 23 meeting.

MOTION by Akil Patterson to amend the minutes to clarify no data set is excluded at this time.
Board Vote:
Yea: Akil Patterson, Shelley Bailey, Richard Bruno, Daniel Hartung
Abstain: Amy Burns.
Motion passed 4-0.

Vice Chair Shelley Bailey made a motion to approve the amended minutes. Daniel Hartung provided a second

MOTION by Shelley Bailey to approve the amended minutes.
Board Vote:
Yea: Akil Patterson, Shelley Bailey, Richard Bruno, Daniel Hartung
Abstain: Amy Burns.
Motion passed 4-0.

End of amended section

Insulin Data Review: **Cortnee Whitlock** reviewed the insulin data received from the All Payers All Claims (APAC) data page on Pages 73-80 and also located on the website. **Robert Judge** asked if the data is prior to rebates and

staff said yes. He noted the board is looking at the data in a rearview mirror because it is from 2022. He recommended identifying and removing drugs that manufacturers have announced price reductions for in the future. **John Murray** recommended the same for drugs affected by the future federal cap on insulin costs. **Dan Hartung** said, while this data shows out of pocket cost per patient, it lacks aggregated spending overall similar to the other data files. He said some of the drugs on this list have low utilization. If the board has to pick one, they want to make sure they are not missing something used by the most Oregonians. **Ralph Magrish** said staff could request that information from APAC. He said people may be wondering why this list does not include diabetes drugs also approved for weight loss. He said it is not certain those would be categorized as insulin products at this time. **Dan Hartung** agreed. **Shelley Bailey** asked about indicating insulin types by color code or another method so board members can see which insulins are which types. **Ralph Magrish** said it is a great recommendation and staff will do that for next month's review. **John Murray** said the GPL-1 drugs are on other lists and will be part of the board's other prescription drug discussions. Citing Admelog Solo Star and HumaLOG on the insulin list, he asked how does the board choose one of these products when there are exactly the same therapeutic drugs? **Ralph Magrish** said it is a great question and staff will ask PORTAL about it. **Shelley Bailey** asked what is the definition for total claimants. **Cortnee Whitlock** said it is the total number patients. **Akil Patterson** thanked the board for the robust exercise. He said as they dig down, they will need the support of the clinicians on the board who deal with these medications on a daily basis.

Public comment: No one signed up to speak to the board. Dharia McGrew, state policy director, PhRMA, provided written testimony to the board. It is posted on the PDAB website.

Adjournment: The meeting was adjourned at 11:25 a.m. by **Chair Akil Patterson,** with a motion by **John Murray** and a second by **Robert Judge**.

Board Member	Data suggestions
Shelley Bailey	• Filter by the number of enrollees and prescriptions, then by total annual spend and year-over-year increase. • Show the cost per enrollee (total annual spend divided by the number of enrollees). • Remove orphan designations • Ask carriers for bin, PCN and group number for their PBM partner • Insulin: color code types of insulin so it is easier for viewing
Richard Bruno	• Focus on the medications that require prior authorization and are difficult for patients to get
Daniel Hartung	• Research if increases are due to acquisition costs or increased utilization • Add dosing information to the carrier data list • Insulin: add aggregated spending overall, similar to other data files • Insulin: be sure to pick a drug used by most Oregonians
Robert Judge	• Column I "List Type" may not be helpful • Later in the process, remove Humira because a biosimilar is coming to market. Find out similar market information for other drugs. • Insulin: remove drugs manufacturers have announced price reductions for in the future • Recommendation for Legislature: port over data elements such as biosimilars and therapeutic equivalents from the manufacturer list into the carrier list
John Murray	• Most costly drugs should be a priority • Insulin: remove drugs affected by a future federal cap • Insulin: when choosing one, be aware different products are the same therapeutic drug
Akil Patterson	• Data availability and integrity, whether the information is useable • How drug prices are determined within the data sets; how they are negotiated with the carriers and the pharmaceutical companies. • Drug price impact on different regions of the state; how the carrier data represents different socioeconomic statuses and demographics • Impact on patients and trends in out-of-pocket expenses related to prescription drugs • Drug price effect on choice of medications, adherence to treatments, and selection of insurance plans in relation to drug care, coverage, and costs • Reaching out to health care providers, including on the board, to offer guidance about relationship between pharmacies, providers, and insurers on overall drug prices • Impact on Medicare and Medicare costs • Long-term effects on quality of care from the medications the board will be reviewing.

Senator Ron Wyden's Message to the Prescription Drug Affordability Board, August 23, 2023

Good morning, and thank you all for inviting me. Each day, seniors and families in Oregon go to fill a prescription at the pharmacy counter, and so often they feel like they're getting hit with a wrecking ball. Since I became chairman of the Senate Finance Committee, I've made it a top priority to take on big pharma and deliver lower cost to families that are getting clobbered by the cost of medicine. So I am pleased to see this affordability board up and running. I know you're going to work for positive change in our state now. I'd like to use my time this morning to update Oregonians on what's been accomplished at the federal level, specifically, what we've done with respect to prescription drug pricing and what's still on the way. One year ago, President Biden signed the Inflation Reduction Act into law. The key provisions came from the Senate Finance Committee and this landmark law includes the most comprehensive reform in the way the federal government pays for prescription drugs since the creation of Medicare Part D in 2003. Each piece of this part of the bill is focused on one idea – seniors and taxpayers must pay less for prescription drugs.

Here's how that's going to work. First, The Inflation Reduction Act, because of our advocacy, has created a price-gouging penalty for the first time. What that means is big pharma can't hike prices faster than inflation without consequences for Medicare Part D. For drugs which are administered in the doctor's office, the penalty is already in effect. The price-gouging penalty goes right back to lowering coinsurance for seniors for each dose of their prescription. So that's going to make a big difference for drugs like Humira, the big arthritis drug that so many seniors use.

The law also made most common vaccines free for seniors. Some vaccines, like shingles, cost nearly $250 a dose, and the seniors used to be on the hook for nearly a third of the cost today. That's completely free to seniors. Next week Medicare is going to begin to negotiate lower prices by selecting 10 drugs for negotiation that costs seniors and Medicare the most. They are going to start with the high-cost drugs beginning in January. There will be an out-of-pocket cap that will deliver significant financial savings to seniors who are getting clobbered by especially expensive medications. 186,000 seniors in Oregon with Medicare Part D will see an average savings of $231 in 2024. In 2025, seniors, will see average savings of $388.

Now there is a lot more to do. Just last month the Finance Committee passed a bipartisan package of proposals that are going to take on another side of big pharma. There are drug middlemen who are known as pharmacy benefit managers and they have been paying out profits instead of fighting for lower prices like they're supposed to. The Finance Committee proposal focuses on identifying the incentives that cause these PBMs to favor higher prices. Can we eliminate them from Medicare? This effort is going to be moving ahead full steam when Congress returns to session this fall. That's because the Senate Finance Committee passed my bill overwhelmingly before the summer break. Thank you all again for your incredibly hard work. Look forward to working with you closely in the days ahead.