Oregon Prescription Drug Affordability Board

350 Winter Street NE, Salem, OR 97309-0405 | 971-374-3724 | pdab@dcbs.oregon.gov | dfr.oregon.gov/pdab

Agenda

Date: **October 18, 2023** | *Time*: **9:30 a.m.**
This agenda is subject to change.

Meeting name	**Prescription Drug Affordability Board**
Meeting location	Virtual
Zoom link	Register for the meeting

Board Members: Chair Akil Patterson; Vice Chair Shelley Bailey; Daniel Hartung; Dr. Richard Bruno; Amy Burns, Robert Judge; John Murray

Staff: Ralph Magrish, executive director; Cortnee Whitlock, policy analyst; Stephen Kooyman, project manager; Brekke Berg, policy analyst, Amanda Claycomb, research analyst, Melissa Stiles, administrative specialist; Jake Gill, counsel; Pramela Reddi, counsel

	Subject	Presenter	Time Allotted
☐	Call to order, roll call, and approval of minutes	Chair Patterson	5 minutes
☐	Executive director's program update • 2024 board meeting calendar	Ralph Magrish	5 minutes
☐	Federal court ruling on copay accumulators	Jessie O'Brien	10 minutes
☐	Board review of proposed policy recommendations • Submissions by the public	Ralph Magrish	15 minutes
☐	Board continuation of affordability review outlined in OAR 925-200-0010. Board considers the following for the selection of prescription drugs: 1. On each of the insurer reported top 25 reports 2. On the manufacturer new drug or price increase reports 3. Price increase based on wholesale acquisition cost (WAC) 4. FDA approval date and any expedited pathway approvals 5. Cost and availability of therapeutic alternatives, if any 6. Patent expiration or data exclusivity expiration within 18 months 7. For insulin, highest insurer reported for overall spend, per-patient spend, patient out-of-pocket cost.	Ralph Magrish, Brekke Berg, and Amanda Claycomb	75 minutes

☐	Announcements	Staff	3 minutes
☐	Public comment	Chair Patterson	5 minutes
☐	Adjournment	Chair Patterson	2 minutes

Next meeting

Nov. 15, 2023, at 9:30 a.m.

Accessibility

Anyone needing assistance due to a disability can contact Melissa Stiles at least 48 hours ahead of the meeting at pdab@dcbs.oregon.gov or 971-374-3724. advance.

How to submit public comment

Oral testimony

For oral comments, please submit the PDAB Public Comment Form no later than 24 hours before the PDAB meeting. The form is located on the Oregon Prescription Drug Affordability Board website here: https://dfr.oregon.gov/pdab/Pages/public-comment.aspx

Written testimony

For written comments, please submit the PDAB Public Comment Form no later than 72 hours before the PDAB meeting. The form is located on the Oregon Prescription Drug Affordability Board website here: https://dfr.oregon.gov/pdab/Pages/public-comment.aspx Written comments will be posted to the PDAB website.

Open and closed sessions

All board meetings except executive sessions are open to the public. Pursuant to ORS 192.660, executive sessions are closed, with the exception of news media and staff. No final actions will be taken in the executive session. When action is necessary, the board will return to an open session.

Oregon Prescription Drug Affordability Board

Oregon Prescription Drug Affordability Board (PDAB) Meeting
Wednesday, September 20, 2023
Draft Minutes

Chair Akil Patterson called the meeting to order at 9:35 am and asked for the roll call.
Board members present: Chair Akil Patterson, Vice Chair Shelley Bailey, Dr. Richard Bruno, Dr. Amy Burns, Dr. Daniel Hartung, Robert Judge (alternate), John Murray (alternate)
Board members absent: none

Executive Session: The chair said the board would adjourn to executive session pursuant to ORS 192.660(2)(f) which allows the board to meet in closed session to consult with counsel concerning legal advice. Staff and news media were allowed to attend while all other audience members were not. No decision may be made in executive session. **Return to open session**: The chair announced the end of executive session and the return to open session. He called for the roll.
Board members present: Chair Akil Patterson, Vice Chair Shelley Bailey, Dr. Richard Bruno, Dr. Amy Burns, Dr. Daniel Hartung, Robert Judge, John Murray
Board members absent: none

Approval of minutes: Chair Akil Patterson made a motion to amend the minutes on Pages 3-8 in the agenda packet: https://dfr.oregon.gov/pdab/Documents/20230920-PDAB-document-package.pdf. The chair's motion clarifies 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. Shelley Bailey moved to approve the amended minutes and Daniel Hartung provided a second.

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.

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.

Program update: Executive Director Ralph Magrish announced a board vacancy from Dr. Rebecca Spain's resignation due to her new responsibilities at the Multiple Sclerosis Center of Excellence at the Veterans Administration. He said the board is grateful for her work and contributions. The board is recruiting through Oct. 30 for a clinician from a rural area. Information is available on the PDAB website. OHA's Healthcare Market Oversight Program asked staff to review concerns about pharmacy access related to the Kroger Albertsons merger. As part of the board public engagement process, the board will accept potential policy recommendations for the board to consider for inclusion in its recommendations to the legislature. Recommendations should be sent by 5:00 pm Friday, Oct. 6, 2023, to pdab@dcbs.oregon.gov. Submissions will be posted to the website and the board will review them at the Oct. 18 meeting. The carrier data from the data call will be returned to DCBS by Sept. 29. Staff will receive All Payer All Claims data in the first part of October.

The board will have this additional data to review soon. Ralph Magrish said he has upcoming meetings with the Cascades Aids Project and the incoming president of the Oregon State Pharmacy Association.

Senate Bill 192 Implementation: Ralph Magrish reviewed the implementation plan shown on Pages 9-13 of the agenda packet.

Policy Updates: **Cortnee Whitlock**, policy analyst, reviewed the amended policies on Pages 6-27 of the agenda packet. During the update, the board meeting ended unexpectedly due to a Zoom system outage. Staff started the Zoom meeting again and board members and participants returned. Chair Patterson made a motion to extend the length of the meeting and all members agreed. Returning to the policy discussion, Amy Burns made a motion to approve the amended policies, Shelley Bailey provided a second.

MOTION by Amy Burns to approve the amended policies.
Board Vote:
Yea: Akil Patterson, Shelley Bailey, Amy Burns, Richard Bruno, Daniel Hartung
Nay: None
Motion passed 5-0.

Board review and discussion of reports from Drug Price Transparency (DPT) program: **Brekke Berg, policy analyst,** reviewed the proposed timeline on Page 37 of the agenda packet. **Cortnee Whitlock** reviewed the carrier and insulin data on Pages 39-44, also located on the PDAB website. **Robert Judge** asked if the board would receive additional data sets to help them in the process of narrowing down the prescription drugs and staff said yes. **Chair Akil Patterson** said the board needs to find a balance between too much data and not enough data. The board needs to ask if it will look at all 500 prescription drugs or look at a subset of 25 to 30 the board will use to narrow down to the nine drugs. **Shelley Bailey** said focusing on the top 25 drugs tab would give the board a good starting point.

Amy Burns said Column AC in the Top Drugs to Review tab of the DPT carrier data list shows drugs that appear on more than one list, which is something to flag. She said a number of the drugs on this list are IV infusions. Medications dispensed from a pharmacy have certain commonalities when compared to medications given at a place of infusion, she said. **Akil Patterson** asked if the administered drug costs include the cost to administer it or medication only. He said he spoke with an 18-year-old with Crone's disease who pays for physician-administered medication out of pocket. Insurance might pay for the administration but the patient still has to pay for the medication, he said.

Robert Judge said the board's mission is to identify drugs that may create an affordability challenge for individuals and the health care system. The board needs to look at not only the cost of the drug but the course of treatment, which the board does not have. The board also needs to look at how broadly the medication is used, he said. The more the drug is utilized, the greater the weight and impact on the health care system, he said. He recommends focusing on three elements: medication cost; course of treatment cost; and what is the patient out-of-pocket spending on this medication. He said this should be the focus for all drugs, whether therapeutic alternatives, brand or generic. **Ralph Magrish** said the staff will do analysis on defining course of treatment.

Daniel Hartung said the Medicaid tab on the CCO spreadsheet shows significant drugs that are not on the carrier list because of the population difference. The list has drugs that should be added to the board's preliminary 30 to 50 subset, including HIV meds and cystic fibrosis medications, which have been major burdens for the Medicaid programs. **Richard Bruno** cautioned the board not to use administration cost as part of this

determination. **Akil Patterson** asked staff to confirm administration costs were not included in the data. **Amanda Claycomb**, data analyst, confirmed the carrier data does not include administrative costs. **Shelley Bailey** asked if Column AC in the Top Drugs to Review tab included drugs on the CCO carrier list as well. **Ralph Magrish** said Column AC shows overlap but there could be other drugs on the CCO list that do not appear here. He said it could be an important cost driver for the CCO-based population.

Akil Patterson said currently the board has for its review the 25 most prescribed drugs, 25 most costly, 25 biggest increase, 25 most expensive lists. Does the board want to pull 20 of these with the greatest impact that will allow the board to reach nine drugs by November? **Daniel Hartung** said he thinks costly drugs from the Medicaid list should be included in this preliminary list of 25-30 drugs. The board would use this subset to narrow down to nine drugs plus insulin. **Ralph Magrish** asked about a threshold. **Daniel Hartung** suggested the board could look at the top 25 Medicaid and the top 25 carrier health plans. It would add in HIV, cystic fibrosis, Hepatitis C drugs and other drugs that are more heavily predominate in the Medicaid population. **Shelley Bailey** agreed and said the board should create a more global list to work from. For future meetings, she requested information about the number of individuals using the prescriptions.

John Murray said he agrees with the discussions. He said it is a difficult task to get down to a number of drugs the board can manage. His concern is how the board will highlight the cost impact on patients if the board focuses on health care system costs. He wants the board to think about the people who come in the pharmacy to talk to him, who do not take their medicines because they cannot afford them, who do not buy groceries because they have to pay for prescriptions. It comes down to how it impacts people in rural areas who are not taking their medicine. **Akil Patterson** commended rural community pharmacist's compassion for clients and neighbors. Pharmacists have to explain the medications and talk to patients on a daily basis. The chair said he comes from a major inner city and understands because he has friends and grandmothers who have had to make that hard decision to break a pill in half. **Shelley Bailey** said once the board gets down to the nine drugs, the board can look at things from the lens of affordability to the individual, including out of pocket expenses, and to the health system in general. **Akil Patterson** reminded the board they will be making recommendations annually.

Cortnee Whitlock asked if board members would like to narrow the medications based on the date range in FDA approvals, 5 or 10 years, for example, or based on a range for the number of enrollees. Prioritizing the columns on the spreadsheet would help staff with future analysis, she said. **Shelley Bailey** and **Daniel Hartung** said the board should not set criteria for enrollees until it has a smaller list to work from. **Akil Patterson** said the board currently has a review list of 500 prescription drugs, which is not feasible for a volunteer board. He asked for recommendations about narrowing the list. **Robert Judge** suggested looking at the most costly tab, followed by utilization and patient out of pocket costs. **Shelley Bailey** suggested filtering the data by the number of carriers impacted. She suggested the board focus on drugs that impact all carriers, which would help the board remove issues with plan design. **Akil Patterson** invited a motion. **Shelley Bailey** made a motion to combine the top drugs to review from the DPT carrier list, filter it by percent of carriers impacted, add the top 20 drugs from the CCO list, flush out duplicates, and choose the top 30 drugs from there. **Daniel Hartung** said he does not know what the variable indicates, if carriers do not cover that drug or if they do not report on that drug. **Robert Judge** said just because it is not flagged in the carrier column does not mean it is not a covered drug. It just did not rank as top 25. He recommended looking at the carrier information as one of the criteria when the board gets in the culling exercise but not use it to create the list for reviewing now.

Richard Bruno suggested the board develop a formula to weigh criteria differently. Total spend is very important to him, but also number of patients and number of claims are high priorities for him. Percentage of carriers

would probably be a lower variable to him. If the board weights the criteria, it would help the top picks emerge more strategically.

Akil Patterson said the message has been that total cost is a board priority. **Shelley Bailey** amended her motion to add the DPT most costly drugs in the list, scrub against top 25 for CCOs, filter based on total costs, and pick no more than 30 drugs, including insulin, for the board to review. **Daniel Hartung** requested the board have a separate process for the insulin drugs. **Ralph Magrish** read a message from the Department of Justice counsel that said there is no need for a motion. The board is free to discuss narrowing and identifying subsets without formalizing that in any way. However, there is need for staff direction to provide the analytics to support the board.

Executive Session: The chair said the board would adjourn to executive session pursuant to ORS 192.660(2)(f) which allows the board to meet in closed session to consult with counsel concerning legal advice.
Return to open session: The chair announced the end of executive session and the return to open session.
Recommendations: Chair Akil Patterson said it was determined the board does not need to make a motion. He said the board is providing directives to staff to help continue to pare down, create a subset and have a final group ready for November.

- Combine total cost and carrier cost. Look at the DPT drug data to mesh with the top 25 of the CCO data.
- Look at the insulin separately and pare down that list moving forward.

Announcements: Next board meeting Oct. 18, 2023 at 9:30am.

Public comment: Chair Patterson called on the person who signed up in advance to speak to the board. Eric Lohnes, PhRMA, provided oral and written testimony to the board. The American Diabetes Association also provided written testimony to the board. The written testimony is posted on the PDAB website.

Adjournment: The meeting was adjourned at 11:45 a.m. by a motion from **Vice Chair Shelley Bailey,** a second by **Daniel Hartung** and all voted in favor.

Board Member	Summary of suggestions from the 9/20 board meeting
Shelley Bailey	• Filter the data by the number of carriers impacted to remove the issue of plan design. • It is too early in the process to set criteria for enrollees or FDA approvals. • Recommendation: add the DPT most costly drugs in the list, scrub against top 25 for CCOs, filter based on total costs, and pick no more than 30 drugs, including insulin, for the board to review.
Richard Bruno	• Board members should prioritize, rank or weight the different criteria.
Amy Burns	• A number of drugs on the list are IV infusions. The board may not be able to use the same attributes for comparing them with medications dispensed at a pharmacy. Patient out of pocket expenses might look very different. • Drugs appear on more than one list, which is something to flag.
Daniel Hartung	• Total cost is a board priority. • Include the Medicaid tab from the CCO list with the carrier data to include drugs that impact health care system affordability. • It is too early in the process to set criteria for enrollees or FDA approvals. • Board should not filter the data by carrier impact because it does not necessarily indicate carrier coverage. • Have a separate process for insulin.
Robert Judge	• In addition to cost, board should look at cost of treatment and how broadly the medication is used. • Board should focus on three elements: medication cost; course of treatment cost; patient out-of-pocket spending on the medication. • Board should not filter the data by carrier impact because it does not necessarily indicate carrier coverage.
John Murray	• Patient affordability ranks higher than health care system affordability. • Board should focus on patient out-of-pocket spending. Board should remember the patients who are not taking their medications because they cannot afford them.
Akil Patterson	• The board has 500 prescription drugs, a list that is not feasible for review. The board needs to narrow the list to a subset to reach the goal of selecting 9 drugs and at least 1 insulin product by November. • Recommendation: combine total cost and carrier cost. Look at the DPT drug data to mesh with top 25 of the CCO data. • Recommendation: Look at the insulin separately.

Oregon Prescription Drug Affordability Board

2024 Board Calendar

Meeting 1	Wednesday, Jan. 17	9:30 – 11:30 a.m.
Meeting 2	Wednesday, Feb. 21	9:30 – 11:30 a.m.
Meeting 3	Wednesday, March 20	9:30 – 11:30 a.m.
Meeting 4	Wednesday, April 17	9:30 – 11:30 a.m.
Meeting 5	Wednesday, May 15	9:30 – 11:30 a.m.
Meeting 6	Wednesday June 26	9:30 – 11:30 a.m.
	No meeting in July	
Meeting 7	Wednesday, Aug. 21	9:30 – 11:30 a.m.
Meeting 8	Wednesday, Sept. 18	9:30 – 11:30 a.m.
Meeting 9	Wednesday, Oct. 16	9:30 – 11:30 a.m.
Meeting 10	Wednesday, Nov. 20	9:30 – 11:30 a.m.
Meeting 11	Wednesday, Dec. 18	9:30 – 11:30 a.m.

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Oregon Prescription Drug
Affordability Board

Submissions:
Proposed policy recommendations

The following letters and emails on PDF pages 13-27 were submitted by the public for board review. A summary of the proposals is included on pages 10-12.

Background: At the 9/20/2023 board meeting, the PDAB announced it was seeking policy recommendations from the public. The board will consider these proposals for possible inclusion in the board's 2023 recommendations to the Oregon Legislature. PDAB is charged with making recommendations that are solution based that will make prescription drugs more affordable for Oregonians. The board accepted submissions until 5 pm Friday, October 6. The board received six submissions. In addition, the board received policy recommendations from four groups who gave presentations at board meetings this past year.

Proposed policy recommendations summary

Recommendations from groups who presented to the board:

1. Oregon State Pharmacy Association (OSPA)
Submitted by Brian Mayo, executive director, and Kevin Russell, central Oregon director, on 1/18/2023
Recommended solutions:

- Implement a cost-plus-fee reimbursement for pharmacies.
- Move to administrative fee only model for paying PBMs.
- Support local pharmacists.

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2. Oregon Primary Care Association (OPCA)
Submitted by Marty Carty, governmental affairs director, on 3/15/2023
Recommendations

- Make it easier for FQHCs to operate retail pharmacies.
- Increase PBM regulations.
- Allow more flexibility in using a contract pharmacy.

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3. America's Health Insurance Plans (AHIP)
Submitted by Sean Dickson, senior vice president of pharmaceutical policy and strategy, on 5/17/2023
State Solutions to Increase Prescription Drug Affordability

- Accelerate the availability of biosimilars
    - Ensure that state substitution laws do not create barriers to biosimilar access for patients.
- Reform the system for provider-acquired drugs
    - Prevent harmful mark-ups and increased costs for patients by protecting the use of specialty pharmacies to access lower drug costs.
- Address drug manufacturer abuse of charitable structures
    - Put an end to coupons, which are considered kickbacks by federal programs.
    - Increase scrutiny of patient assistance charities.

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4. T1International
Submitted by Allison Hardt, advocacy manager, on 6/21/2023
Solutions:

- Copay caps.
- Amend Kevin's Law, which allows a pharmacist to prescribe limited amounts of insulin in emergencies, to require insurance to pay the list price.
- Implement Alec's Law, which allows a 30-day supply for a $35 copay, once a year.
- Consider manufacturing insulin. This would be similar to California's partnership with Civica.
- Allow pharmacists to prescribe insulin.

Proposed policy recommendations summary

Policy recommendation ideas from stakeholders:

1. American Diabetes Association
Submitted by Carissa Kemp, director, state government affairs, on 09/06/2023
Policy recommendations:

- Remove the requirement that the copay cap on insulin be adjusted with the consumer price index.
    - As a result of a 2021 legislative language, the copay cap has increased twice and is now $85. When the cost-of-living increases, it makes it more challenging for people to afford their medication and tying the copay cap to the CPI only puts the life-saving medication further out of reach.
- Lower the copay amount to $35 in line with Medicare and other states across the country.

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2. Chronic Disease Coalition
Submitted by Nathaniel Brown, director of advocacy, on 09/26/2023
Recommended solutions:

- Ban copay accumulators.
- Enhance PBM transparency requirements.
    - Ensure savings negotiated by PBMs are passed on to patients. They support the recommendations in the Oregon Secretary of State audit, "Pharmacy Benefit Managers: Poor Accountability and Transparency Harm Medicaid Patients and Independent Pharmacies," https://sos.oregon.gov/audits/Pages/audit-2023-25-Pharmacy-Benefit-Managers.aspx.

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3. Strategies360
Submitted by Bethanne Darby, senior vice president, public affairs, on 10/5/2023

- Change current statute to better align the substitution of biosimilars with that of generic drugs, allowing for more widespread substitution of biosimilars and lowering drugs prices for consumers. Here are suggested changes:
    - **689.522 Substitution of biological products for prescribed biological products; rules.** (1) A pharmacy or pharmacist filling a prescription order for a biological product may not substitute a biological product for the prescribed biological product unless:

    (a) The substitute biological product has been ~~determined~~ licensed by the United States Food and Drug Administration ~~to be~~ as a biosimilar to or interchangeable with the prescribed biological product;

    (b) The prescribing practitioner has not designated on the prescription that substitution is prohibited;

    ~~(c) The patient for whom the biological product is prescribed is informed of the substitution in a manner reasonable under the circumstances;~~ and

    ~~(d)~~(c) The pharmacy or pharmacist retains a record of the substitution for a period of not less than three years.

    ~~(2) The State Board of Pharmacy shall, on a website maintained by the board, maintain a link to the current list, if available, of biological products determined by the United States Food and Drug Administration to be interchangeable.~~

    ~~(3)~~(2)(a) For purposes of this section, the board shall adopt by rule definitions for the terms "biological product," "biosimilar" and "interchangeable."

    (b) The rule defining the terms "biological product" and "biosimilar" must be consistent with 42 U.S.C. 262(i)(1) and (2).

    (c) The rule defining the term "interchangeable" must:

(A) For biological products licensed under the Public Health Service Act, define the biological products that may be substituted for other biological products as having been determined by the United States Food and Drug Administration as meeting the standards in 42 U.S.C. 262(k)(4); and

(B) For biological products approved by the United States Food and Drug Administration under the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 301 et seq., define the biological products that may be substituted for other biological products as having been determined by the United States Food and Drug Administration as therapeutically equivalent as set forth in the latest edition or supplement of the Approved Drug Products with Therapeutic Equivalence Evaluations. [2013 c.342 §2; 2013 c.342 §4; 2016 c.43 §§1,2]

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4. Johnson & Johnson

Submitted by Terrell Sweat, director, US State Government Affairs, on 10/6/2023

Policy recommendations:

- Require that PBM rebates and discounts be directly shared with patients at the pharmacy counter.
- Examine the use of utilization management tools and evaluate how best to regulate them in the interest of patient access and minimizing out-of-pocket costs.
- Prohibit diversion of cost-sharing assistance to ensure payment made by or on behalf of patients counts towards their cost-sharing burden.

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5. PhRMA

Submitted by Dharia McGrew, PhD, director, state policy, on 10/6/2023

Policy solutions:

- Rebate passthrough at the point of sale.
  - Requiring PBMs and health plans to share the savings they receive on medicines directly with patients at the pharmacy counter would lower patient out-of-pocket costs and help realign payer incentives.
- Delink compensation from the price of a medicine.
  - "Delinking" policies require that PBMs and other supply chain entities receive a fixed fee based on the value of the services they provide, rather than receiving compensation based on the price of a medicine.
- Subject PBMs to a duty of care.
  - They support the Oregon Secretary of State's Audit Division recommendations in the report, "Pharmacy Benefit Managers: Poor Accountability and Transparency Harm Medicaid Patients and Independent Pharmacies."
- Anti-steering - prohibit PBMs from directing patients to affiliate pharmacies.
  - They support the Oregon Secretary of State's audit report concerning PBM practices related to community pharmacies. Prohibiting PBMs from directing patients to affiliate pharmacies can improve competition and reduce incentives for PBMs to self-deal, allowing independent pharmacies a chance to compete and providing patients with access and choice for fulfilling their prescriptions.

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6. International Cancer Advocacy Network

Submitted by Steve Horn, director, governmental relations, on 10/6/2023

Policy solutions:

- They support the recommendations in the Oregon Secretary of State August 2023 report, "Pharmacy Benefit Managers Poor Accountability and Transparency Harm Medicaid Patients and Independent Pharmacies."

From: Nathaniel Brown <nathaniel@chronicdiseasecoalition.org>
Sent: Thursday, September 28, 2023 1:18 PM
To: PDAB * DCBS <PDAB@DCBS.oregon.gov>
Subject: Re: Policy considerations for 2024
Hi Melissa,

If I might add one more request for Board consideration: A recent Oregon Secretary of State audit of PBMs found that Oregon's regulation of PBMs is "limited and fragmented."

https://sos.oregon.gov/audits/Pages/audit-2023-25-Pharmacy-Benefit-Managers.aspx

I would love to see PDAB discuss ways to shine a light on PBM practices by enhancing transparency requirements and ensure that savings negotiated by PBMs are passed on to patients. I can be more specific if needed, but the link above will take you to recommendations from OHA and SOS.

Thanks,

Nathaniel Brown | **Director of Advocacy** | **Chronic Disease Coalition**
6605 S Macadam Avenue, Suite 200 | Portland, OR 97239
971-219-5561

Chronic Disease Coalition

From: Nathaniel Brown <nathaniel@chronicdiseasecoalition.org>
Sent: Tuesday, September 26, 2023 11:47 AM
To: PDAB * DCBS <pdab@dcbs.oregon.gov>
Subject: Policy considerations for 2024
Importance: High
To whom it may concern,

Given the Oregon PDAB's charge to recommend solutions-oriented policy proposals that help reduce costs for patients, the Chronic Disease Coalition would welcome your consideration of a copay accumulator ban in 2024. We have been advocating on this bipartisan issue for many years, as have other patients and patient advocacy groups. Please see attached testimony from 2023 session for more context, and if you'd like to discuss further, I am happy to do so.

Many thanks,

Nathaniel Brown | **Director of Advocacy** | **Chronic Disease Coalition**
6605 S Macadam Avenue, Suite 200 | Portland, OR 97239
971-219-5561

Oregon Senate Committee on Health Care
900 Court St. NE
Salem, OR 97301

March 6, 2023

Chair Patterson and members of the committee:

On behalf of the Chronic Disease Coalition, thank you for the opportunity to provide support for SB 565, a bipartisan bill that would ban harmful copay accumulator programs that impact thousands of Oregon chronic disease patients.

Based in Portland, the Chronic Disease Coalition is a nationwide nonprofit organization dedicated to protecting the rights of chronic disease patients against discriminatory policies and practices. The coalition was founded in 2015 and has since worked to advocate for people living with long-term or lifelong health conditions such as diabetes, kidney disease, multiple sclerosis, psoriasis, cancer, and other chronic diseases.

We are pleased to support this legislation, which would ensure that all payments, including those by third parties, count toward insured Oregonians' total cost-sharing requirements. Many chronic disease patients and their families rely on various types of copay assistance to afford the medications they need to manage their conditions.

Unfortunately, insurers continue implement programs that ban all third-party copay assistance – real dollars paid to the insurer – from counting towards patients' out-of-pocket costs. This forces chronic disease patients to pay twice (or more), while dissuading charitable assistance for future patients.

Many pharmaceutical manufacturers support patient assistance programs by providing funds for what are commonly known as copay coupons or manufacturer copay cards. Previously, payments using funds from these programs counted towards a patient's deductible, helping them afford coverage until the copay assistance is utilized and the benefits from insurance coverage begin.

Copay accumulator programs or accumulator adjustment programs maximize the use of copay assistance without assisting in the patient's deductible, leaving chronic disease patients with exorbitant out-of-pocket costs on top of the many other challenges that come with their diagnoses.

Simply put, if money is put into the system to benefit a patient, it should. As health care leaders in Oregon, we urge you to join the Chronic Disease Coalition in supporting this bipartisan legislation. This is an important step that will lead to better patient outcomes across the state.

Thank you,

Nathaniel Brown, director of advocacy
nathaniel@chronicdiseasecoalition.org
971.219.5561

From:	Carissa Kemp
To:	PDAB * DCBS
Cc:	Molly McGrew; MAGRISH Ralph M * DCBS; WHITLOCK Cortnee * DCBS
Subject:	ADA Insulin Affordability Policy
Date:	Wednesday, September 6, 2023 1:24:25 PM
Attachments:	image001.png Oregon Insulin Policy .pdf

Chair Akil Patterson and Executive Director Ralph Magrish,

Thank you for the opportunity to share the American Diabetes Association's policy priority related to addressing the Oregon insulin copay cap. Please see the attached document which outlines two opportunities to address:

1. Removing the requirement that the copay cap be tied to the CPI. As a result of this language, the copay cap has increased twice and is now $85.
2. Lower the copay cap amount to $35 in alignment with Medicare and other states across the country.

We appreciate the opportunity to present this critical issue. Please do not hesitate to reach out if you have any questions.

Carissa Kemp

American Diabetes Association.
Connected for Life

Carissa Kemp
Director, State Government Affairs
(AK, CO, ID, MN, MT, ND, NV, OR, SD, UT, WA, WY)

Phone: 703-299-2053 ext. 2053 Mobile: 715-573-1234
diabetes.org
1-800-DIABETES (800-342-2383)

Leading the Fight for Insulin Affordability

Insulin saves lives. That's why we're fight to make it more affordable. Through tireless advocacy and powerful partnerships with health organizations and insulin manufacturers, we're breaking down barriers to affordable care. Together, we can ensure all of the 8.4 million Americans who rely on insulin can access and afford it.

Burden of Diabetes in Oregon[1]

- Approximately 306,000 people in Oregon, or 9.5% of the adult population, have diagnosed diabetes.
- An additional 93,000 people in Oregon have diabetes but don't know it, greatly increasing their health risk.
- There are 1,097,000 people in Oregon, 33.5% of the adult population, who have prediabetes.
- Every year an estimated 20,000 people in Oregon are diagnosed with diabetes.

The problem

In 2021, the Oregon legislature passed House Bill 2623 to cap copayments for insulin. At the time, the legislation capped copayments at $75 for a one-month supply of insulin for people on state-regulated plans. At the time, Oregon was the 18th state to address cost-sharing for insulin. Today, 25 states plus the District of Columbia have passed similar legislation. We applaud Oregon's steps to address insulin, but we can do better:

1. Remove the requirement that the copay cap on insulin be adjusted with the consumer price index. Since 2021, the copay cap has increased and will now be $85. People are having to make difficult choices between paying their bills, rent, and paying for their prescription medication. When the cost-of-living increases, it makes it more challenging for people to afford their medication and tying the copay cap to the CPI only puts the life-saving medication further out of reach. **The ADA supports legislation to remove this requirement**.
2. Lower the copay amount to $35 in line with Medicare and other states across the country. **The ADA supports legislation to lower the copay cap amount**.

If you have questions please contact Carissa Kemp, Director of State Government Affairs, ckemp@diabetes.org.

[1] http://main.diabetes.org/dorg/docs/state-fact-sheets/ADV_2020_State_Fact_sheets_OR.pdf

From: BethAnne Darby <bethanned@strategies360.com>
Sent: Thursday, October 5, 2023 1:34 PM
To: PDAB * DCBS <PDAB@dcbs.oregon.gov>
Cc: Inga Deckert <inga@proxygr.com>
Subject: Policy Recommendation from OCAP

Dear PDAB Board – On behalf of the Oregon Coalition of Affordable Prescriptions (OCAP) we submit a policy recommendation on biosimilars as follows:

We suggest changes to current statute that would better align the substitution of biosimilars with that of generic drugs, allowing for more widespread substitution of biosimilars and lowering drugs prices for consumers. Suggested changes to current statute are in redline below. Thank you for your consideration.

689.522 Substitution of biological products for prescribed biological products; rules. (1) A pharmacy or pharmacist filling a prescription order for a biological product may not substitute a biological product for the prescribed biological product unless:

(a) The substitute biological product has been ~~determined~~ licensed by the United States Food and Drug Administration ~~to be~~ as a biosimilar to or interchangeable with the prescribed biological product;

(b) The prescribing practitioner has not designated on the prescription that substitution is prohibited;

~~(c) The patient for whom the biological product is prescribed is informed of the substitution in a manner reasonable under the circumstances;~~ and

~~(d)~~(c) The pharmacy or pharmacist retains a record of the substitution for a period of not less than three years.

~~(2) The State Board of Pharmacy shall, on a website maintained by the board, maintain a link to the current list, if available, of biological products determined by the United States Food and Drug Administration to be interchangeable.~~

~~(3)~~(2)(a) For purposes of this section, the board shall adopt by rule definitions for the terms "biological product," "biosimilar" and "interchangeable."

(b) The rule defining the terms "biological product" and "biosimilar" must be consistent with 42 U.S.C. 262(i)(1) and (2).

(c) The rule defining the term "interchangeable" must:

(A) For biological products licensed under the Public Health Service Act, define the biological products that may be substituted for other biological products as having been determined by the United States Food and Drug Administration as meeting the standards in 42 U.S.C. 262(k)(4); and

(B) For biological products approved by the United States Food and Drug Administration under the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 301 et seq., define the biological products that may be substituted for other biological products as having been determined by the United States Food and Drug Administration as therapeutically equivalent as set forth in the latest edition or supplement of the Approved Drug Products with Therapeutic Equivalence Evaluations. [2013 c.342 §2; 2013 c.342 §4; 2016 c.43 §§1,2]

S360

BETHANNE DARBY

Senior Vice President, Public Affairs

(she/her)
C **503.510.3153**
PORTLAND, OR

STRATEGIES360.COM

Submitted by email to: PDAB@dcbs.oregon.gov

October 6, 2023

Dear Members of the Oregon Prescription Drug Affordability Board,

At Johnson & Johnson (J&J), for more than 130 years, cutting-edge technologies and expert insight have helped us understand and address the serious health problems of today and unlock the potential medicines of tomorrow. We apply rigorous science and compassion to confidently address the most complex diseases of our time. We also recognize these innovative medicines can only have an impact if patients can access and afford them.

We welcome the opportunity to provide to the Oregon Prescription Drug Affordability Board (PDAB) J&J's policy recommendations to offer to the Oregon legislature, with the following principles in mind: 1) patients should have affordable and timely access to the most appropriate, effective treatment options and sites of care now and in the future, and 2) treatment decisions belong in the hands of patients and their healthcare providers, not commercial payers with no accountability for patient outcomes due to misaligned incentives.[1]

I. Any focus on drug list price to make policy recommendations would be misguided in addressing prescription drug affordability.

Achieving patient affordability must include an examination of the complexity of the entire drug supply chain ecosystem, including insurance benefit design, and patient OOP costs. The list price of a medicine is a starting point that is ultimately reduced to a net price, the amount a manufacturer receives after negotiating and providing rebates, discounts and/or fees to different parts of the healthcare system. These include negotiations with private insurance companies, Pharmacy Benefit Managers (PBMs) and entities where medications are dispensed or administered (e.g., hospitals, clinics and private physician practices). In addition, there are mandatory or statutory price reductions provided through government programs. Government programs (e.g., Medicare, Medicaid, etc.) receive prices reduced by both private negotiations and statutory discounts. Vigorous private market negotiations throughout the system result in lower net prices for commercial payers and government programs.

While commercial insurers pay lower net prices, many patients do not directly benefit from these lower prices and continue to pay higher out-of-pocket (OOP) costs. Manufacturers do not have input into insurance benefit design that dictates patient OOP costs. Patients pay higher OOP costs because their cost-sharing amount, set by their insurance plan benefit design, is often based on the initial list

[1] https://transparencyreport.janssen.com/#what-we-believe-section

price, not the negotiated lower net price the commercial insurer pays. The difference between the list price and net price has grown significantly, with one analysis putting the total at more than $200 billion in 2021 for the entire healthcare system.[2] Some states have implemented solutions by enacting legislation requiring PBMs share the savings with the patients.[3,4,5]

Policy Recommendation: Require that PBM rebates and discounts be directly shared with patients at the pharmacy counter.

II. Patients should not face restrictive utilization management programs that interfere with access, affordability, and treatment choice.

Policy goals will not be met by establishing price controls, which may have long-term negative impacts across benefit design, patient access, pricing, contracting, and future innovation. Furthermore, patients may experience limited treatment choice and have little to no reduction in their OOP costs as a result of price control policy.

Policy solutions should be sought to alleviate patient access and affordability challenges that result from increasingly restrictive utilization management programs, and which interfere with medical decision-making.

Utilization management is the use of administrative mechanisms (e.g., prior authorization) and financial mechanisms (e.g., patient cost sharing), which commercial insurers and PBMs implement to control or restrict patient access to healthcare. One such example is the increasing use of exclusion lists, which are designed to block patients from accessing a medicine that their own doctor has prescribed. Since 2014, these exclusion lists have grown more than 961% to include more than 1,156 unique products.[6] Exclusion lists are also being leveraged with specialty drugs, which could disproportionately affect patients with very serious and specialized treatment needs. Additionally, utilization management programs include expanded tiered lists with varying cost sharing, prior authorization, non-medical switching and step therapy. De-escalation in utilization management has the potential to improve patient accessibility and affordability towards medically necessary treatments, and research indicates a reduction in systemic costs.[7]

[2] https://www.drugchannels.net/2022/03/warped-incentives-update-gross-to-net.html
[3] https://www.wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=HB2263%20SUB%20ENR.htm&yr=2021&sesstype=RS&billtype=B&houseorig=H&i=2263
[4] https://iga.in.gov/pdf-documents/123/2023/senate/bills/SB0008/SB0008.06.ENRH.pdf
[5] https://www.arkleg.state.ar.us/Home/FTPDocument?path=%2FACTS%2F2023R%2FPublic%2FACT333.pdf
[6] https://www.xcenda.com/-/media/assets/xcenda/english/content-assets/white-papers-issue-briefs-studies-pdf/xcenda_pbm_exclusion_may_2022.pdf
[7] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.00036

The American Medical Association found prior authorization (PA) to be a burdensome process that can lead to negative patient outcomes.[8] An AMA physician survey on prior authorization in 2022 found that 91% of respondents reported that PA can lead to negative clinical outcomes; 82% reported that PA can lead to patients abandoning their course of treatment, and 34% reported PA has led to a serious adverse event for a patient in their care.[9] Prior authorization should not create unnecessary burdens on health care providers, nor should it result in delayed care for patients in need.

In addition, any policy approach should recognize the significant difference of transformative cell and gene therapies in their potential to be curative. Consideration should be given to innovative therapies that involve a complex patient journey across sites of care in the health care system, leading to unique affordability challenges for patients based on their insurance plan's benefit design.

Legislative solutions should ensure that patients have timely, predicable, patient-centered, and straight-forward access to care. Medical decision-making should remain between a provider and the patient, and coverage policies should facilitate patient access to the most medically appropriate care.

Policy Recommendation: Examine the use of utilization management tools and evaluate how best to regulate them in the interest of patient access and minimizing OOP costs.

III. Patients should benefit from cost-sharing assistance that is intended to count towards their cost-sharing burden.

Insurers may negotiate with manufacturers for rebates to reduce the plan's overall expenses, but these rebates are often not directly shared with patients. When patients are left with high out of pocket costs, they may look to manufacturer patient assistance programs for additional support but often face the growing threat of patient assistance diversion programs, which are schemes implemented by commercial insurers, PBMs or other third-party intermediaries that divert patient assistance money away from patients to the financial benefit of non-patient third parties. These programs have numerous, deceptive names (e.g., accumulators, maximizers, optimizers or Alternative Funding Programs); yet, they all have the same purpose – to make it harder for patients to access and afford needed healthcare in order that the program operators may financially benefit.

[8] American Medical Association, *What is Prior Authorization?* July 12, 2022, https://www.ama-assn.org/practice-management/prior-authorization , July 21, 2022 (citing 2021 AMA Prior Authorization Physician Survey, https://www.ama-assn.org/system/files/prior-authorization-survey.pdf).
[9] *See* AMA Prior Authorization (PA) Physician Survey, https://www.ama-assn.org/system/files/prior-authorization-survey.pdf, 2021.

Prohibiting diversion of assistance funds away from patients would require legislative solutions that ensure that payments made by or on behalf of enrollee count towards costs of prescription drugs when calculating enrollee's contribution to OOP maximum, deductible, copayment, coinsurance, or other cost-sharing for drugs. Currently, nineteen states and Puerto Rico have passed legislation to prohibit diversion of cost-sharing assistance. Analysis has shown that state laws that have protected patient assistance by prohibiting diversion practices has not resulted in premium increases.[10]

Policy Recommendation: Prohibit diversion of cost-sharing assistance to ensure payment made by or on behalf of patients counts towards their cost-sharing burden.

As one of the nation's leading healthcare companies, we have a responsibility to engage with stakeholders in constructive dialogue to address these gaps in affordability and access, and to protect our nation's leading role in the innovation ecosystem.

We recommend that the Oregon PDAB and Legislature seek to advance sound policy solutions that would support patient access to innovative medicines, improve patient affordability, and allow for treatment decisions to remain in the hands of patients and their healthcare providers. If you have any questions, I can be reached at tsweat@its.jnj.com.

Sincerely,

Terrell Sweat
Director, US State Government Affairs

[10] https://ghlf.org/copay-assistance-protection/

PhRMA
RESEARCH • PROGRESS • HOPE
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October 6, 2023

Oregon Prescription Drug Affordability Board
350 Winter Street NE
Salem, OR 97309-0405
pdab@dcbs.oregon.gov

Re: Oregon Prescription Drug Affordability Review: Call for policy recommendations that will make prescription drugs more affordable for Oregonians.

Dear Members of the Oregon Prescription Drug Affordability Board:

PhRMA appreciates the opportunity to provide potential policy recommendations for the Board's consideration as part of the Board's 2023 policy recommendations to the Oregon Legislature. We believe that the Board's policy recommendations should focus on the factors that impact consumer affordability of prescription drugs, specifically focusing on patient out-of-pocket costs. There are a full range of factors driving such out-of-pocket costs, including benefit design (e.g., cost-sharing requirements such as coinsurance and deductibles, and accumulator adjustment and copay maximizer programs) and rebates, discounts, and other price concessions and reductions paid by drug manufacturers to pharmacy benefit managers ("PBMs") and health insurance plans that the PBMs and plans are not sharing directly with patients at the point-of-sale.

As an industry, we believe that patients need lower out-of-pocket costs without a reduction in health care choice, quality, or access. Biopharmaceutical companies continue to pay billions in rebates and discounts negotiated with insurers and PBMs, while at the same time premiums and patient out of pocket costs continue to rise.[1] There is a flaw in the system when rebates and discounts continue to grow without any meaningful benefit directly to patients taking those medicines. PhRMA proposes the following policy solutions to help make medicines more affordable and the system work better for patients:

Policy Solutions to Make Medicines More Affordable for Oregonians

Rebate Passthrough at the Point-of-Sale

The net price of a medicine reflects the final price paid by the PBM and the plan sponsor. Yet in the majority of cases, the net price is not the price available to patients with insurance at the pharmacy counter. Instead, PBMs and insurers typically require patients with deductibles and coinsurance – who pay a percentage of the cost of their medicine rather than a fixed copayment – to pay based on the undiscounted list price, rather than the discounted net price paid by the PBM. In contrast, health plans typically base patient out-of-pocket spending for care received from doctors and hospitals within the plan's provider network on the discounted rates negotiated by the plan on patients' behalf. Requiring PBMs and health plans to share the savings they receive on medicines directly with patients at the pharmacy counter would lower patient out-of-pocket costs and help realign payer incentives.

[1] Fein AJ. "The 2023 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers." Drug Channels Institute. March 2023.

In the commercial market, actuaries estimate that sharing negotiated rebates directly with patients at the point-of-sale would increase premiums by an average of 1 percent or less.[2] Recognizing that lower cost sharing can improve patient access to medicines, some PBMs have already adopted point-of-sale passthrough programs for their commercial market customers. Within two months of implementing such a program for fully insured group health plans, OptumRx observed up to a 16 percent improvement in medication adherence.[3] Similarly, CVS Health recently noted that "Not only do [point-of-sale] rebates save employees money, they also make prescription purchases more transparent."[4] In 2021, West Virginia became the first state in the nation to require PBMs to pass through manufacturer rebates at the point-of-sale.[5] In 2023, Arkansas and Indiana passed legislation to share the savings with patients.[6]

Delinking Compensation from the Price of a Medicine

"Delinking" policies require that PBMs and other supply chain entities receive a fixed fee based on the value of the services they provide, rather than receiving compensation based on the price of a medicine. This would disrupt the misaligned incentives in the current system that encourage PBMs to prefer higher prescription drug prices over lower ones.[7] Industry experts have noted that the current compensation model has propelled PBMs to adopt business practices that systematically drive up prescription drug prices.[8]

Duty of Care

In August, the Oregon Secretary of State's Audit Division released an audit entitled "Oregon Health Authority, Pharmacy Benefit Managers: Poor Accountability and Transparency Harm Medicaid Patients and Independent Pharmacies."[9] That report found that,

> Certain PBM practices create risks for private insurers and federal and state health programs. PBMs have merged with other entities to remain competitive and to increase their revenue streams … PBMs have considerable influence on which drugs are covered by insurers and can require consumers to get certain prescriptions filled at a specialty or mail order pharmacy, which the PBM may own … Vertical integration in the pharmaceutical system poses risks of decreased

---

[2] Milliman. "Measuring the Impact of Point of Sale Rebates on the Commercial Health Insurance Market," July 2021.https://www.milliman.com/en/insight/measuring-the-impact-of-point-of-sale-rebates-on-the-commercial-health-insurancemarket

[3] UnitedHealth Group. "Successful Prescription Drug Discount Program Expands to Benefit More Consumers at Point-of-Sale." March 12, 2019. https://www.unitedhealthgroup.com/newsroom/2019/2019-03-12-prescription-drug-program-expands-tobenefit-consumers-point-of-sale.html

[4] "Prescription Coverage: CVS/Caremark." Indiana State Personnel Department. Accessed March 12, 2022. https://www.in.gov/spd/benefits/prescription-coverage/

[5] Kelly C. "Rebate Reform: West Virginia Law Requires PBMs to Share the Savings." Pink Sheet. April 29, 2021. https://pink.pharmaintelligence.informa.com/PS144231/Rebate-Reform-West-Virginia-Law-Requires-PBMs-To-Share-The-Savings

[6] Arkansas House Bill 1481 (Act 333 of 2023) and Indiana SB 8, 2023.

[7] Frier Levitt, LLC and Community Oncology Alliance. "Pharmacy Benefit Manager Exposé: How PBMs Adversely Impact Cancer Care While Profiting at the Expense of Patients, Providers, Employers, and Taxpayers." February 2022. https://communityoncology.org/wp-content/uploads/2022/02/COA_FL_PBM_Expose_2-2022.pdf

[8] PBM Accountability Project, "Understanding the Evolving Business Models and Revenue of Pharmacy Benefit Managers", 2021. https://b11210f4-9a71-4e4c-a08f-cf43a83bc1df.usrfiles.com/ugd/b11210_264612f6b98e47b3a8502054f66bb2a1.pdf

[9] Oregon Health Authority, Pharmacy Benefit Managers: Poor Accountability and Transparency Harm Medicaid Patients and Independent Pharmacies, https://sos.oregon.gov/audits/Pages/audit-2023-25-Pharmacy-Benefit-Managers.aspx

consumer access to medications and affordability to everyone, not just those receiving Medicaid benefits.

To address the concerns raised by the Secretary of State's report, the Board could recommend PBMs be subject to a duty of care. Expressly imposing a duty or standard of care on PBMs and requiring these companies to act in the best interest of patients, providers, and their clients (health plans)—and when in conflict, the patient first—would be an important step for the Oregon Legislature to take so that PBMs act in a transparent manner and place their duties to patients, providers, and their clients before their own financial interests.

Anti-Steering

The Oregon Secretary of State's audit report also found concerning PBM practices as it relates to community pharmacies. The report found that, "independent pharmacies are more likely to be reimbursed less for prescriptions than national chain pharmacies … On average, the estimated profits for national chain and specialty/mail order pharmacies are more than twice the amount independent pharmacies receive."[10] Prohibiting PBMs from directing patients to affiliate pharmacies can improve competition and reduce incentives for PBMs to self-deal, allowing independent pharmacies a chance to compete and providing patients with access and choice for fulfilling their prescriptions.

* * *

We thank you again for this opportunity to provide comments and feedback, and for your consideration of our proposed policy solutions. We stand ready to be a constructive partner in this dialogue and help identify solutions that will help Oregon patients better afford their medicines. Please contact dmcgrew@phrma.org with any questions.

Sincerely,

Dharia McGrew, PhD
Director, State Policy

[10] Oregon Health Authority Pharmacy Benefit Managers: Poor Accountability and Transparency Harm Medicaid Patients and Independent Pharmacies, https://sos.oregon.gov/audits/Pages/audit-2023-25-Pharmacy-Benefit-Managers.aspx

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ican international cancer advocacy network
the virtual lifeline for proactive cancer patients

October 6, 2023

Mr. Akil Patterson
Chair
Prescription Drug Affordability Board
PO Box 14480
Salem, OR 97309

Ms. Shelley Bailey
Vice Chair
Prescription Drug Affordability Board
PO Box 14480
Salem, OR 97309

Dear Chair Patterson, Vice Chair Bailey, and Members of the Prescription Drug Affordability Board

We greatly appreciate the willingness of the Oregon Prescription Drug Affordability Board to consider recommendations from patient advocacy groups on ways to help lower the costs of drugs to patients.

ICAN, International Cancer Advocacy Network, is a 501(c)(3) non-profit organization (EIN 86-0818253), based in Phoenix, Arizona. During the past 27 years, we have helped more than 17,500 Stage IV cancer patients in all 50 states—including Oregon—and in 72 foreign countries.

Our goal for each patient is to extend life with the highest achievable quality of life. We deal with all cancers and connect patients with brilliant oncologists, find clinical trials, help interpret molecular profiling reports, and arrange pre-approval access and compassionate use/Right to Try requests.

We have been active participants in several of the discussions regarding prescription drug pricing issues and have had several of our Oregon patients testify along with ICAN's Director of Governmental Relations.

First, some areas of agreement:

1) We all share the goal of lowering prescription drug costs (and health care costs in general) for both health care systems and for patients.

2) We greatly appreciate that Quality Adjusted Life Years ("QALYs") will not be used as a metric as the Board carries out its important work.

3) There are areas where great savings can be made without the negative impacts on the drug discovery pipeline that price controls create.

One of the areas where broad agreement could be created is in reform of Pharmacy Benefit Managers (PBMs).

If the Members of the Board have not seen it, we would like to strongly recommend the recent report of the Audits Division of the Secretary of State entitled: *Oregon Health Authority Pharmacy Benefit Managers Poor Accountability and Transparency Harm Medicaid Patients and Independent Pharmacies August 2023 Report 2023-25* which can be found at this link: https://sos.oregon.gov/audits/Pages/audit-2023-25-Pharmacy-Benefit-Managers.aspx

The Report lays out, in meticulous, well-researched detail, exactly how the PBM system is failing patients. We will not belabor that failure and those details here as we are sure the Members know that just three PBMs control 80% of the market, and that patients pay considerably more for drugs than they should because of PBM practices.

Rather, we wish to endorse the recommendations of the Report (page 31) and especially to draw your attention to the areas where Oregon has fallen behind other states in requiring PBM transparency. Indeed, of nine specific areas of transparency reform, Oregon only requires PBMs to be transparent on four (see page 23 of the Report). That is in contrast to states ranging from Michigan to Texas that require substantially more transparency than does Oregon.

This is the great opportunity for the PDAB Board to make recommendations to the legislature for prompt consideration and passage of a bill requiring PBM transparency in these areas.

On the federal level, Senator Wyden, as Chair of the Senate Finance Committee, has been leading the way on PBM reform. The state legislature should do likewise.

We urge consideration of these and other cost-reducing measures that promise much more direct impact on prices, and on a greater number of drugs, than price controls on a handful of drugs. These reforms have the advantage of preserving (and indeed, increasing) access to drugs for patients.

Please do not hesitate to contact me at marcia@askican.org or at (602) 618-0183 if you need any additional information. Thank you for your consideration.

Respectfully submitted,

Marcia K. Horn, JD
President and CEO
ICAN, International Cancer Advocacy Network
27 West Morten Avenue
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http://askican.org

Oregon Prescription Drug
Affordability Board

Affordability Review
Rule 925-200-0010

Ralph Magrish, executive director
Amanda Claycomb, research analyst
Brekke Berg, data analyst

Rule 925-200-0010

PDAB will select from the list of eligible prescription drugs, provided under ORS 646A.694, a **subset of drugs** to prioritize for an affordability review under OAR 925-200-0020 by **considering** the following for the selection of prescription drugs:

1. Insurer reported top 25 lists
2. Manufacturer new specialty drug report and price increase report
3. Historical and current manufacturer drug price increases, based on WAC
4. Date of FDA approval of the prescription drug and whether the drug was approved through an expedited pathway; brand-name drugs and biological products, that have approved and marketed generic drugs or biosimilar drugs
5. Therapeutic alternatives, cost and availability
6. Whether the prescription drugs have a patent expiration or data exclusivity expiration within 18 months
7. For insulin drugs, criteria may include, but not limited to, the highest insurer reported: (a) Overall spend; (b) Per-patient spend; and (c) Patient out-of-pocket cost

1. Consider whether any prescription drugs are on each of the insurer-reported top 25 lists under ORS 743.025.

PDAB received insurer-reported data under ORS 743.025 identifying the top 25 drugs that were the **Most Prescribed**, **Most Costly**, and had the **Greatest Increase** in price. The **Most Expensive** list type is additional information provided by the Drug Price Transparency (DPT) program for drugs that had the highest cost per prescription.

The board discussed at previous meetings.

2. Consider whether the prescription drug is included in the manufacturer new drug report or price increase report under ORS 646A.689 for the previous calendar year.

Additional review consideration: Staff reviewed the annual price increase report and identified two drugs for board consideration.

Maci & Keveyis

Does the board want to consider reviewing the two drugs?

3. Consider historical and current manufacturer drug price increases, based on wholesale acquisition cost (WAC) information. For drugs with multiple national drug codes (NDC), a measure of central tendency will be used for a price comparison.

Does the board want to use WAC to remove or add any drugs from the subset list?

4. Consider the **date** of U.S. Food and Drug Administration (FDA) **approval** of the prescription drug **and** whether the prescription drug was **approved through an expedited pathway**. Expedited approval includes fast track, priority review, accelerated approval, and breakthrough therapy designations. **For brand-name drugs and biological products**, whether there are **any approved and marketed generic drugs or biosimilar** drugs for the specific brand-name drug or biological product.

- Does the board want to use approval date and expedited pathway to remove or add any drugs from the subset list?
- Does the board want to filter out drugs with approved and marketed generic drugs or biosimilars?

5. Consider where there are therapeutic alternatives, the cost and availability of potential alternatives.

Staff suggests the board review therapeutic alternatives on the selected subset drugs as part of OAR 925-200-0020.

Does this effect your decision to select the subset?

6. Consider whether the prescription drugs have a patent expiration or data exclusivity expiration within 18 months.

Does the board want to use the drug patent or exclusivity expiration to remove or add any drugs from the subset list?

Insulin

- The board has completed a review under OAR 925-200-0010 for prescription drugs.
- The board will now discuss insulin and identify the subset, following the same steps for review under OAR 925-200-0010.

7. For insulin drugs marketed in the U.S. and available in Oregon, consider the criteria for selection may include, but not be limited to, those products with the highest insurer reported:

Overall spend; Per-patient spend; and Patient out-of-pocket cost.

Does the board want to remove or add any drugs from the insulin subset list?

Oregon Prescription Drug
Affordability Board

The information on the following pages of the agenda packet is provided by the Department of Consumer and Business Services (DCBS) Drug Price Transparency Program and the Oregon Health Authority's All Payer All Claims data base. Click on the Prescription Drug Affordability Board data web page to access spreadsheets in Excel format:

- PDAB top drug list
- DPT manufacturer data annual price increase report 2022
- DPT manufacturer data new specialty drugs report 2022
- Insulin data analysis 2021 through 2022

DPT carrier data & CCO top costs lists - top drugs to review

Therapy class	Proprietary name(s)	Non-proprietary name	Number of presciptions	Number of enrollees	Total annual spend	Year over year increase	Total annual spend per enrollee	Beginning 2022 package WAC	End 2022 package WAC	WAC price change % 2022	Avg YoY price change (over past 5 years)	Average cost per prescription	Has orphan designation(s) per FDA	Number of carriers	Percent of carriers	Brand or generic	Drug has a therapeutic equivalent or biosimilar	First FDA approval date	Drug approved through an expedited pathway	Patent expiration date within 18 months	Exclusivity expiration date within 18 months	Drug part of IRA CMS negotiation list	Drug also on the CCO list
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	Keytruda	Pembrolizumab	1,611	269	$28,248,898	$11,840,653	$105,014.49	$6,845.81	$7,122.35	4.04%	1.83%	$17,535	Both Orphan and Non-Orphan	9	100%	Brand	None listed	9/4/2014	Yes	No Data	No	No	Top Costs / Top Cost Change
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	Opdivo	Nivolumab	887	109	$10,884,240	$2,274,979	$99,855.41	$3,601.53	$3,673.56	2.00%	1.78%	$12,271	Both Orphan and Non-Orphan	8	89%	Brand	None listed	12/22/2014	Yes	No Data	No	No	Top Costs / Top Cost Change
PASSIVE IMMUNIZING AND TREATMENT AGENTS	Gammagard / Gammaked / Gamunex-C	Immune Globulin (Human) IV or Subcutaneous	2,339	129	$10,747,945	$4,312,556	$83,317.41	$1,700.93	$1,761.42	3.56%	3.63%	$4,595	Both Orphan and Non-Orphan	7	78%	Brand	None listed	8/27/2003	No	No Data	No	No	Top Cost Change
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	Ocrevus	Ocrelizumab	352	164	$10,932,003	$1,784,101	$66,658.56	$17,796.78	$17,796.78	0.00%	2.48%	$31,057	No	8	89%	Brand	None listed	3/28/2017	Yes	No Data	No	No	Top Costs
GASTROINTESTINAL AGENTS - MISC.	Entyvio	Vedolizumab	2,038	354	$17,655,131	$2,801,800	$49,873.25	$7,276.63	$7,713.23	6.00%	4.60%	$8,663	No	7	78%	Brand	None listed	5/20/2014	Yes	No Data	No	No	Top Costs / Top Cost Change
DERMATOLOGICALS	Stelara	Ustekinumab	2,717	615	$28,957,943	$3,077,394	$47,086.09	$16,127.21	$16,998.08	5.40%	5.20%	$10,658	No	8	89%	Brand	None listed	9/25/2009	No	No	No	Yes	Top Costs / Top Cost Change
DERMATOLOGICALS	Skyrizi / Skyrizi Pen	Risankizumab-rzaa	1,199	372	$15,517,811	$8,385,287	$41,714.54	$12,760.33	$13,704.59	7.40%	7.65%	$12,942	No	8	89%	Brand	None listed	4/23/2019	No	No Data	No	No	Top Cost Change
ANALGESICS - ANTI-INFLAMMATORY	Humira / Humira Pediatric Crohns Start / Humira Pen / Humira Pen-CD/UC/HS Starter / Humira Pen-Pediatric UC Start / Humira Pen-Ps/UV/Adol HS Start / Humira Pen-Psor/Uveit Starter	Adalimumab	14,283	1,842	$75,241,110	$3,682,844	$40,847.51	$9,449.65	$10,099.85	6.88%	6.95%	$5,268	Both Orphan and Non-Orphan	8	89%	Brand	Yes	12/31/2002	No	No	No	No	Top Costs / Top Cost Change
ANALGESICS - ANTI-INFLAMMATORY	Enbrel / Enbrel SureClick	Etanercept	4,805	644	$22,017,823	$89,696	$34,189.17	$2,797.58	$3,029.41	8.29%	6.14%	$4,582	Both Orphan and Non-Orphan	9	100%	Brand	Yes	11/2/1998	Yes	No Data	No	Yes	Top Costs
DERMATOLOGICALS	Cosentyx / Cosentyx Sensoready Pen / Cosentyx Sensoready	Secukinumab	4,401	590	$18,723,855	$2,560,019	$31,735.35	$5,336.40	$5,824.14	9.14%	6.81%	$4,254	No	8	89%	Brand	None listed	1/21/2015	No	No Data	No	No	Top Costs / Top Cost Change
DERMATOLOGICALS	Tremfya	Guselkumab	708	144	$4,336,168	$1,575,599	$30,112.28	$11,938.37	$12,583.04	5.40%	5.21%	$6,125	No	5	56%	Brand	None listed	7/13/2017	Yes	No Data	No	No	Top Cost Change
DERMATOLOGICALS	Dupixent	Dupilumab	4,406	577	$12,665,407	$3,333,668	$21,950.44	$2,082.20	$2,200.14	5.66%	4.07%	$2,875	Both Orphan and Non-Orphan	9	100%	Brand	None listed	3/28/2017	Yes	No Data	No	No	Top Costs / Top Cost Change
OPHTHALMIC AGENTS	Eylea	Aflibercept	2,626	471	$8,222,980	$1,059,030	$17,458.56	$925.00	$925.00	0.00%	0.00%	$3,131	Both Orphan and Non-Orphan	7	78%	Brand	None listed	11/18/2011	Yes	No	Yes	No	Top Costs / Top Cost Change
GASTROINTESTINAL AGENTS - MISC.	Inflectra	Infliximab-dyyb	6,209	1,075	$16,516,923	$5,489,239	$15,364.58	$946.28	$946.28	0.00%	0.00%	$2,660	No	8	89%	Brand	Yes	4/5/2016	No	No Data	No	No	Top Costs / Top Cost Change
NEUROMUSCULAR AGENTS	Botox	OnabotulinumtoxinA	5,940	1,873	$6,673,692	$710,048	$3,563.10	$622.00	$634.00	1.93%	1.08%	$1,123.52	Both Orphan and Non-Orphan	9	100%	Brand	None listed	12/9/1991	No	No Data	No	No	Top Costs
ANTIDIABETICS	Trulicity	Dulaglutide	13,176	2,702	$8,970,087	$907,047	$3,319.80	$554.10	$554.10	0.00%	5.14%	$680.79	No	8	89%	Brand	None listed	9/18/2014	No	No Data	No	No	Top Costs / Top Cost Change
ANTIDIABETICS	Rybelsus / Ozempic	Semaglutide	16,774	3,657	$10,581,528	$3,238,534	$2,893.50	$816.12	$860.20	5.40%	4.55%	$631	No	9	100%	Brand	None listed	12/5/2017	Yes	No	Yes	No	Top Costs / Top Cost Change
ANTICOAGULANTS	Eliquis / Eliquis DVT/PE Starter Pack	Apixaban	15,396	3,574	$8,812,210	$1,296,820	$2,465.64	$687.74	$687.74	0.00%	6.00%	$572.37	No	9	100%	Brand	Yes	12/28/2012	Yes	No	No Data	Yes	Top Costs / Top Cost Change
ANTIDIABETICS	Jardiance	Empagliflozin	17,174	4,160	$7,262,309	$1,632,440	$1,745.75	$914.23	$713.10	-22.00%	5.00%	$423	No	9	100%	Brand	None listed	8/1/2014	Yes	No	No	Yes	Top Costs / Top Cost Change
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	Vyvanse	Lisdexamfetamine Dimesylate	21,520	4,663	$7,558,385	$1,104,457	$1,620.93	$1,116.61	$1,172.44	5.00%	4.60%	$351.23	No	9	100%	Brand	None listed	2/23/2007	No	No	No Data	No	Top Costs
ANTIVIRALS	Biktarvy	Bictegravir-Emtricitabine-Tenofovir Alafenamide Fumarate	5,108	978	$26,988,465	$1,926,579	$27,595.57	$2,468.84	$2,468.84	0.00%	2.78%	$5,283.57	Orphan Only	9	100%	Brand	None listed	2/7/2018	Yes	No	No	No	Top Costs / Top Cost Change
RESPIRATORY AGENTS - MISC.	Trikafta	Elexacaftor-Tezacaftor-Ivacaftor	856	97	$21,559,651	$4,417,699	$222,264.44	$25,067.04	$25,067.04	0.00%	1.84%	$25,187	Orphan Only	7	78%	Brand	None listed	10/21/2019	Yes	No	No	No	Top Costs / Top Cost Change
ANTIVIRALS	Mavyret	Glecaprevir-Pibrentasvir	13	7	$143,605	$130,205	$20,515.07	$10,560.03	$10,560.03	0.00%	0.00%	$11,046.57	Orphan Only	2	22%	Brand	None listed	8/3/2017	Yes	No	No	No	Top Costs

DPT carrier data & CCO top costs lists - top drugs to review

Therapy class	Proprietary name(s)	Non-proprietary name	Number of presciptions	Number of enrollees	Total annual spend	Year over year increase	Total annual spend per enrollee	Beginning 2022 package WAC	End 2022 package WAC	WAC price change % 2022	Avg YoY price change (over past 5 years)	Average cost per prescription	Has orphan designation(s) per FDA	Number of carriers	Percent of carriers	Brand or generic	Drug has a therapeutic equivalent or biosimilar	First FDA approval date	Drug approved through an expedited pathway	Patent expiration date within 18 months	Exclusivity expiration date within 18 months	Drug part of IRA CMS negotiation list	Drug also on the CCO list
ANALGESICS - OPIOID	Bunavail / Buprenorphine HCl-Naloxone HCl / Suboxone / Zubsolv	Buprenorphine HCl-Naloxone HCl Dihydrate	18,576	2,268	$2,230,947	$189,468	$983.66	$130.75	$128.90	-1.42%	-2.92%	$120.10	Orphan Only	8	89%	Both	Yes	8/30/2010	No	No	No Data	No	Top Costs / Top Claims / Top Cost Change
HEMATOLOGICAL AGENTS - MISC.	Hemlibra	Emicizumab-kxwh	146	13	$6,574,803	$2,584,640	$505,754.09	$9,079.26	$9,079.26	0.00%	1.80%	$45,033	Orphan Only	5	56%	Brand	None listed	11/16/2017	Yes	No Data	No	No	Top Costs / Top Cost Change
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	Albuterol Sulfate / Albuterol Sulfate ER / Albuterol Sulfate HFA / ProAir HFA / ProAir RespiClick / Proventil HFA / Ventolin HFA	Albuterol Sulfate	141,372	68,376	$3,549,427	$470,108	$51.91	$295.08	$274.76	-6.89%	-1.30%	$25.11	No	9	100%	Both	Yes	12/5/1989	No	No	No Data	No	Top Costs / Top Claims
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	Budesonide-Formoterol Fumarate / Symbicort	Budesonide-Formoterol Fumarate Dihydrate	7,183	2,351	$1,635,595	$318,280	$695.70	$272.33	$272.33	0.00%	1.77%	$227.70	No	7	78%	Both	Yes	7/21/2006	No	No	No Data	No	Top Costs
DIGESTIVE AIDS	Creon / Pancreaze / Pertzye / Viokace / Zenpep	Pancrelipase (Lipase-Protease-Amylase)	1,267	342	$2,701,230	$1,091,525	$7,898.33	$672.97	$697.91	3.71%	3.31%	$2,131.99	No	6	67%	Brand	None listed	4/30/2009	Yes	No Data	Yes	No	Top Costs
ANTICOAGULANTS	Xarelto / Xarelto Starter Pack	Rivaroxaban	7,452	2,000	$4,726,361	$514,645	$2,363.18	$1,961.26	$2,057.36	4.90%	5.25%	$634.24	No	8	89%	Brand	None listed	7/1/2011	Yes	Yes	Yes	Yes	Top Costs
ANTIVIRALS	Triumeq / Triumeq PD	Abacavir-Dolutegravir-Lamivudine	1,009	147	$4,371,265	$366,797	$29,736.50	$3,339.06	$2,170.39	-35.00%	5.31%	$4,332.27	No	7	78%	Brand	None listed	8/22/2014	Yes	No	No	No	Top Costs
ANTIVIRALS	Genvoya	Elvitegravir-Cobicistat-Emtricitabine-Tenofovir Alafenamide	727	112	$3,400,080	No Data	$30,357.86	$3,583.80	$3,583.80	0.00%	5.20%	$4,676.86	No	5	56%	Brand	None listed	11/5/2015	Yes	No	No Data	No	Top Costs
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	Lenalidomide / Revlimid	Lenalidomide	627	122	$10,432,994	$2,350,557	$85,516.35	$51,868.25	$34,549.49	-33.39%	0.91%	$16,640	Orphan Only	9	100%	Both	Yes	12/27/2005	Yes	No	No	No	Top Costs
HEMATOLOGICAL AGENTS - MISC.	Ultomiris	Ravulizumab-cwvz	88	19	$8,640,498	$2,566,297	$454,763.06	$12,096.44	$12,096.44	0.00%	0.00%	$98,187	Orphan Only	6	67%	Brand	None listed	12/21/2018	Yes	No Data	No	No	No
VACCINES	Shingrix	Zoster Vaccine Recombinant Adjuvanted	35,123	27,538	$6,822,359	$319,706	$247.74	$943.63	$943.63	0.00%	5.56%	$194.24	Orphan Only	9	100%	Brand	None listed	10/20/2017	No	No Data	No	No	No

Trade name / proprietary name	Non-proprietary name	Therapeutic class	2022 Calculated AWAC	Beginning WAC 2022	Beginning WAC 2023	Avg YoY price change (over past 5 years)	Introductory price	Price per unit	Net increase percentage	Rank GI	Rank MC	Rank ME	Has orphan indications	Brand or generic	Drug has a therapeutic equivalent or biosimilar	First FDA approval date	Drug approved through an expedited pathway	Patent expiration date within 18 months	Exclusivity expiration date within 18 months	Drug part of IRA CMS negotiation list
Maci	Autologous Cultured Chondrocytes	Musculoskeletal Therapy Agents	$83,190.02	$62,548.00	$104,504.00	15.48%	$47,750.00	$41,595.01	67%	5	1	1	No	Brand	None listed	12/13/2016	No	No Data	No	No
Keveyis	Dichlorphenamide	Diuretics	$28,363.24	$24,963.28	$30,150.67	9.54%	$13,650.00	$283.63	21%	24	2	15	No	Brand	Yes	8/7/2015	No	No Data	No Data	No

Detailed Data - Insulin Spend 2021 and 2022 by Insulin Type, Drug Base, and Proprietary Name

			2021					2022					Year Over Year Comparison	
Insulin type	Drug base name	Proprietary name	Sum of Claimants	Overall spend	Per patient spend	Total patient out of pocket costs	Out of pocket costs per person	Sum of Claimants	Overall spend	Per patient spend	Total patient out of pocket costs	Out of pocket costs per person	2021-2022 Overall Spend Change ($)	2021-2022 Overall Spend Change (%)
Intermediate and Rapid-Acting	Insulin Aspart Protamine & Aspart (Human)	Insulin Asp Prot & Asp FlexPen	88	$167,667	$1,905	$2,481	$28	102	$176,246	$1,728	$959	$9	$8,579.06	5%
Intermediate and Rapid-Acting	Insulin Aspart Protamine & Aspart (Human)	Insulin Aspart Prot & Aspart	15	$15,501	$1,033	$130	$9	17	$26,426	$1,554	$600	$35	$10,925.05	70%
Intermediate and Rapid-Acting	Insulin Aspart Protamine & Aspart (Human)	NovoLOG 70/30 FlexPen ReliOn	13	$2,405	$185	$124	$10	12	$8,743	$729	$1,438	$120	$6,337.94	264%
Intermediate and Rapid-Acting	Insulin Aspart Protamine & Aspart (Human)	NovoLOG Mix 70/30	28	$132,656	$4,738	$7,320	$261	17	$58,294	$3,429	$2,537	$149	-$74,361.88	-56%
Intermediate and Rapid-Acting	Insulin Aspart Protamine & Aspart (Human)	NovoLOG Mix 70/30 FlexPen	124	$641,942	$5,177	$26,440	$213	44	$246,159	$5,595	$9,217	$209	-$395,782.82	-62%
Intermediate and Rapid-Acting	Insulin Aspart Protamine & Aspart (Human)	NovoLOG Mix 70/30 ReliOn	0	$0	NULL	$0	NULL	5	$2,332	$466	$20	$4	$2,332.16	
Intermediate and Rapid-Acting	Insulin Lispro Protamine & Lispro	HumaLOG Mix 50/50	2	$853	$426	$10	$5	2	$2,013	$1,006	$0	$0	$1,160.06	136%
Intermediate and Rapid-Acting	Insulin Lispro Protamine & Lispro	HumaLOG Mix 50/50 KwikPen	13	$51,643	$3,973	$980	$75	7	$25,581	$3,654	$550	$79	-$26,061.65	-50%
Intermediate and Rapid-Acting	Insulin Lispro Protamine & Lispro	HumaLOG Mix 75/25	11	$83,891	$7,626	$3,587	$326	9	$66,953	$7,439	$2,155	$239	-$16,937.97	-20%
Intermediate and Rapid-Acting	Insulin Lispro Protamine & Lispro	HumaLOG Mix 75/25 KwikPen	59	$354,498	$6,008	$14,345	$243	49	$319,094	$6,512	$13,993	$286	-$35,403.78	-10%
Intermediate and Rapid-Acting	Insulin Lispro Protamine & Lispro	Insulin Lispro Prot & Lispro	20	$26,575	$1,329	$3,856	$193	16	$14,299	$894	$1,875	$117	-$12,276.73	-46%
Intermediate and Short-Acting	Insulin NPH Isophane & Reg (Human)	HumuLIN 70/30	348	$364,738	$1,048	$26,575	$76	315	$357,996	$1,136	$26,061	$83	-$6,742.16	-2%
Intermediate and Short-Acting	Insulin NPH Isophane & Reg (Human)	HumuLIN 70/30 KwikPen	82	$285,150	$3,477	$19,671	$240	89	$306,887	$3,448	$21,176	$238	$21,736.69	8%
Intermediate and Short-Acting	Insulin NPH Isophane & Reg (Human)	NovoLIN 70/30	100	$178,105	$1,781	$16,825	$168	72	$122,626	$1,703	$6,155	$85	-$55,478.71	-31%
Intermediate and Short-Acting	Insulin NPH Isophane & Reg (Human)	NovoLIN 70/30 FlexPen	60	$102,735	$1,712	$7,153	$119	79	$152,517	$1,931	$5,243	$66	$49,781.16	48%
Intermediate and Short-Acting	Insulin NPH Isophane & Reg (Human)	NovoLIN 70/30 FlexPen Relion	8	$943	$118	$20	$3	13	$1,655	$127	$277	$21	$711.81	75%
Intermediate and Short-Acting	Insulin NPH Isophane & Reg (Human)	NovoLIN 70/30 ReliOn	31	$11,672	$377	$1,744	$56	28	$11,694	$418	$1,043	$37	$21.77	0%
Intermediate-Acting	Insulin NPH (Human) (Isophane)	HumuLIN N	3,989	$2,808,105	$704	$290,306	$73	3,767	$2,648,334	$703	$257,946	$68	-$159,771.25	-6%
Intermediate-Acting	Insulin NPH (Human) (Isophane)	HumuLIN N KwikPen	391	$573,543	$1,467	$52,968	$135	498	$672,121	$1,350	$50,824	$102	$98,578.01	17%
Intermediate-Acting	Insulin NPH (Human) (Isophane)	NovoLIN N	347	$361,889	$1,043	$27,285	$79	280	$294,701	$1,053	$26,681	$95	-$67,187.75	-19%
Intermediate-Acting	Insulin NPH (Human) (Isophane)	NovoLIN N FlexPen	131	$101,247	$773	$6,556	$50	149	$109,905	$738	$11,850	$80	$8,658.09	9%
Intermediate-Acting	Insulin NPH (Human) (Isophane)	NovoLIN N FlexPen ReliOn	33	$3,723	$113	$658	$20	29	$4,061	$140	$417	$14	$337.43	9%

Detailed Data - Insulin Spend 2021 and 2022 by Insulin Type, Drug Base, and Proprietary Name

			2021					2022					Year Over Year Comparison	
Insulin type	Drug base name	Proprietary name	Sum of Claimants	Overall spend	Per patient spend	Total patient out of pocket costs	Out of pocket costs per person	Sum of Claimants	Overall spend	Per patient spend	Total patient out of pocket costs	Out of pocket costs per person	2021-2022 Overall Spend Change ($)	2021-2022 Overall Spend Change (%)
Intermediate-Acting	Insulin NPH (Human) (Isophane)	NovoLIN N ReliOn	76	$17,099	$225	$5,126	$67	83	$15,506	$187	$2,169	$26	-$1,592.59	-9%
Long-Acting	Insulin Degludec	Tresiba	77	$212,461	$2,759	$12,268	$159	76	$229,225	$3,016	$11,591	$153	$16,763.97	8%
Long-Acting	Insulin Degludec	Tresiba FlexTouch	2,210	$8,780,992	$3,973	$427,160	$193	2,279	$9,116,082	$4,000	$377,969	$166	$335,090.21	4%
Long-Acting	Insulin Detemir	Levemir	152	$496,635	$3,267	$47,429	$312	116	$325,282	$2,804	$21,763	$188	-$171,353.27	-35%
Long-Acting	Insulin Detemir	Levemir FlexTouch	700	$2,260,193	$3,229	$171,177	$245	692	$1,972,542	$2,850	$134,699	$195	-$287,650.75	-13%
Long-Acting	Insulin Glargine	Basaglar KwikPen	4,634	$8,583,641	$1,852	$291,729	$63	4,477	$7,887,080	$1,762	$166,387	$37	-$696,560.62	-8%
Long-Acting	Insulin Glargine	Lantus	2,446	$5,803,169	$2,373	$603,538	$247	1,782	$3,478,800	$1,952	$309,471	$174	-$2,324,368.51	-40%
Long-Acting	Insulin Glargine	Lantus SoloStar	6,085	$16,049,090	$2,637	$1,849,731	$304	4,336	$11,170,906	$2,576	$1,046,071	$241	-$4,878,184.44	-30%
Long-Acting	Insulin Glargine	Semglee	80	$21,784	$272	$1,723	$22	51	$8,535	$167	$2,291	$45	-$13,248.72	-61%
Long-Acting	Insulin Glargine	Toujeo Max SoloStar	408	$2,274,327	$5,574	$153,906	$377	483	$2,650,691	$5,488	$152,599	$316	$376,364.47	17%
Long-Acting	Insulin Glargine	Toujeo SoloStar	784	$3,157,107	$4,027	$381,493	$487	776	$2,845,849	$3,667	$269,302	$347	-$311,258.06	-10%
Long-Acting	Insulin-Incretin Mimetic Combination - Two Ingredient	Soliqua	44	$158,443	$3,601	$17,785	$404	39	$159,491	$4,090	$23,495	$602	$1,047.92	1%
Long-Acting	Insulin-Incretin Mimetic Combination - Two Ingredient	Xultophy	26	$192,929	$7,420	$7,250	$279	14	$120,522	$8,609	$4,192	$299	-$72,406.63	-38%
Rapid-Acting	Insulin Aspart	Fiasp	101	$473,256	$4,686	$39,698	$393	108	$532,853	$4,934	$31,839	$295	$59,597.53	13%
Rapid-Acting	Insulin Aspart	Fiasp FlexTouch	144	$466,184	$3,237	$28,627	$199	158	$688,589	$4,358	$41,568	$263	$222,404.74	48%
Rapid-Acting	Insulin Aspart	Fiasp PenFill	13	$34,347	$2,642	$3,739	$288	21	$100,442	$4,783	$5,207	$248	$66,094.60	192%
Rapid-Acting	Insulin Aspart	Insulin Aspart	970	$2,002,431	$2,064	$107,938	$111	847	$1,919,410	$2,266	$72,369	$85	-$83,021.00	-4%
Rapid-Acting	Insulin Aspart	Insulin Aspart FlexPen	1,418	$1,945,707	$1,372	$73,562	$52	1,401	$1,897,537	$1,354	$53,766	$38	-$48,169.31	-2%
Rapid-Acting	Insulin Aspart	Insulin Aspart PenFill	196	$376,078	$1,919	$9,538	$49	195	$385,597	$1,977	$6,674	$34	$9,519.55	3%
Rapid-Acting	Insulin Aspart	NovoLOG	856	$4,651,818	$5,434	$347,577	$406	863	$5,359,605	$6,210	$279,086	$323	$707,786.42	15%
Rapid-Acting	Insulin Aspart	NovoLOG FlexPen	1,180	$4,654,644	$3,945	$322,787	$274	960	$3,947,832	$4,112	$219,054	$228	-$706,812.37	-15%
Rapid-Acting	Insulin Aspart	NovoLOG FlexPen ReliOn	38	$6,673	$176	$1,179	$31	108	$40,927	$379	$8,215	$76	$34,254.23	513%
Rapid-Acting	Insulin Aspart	NovoLOG PenFill	133	$488,150	$3,670	$39,016	$293	125	$617,007	$4,936	$34,006	$272	$128,856.66	26%

Detailed Data - Insulin Spend 2021 and 2022 by Insulin Type, Drug Base, and Proprietary Name

			2021					2022					Year Over Year Comparison	
Insulin type	Drug base name	Proprietary name	Sum of Claimants	Overall spend	Per patient spend	Total patient out of pocket costs	Out of pocket costs per person	Sum of Claimants	Overall spend	Per patient spend	Total patient out of pocket costs	Out of pocket costs per person	2021-2022 Overall Spend Change ($)	2021-2022 Overall Spend Change (%)
Rapid-Acting	Insulin Aspart	NovoLOG ReliOn	26	$13,882	$534	$2,882	$111	46	$49,220	$1,070	$9,693	$211	$35,338.21	255%
Rapid-Acting	Insulin Glulisine	Apidra	10	$44,428	$4,443	$3,078	$308	9	$40,554	$4,506	$4,080	$453	-$3,874.56	-9%
Rapid-Acting	Insulin Glulisine	Apidra SoloStar	22	$129,596	$5,891	$22,950	$1,043	14	$94,414	$6,744	$2,205	$158	-$35,181.96	-27%
Rapid-Acting	Insulin Lispro	Admelog	488	$801,465	$1,642	$6,853	$14	443	$554,213	$1,251	$4,965	$11	-$247,251.77	-31%
Rapid-Acting	Insulin Lispro	Admelog SoloStar	1,181	$1,663,266	$1,408	$10,930	$9	1,102	$1,209,357	$1,097	$6,273	$6	-$453,908.91	-27%
Rapid-Acting	Insulin Lispro	HumaLOG	3,164	$11,521,231	$3,641	$581,072	$184	2,995	$11,261,929	$3,760	$506,966	$169	-$259,301.28	-2%
Rapid-Acting	Insulin Lispro	HumaLOG Junior KwikPen	296	$564,290	$1,906	$55,116	$186	301	$645,193	$2,143	$46,898	$156	$80,902.57	14%
Rapid-Acting	Insulin Lispro	HumaLOG KwikPen	2,648	$8,378,546	$3,164	$582,805	$220	2,703	$8,540,264	$3,160	$464,282	$172	$161,718.02	2%
Rapid-Acting	Insulin Lispro	Insulin Lispro	783	$1,205,726	$1,540	$106,707	$136	796	$876,082	$1,101	$92,146	$116	-$329,643.90	-27%
Rapid-Acting	Insulin Lispro	Insulin Lispro (1 Unit Dial)	928	$1,068,915	$1,152	$90,094	$97	969	$689,273	$711	$74,407	$77	-$379,642.20	-36%
Rapid-Acting	Insulin Lispro	Insulin Lispro Junior KwikPen	75	$67,024	$894	$7,896	$105	114	$79,009	$693	$10,486	$92	$11,984.76	18%
Rapid-Acting	Insulin Lispro	Lyumjev	60	$235,953	$3,933	$39,335	$656	76	$416,258	$5,477	$28,544	$376	$180,305.17	76%
Rapid-Acting	Insulin Lispro	Lyumjev KwikPen	71	$174,158	$2,453	$42,578	$600	89	$313,053	$3,517	$26,622	$299	$138,895.03	80%
Rapid-Acting	Insulin Regular (Human)	Afrezza	15	$150,195	$10,013	$18,870	$1,258	9	$103,324	$11,480	$9,850	$1,094	-$46,870.88	-31%
Short-Acting	Insulin Regular (Human)	HumuLIN R	1,697	$1,061,111	$625	$104,870	$62	1,686	$1,037,543	$615	$98,760	$59	-$23,567.53	-2%
Short-Acting	Insulin Regular (Human)	HumuLIN R U-500 (CONCENTRATED)	116	$1,462,149	$12,605	$27,813	$240	115	$1,229,894	$10,695	$15,080	$131	-$232,255.69	-16%
Short-Acting	Insulin Regular (Human)	HumuLIN R U-500 KwikPen	152	$1,882,707	$12,386	$47,982	$316	157	$1,894,053	$12,064	$26,993	$172	$11,345.66	1%
Short-Acting	Insulin Regular (Human)	NovoLIN R	125	$187,764	$1,502	$13,941	$112	100	$161,776	$1,618	$11,465	$115	-$25,988.37	-14%
Short-Acting	Insulin Regular (Human)	NovoLIN R FlexPen	34	$26,668	$784	$2,473	$73	34	$34,256	$1,008	$2,122	$62	$7,587.71	28%
Short-Acting	Insulin Regular (Human)	NovoLIN R FlexPen ReliOn	3	$557	$186	$184	$61	3	$240	$80	$0	$0	-$317.31	-57%
Short-Acting	Insulin Regular (Human)	NovoLIN R ReliOn	31	$7,072	$228	$2,033	$66	25	$4,899	$196	$1,053	$42	-$2,172.90	-31%
Grand Total			**40,589**	**$100,023,342**	**$2,464**	**$7,223,472**	**$178**	**37,375**	**$90,333,751**	**$2,417**	**$5,157,686**	**$138**	**-$9,689,591.57**	**-10%**

Detailed Data - Insulin Spend 2021 and 2022 by Insulin Type and Drug Base

		2021					2022					Year Over Year Comparison	
Insulin type	Drug base name	Sum of Claimants	Overall spend	Per patient spend	Total patient out of pocket costs	Out of pocket costs per person	Sum of Claimants	Overall spend	Per patient spend	Total patient out of pocket costs	Out of pocket costs per person	2021-2022 Overall Spend Change ($)	2021-2022 Overall Spend Change (%)
Intermediate and Rapid-Acting	Insulin Aspart Protamine & Aspart (Human)	268	$960,171	$3,583	$36,496	$136	197	$518,200	$2,630	$14,771	$75	-$441,970	-46%
Intermediate and Rapid-Acting	Insulin Lispro Protamine & Lispro	105	$517,460	$4,928	$22,778	$217	83	$427,940	$5,156	$18,573	$224	-$89,520	-17%
Intermediate and Short-Acting	Insulin NPH Isophane & Reg (Human)	629	$943,343	$1,500	$71,987	$114	596	$953,374	$1,600	$59,954	$101	$10,031	1%
Intermediate-Acting	Insulin NPH (Human) (Isophane)	4,967	$3,865,606	$778	$382,899	$77	4,806	$3,744,628	$779	$349,887	$73	-$120,978	-3%
Long-Acting	Insulin Degludec	2,287	$8,993,453	$3,932	$439,428	$192	2,355	$9,345,307	$3,968	$389,560	$165	$351,854	4%
Long-Acting	Insulin Detemir	852	$2,756,829	$3,236	$218,605	$257	808	$2,297,824	$2,844	$156,462	$194	-$459,004	-17%
Long-Acting	Insulin Glargine	14,437	$35,889,117	$2,486	$3,282,120	$227	11,905	$28,041,861	$2,355	$1,946,120	$163	-$7,847,256	-22%
Long-Acting	Insulin-Incretin Mimetic Combination - Two Ingredient	70	$351,372	$5,020	$25,035	$358	53	$280,013	$5,283	$27,687	$522	-$71,359	-20%
Rapid-Acting	Insulin Aspart	5,075	$15,113,170	$2,978	$976,543	$192	4,832	$15,539,019	$3,216	$761,475	$158	$425,849	3%
Rapid-Acting	Insulin Glulisine	32	$174,024	$5,438	$26,028	$813	23	$134,968	$5,868	$6,285	$273	-$39,057	-22%
Rapid-Acting	Insulin Lispro	9,694	$25,680,574	$2,649	$1,523,386	$157	9,588	$24,584,632	$2,564	$1,261,589	$132	-$1,095,943	-4%
Rapid-Acting	Insulin Regular (Human)	15	$150,195	$10,013	$18,870	$1,258	9	$103,324	$11,480	$9,850	$1,094	-$46,871	-31%
Short-Acting	Insulin Regular (Human)	2,158	$4,628,029	$2,145	$199,296	$92	2,120	$4,362,660	$2,058	$155,473	$73	-$265,368	-6%
Grand Total		**40,589**	**$100,023,342**	**$2,464**	**$7,223,472**	**$178**	**37,375**	**$90,333,751**	**$2,417**	**$5,157,686**	**$138**	**-$9,689,592**	**-10%**