Oregon Prescription Drug Affordability Board

Oregon Prescription Drug Affordability Board (PDAB) Meeting
Wednesday, September 20, 2023
Minutes
Approved by the board on Oct. 18, 2023

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.