Prescription Drug Price Transparency Program results and recommendations – 2024

(As required by ORS 646A.689)

DCBS | Department of Consumer and Business Services

Nov. 27, 2024

About DCBS:
The Department of Consumer and Business Services (DCBS) is Oregon's largest consumer protection and business regulatory agency.

For more information, visit https://www.oregon.gov/dcbs.

About Oregon DFR:
The Division of Financial Regulation (DFR) protects consumers and regulates insurance, depository institutions, trust companies, securities, and consumer financial products and services and is part of DCBS. Visit dfr.oregon.gov.

About the Drug Price Transparency Program:
Oregon's Drug Price Transparency Program is part of DFR and provides accountability for prescription drug pricing through the notice and disclosure of specific drug costs and price information from pharmaceutical manufacturers, health insurers, pharmacy benefit managers, and consumers.

Visit https://dfr.oregon.gov/drugtransparency. We encourage consumers to report price increases to us online at https://dfr.oregon.gov/rxdrugprices or contact the program at rx.prices@dcbs.oregon.gov or leave a message at 503-947-7200 (or toll-free at 833-210-4560).

Terms and acronyms used throughout this report:
National drug code (NDC): Drug products are identified using these unique numbers, which serve as universal product identifiers for drugs and can be found online in the U.S. Food and Drug Administration (FDA) NDC directory.

Pharmacy benefit manager (PBM): An organization that handles some or all the pharmacy benefits for a health plan and generally controls formulary decisions, pharmacy networks, and price negotiations with others in the supply chain. Some PBMs have corporate ownership or affiliation with insurers, manufacturers, pharmacy chains, and other health care entities.

Wholesale acquisition cost (WAC): The manufacturer's list price to wholesalers or other direct purchasers in the U.S. not including any price reductions, sometimes referred to as the "list price." This term is defined in federal law.

See additional pharmaceutical terms in the glossary on our website.

Additional report information:
This report is based on all data submitted to the program from Sept. 1, 2023, through Aug. 31, 2024, and consumer survey responses received before the finalization of the report.

Throughout our report we also reference drug prices and therapeutic class information extracted from the Medi-Span drug database:

Acknowledgments

The annual report on prescription drug price transparency and recommendations to the Legislature were prepared by the following staff members:

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Introduction

This sixth annual report to the Oregon Legislature describes information collected by the Oregon Drug Price Transparency Program with recommendations for legislative changes to contain the cost of prescription drugs and reduce the effects of price increases. This report provides information about prescription drug costs and trends based on data received from prescription drug manufacturers, health insurance companies, pharmacy benefit managers (PBMs), and consumers in the following sections:

- Background on prescription drugs and spending
- Oregon's Drug Price Transparency Program and consumer reported information
- Prescription drug manufacturer information and data collected from reports
- Compliance and enforcement efforts
- Trade secret claims
- PBM reporting data
- Insurance company reporting data
- Policy recommendations to the Legislature

These topics are covered briefly in the executive summary, followed by detailed information in the appropriate sections, concluding with key findings.

Executive summary

Background

Prescription drugs help many Oregonians to live longer and have a greatly improved quality of life. Not being able to afford lifesaving, life-improving prescriptions causes harm to patients and their families and contributes to additional burdens on our health care system. Some can only afford prescriptions by doing without other needs, which often leads to a reduction in quality of life and affects their overall health. Affordability and access remain of high concern to consumers and lawmakers alike.

To gather more information about these high prices, the Oregon Legislature created the Drug Price Transparency (DPT) Program by passing Oregon's Prescription Drug Price Transparency Act in 2018 (House Bill 4005).[1] The program's purpose is to provide accountability by disclosing to the public specific pricing information reported by pharmaceutical manufacturers, health insurers, PBMs, and consumers.

Program overview

The program was recently affected by a federal court ruling that limited the program's ability to collect data on increases in drug prices. Section 2(3) of the Prescription Drug Price Transparency Act, codified in ORS 646A.689(3), requires drug manufacturers to annually submit a price increase report for any of their drugs with a list price of $100 or more for a 30-day supply or a shorter course of treatment that experiences a net price increase of 10 percent or more from the previous year.

On Feb. 16, 2024, the U.S. District Court for Oregon, in *Pharmaceutical Research and Manufacturers of America v. Stolfi*, issued a declaratory judgment that section 2(3) of the Act violates the First Amendment to the U.S. Constitution and is, therefore, unenforceable. The court's order suspended the requirement under ORS 646A.689(3) for drug manufacturers to report annual price increases. DCBS believes the order was entered in error and has appealed the case to the U.S. Court of Appeals for the Ninth Circuit.

In prior years, the DPT program was able to report:

- Drugs meeting the price increase threshold and actual increase amounts
- Manufacturer explanations for price increase factors
- Aggregated manufacturer profit and revenue data
- Aggregated direct manufacturer costs for marketing, manufacturing, distribution, and safety/effectiveness research
- Drug prices in other countries

Receiving such limited data means the program is no longer able to provide the following types of analysis for the transparency factors listed:

- Comparison of generics versus brand name drugs
- Comparison of drug price increases to inflation
- Categorization by most common drug classes
- Tracking all trends over time

The program continues to engage manufacturers and collect information to inform the public hearing and legislative reports. Data from

[1] House Bill 4005 (2018), https://olis.oregonlegislature.gov/liz/2018R1/Measures/Overview/HB4005. Accessed Oct. 31, 2024.

consumers, insurers, PBMs, and pharmaceutical manufacturers is collected and analyzed by program staff members throughout the year. This report summarizes the findings from data collected since the 2023 annual legislative report.

In 2024, the program will hold its sixth annual public hearing. Program staff members will submit this report to the Oregon Legislature by Dec. 15 and post it to the program's website for public access.

Results

Oregon's DPT Program has been collecting and analyzing information received from drug manufacturers, health insurers, and consumers for several years, and now also PBMs. The program is working to deepen the state's understanding of the factors that influence prescription drug prices and how drug prices affect Oregonians.

Based on the information collected, here are highlights of the data in this report:

- **Insurer rebates**: Most health insurers reported receiving rebates ranging from 9.9 percent and 27.3 percent of their total pharmaceutical spending. Providence reported the highest rebates received as a percentage of prescription spending at 27.3 percent. Kaiser reported the lowest rebates received at 0.3 percent.
  - The program does not have sufficient data to suggest whether there are any correlations between rebates and spending within the prescription drug data.
- **Drug with highest insurer spending**: Humira, manufactured by AbbVie Inc. to treat inflammatory conditions, continues to be the most costly drug contributing to increased plan spending than any other drug for six years running. In 2024, health insurance companies in Oregon reported spending more than $53.2 million on Humira.
- **Most common new drug reporting**: Antineoplastics and adjunctive therapies, which are used to treat cancer, were again the most common category of new prescription drugs reported to the program by manufacturers.
- **Highest prices of new drugs reported**: The highest wholesale acquisition cost (WAC) reported for new prescription drugs were for the following hematological and hematopoietic agents (all three are brand-name prescription drugs):
  - $3.5 million for Beqvez™, a treatment for hemophilia B, manufactured by Pfizer
  - $3.1 million for Lyfgenia™, a treatment for sickle cell disease, manufactured by bluebird bio Inc.
  - $2.2 million for Casgevy™, a treatment for sickle cell disease, manufactured by Vertex Pharmaceuticals Inc.
- **Manufacturer reporting quality and trade secret claims**: The quality of information submitted by manufacturers was extremely variable, ranging from initial refusals to provide information, to generalized descriptions, to detailed information of a company's reasons for determining the price of a drug. This variability continues to be an issue when attempting to determine the reasons why a drug is priced high when it comes to market.
  - For context, the program has received more than 2,500 reports that claimed one or more data elements as a trade secret since 2019.

Within these 2,500 reports, more than 11,500 data elements have been claimed as trade secrets. Of that total, 598 reports with 1,262 data elements claimed as trade secret have been received since last year's report.

- **Manufacturer reporting compliance**: The program's compliance efforts have progressed to issuing noncompliance warning notices to manufacturers to address their behavior and the volume, variances, and complexities mentioned above. If the manufacturers do not come into compliance following our initial noncompliance notices, we will send a file to the enforcement unit with DFR. DCBS issued its first civil penalties totaling $75,000 in 2024.
- **PBM rebates and manufacturer payments**: The program received PBM reports in 2024 for the first time. These reports provided information about manufacturer payments collected and whether that payment went back to the insurers, was passed to enrollees of the pharmacy program, or was kept as revenue by the PBM. Across 17 PBMs not exempt to our reporting requirements, just under $287.5 million was collected in manufacturer payments. Of this amount, $283.6 million (98.7 percent of payments received) was passed to the insurers. $2.2 million (0.78 percent of payments received) was passed to enrollees, and $1.6 million (0.56 percent of payments received) was kept as revenue by the PBMs.

Recommendations

This report is required by the Prescription Drug Price Transparency Act, which also requires recommendations for legislative changes to contain the cost of prescription drugs and reduce the effects of price increases.

Recommendation 1: Expand patient assistance program reporting

As in previous reports, the program recommends the Legislature consider requiring all reporting manufacturers to report annually on all patient assistance programs they maintain, support, or fund.

Recommendation 2: Require insurers and PBMs to report on "copay accumulator" programs

As a companion to expanded reporting on patient assistance programs, the program continues to recommend the Legislature require insurers and PBMs to annually report data to the DPT regarding their "copay accumulator" programs in Oregon.

Recommendation 3: Expand and strengthen Oregon's bulk purchasing authority

As in previous annual reports, the program continues to recommend the Legislature establish a multistate purchasing authority on behalf of the state. The program also recommends that the Legislature require state entities purchasing prescription drugs to do so through the Oregon Prescription Drug Program (OPDP) unless greater discounts and aggregate savings are available elsewhere. To enhance accountability and transparency, the program also recommends that OPDP be required to report to the Legislature annually regarding its programs, the number of Oregonians served, and savings generated.

Recommendation 4: Centralize state Medicaid drug purchasing

The program recommends that the Legislature centralize state Medicaid drug purchasing to create administrative efficiencies, adequate oversight, cost savings, and equitable consumer experiences.

Recommendation 5: Centralize pharmacy purchasing and analytics

The program recommends that the Legislature centralize pharmacy purchasing to provide coordination and oversight for all state prescription drug purchasing to ensure Oregon is leveraging the entirety of the state's position in the marketplace.

Background

Throughout our country, people are having trouble affording necessary medications. Prescription drugs help many Oregonians to live longer and have an improved quality of life. In a 2023 Kaiser Family Foundation (KFF) poll, 30 percent of respondents have reduced prescription drug costs by skipping doses, cutting pills in half, or using less effective over-the-counter alternatives. That KFF poll also found that people in all age groups and with a large span of income levels are struggling to afford their prescription medications.[2]

The more recent KFF poll in Figure 1 asked people what they are most worried about; not being able to afford and prescription drug costs was in the top 10, along with unexpected medical bills, health care services expenses, and insurance premiums.[3]

Not being able to afford lifesaving, life-improving prescriptions causes harm to patients and their families and contributes to additional burdens on our health care system. Some can only afford prescriptions by doing without other needs, and there is a reduction in quality of life that affects overall health. Some cannot afford necessary medications at all to the great detriment of their well-being. Consumers and lawmakers remain highly concerned about affordability and access.

To gather more information about these high prices, the Oregon Legislature created the DPT Program by passing Oregon's Prescription Drug Price Transparency Act in 2018 (House Bill 4005).[4] The program's purpose is to provide accountability by disclosing to the public specific pricing information reported by pharmaceutical manufacturers, health insurers, and consumers. In 2023, Senate Bill 192 was passed creating reporting requirements for PBMs.[5]

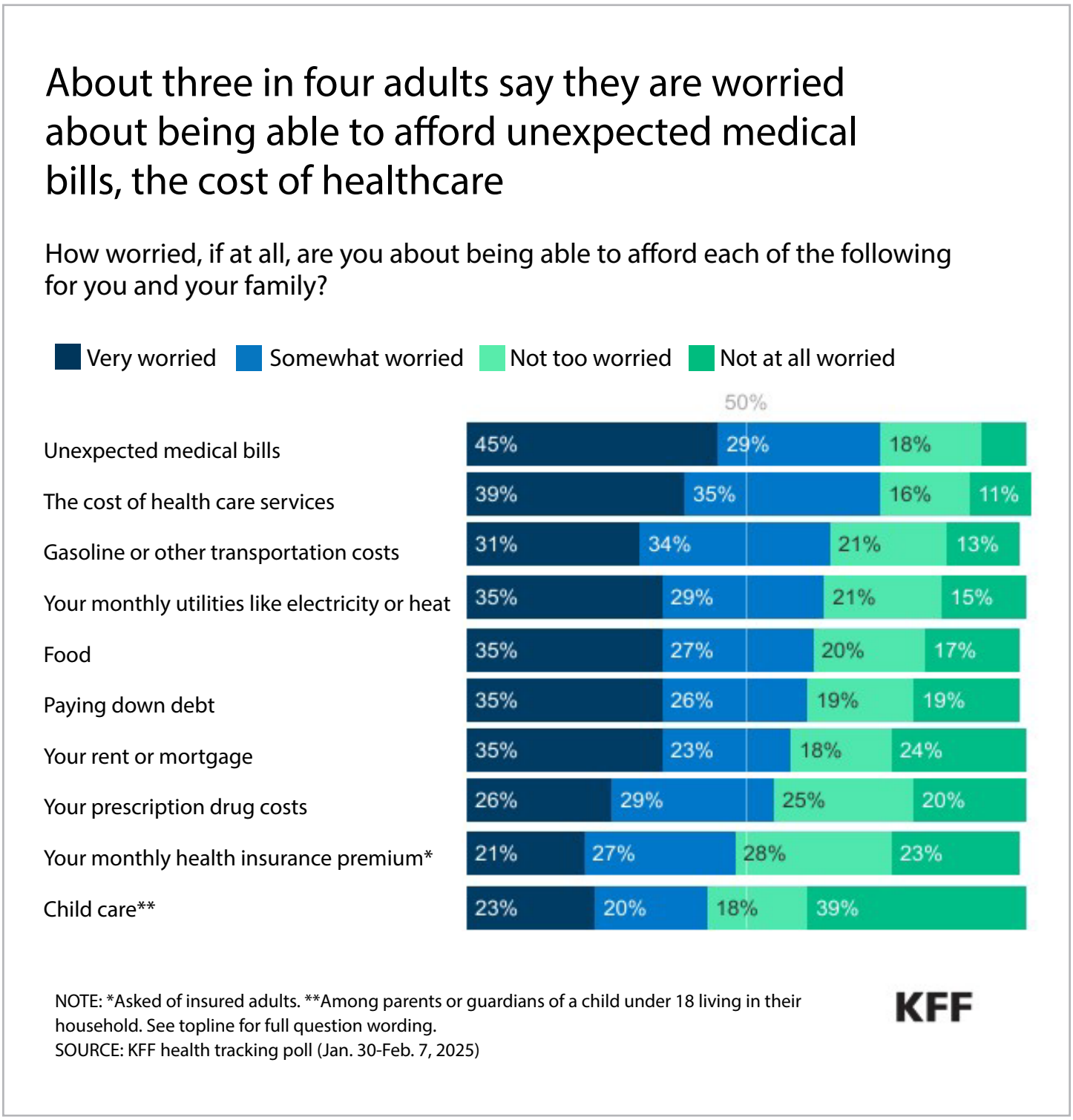
[2] Kirzinger, Ashley et al. "Public Opinion on Prescription Drugs and Their Prices." KFF, Aug. 21, 2023. https://www.kff.org/health-costs/poll-finding/public-opinion-on-prescription-drugs-and-their-prices/. Accessed Oct. 17, 2024.

[3] Kearney, Audrey et al. "KFF Health Tracking Poll February 2024." KFF, Feb. 21, 2024. https://www.kff.org/affordable-care-act/poll-finding/kff-health-tracking-poll-february-2024-voters-on-two-key-health-care-issues-affordability-and-aca/. Accessed Oct. 17, 2024.

[4] House Bill 4005 (2018), https://olis.oregonlegislature.gov/liz/2018R1/Measures/Overview/HB4005. Accessed Oct. 31, 2024.

[5] House Bill 192 (2023), https://olis.oregonlegislature.gov/liz/2023R1/Measures/Overview/SB192. Accessed Oct. 31, 2024.

Figure 1: Prescription drugs and other medical costs are in the top 10 financial concerns[6]



[6] Kearney, Audrey, et al. "KFF Health Tracking Poll February 2024: Voters on Two Key Health Care Issues: Affordability and ACA." KFF, Feb. 21, 2024. https://www.kff.org/affordable-care-act/poll-finding/kff-health-tracking-poll-february-2024-voters-on-two-key-health-care-issues-affordability-and-aca/. Accessed Oct. 17, 2024.

Overview of prescription drugs

A prescription drug is a substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease. It is prescribed by a health care practitioner to a person and is required to be purchased from a pharmacy when administered by the patient.[7] A prescription drug can be either a brand-name drug or generic drug. Brand-name prescription drugs are generally covered by a patent that provides protections to the drug developer for a set period of time in which no one else can produce the same drug. A generic drug has the same active ingredients as a brand-name drug and competes with the brand name once the patent has expired.[8] Generic drugs typically cost less than brand-name drugs and are used more frequently due to their reduced cost.

Drugs can also be distinguished between small molecule and biologic drugs. Small molecule drugs are generally manufactured through a controlled chemical reaction, while biologics are generally manufactured through the manipulation of living cells.[9] Many high-cost prescription drugs and new innovative therapies are considered biologics, including technologies such as chimeric antigen receptor T-cells (CAR-T) and monoclonal antibodies. However, even some well-established prescription compounds such as insulin and human growth hormone technically would be considered biologics under current law if they were developed today.[10]

Most prescription drugs are initially priced by the drug manufacturer with a WAC, which is sometimes referred to as the list price. It is the starting point for the drug price and does not include any rebates or discounts. There are several other ways to measure the cost of prescription drugs, such as average wholesale price (AWP) and average manufacturer price (AMP), which are used as starting points for negotiating drug prices between pharmaceutical supply chain entities.

The cost to the consumer purchasing a drug at the pharmacy is determined through a complex set of factors throughout the pharmaceutical supply chain. Manufacturers, wholesale distributors, PBMs, health insurance companies, medical providers, pharmacies, and consumers make up the majority of the actors involved in the pharmaceutical supply chain.

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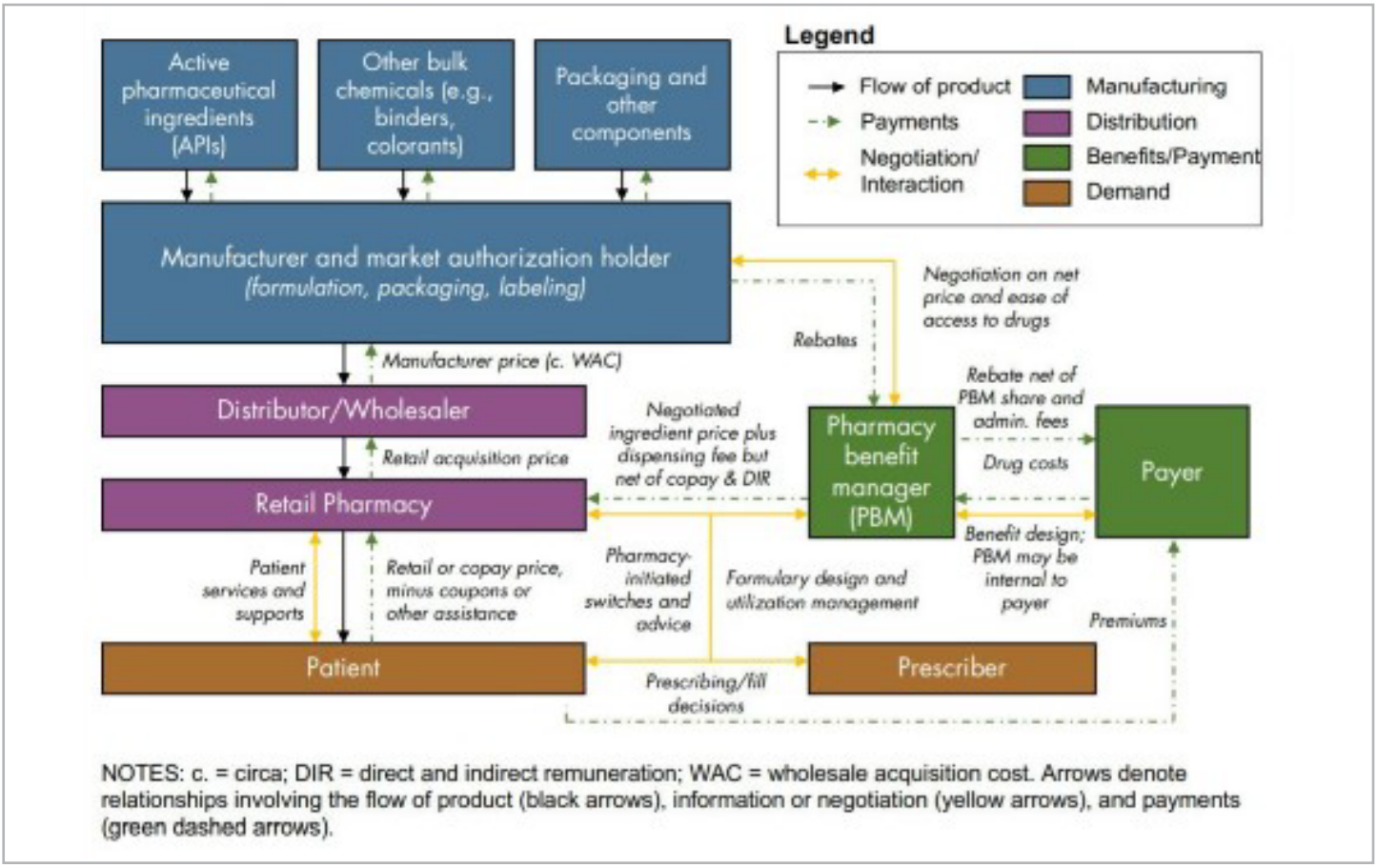
[7] "Prescription Drugs and Over-the-Counter (OTC) Drugs: Questions and Answers." U.S. Food & Drug Administration, Nov. 13, 2017. https://www.fda.gov/drugs/questions-answers/prescription-drugs-and-over-counter-otc-drugs-questions-and-answers. Accessed Oct. 17, 2024.

[8] "Generic Drugs: Questions & Answers." U.S. Food & Drug Administration, March 16, 2021. https://www.fda.gov/drugs/frequently-asked-questions-popular-topics/generic-drugs-questions-answers. Accessed Oct. 17, 2024.

[9] "Biological Product Definitions." U.S. Food & Drug Administration. https://www.fda.gov/files/drugs/published/Biological-Product-Definitions.pdf. Accessed Oct. 17, 2024.

[10] Morrow, Thomas MD, and Hull Felcone, Linda. "Defining the Difference: What Makes Biologics Unique." Biotechnology Healthcare, vol. 1,4, 24-9, September 2004. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3564302/. Accessed Oct. 17, 2024.

Figure 2: Pharmaceutical supply chain for brand-name drugs dispensed through retail pharmacies[11]



The price a consumer pays at the pharmacy can be influenced by the industry practices and financial negotiations between pharmaceutical supply chain entities and the consumer's health insurance. Figure 2 shows a supply chain example for a brand-name drug for a person insured through their employer. People who are uninsured typically pay the list price of the drug, which can be changed by the drug manufacturer. Both the insured and uninsured can also use a discount card program such as Oregon's ArrayRx to receive a lower cost.[12]

For people with health insurance, prescription drug costs are typically determined through placement on a formulary tier determined by their insurance company. The formulary can change from year to year. Many insurance companies pay a PBM to determine their formulary tiers for them. Placement on a higher tier typically results in a higher cost to the consumer. Many health insurance companies will require a copay or coinsurance payment when the consumer pays for the prescription drug at the pharmacy. A copay is a flat fee, such as $10 per prescription, and coinsurance is a percentage of the drug cost, such as 20 percent of the drug price. Additionally, the negotiated reimbursement rate between the

[11] Mulcahy, Andrew W. and Kareddy, Vishnupriya. "Typical Supply Chain for Brand-Name Drugs Dispensed Through Retail Pharmacies." Rand Health Q, June 30, 2022; 9(3):7. 2021. https://pmc.ncbi.nlm.nih.gov/articles/PMC9242571/figure/figure-1/. Accessed Oct. 17, 2024.

[12] Oregon Prescription Drug Program. https://www.oregon.gov/oha/hpa/dsi-opdp/Pages/index.aspx. Accessed Oct. 17, 2024.

pharmacy and a health insurance company can affect what the consumer pays for the drug. Some drugs have a zero copay and some drugs are not covered. Once a person reaches the maximum out-of-pocket amount for their health insurance plan, they no longer have a copay or coinsurance.

There are several ways prescription drugs can be categorized: based on the disease they treat (therapeutic class); what type of pharmacy the prescription drug is obtained from (retail or nonretail); or by the specific national drug code (NDC) given to identify the dosage and packaging of the prescription drug. These categories will be used throughout this report to describe the data received from manufacturers, health insurers, PBMs, and consumers.

Prescription drug spending in the U.S. and Oregon

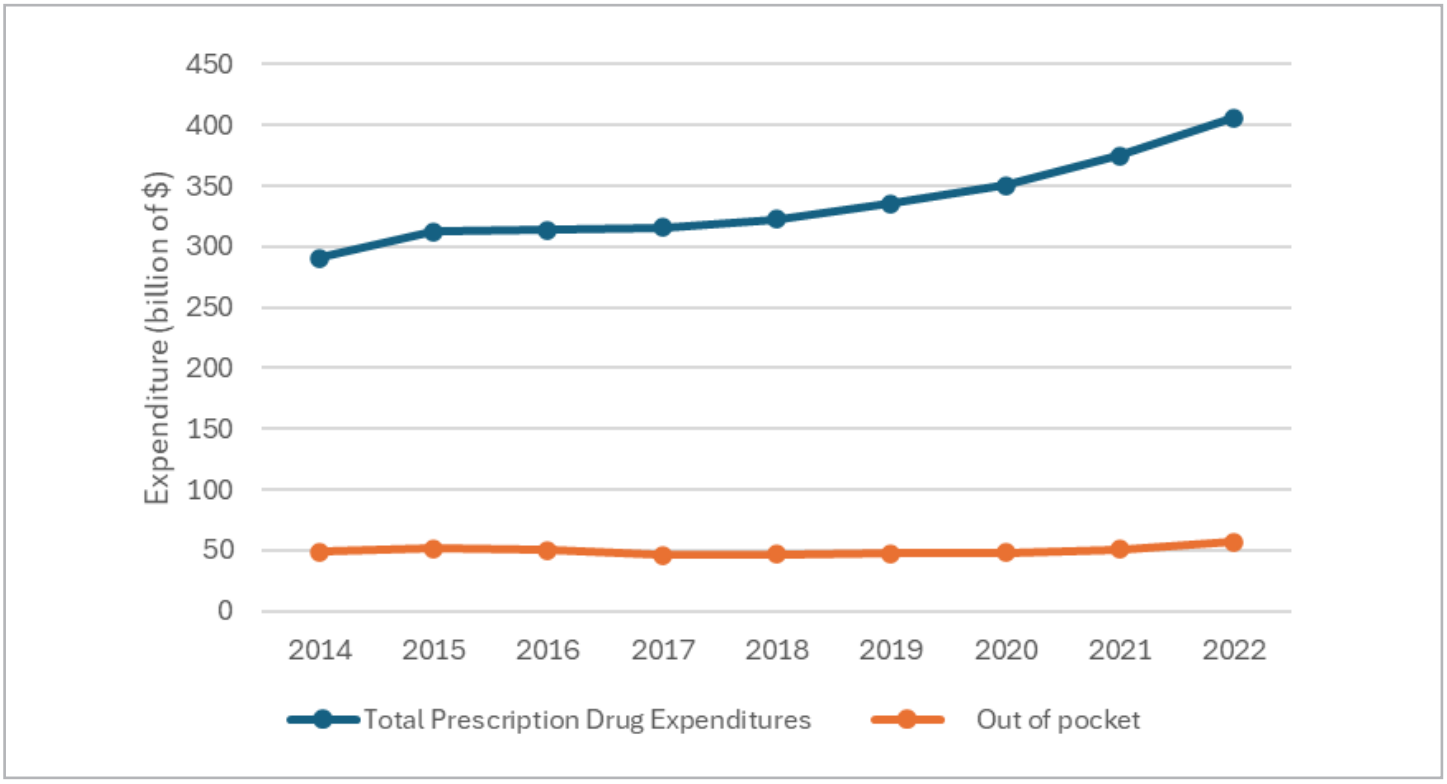
In 2022, U.S. health care spending reached $4.5 trillion, a 4.1 percent growth from the prior year, and $405.9 billion of that was retail prescription drug spending.[13] For 2022, prescription drug expenditures grew by 8.4 percent, increasing at a rate double the rate increase for all other health care expenditures. Figures 3 and 4 show the U.S. increase in prescription drug expenditures from 2014 through 2022 along with the amount of out-of-pocket costs for consumers and the view over a longer span of time. Calendar year 2022 data is the most recent data available.

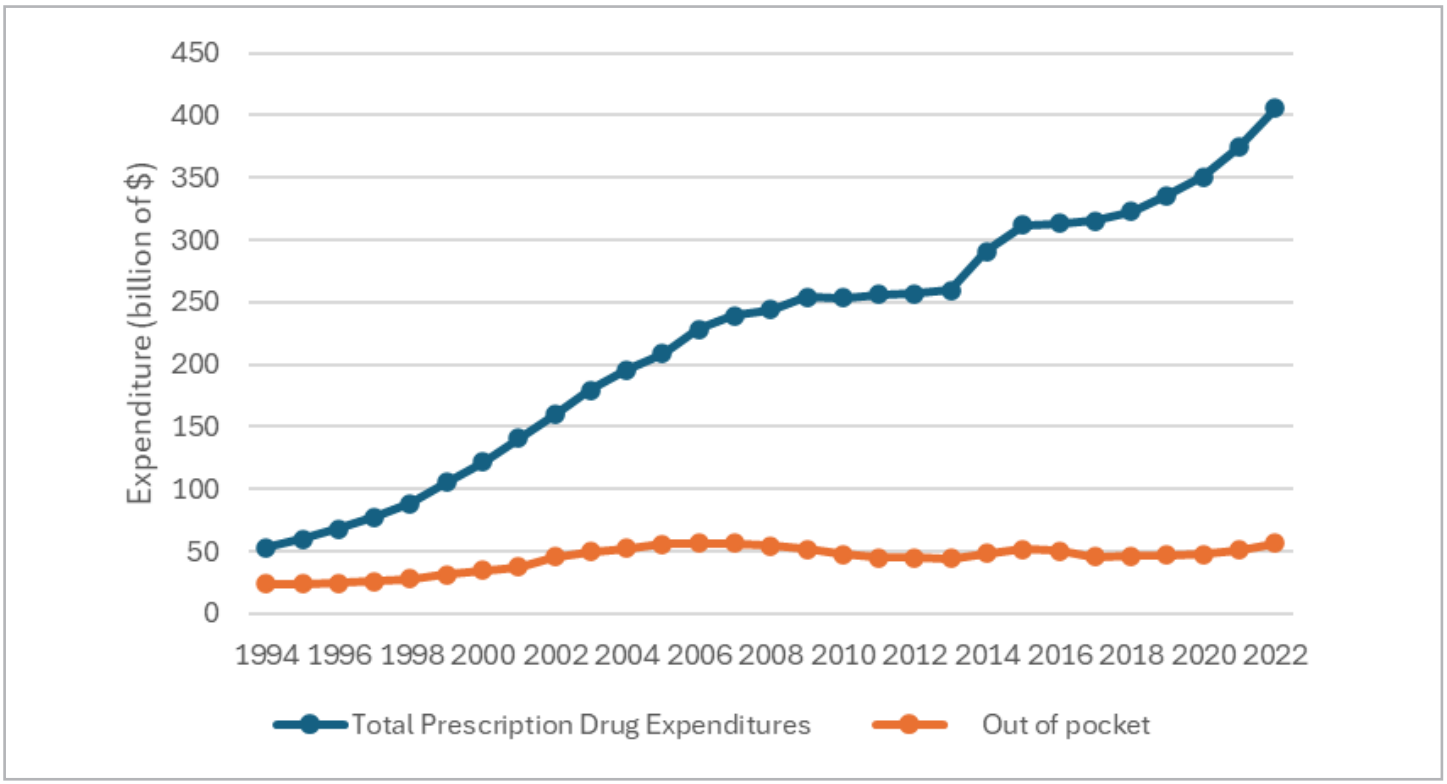
An estimated 72.2 million people did not seek medical care due to the cost, and about 31 percent were also concerned about affording their prescription drugs.[14] The program hears stories of how high costs affect people, particularly those who need expensive prescription drugs to treat cancer, manage diabetes, and address heart conditions. These stories illustrate the effects prescription drug costs have on households around the country and in Oregon.

[13] "NHE Fact Sheet: Historical NHE, 2022." Centers for Medicare & Medicaid Services. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet. Accessed Oct. 17, 2024.

[14] "New Study Reveals More Struggling to Afford Healthcare." Westhealth, July 17, 2024. https://westhealth.org/news/new-study-reveals-more-struggling-to-afford-healthcare/. See also "West Health-Gallup Healthcare Affordability and Value Indexes 2021-2024." West Health, 2024. https://www.gallup.com/analytics/611153/west-health-healthcare-in-america.aspx. Accessed Oct. 17, 2024.

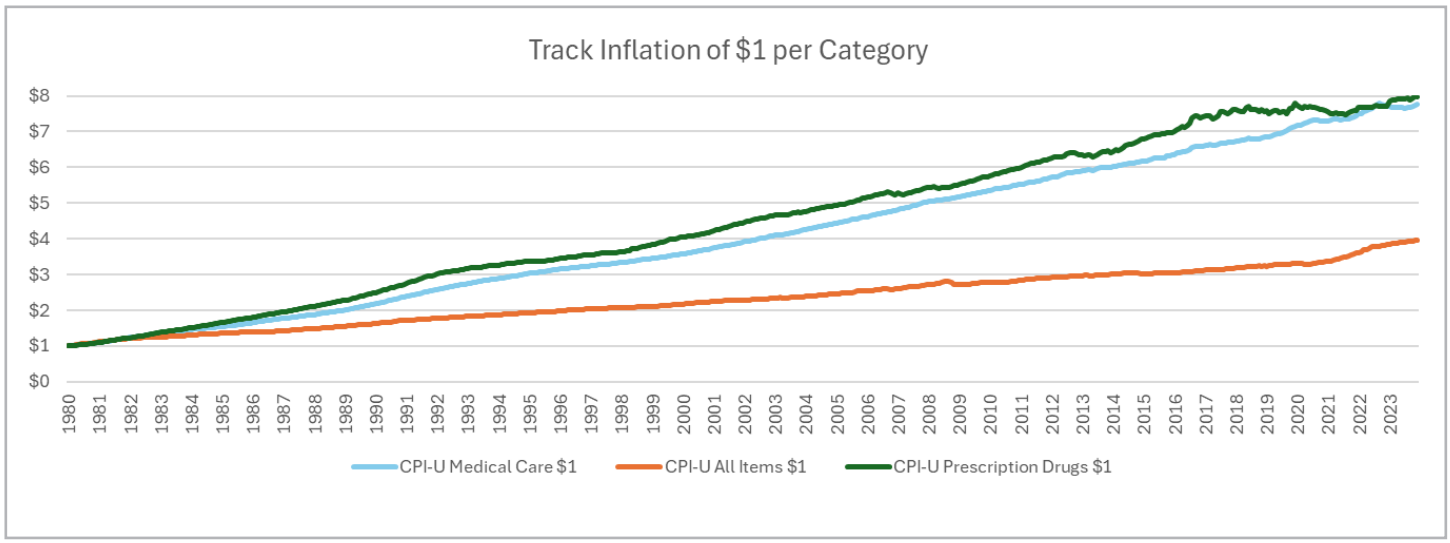
Figures 3 and 4: Estimated expenditure and consumer-out-of-pocket costs on prescription drugs in the U.S. from 2014 to 2022 and a longer view from 1994 to 2022[15]





[15] "Historical." Centers for Medicare and Medicaid, National health expenditure data, Sept. 10, 2024. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical. Accessed Oct. 17, 2024.

Figure 5: Inflation compared to the increases for prescription drugs and medical expenses from 1980 through 2023



Starting in 1980 and ending in 2023, Figure 5 shows that prices for prescription drugs inflated 100 percent more than the rate for all items in the Consumer Price Index for All Urban Consumers (CPI-U).[16] The chart shows that the increase in medical expenses and prescription drugs are having a large effect on inflation.

Oregon prescription drug spending

Prescription drug spending and the effects of costs on Oregonians has been important to policymakers, health care providers, and the public for several years. The state is a major purchaser of prescription drugs through health insurance or direct purchases for Oregonians. Reports show that the Oregon Health Authority (OHA) spent more than $1.46 billion between January and December 2023 on prescription drugs for those enrolled in the Oregon Health Plan.[17] The total prescription drug spending expectation for 2023 was more than $17 million for the CAREAssist program (Oregon's AIDS Drug Assistance Program – ADAP) and is expected to be more than $17 million for 2024.[18] Prescription drug spending by the Public Employees' Benefit Board (PEBB) was $145 million in paid pharmacy costs after rebates for 2023 for 135,678 members. The Oregon Educators Benefit Board (OEBB), with 132,077 members, recorded $102 million in paid pharmacy

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[16] "Consumer price index for all urban consumers: Medical care in U.S. city average." Federal Reserve Bank of St. Louis Fred Economic Data. https://fred.stlouisfed.org/series/CPIMEDSL. See also "Consumer price index for all urban consumers: All items in U.S. city average." Federal Reserve Bank of St. Louis Fred Economic Data. "https://fred.stlouisfed.org/series/CPIAUCSL. See also "BLS Data View." U.S. Bureau of Labor Statistics. https://data.bls.gov/dataViewer/view/timeseries/CUSR0000SEMF01;jsessionid=95E7085FC504B86A4B4ED23DFB016957. Accessed Oct. 29, 2024.

[17] "Pharmacy Utilization Summary Report: January 2023 – December 2023: Total Amount Paid." Drug Use Research & Management Program, DHS Health Systems Division, Oregon State University College of Pharmacy, Page 1, July 18, 2024. CAREAssist program data provided from Oregon Health Authority. https://www.orpdl.org/durm/reports/utilization/2024/DUR_Utilization_2024_Q2.pdf. Accessed Oct. 17, 2024.

[18] "Background Brief on Prescription Drugs." Legislative Policy and Research Office, September 2014. https://www.oregonlegislature.gov/lpro/Publications/BB2014PrescriptionDrugs.pdf. Accessed Oct. 17, 2024.

costs after rebates for the 2022-23 plan year (October 2022 to September 2023).[19,20] The Oregon Youth Authority, Oregon Department of Corrections, and Oregon State Hospital also purchase prescription drugs for the people in their care.

Oregon has a prescription drug assistance program called the ArrayRx Discount Card Program. ArrayRx is a partnership between the states of Oregon, Washington, Nevada, Ohio, and Connecticut serving almost 775,000 people. The discount card program helps Oregonians and residents of the other states (more than 90,000 people) save on prescription drug costs when they are uninsured, underinsured, or their medication is not covered by their insurance. Prescriptions purchased through the program do not count toward insurance deductibles or out-of-pocket maximums. ArrayRx services also include a broad suite of programs designed to help states and participating programs with administering their pharmacy programs. Throughout the five states, these include 660,000 group-insured people, managed Medicaid programs serving about 75,000, and vouchers serving more than 15,000. ArrayRx has resulted in more than $155 million in savings to Oregon and the other participating states through these programs over the past five years.[21]

Though we do not have amounts for all prescription drug spending for Oregonians, information from insurers that report to the DPT Program will be shown later in this report.

[19] "Oregon Public Employees' Benefit Board, July Utilization Review." Mercer presentation to the Oregon Health Authority and Public Employees' Benefit Board, Page 31, July 16, 2024. https://www.oregon.gov/oha/PEBB/MeetingDocuments/PEBB-Board-Agenda-Attachments-1-20240716.pdf#page=31. Accessed Sept. 27, 2024.

[20] Oregon Educators Benefit Board (OEBB) data provided from Oregon Health Authority in 2024. https://www.oregon.gov/oha/Pages/index.aspx. Accessed Sept. 27, 2024.

[21] Oregon Prescription Drug Program and ArrayRx data provided from Oregon Health Authority in 2024. https://www.oregon.gov/oha/hpa/dsi-opdp/Pages/index.aspx. Accessed Sept. 27, 2024.

Oregon's Drug Price Transparency (DPT) Program

The program continues to engage manufacturers and collect information to inform the annual public hearing and legislative report. In December 2024, the program will hold its sixth public hearing. Program staff members will submit this report to the Legislature by Dec. 15 and post it to the program's website for public access.

Data from consumers, pharmaceutical manufacturers, PBMs, and insurers is collected and analyzed by program staff members throughout the year. We receive increase notices and stories from consumers. Manufacturers are required to file certain reports with us. This is the first year that the data will include information reported by PBMs for the total dollar amount of rebate, fee, price protection payment, and any other payments the PBM received from manufacturers that were passed on to insurers or enrollees at the point of sale of a prescription drug. This information also includes the amount retained as revenue by the PBM. Starting this year, data collection from insurers expanded to include more state-regulated health plans to ensure a more complete and accurate picture of drug costs in Oregon.

Program staff members help pharmaceutical manufacturers with questions, registration, billings, and filing required reports. Efforts to increase manufacturer reporting compliance and review claims of trade secrets have increased. The program also is working to increase outreach to consumers.

This report summarizes the findings from data collected since the 2023 annual legislative report. As noted in the trade secret section , the program does not immediately release and carefully analyzes all information claimed as trade secret. Any directly identifiable information in this report was not claimed as a trade secret in the manufacturer's submission. Some data has been aggregated to protect trade secrets and still provide as much information to the public as possible.

Consumer price increase notices

Anyone can provide notification of an increase in the cost of prescription drugs to the DPT Program through phone, email, or an online submission form. The form includes information about the consumer's insurance coverage, the drug that increased in price, and when and where the consumer experienced the price increase. The form is available in English, Spanish, Russian, Vietnamese, and Chinese. To make reporting easier, we created a simplified reporting survey in English and Spanish this year and are hoping more consumers will provide us with information. We are developing new strategies to reach consumers and bridge the gap in reporting drug price increases.

During the past year, the department received only six price increase or high price notifications from Oregon consumers. Three of the reported high or increased prices were so unaffordable, the people reporting planned to do without or reduce their medication, which caused them much stress. They all said the cost of their medications was causing financial difficulty.

Here are some quotes from consumers reporting high or increased drug prices:

"BlinkRx sent me a free 3ml bottle. After that I was told refills are $300 copay with my Medicare Advantage Plan. These drops helped relieve my dry eye and improved my vision. I cannot afford $300 monthly copay. These drops are available over the counter in Europe for around $20 per 3ml bottle (30 supply). These drops help my vision, yet I can't afford them." (Report is about Miebo, manufactured by Bausch & Lomb Inc.)

"I'm concerned that Aetna will not cover insulin prices when Providence changes next fall. This is extremely concerning and my insulin regimen w/o insurance would be $1,700 per month." (Report is about Lantus, manufactured by Sanofi-Aventis U.S. LLC.)

"I previously paid $30.99 with my insurance a few times. Then, for this particular month, I was told the price was $128.96 with insurance. It should be a crime that the prescription price increased significantly in one month and was so much cheaper to pay without my insurance." (This person reported using GoodRx to bring the price down to $38.90. Report is about a generic version of Adderall XR; the manufacturer is not identified.)

"The enzymes cost OHP over $4,000 a month and if I don't have them, I can't process or take in any nutrition due to my successful fight with pancreatic cancer. I am having tremendous trouble trying to find an employer with good enough insurance to cover my prescription and I am unable to afford a $50,000 a year food bill so I'm stuck in poverty." (Report is about Creon, manufactured by AbbVie Inc.)

We are hopeful for an increase in consumer reporting in the future to allow for more meaningful analysis. The program will continue to reach out to Oregonians using a variety of strategies including DFR consumer information events and social media advertising. Program staff members will be looking for suggestions and input to increase consumer reporting, because reports help provide information about the real effects these increases have on consumers.

Stories from Oregonians

In addition to price increase reports, the program also asked Oregonians to submit their stories about prescription drug pricing. We have received a number of responses, with a few consistent threads. Read all stories in the report exhibit. The submissions have been lightly edited and any names removed. The concerns presented by Oregonians are a vital part of our process and will guide our continuing implementation of the Drug Price Transparency Act, as well as future legislative actions.

Here is a story about price increases occurring every year:

"In 2022 I paid $20 per prescription. In 2023, that went up to $30 for no reason other than it was 2023. Now in 2024, the same prescription is $40, so it has doubled in just over a year just because the calendar changed. Same medication. Same amount. Same person. Pure profit for someone other than me."

Here is someone referring to costs and access for a restricted medicine required to maintain a better quality of life:

"I need opium tincture to be able to leave my home due to chronic diarrhea due to surgery that went wrong and losing a lot of my small intestine. I have had this prescription for 14 years and my doctor has to call in for every refill. This drug does not get you 'high' at all. It just slows down your gut so you can live a normal life. I have gone into the pharmacy to get my prescription and been told they didn't carry it any more. This is so scary when I only get enough to get me month to month, and hear it might be days now before I can find a pharmacy that has it. I've had to change pharmacies over 6 times, because it's hard to find a pharmacy willing to carry it, as it has the word 'opium' on it. Anyone who has had diarrhea has to just imagine what their life would be like if they didn't have a drug to control it. It's scary to think that one day I may have to be housebound. And even with this drug, I'm still in the restroom up to 10 times a day. And the price! I have insurance but still have to pay $195 co-pay per 40 days for my prescription! My last

pharmacy would give me 30 days for a $95 co-pay, but the pharmacy I go to now says that they can't open the bottle that holds 40 days in it and give me just 30 days, so I am stuck paying about $90 more for just 10 more days. Because they say they have to distribute the whole thing (by law). I don't believe that, but I don't argue because I need that medicine."

Here is a story from someone on Medicare:

"I'm a senior. Since I've recently been approved and now receive SSDI, I'm now on Medicare. Paying for my scripts instead of the insurance covering the costs takes away money from other necessary things like food, over the counter medicines, and everyday household items. The increase in medicine costs have made a negative impact to my budget. My food stamps have been reduced as well, so the funds used to pay for meds now means less money for those other items and less for food. It seems one way or another, the 'system' and those who make these policies just want to keep the poor struggling to make ends meet. We pay enough over the years for insurance coverage, but they continuously want more. As a senior citizen, it would be spectacular to have a 'system' that actually treats its seniors with respect and care."

Here is a story from a pharmacist:

"I would like to share my story from a pharmacy perspective. Smaller pharmacies are closing at an unprecedented rate. … There's a push to unionize across the industry and we're not only seeing strikes and walkouts, we're seeing pharmacies closing for a day, a weekend, or shortening their hours with no notice due to lack of staffing. This is going to get much worse in the near future without some drastic changes in health care.

"Pharmacy benefits managers (PBMs) are making millions of dollars annually to the detriment of doctors, patients and pharmacies. … We spend a large portion of our time fighting for our patients' right to get the medications that they need, paid for in a timely manner. And we see, on a daily basis people going without, or waiting for weeks to get their meds.

"[The full story is included in the report exhibit, which includes issues around: PBM/insurance requirements for specific measurements and audit issues, differences in allowances for eye drops that make some patients run out before they can get a refill, insulin issues and differences creating extra costs or not being able to test often enough or being forced to get a certain brand of tester, drug shortages, Medicaid/Medicare issues, formulary issues, and requirements if the doctor wants to prescribe something differently than the insurer wants to cover it.]

"All of these examples are not isolated or rare. They're happening dozens of times daily in just my pharmacy. They're resulting in serious lapses in treatment and patients paying out of pocket or going without. … What gives an insurance company the right to decide which medication or regimen is best for the patients? Most pharmacies aren't even answering their phones, because they lack the staff, or are calling doctors back for clarification, or permission to switch to tabs or caps, or are on endless holds with insurance companies. Most patients are going without other needs to pay for their meds out of pocket, if they can. Please help us help our patients! I would love to testify in person, but we don't have enough staff for me to take the day off."

Prescription drug manufacturers

This report is based on data submitted to the program from Sept. 1, 2023, through Aug. 31, 2024. Prescription drug manufacturers are required to submit reports to the program for new prescription drugs and prescription drug price increases that exceed the threshold for that reporting requirement. The three types of reports are:

- **New prescription drug report**: Manufacturers submit a new prescription drug report within 30 days of introducing a new prescription drug with a list price of $670 or more for a 30-day supply or for a course of treatment shorter than one month. DCBS expects to finalize rule changes next year to raise the threshold to match the current federal amount of $950 or more for a 30-day supply.
- **Annual price increase report**: Manufacturers annually submit a price increase report for each prescription drug with a list price of $100 or more for a 30-day supply, or for a course of treatment shorter than one month that experiences a net price increase of 10 percent or more during the previous calendar year and has a patient assistance program available in Oregon. Changes to this reporting because of the decision issued by the U.S. District Court for Oregon are explained in DFR Bulletin No. 2024-3.[22]
- **60-day notice price increase report**: Manufacturers submit a price increase report 60 days before the planned increase takes effect when the threshold is met. The threshold for a brand name prescription drug is when the cumulative price increase is at least 10 percent or $10,000 within a 12-month period. For a generic prescription drug it is when the cumulative price increase is at least $300, and the increase is also 25 percent or more, within a 12-month period.

Manufacturers submit a report for each qualifying national drug code (NDC) the manufacturer sells. Each unique formulation, dosage, and packaging of a manufacturer's drug gets its own NDC, so the program may receive multiple reports for a single drug if it is manufactured in a variety of dosages or sold in different package sizes.

A single drug will generally be sold under several NDCs. For example, a manufacturer may sell two bottles of generic ibuprofen, one with 25 tablets and the other with 50 tablets. In that case, both bottles would have a different NDC, even though they are for the same drug. In our analysis, we will group together NDCs for the same drug from the same manufacturer when describing our data.

In some parts of this report, we analyze information for a drug at the "product family" level, which includes all NDCs for the same brand name or active chemical agent, rather than individual NDCs. Generally, manufacturers provide aggregate and track information by "product family" or other methods. When we say "drug product family," we are referring to a set of NDCs from a manufacturer with the same reported trade name, and "drug" in the same context may be used to refer to a product family rather than an individual NDC.

[22] "Bulletin No. DFR 2024-3." Oregon Department of Consumer and Business Services Division of Financial Regulation. https://dfr.oregon.gov/laws-rules/Documents/Bulletins/bulletin2024-03.pdf. Accessed Sept. 27, 2024.

New prescription drug reports

From Sep. 1, 2023, through Aug. 31, 2024, the program received 529 new prescription drug reports. These reports were submitted by 133 different manufacturers, and each report is for a single NDC.

We received new prescription drug reports for 265 generic drugs that came from 59 manufacturers. We also received reports for 264 brand-name drugs that came from 86 manufacturers. This information is displayed year to year in Figure 6.

Figure 6: Report counts for generic and brand-name new prescription drugs from 2019 to 2024

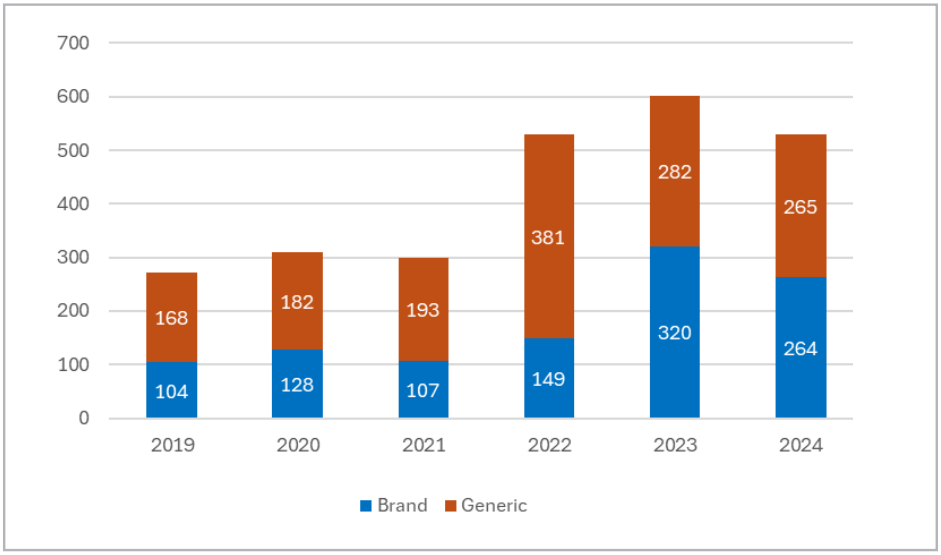
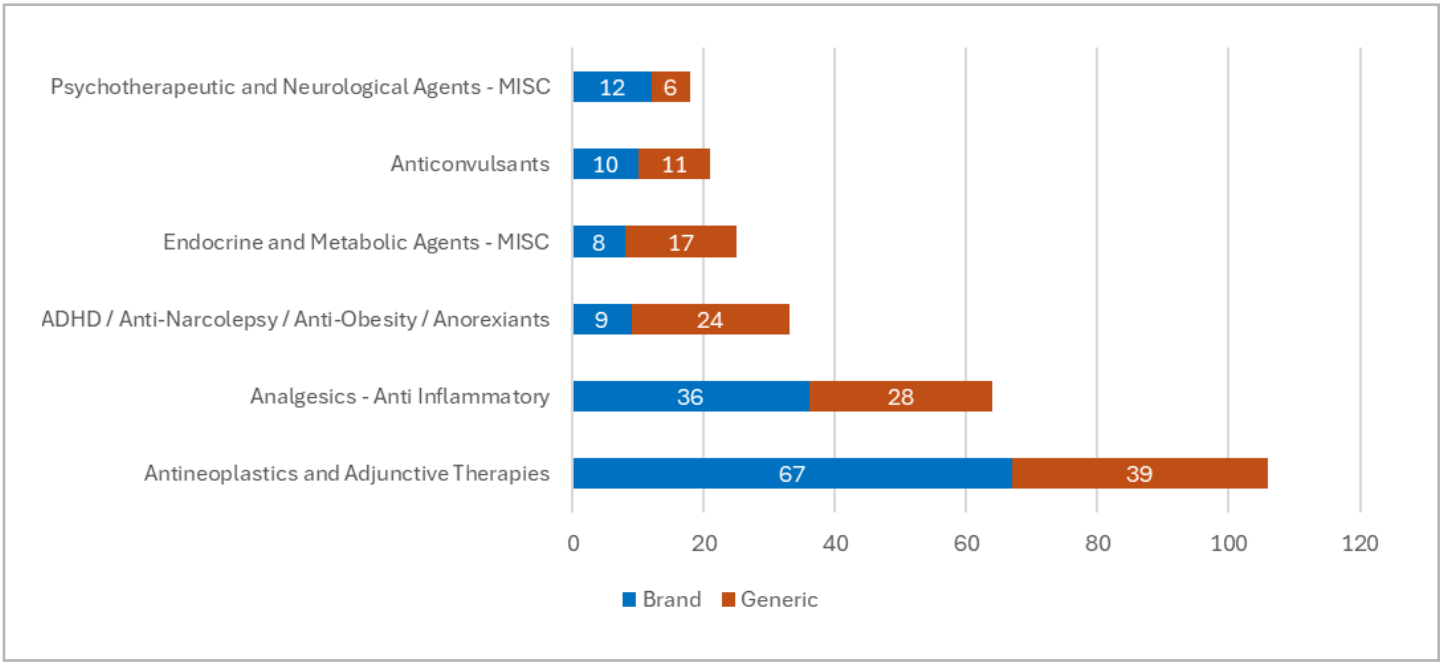
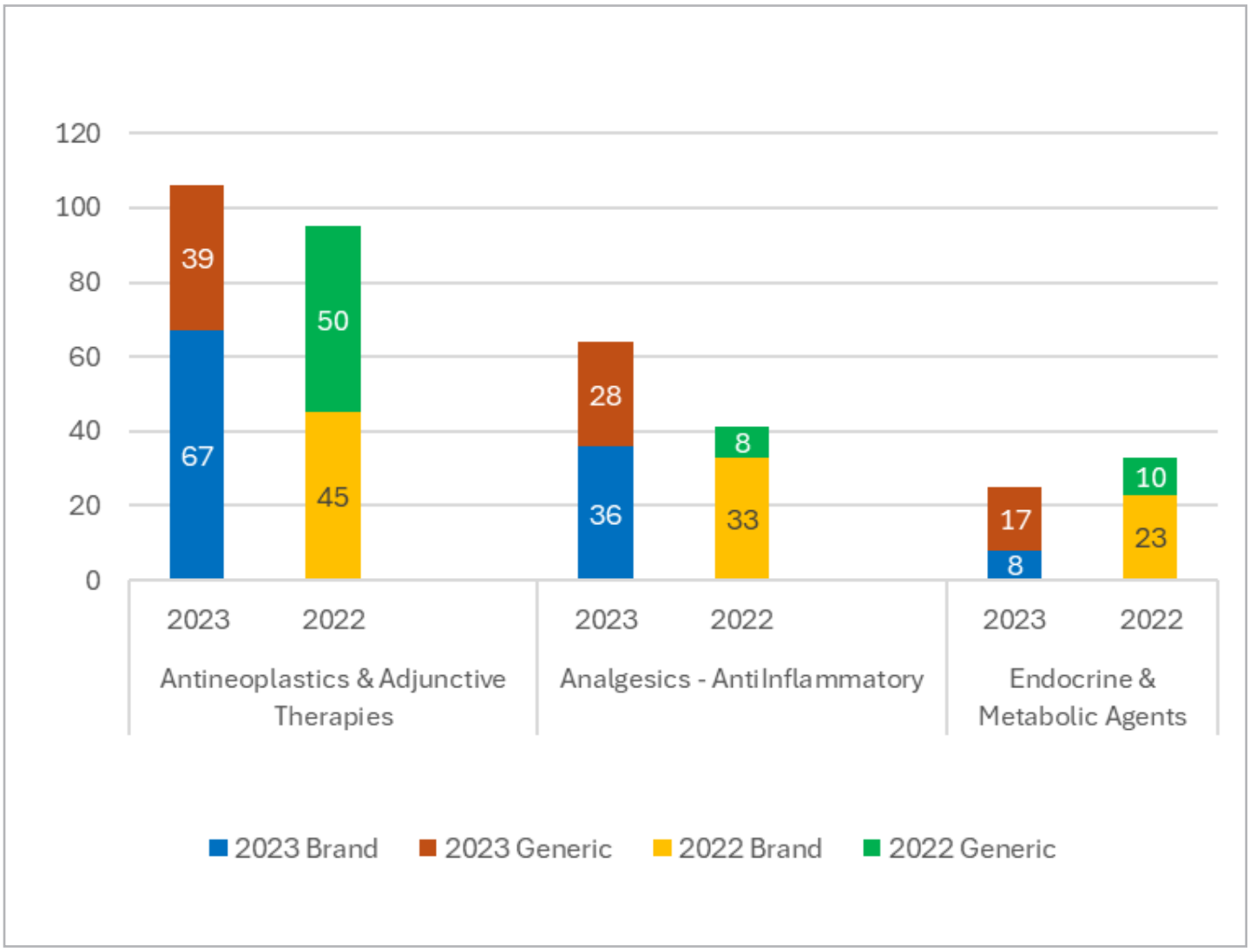


Figure 7: Distribution of brand-name and generic new prescription drugs by most common therapeutic classes



In Figure 7, the most common therapeutic class of drugs in these reports were antineoplastic and adjunctive therapy drugs, with 106 drug reports falling into this category. Among those 106 reports, 39 were for generic versions and 67 were for brand-name versions of antineoplastic drugs. The second-most common class of drugs in these reports were analgesics/anti-inflammatory drugs, with 64 reports. Of these 64 reports, 28 were for generics and 36 were for brand-named drugs. The third-most common class was attention-deficit/hyperactivity disorder (ADHD)/anti-narcolepsy/anti-obesity/anorexiants with 33 reports, 24 of which were for generic drugs of this category and nine of which were for the brand-name drugs. Figure 7 shows the six most common drug classes.

Figure 8: Brand name versus generic new prescription drug report counts for three drug families compared between 2022 and 2023



Visualized in Figure 8 are the counts of new prescription drug reports received across three drug families: antineoplastic and adjunctive therapies, analgesics – anti-inflammatory drugs, and endocrine and metabolic agents. While the number of new generics in these categories remained about the same each year, reports for brand-name drugs experienced a significant increase from 2022 to 2023 across all three drug families. These drug families were chosen because they had the highest report count from last year's filings.

Highest WAC prices in new prescription drug reports

The program received new prescription drug reports for drugs with WAC prices ranging from $5.61 to $3.5 million. It is possible that a drug with a WAC less than $670 may still require a report to the program, depending on the length of a course of treatment. For example, a drug with a WAC of $335 for a single dose that requires two doses in one month would cost $670 for a course of treatment, prompting a report. However, it is likely that some of the reports we received with lower WAC prices have been submitted in error.

Figure 9 shows the 10 highest WAC prices for new brand-name drugs reported to the program this year. It is important to note this is not the price that will be billed to most patients or their insurance companies, but it is a factor in that price, which is typically calculated as a set percentage of a drug's WAC.

The highest WAC reported this year was for a hematological agent, Beqvez, at $3.5 million. Beqvez is a one-time gene therapy used for the treatment of adults with moderate to severe hemophilia B who are receiving routine prophylaxis, have a current life-threatening bleed, or a history of life-threatening bleeds, or have repeated serious spontaneous bleeds.[23]

The second-highest reported WAC was for a hematopoietic agent, Lyfgenia, at $3.1 million. Lyfgenia (lovotibeglogene autotemcel) is a gene therapy that is given as a one-time intravenous suspension to treat adults and children ages 12 years and older who have sickle cell disease with a history of vaso-occlusive crises (VOCs). VOCs occur when sickled red blood cells block blood flow, depriving tissues of oxygen.[24]

Figure 9: Highest-reported WACs for new brand-name drugs

Drug	WAC	Therapeutic class	Manufacturer
Beqvez™	$3.5 million	Hematological agents – miscellaneous	Pfizer
Lyfgenia™	$3.1 million	Hematopoietic agents	bluebird bio Inc.
Casgevy®	$2.2 million	Hematopoietic agents	Vertex Pharmaceuticals
Tecelra®	$727,000	Antineoplastics and adjunctive therapies	Adaptimmune LLC
Amtagvi™	$515,000	Antineoplastics and adjunctive therapies	Iovance Biotherapeutics Inc.
Rivfloza™	$62,880 – 50,304	Genitourinary agents – miscellaneous	Novo Nordisk Inc.
Adstiladrin ®	$60,000	Antineoplastics and adjunctive therapies	Ferring Pharmaceuticals Inc.
Sohonos®	$47,880	Musculoskeletal therapy agents	Ipsen Biopharmaceuticals Inc.
Fabhalta®	$45,205	Hematological agents – miscellaneous	Novartis Pharmaceuticals
Wainua™	$41,583	Psychotherapeutic and neurological agents – miscellaneous	AstraZeneca Pharmaceuticals LP

[23] "Beqvez: a one-time gene therapy for certain adults with moderate to severe hemophilia B." Pfizer 2024. https://www.beqvez.com/. Accessed Oct. 31, 2024

[24] Pope, Carmen. "Lyfgenia." Drugs.com, Jan.4, 2024. https://www.drugs.com/lyfgenia.html. Accessed Oct. 31, 2024.

Figure 10: Highest reported WACs for new generic drugs

Drug	WAC per unit	WAC	Therapeutic class	Manufacturer
Lanreotide acetate	$13,387 / ML	$6,693	Endocrine and metabolic agents – miscellaneous	Cipla USA Inc.
Tasimelteon	$686 / capsule	$20,571	Hypnotics / sedatives / sleep disorder agents	Apotex Corp.
Nitisinone	$643 / 20 g capsule	$38,580 – $9,645	Endocrine and metabolic agents – miscellaneous	Eton Pharmaceuticals Inc.
Mifepristone	$608.70 / tablet	$170,435	Endocrine and metabolic agents - miscellaneous; progesterone receptor antagonists (abortifacient)	Corcept Therapeutics Inc.
Mifepristone	$598 / tablet	$16,734	Endocrine and metabolic agents – miscellaneous; progesterone receptor antagonists (abortifacient)	Teva Pharmaceuticals
Indomethacin suppositories 50 mg N+	$344 / suppository	$10,314	Analgesics / anti-inflammatories	Zydus Pharmaceuticals USA Inc.
Gefitinib	$237 / tablet	$7,103	Antineoplastics and adjunctive therapies	Apotex Corp.
Deferiprone	$140 / tablet	$6,976	Antidotes and specific antagonists	Taro Pharmaceutical USA Inc.
Pazopanib	$128 - $74 / tablet	$15,392 – $8,900	Antineoplastics and adjunctive therapies	Multiple[25]
Tiopronin delayed release (DR) tablets	$85 / 300 mg pill	$8,463 – $7,616	Genitourinary agents – miscellaneous	Torrent Pharma Inc.

Figure 10 shows the 10 highest WAC prices for new generic drugs reported to the program this year. Again, these prices are not necessarily the same as those billed to patients or insurance.

Public funds in new prescription drug reports

Manufacturers are required to report any funding provided by national, state, local, or foreign government entities used in the basic or applied research for the drug, including funding for preclinical and clinical trials.

Manufacturers overwhelmingly reported receiving no public funding for the drugs reported. Out of the 529 new prescription drug reports received, only three reports provided public funding amounts that were not marked as a trade secret.

An entry for Xcopri® (NDC 71699-025-30), an anticonvulsant manufactured by SK Life Science Inc., reported $9.2 million in international public funding and included the following description:

"Korea Drug Development Fund: 9.2 M between 2012 and 2016."

[25] The information for Pazopanib represents five NDCs from these manufacturers: Apotex Corp.; Sun Pharmaceutical Industries Inc.; AvKARE Inc. (also known as AvPak); Teva Pharmaceuticals; and Novugen Pharma USA LLC.

An entry for Fabhalta (NDC 0078-1189-20), a hematological agent manufactured by Novartis, reported $4,815 in national and state public funding and included the following description:

"Project Dates: 10/19/2015 - 11/13/2015 and 01/30/2017 - 02/24/2017. Publication Name: Small-molecule factor B inhibitor for the treatment of complement-mediated diseases. Location: Laboratory at the University of Iowa, Iowa City."

An entry for Anktiva (NDC 81481-803-01), an antineoplastic and adjunctive therapy manufactured by Altor BioScience LLC, reported $4.4 million in national public funding and included the following description:

"Funding from the National Cancer Institute of $4,421,682 was awarded for Novell IL-15 Superagonist Therapy for Bladder Cancer from 2011 to 2019."

Marketing spending and descriptions from new prescription drug reports

Manufacturers are required to submit a description of their marketing for a new prescription drug and the amount the company spends. The spending amounts include marketing directly to consumers, as well as on marketing to health care professionals. The narrative description is required to include the marketing activities a company engaged in or plans to engage in, which may include:

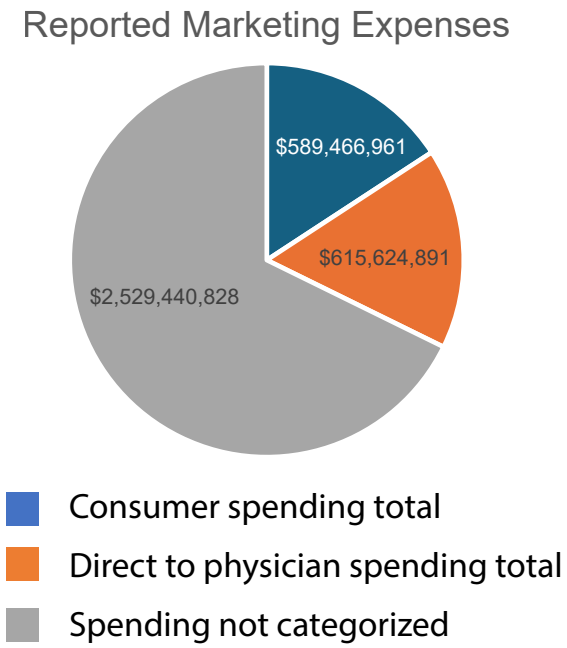
- Advertising on TV and in magazines
- Peer-to-peer communications, such as sponsored speakers at medical seminars
- Employing sales representatives

Many manufacturers claim marketing strategies and costs are trade secrets, so we are using aggregated data to show spending and non-trade secret examples of marketing descriptions. Additional marketing information can be found on the program's data transparency webpages at https://dfr.oregon.gov/drugtransparency/data/Pages/new-drug-reports.aspx#drug.

Marketing spending reported

As illustrated in Figure 11, manufacturers of brand-name drugs reported more than $3.7 billion in total marketing spent in reports received from September 2023 to August 2024. The amounts for marketing are generally representative of the spending during the first year a drug is on the market. Manufacturers did not classify more than two-thirds – $2.5 billion – of their total marketing spending amounts. The remaining one-third of the spending was split nearly evenly between direct-to-consumer marketing and marketing to health care providers. More than one-quarter (26.7 percent) of the marketing descriptions were associated with antineoplastics and adjunctive therapies. Analgesics/anti-inflammatory was the next highest therapeutic class with 8.6 percent reporting marketing spent. Other sources reported that in 2023, drug companies spent an estimated $2.87 billion on direct-to-consumer marketing advertisements for the top 10 pharmaceutical drugs on the market, which included existing drugs not subject to new drug reporting for our program.[26]

Figure 11: New prescription drug reported marketing expenses



[26] Adams, Bend, Park, Andrew, Taylor, Nick Paul. "The top 10 pharma drug ad spenders for 2023." Fierce Pharma, June 3, 2024. https://www.fiercepharma.com/marketing/top-10-pharma-drug-ad-spenders-2023. Accessed Oct. 31, 2024.

Marketing descriptions

Here are samples from submissions during the past year with the marketing description data element not claimed as a trade secret:

AZURITY PHARMACEUTICALS

"*$0 spent on initial marketing to consumers. $250,000 spent and planned spending on initial marketing to physicians and other HCPs. We incorporated paid search, programmatic, email marketing, and one leave-behind for the representatives with business card.*" (Myhibbin™)

DR. REDDY'S LABORATORIES INC

"*Dr. Reddy's did not develop direct-to-consumer marketing or paid advertising for the product. In addition, we do not directly promote the product to physicians. To the extent that our purchasing agents or buyers are licensed pharmacists or HCPs we may provide them with product sell sheets which include product name, product description, available pack information, and order entry details. The spend on such materials is less than $5,000 per year.*" (Cyclophosphamide Injection)

CURIUM PHARMA

"*Detectnet is a radioactive diagnostic agent indicated for use with positron emission tomography and is utilized in hospital or outpatient settings. As such due to the product type and use, Curium does not currently engage in direct to consumer marketing activities and markets to physicians and other health care professionals. Marketing activities include publication of leave behind brochures, hosting of peer to peer webinars, compilation of promotional emails, and attendance at relevant conferences. Marketing costs are estimated at $1,000,000 per year.*" (Detectnet™)

The marketing description for the following filings had trade secret claims. The published information only shows the information we determined was not conditionally exempt from disclosure. Any information that appeared to meet the requirements for nondisclosure was identified in [brackets] with a description of the information not disclosed.

DAY ONE BIOPHARMACEUTICALS INC.

"*Day One Biopharmaceuticals, Inc. (Day One) marketing activities in support of OJEMDA™ (tovorafenib) brand promotion include activities aimed at raising awareness, educating healthcare professionals (HCPs) (namely pediatric oncologists) and caregivers of kids with pediatric low-grade glioma (pLGG). These activities include: • Promotion and digital media: This includes brand campaign development and digital marketing campaigns, as well as promotional materials distributed to healthcare providers. Day One engages in targeted engagements with pediatric oncologists through sales account managers and equip them with materials to support their calls. Day One also promotes directly to HCPs through nonpersonal promotional initiatives to target and support pediatric oncologists. Day One has developed materials and resources to educate on product dosing and safety/potential side effects, as well as clinical trial efficacy and safety data. Day One's digital presence includes product information on OJEMDA.com website, emails, and media assets. Day One drives awareness of OJEMDA through digital media advertising. For HCPs, this includes search advertising, display media on endemic and non-endemic sites and electronic health record platforms, and non-personal educational campaigns through third-party partners on oncology and healthcare relevant websites. For caregivers, our digital media includes search advertising, display media, social media, and point of care advertising. • Conferences: Day One will promote OJEMDA at upcoming medical conferences relevant to pediatric oncologists, nurses, and other allied healthcare professionals, including having a Day One exhibitor booth with information about OJEMDA, and OJEMDA educational programs at select meetings. • Speaker programs: We train and deploy HCPs to conduct peer to peer educational programs about OJEMDA, which include content development, program logistical venue and meal fees, and speaker honoraria. [specific marketing strategy and monetary numbers].*" (Ojemda™)

PFIZER

"*Pfizer plans for marketing TALZENNA® soft gelatin capsules include promoting this formulation of TALZENNA® to physicians, direct to patient marketing (brochure), and promotional activities with payers and accounts. For the four quarters ending March 31, 2024, Pfizer has spent approximately [monetary number] on direct-to-consumer marketing efforts and [monetary number] on promoting to physicians on expenses associated with the preparation and marketing of TALZENNA® soft gelatin capsules in the United States.*" (Talzenna®)

While the program collects this information for all new prescription drug reports, both generic and brand name, we have found that most companies do not engage in any marketing for generic drugs. The scope of promotion for generics is typically limited to listing the drug in wholesaler catalogs. However, generic biologic drugs (biosimilars), tend to be marketed more like a brand name.

Pricing methodology

Manufacturers are also required to submit an explanation of the methodology they used to establish the price of the new prescription drug, including a narrative description and an explanation of all major financial and nonfinancial factors that influenced the initial price. We found that the price of generic drugs is commonly set as a fixed percentage of the price of the drug's brand-name equivalent, while most brand-name manufacturers described a holistic multifactor analysis of economic and clinical factors. We received a wide variety of explanations, some are minimal and others are more detailed. Many manufacturers claim this information is a trade secret.

The program collects this information for all new prescription drug reports, both generic and brand name. We have found that most generic drugs do not use financial and nonfinancial factors in pricing. For generic drugs, it is common to determine a discounted price from the brand-name drug or a comparative price to other generics on the market instead of using other pricing methodologies, such as ones used to price brand drugs.

Here are samples from submissions during the past year for the pricing methodology data element not claimed as a trade secret:

ALEMBIC PHARMACEUTICALS INC.

"*Our product is generic so our pricing is based on competitive pricing in the market. Our WAC pricing is typically set at a minimum of 10 percent below the brand price. In this case it is 46.4 percent below the reference brand product (Hemabate) and is just below the WAC pricing of most other generic manufacturers.*" (carboprost tromethamine injection)

BIOGEN INC.

"*Consistent with our pricing principles, we have established a price for ZURZUVAE that reflects the overall value this treatment brings to patients, caregivers and society. ZURZUVAE is the first and only oral, once-daily 14-day treatment that can provide rapid improvements in depressive symptoms for women with PPD. Biogen has a set of Pricing Principles that inform pricing decisions for its products. Those principles are: 1. Value to Patients, 2. Present and Future Benefit to Society, 3. Fulfilling our commitment to Innovation, 4. Evolution toward Value Based Care, and 5. Affordability & Sustainability. Further information can be found at: https://www.biogen.com/content/dam/corporate/en_us/pdfs/BIOGEN_PricingPrinciplesInfographic_4-26-19.pdf.*" (Zurzuvae™)

GERON CORP.

"*Powered by pioneering science, grounded in world-class expertise, and driven by purpose, Geron aims to change lives by changing the course of blood cancer. For more than 30 years, we've tirelessly dedicated ourselves to the pursuit of new therapies for patients with blood cancers, rooted in the belief in the potential of a novel therapeutic approach targeting and inhibiting the enzyme telomerase. … When pricing RYTELO, Geron considered the value*

the drug delivers to patients, providers, and payers by addressing the significant treatment burden faced by patients. Geron did not use a cost-based pricing model or quality-adjusted pricing. Rather, Geron priced RYTELO using a variety of financial and non-financial factors including: Past and ongoing research and development costs: … Geron continues to invest in research and development of imetelstat, the active drug ingredient in RYTELO, in the treatment of certain blood cancers. Unmet need and limited treatment options: … Currently available treatments for red blood cell transfusion dependent patients relapsed or refractory to or ineligible for ESAs have significant limitations, underscoring the need for novel options. RYTELO's differentiated clinical profile … Payer landscape and market dynamics: … Geron analyzed market dynamics in relevant treatment landscapes, including pricing of analog products, as part of its pricing methodology. Patient affordability and access: Geron is committed to accessibility of the product to appropriate patients. … Minimization of wastage: Geron priced RYTELO to minimize wastage. … The two NDCs were priced linearly by milligram to encourage the ordering of only the amount of drug appropriate and necessary to arrive at the patient's weight-based dose." (Rytelo™)

NOVARTIS PHARMACEUTICALS

"Novartis considered many factors in determining the price of Cosentyx IV. To arrive at a fair price recommendation, the US team assessed several considerations, including patient accessibility and insurance/health plan coverage as well as the market basket of branded and biosimilar agents. Recommended price aligns with clinical value Cos IV brings as the 1st IV IL-17 available, filling unmet needs for patients & health professionals." (Cosentyx®)

UPSHER-SMITH LABORATORIES LLC

"Upsher-Smith Laboratories, LLC intends to provide the product at a competitive price based off the current market landscape today. Upsher-Smith offers Torpenz Tablets as a low cost and generically available alternative to the brand Afinitor. We utilized the Drug Compendium (eg. First Data Bank) to identify the published wholesale acquisition cost (WAC). At the time of Torpenz introduction, Afinitor 5mg 28 count package WAC published price was $18,668.50. Upsher-Smith offered Torpenz 5mg 30cnt Bottles at a 50 percent discount (per tablet) for a published WAC of $9,989.97. The same discounts were applied to the 2.5mg, 7.5mg, and 10mg strengths. The pricing is structured to encourage the use of FDA approved generics and to provide a savings to the healthcare system." (Torpenz™)

[27] "Bulletin No. DFR 2024-3." Oregon Department of Consumer and Business Services Division of Financial Regulation.. https://dfr.oregon.gov/laws-rules/Documents/Bulletins/bulletin2024-03.pdf. Accessed Sept. 27, 2024.

Annual price increase reports

Before Feb. 21, 2024, manufacturers were required to annually submit a price increase report for any of their drugs with a list price of $100 or more for a 30-day supply or a shorter course of treatment that experienced a net price increase of 10 percent or more from the previous year. On or after Feb. 21, 2024, reports were only required if there was a patient assistance program for the drug that met the reporting threshold. Refer to DFR Bulletin 2024-3 for details about this change.[27]

For the current reporting year, as displayed in Figure 12, the program received a total of 12 price increase reports with at least some voluntary data included. This represents a 94 percent decrease in reports received since the previous reporting period. With such a small amount of limited data collected, the program cannot provide meaningful transparency or analysis as it has in prior years. For example, with the current limitations, the program is not able to provide the following information previously reported in the standard annual price increase reports:

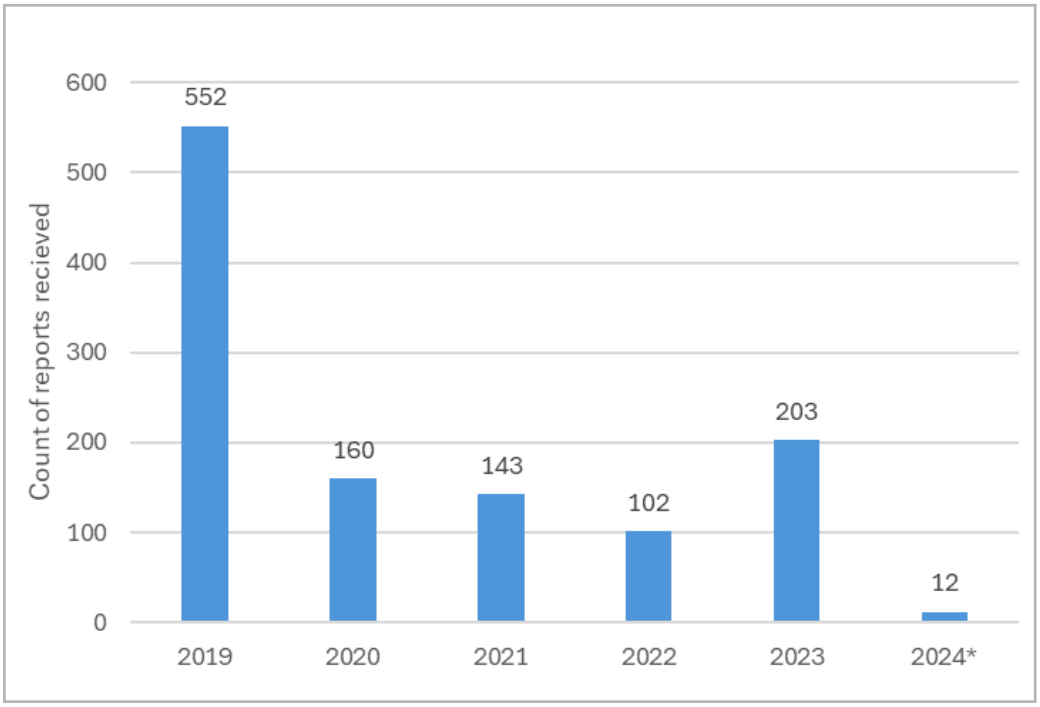
- Drugs meeting the price increase threshold and actual increase amounts
- Manufacturer explanations for price-increase factors
- Aggregated manufacturer profit and revenue data
- Aggregated direct manufacturer costs for marketing, manufacturing, distribution, and safety/effectiveness research
- Drug prices in other countries

Receiving such limited data means the program is no longer able to provide the following types of analysis for the transparency factors listed:

- Comparison of generics versus brand-name drugs
- Comparison of drug price increases to inflation
- Categorization by most common drug classes
- Tracking all trends over time

Reports are filed for price increases that occurred over the preceding calendar year, so reports received in 2024 reflect increases from the average price of the drug in 2022 to the average price of the drug in 2023. Because most data is voluntary for reports received in 2024, we will limit our analysis to the patient assistance program information we received.

Figure 12: Counts for annual price increase reports from 2019 to 2024



Patient assistance data from annual increase reports

The program received patient assistance data from 15 manufacturers, covering 192 patients totaling a value of $16,570,256. This is an average of about $86,303 per patient (ranging from $126 to $171,823 per patient). There were 26 unique brand-name NDCs and two unique generic NDCs associated with the patient assistance reported for 10 therapeutic classes. One of the 10 therapeutic classes, antineoplastic and adjunctive therapies, had 11 unique NDCs. That therapeutic class awarded 99 percent of all reported patient assistance program funds, totaling more than $16.3 million, ranging from $1,500 per patient to $430,487 per patient. Data on patient assistance programs received this year not considered trade secret is shown in Figure 13. We also received data about these therapeutic classes: analgesics – anti-inflammatory; anti-Parkinson and related therapy agents; contraceptives; ophthalmic agents; and psychotherapeutic and neurological agents. That data was marked as a trade secret and is not disclosed in this analysis.

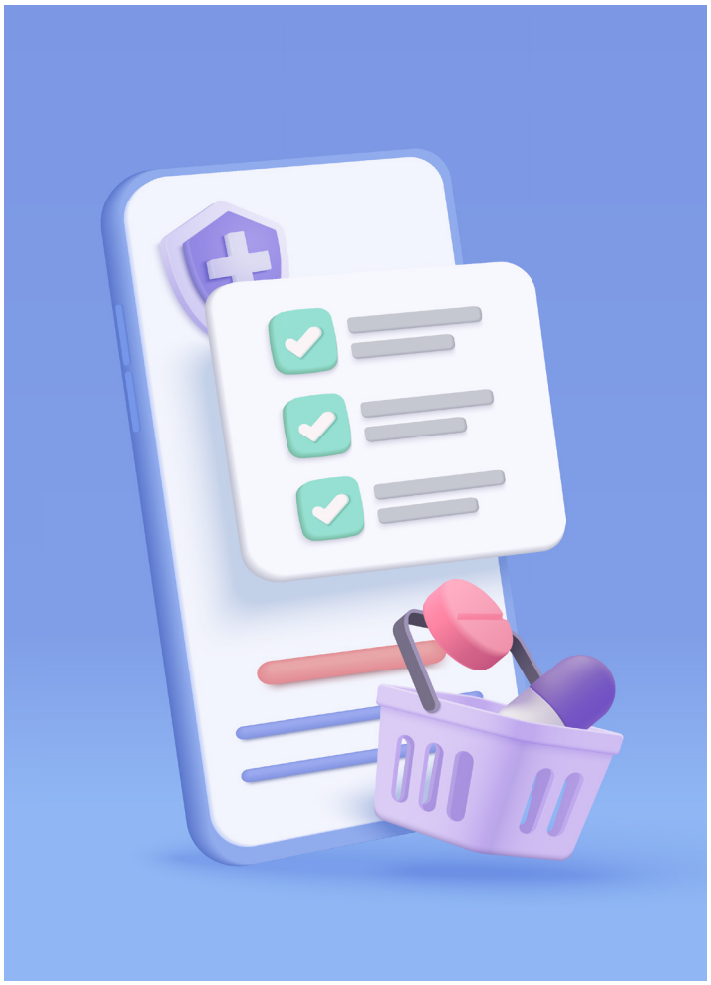


Figure 13: Average patient assistance by therapeutic class

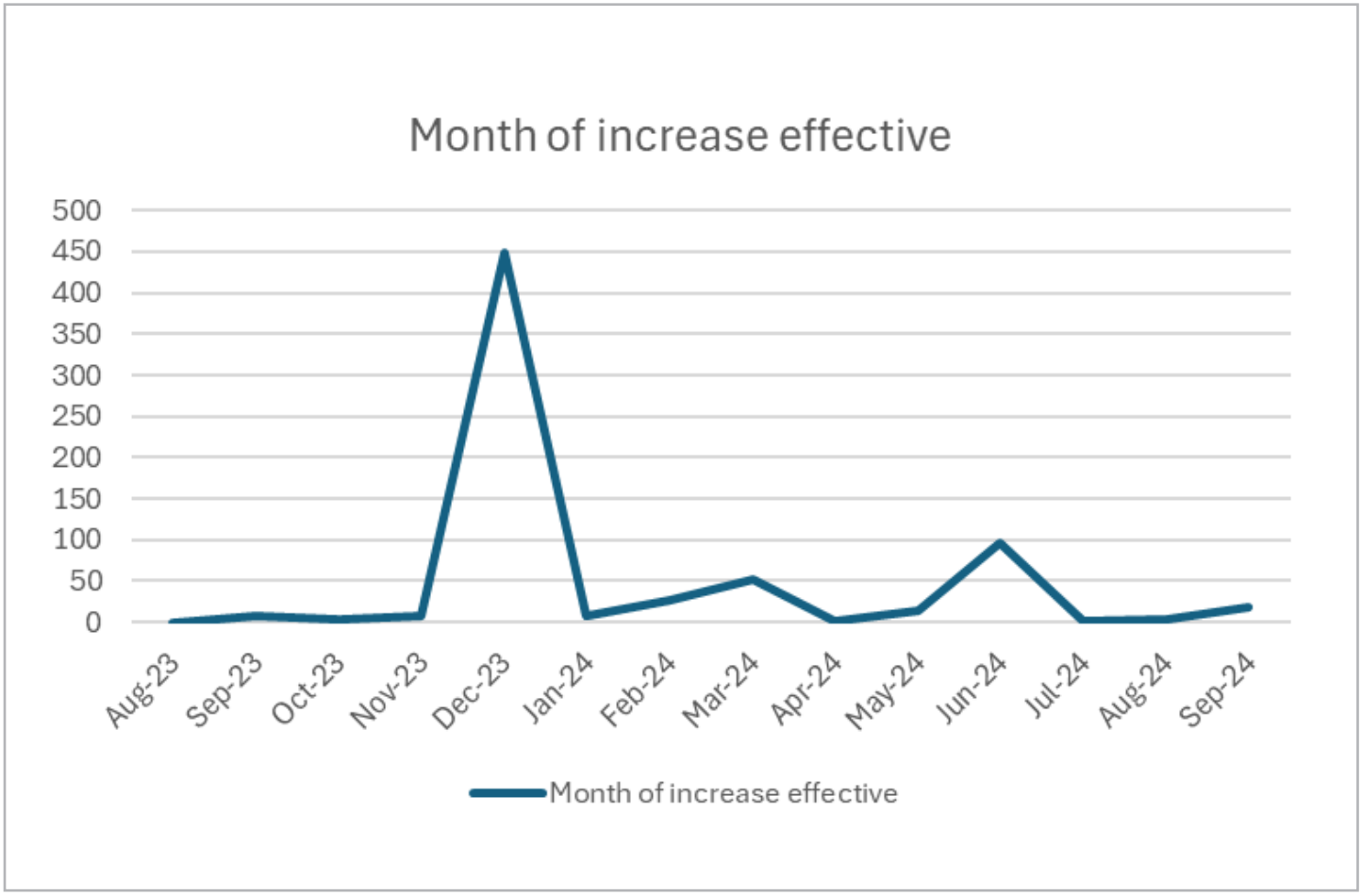
Therapeutic class	Average patient assistance amount per patient
Antiemetics	$28,437 / patient
Antineoplastics and adjunctive therapies	$171,823 / patient
Dermatologicals	$1,260 / patient
Gastrointestinal agents – miscellaneous	$685/ patient
Vaginal and related products	$126 / patient

60-day price increase notices

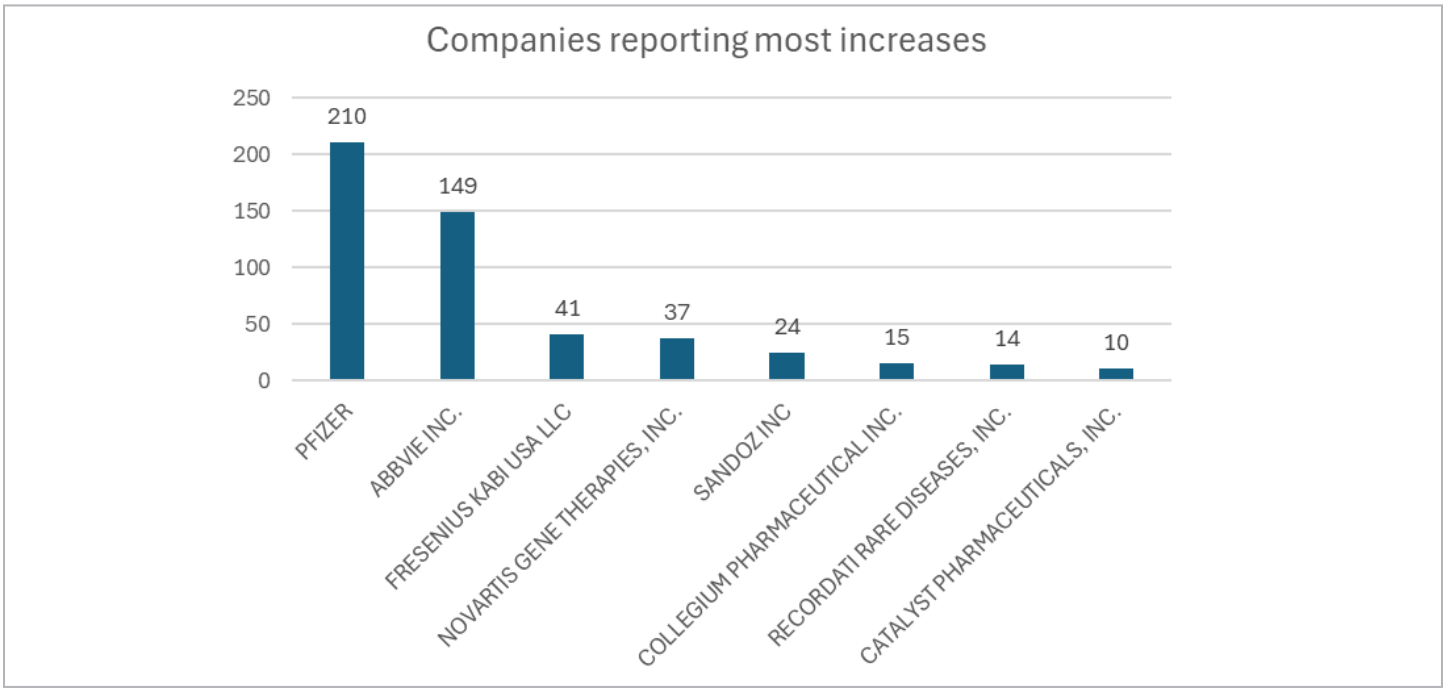
Manufacturers are required to submit a price increase notice 60 days before a planned price increase takes effect when the threshold is met. A report is required for a brand-name prescription drug when the cumulative price increase is at least 10 percent or $10,000 within a 12-month period. A report is required for a generic prescription drug when the cumulative price increase is at least $300, and the increase is also 25 percent or more, within a 12-month period.

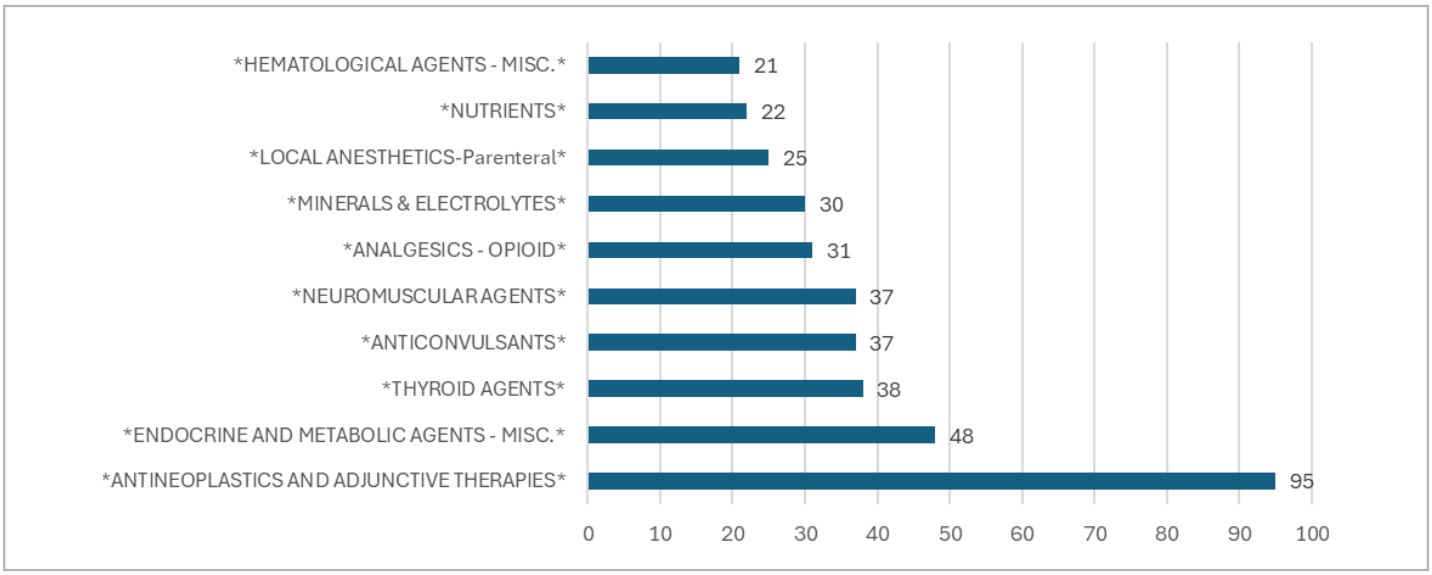
Within the reports, the effective date of the price increase shows that the vast majority (449 of the 691 NDCs reported) occurred around the beginning of the year. Smaller price spikes occurred in June (97 NDCs) and March (51 NDCs).

Figure 14: Number of 60-day price increase notices received based on the month of the planned increase



Figures 15 and 16: Companies and drug categories with the most 60-day price increase notices



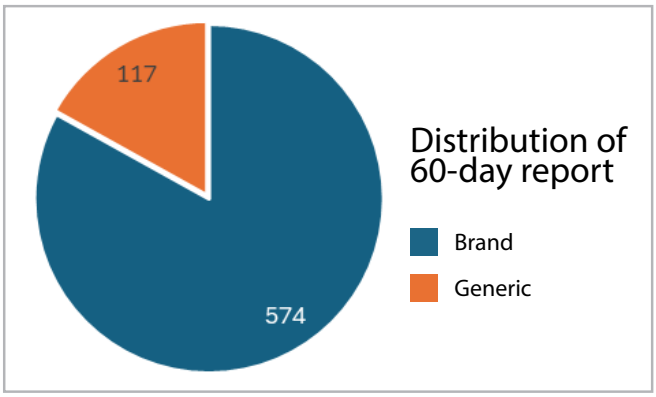


Pfizer submitted the most price increase notices at 210. AbbVie Inc. was next at 149 notices.

The top 10 by therapeutic classification are represented here. Antineoplastics and adjunctive therapies had 95 price increase notices. Next was endocrine and metabolic agents with 48 price increase notices.

Of the 691 notices we received, 117 (about 17 percent) were for generic drugs and 574 (about 83 percent) were for brand-name drugs.

Figure 17: Counts of 60-day price increase notices for generics versus brand-name drugs



Recent trends and market dynamics

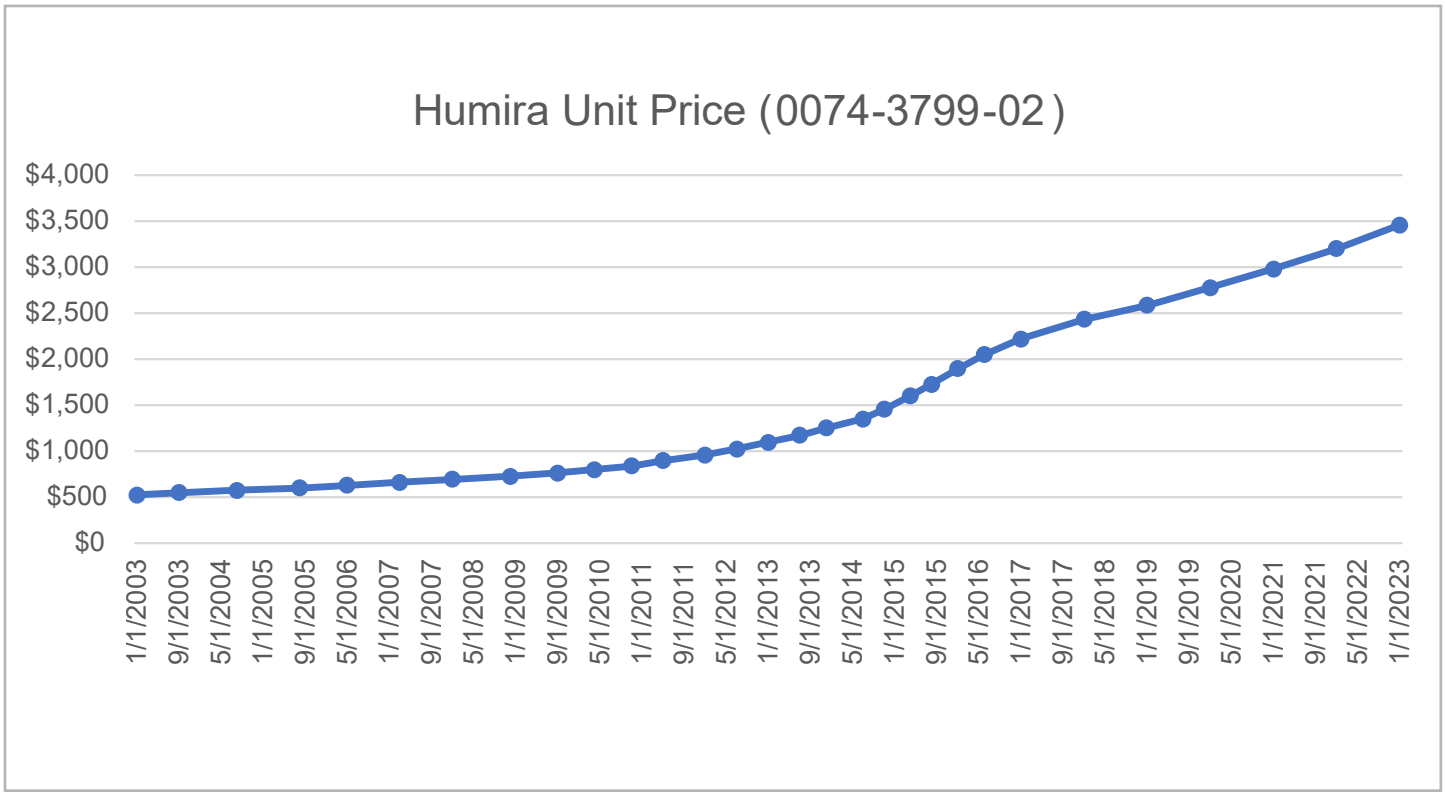
Pharmaceutical drug pricing often does not follow the market dynamics or trends expected for other goods and services. For example, when a new, nearly identical product enters a previously monopolized market, prices are expected to decrease due to competition. However, in many cases this dynamic does not hold true for drug pricing.

Consider as an example, Humira, a brand name for the drug known as adalimumab (NDC 00074-3799-02) manufactured by AbbVie, with the highest insurance plan spending for the last six years. This particular NDC is for a two-syringe kit 40 MG / 0.8ML subcutaneous prefilled syringe. This NDC entered the market at a unit price of $522.64 on Jan. 4, 2003, and has since risen to $3,461.31 on Jan. 3, 2023. Since entering the market on Jan. 4, 2003, Humira's (00074-3799-02) price increased by 562 percent, an average of 28 percent per year.

On Feb. 19, 2024, five new NDCs for Humira from Cordavis Limited, wholly owned by CVS Health, entered the market at an equivalent unit price to the original drug's price on Jan. 3, 2023.[28] Cordavis has entered into an agreement with AbbVie to supply Cordavis with a "committed volume" of Humira to develop a "co-branded" product, "Hyrimoz," which has a planned price point that is more than 80 percent lower than Humira's list price. The DPT program intends to study equivalent drugs from different manufacturers entering the market and their effect on the previously monopolized market with the original drug.

This is just one of many examples. Drugs enter the market at their launch price and increase at varying rates. The two components to evaluate are launch price and increase pattern. "Prescription drug prices are too high in the U.S., and these high prices are driven by the financial incentives present under the current system," according to Thomas Waldrop, a policy analyst focused on prescription drug pricing at the Center for American Progress. "The abuse of government-granted monopoly periods and the inability of payers to meaningfully negotiate prescription drug prices has created a system in which drug companies are able to set prices for their product without regard to the value the drugs provide to patients."[29]

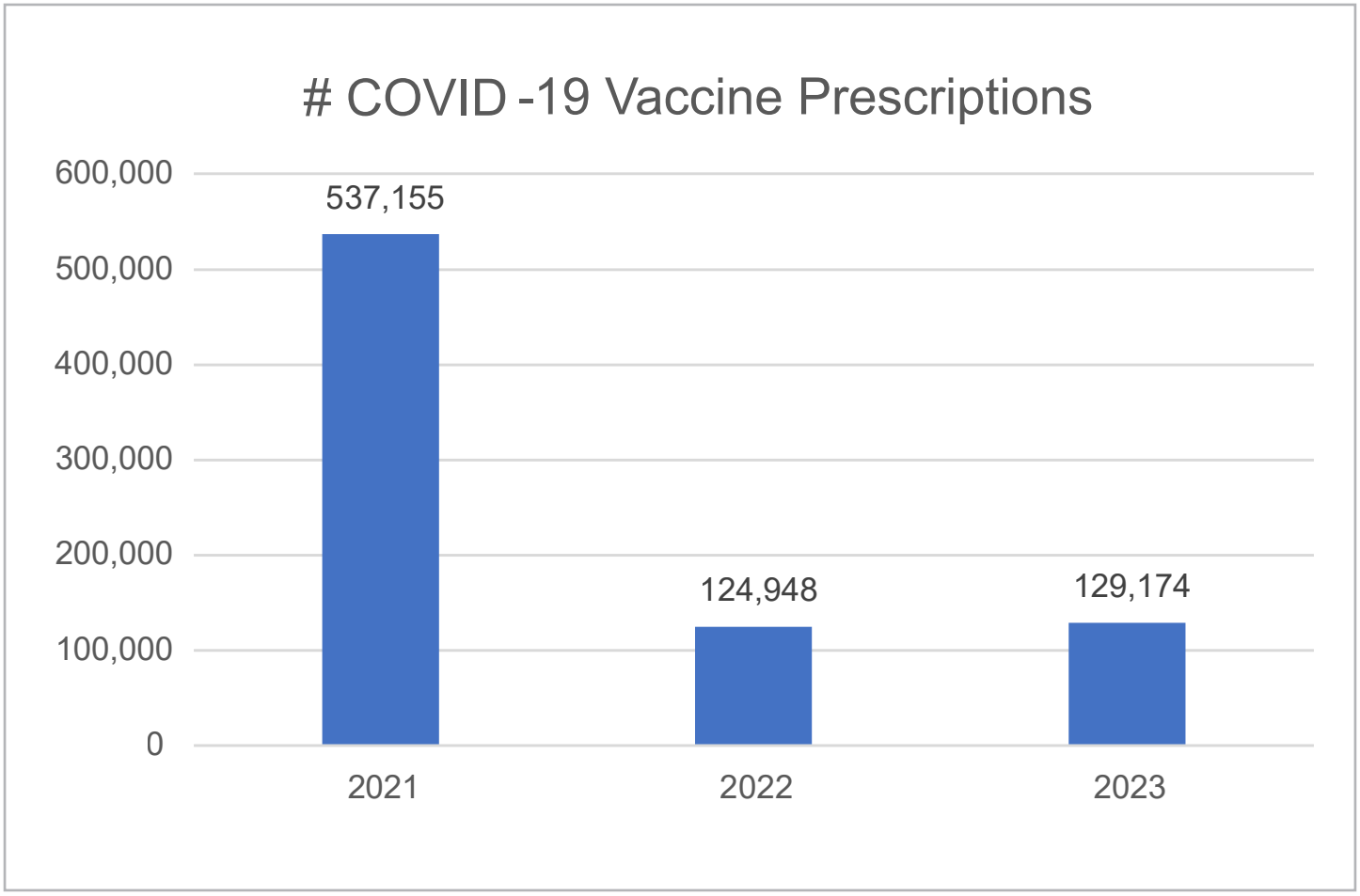
Figure 18: Price history review of Humira



[28] "CVS Health Launches Cordavis." PR Newswire, Aug. 23, 2023. https://www.prnewswire.com/news-releases/cvs-health-launches-cordavis-301908281.html; https://www.reuters.com/business/healthcare-pharmaceuticals/cvs-launches-unit-market-co-produce-biosimilars-2023-08-23/. Accessed Nov. 14, 2024.

[29] Waldrop, Thomas. "Value-Based Pricing of Prescription Drugs Benefits Patients and Promotes Innovation." Center for American Progress, Sept. 13, 2021. https://www.americanprogress.org/article/value-based-pricing-prescription-drugs-benefits-patients-promotes-innovation/. Accessed Oct. 30, 2023.

Figure 19: COVID-19 vaccine counts for the years 2021, 2022, and 2023



Another important trend to study is the effect COVID-19 had on the prescription drug market for the years 2021 through 2023. The Food and Drug Administration (FDA) first granted emergency use authorization to the Pfizer-BioNTech vaccine on Dec. 10, 2020, and mass vaccination began four days later. The Moderna vaccine was granted emergency use authorization on Dec. 17, 2020. The Johnson & Johnson (Janssen) vaccine was granted emergency use authorization on Feb. 27, 2021.

In 2021, insurance companies in Oregon with a COVID-19 vaccine among its top 25 most prescribed drugs reported 537,155 prescriptions for the COVID-19 vaccines. COVID-19 vaccines were the most prescribed drug of 2021. In 2022, that number dropped to 124,948 and, in 2023, there was a slight rise to 129,174 prescriptions.

Manufacturer compliance and enforcement efforts

While many states have passed transparency laws and implemented drug price transparency programs since 2019, Oregon's law remains one of the most ambitious.

The quality of information submitted by manufacturers continues to be extremely variable, ranging from reluctance to provide required information to detailed descriptions of a company's plans for a drug's lifecycle. The program frequently sends requests for more information or clarification to companies with insufficient filings, which sometimes results in more complete information. Other times, we receive no response or incomplete responses resulting in notices of noncompliance.

The program has the authority to impose civil penalties on manufacturers who fail to file required reports or respond to program correspondence. The program issues noncompliance warning notices as the first part of compliance efforts to manufacturers that have not provided the required information on their submitted reports. If the manufacturer does not come into compliance following our initial noncompliance notices, we will prepare a file to send to the division's enforcement unit.

To monitor that all prescription drugs are reported accurately, the department has contracted for access to Medi-Span, a database of WAC pricing data. We used algorithmic analysis of WAC data in Medi-Span to identify NDCs that may have required a new prescription drug or annual price increase report. We do further analysis to identify which NDCs should be reported and then notify the manufacturer to come into compliance or provide documentation that a report is not required.[30] Education efforts and noncompliance warnings have increased compliance with most manufacturers.

[30] Some drugs may not be subject to reporting despite showing up in our analysis of Medi-Span data. For example, specific drugs may not be sold in the state of Oregon (manufacturer only sells to a single provider in a different state) or may be listed in Medi-Span in anticipation of a market launch, but have not actually been offered for sale in the United States.

Trade secret claims from manufacturer reports

When manufacturers report information to the program, they may mark individual data elements (such as cost and profit data and the narrative description of the pricing factors and marketing) as trade secrets. This prevents the Drug Price Transparency (DPT) Program from immediately publishing the data. Before publicly releasing any part of an individual data element claimed to be a trade secret, the program must conduct a lengthy review of the trade secret claim. The trade secret review encompasses these steps:

- An evaluation of manufacturer's provided justification for the trade secret claim
- A review of common industry practice and knowledge
- Research for the availability of the information claimed to be trade secret

If there are claims where the program finds the information is common knowledge or publicly available, or the claim is not substantiated as required, there are the following additional steps:

- A trade secret determination is issued to the manufacturer if any part of the data will be published and the manufacturer has 15 days to appeal the program's determination.
- If not appealed, the determination becomes final.
- If appealed, there is an evaluation of the appeal and the program issues a final trade secret determination.
- After a 21-day waiting period, the information determined not conditionally exempt from disclosure is published to the program's transparency site.

Many reports include invalid or unexplained trade secret claims. We met with representatives for the manufacturers submitting reports with these types of claims. Some of the representatives who work for third-party entities stated they were instructed by the manufacturer to provide as little information as possible and claim trade secrets on all data elements where allowed. All trade secret claims require thorough review and a determination before the program can process the report and publish the data. The program is considering options for preventing the misuse of trade secret claims and its burden on the program as well as removing the option to claim certain data elements as trade secret because they are publicly available.

Across the 529 new prescription drug reports we received in the past year, manufacturers claimed 572 individual data elements as trade secrets on 287 reports. The following data elements were often claimed to be trade secrets:

- Marketing description, including dollars spent
- Methodology used to establish the price of the drug
- Estimated number of patients per month for the drug

To date, the program has received more than 2,500 reports with more than 11,500 data elements claimed as trade secrets. We will continue to review these claims to determine whether the program can publish the information. Information from manufacturers that has been published is available on the DPT Program website at https://dfr.oregon.gov/drugtransparency/data/Pages/new-drug-reports.aspx.

Pharmacy benefit managers (PBMs)

Pharmacy benefit managers contract with pharmacies on behalf of health insurers, coordinated care organizations, as well as the Oregon Prescription Drug Plan.[31] Some of their tasks include:

- Processing claims for prescription drugs and medical supplies dispensed by pharmacies
- Processing payments and negotiating rebates between drug manufacturers, pharmacies, and health insurers
- Creating prescription drug lists (formularies)
- Managing retail pharmacy networks

Starting in 2024, PBMs registered in Oregon and managing pharmacy benefits for companies issuing health benefit plans in the state were required to report payments received from manufacturers and where that money went.[32] In 2025, PBMs will be required to be licensed to operate in Oregon and more extensive PBM reporting will be required. Note that some insurers perform PBM duties within their company and are not registered or licensed as a PBM.

In 2024, PBMs were required to report on the amounts received from drug manufacturers during 2023. These reports were due June 1, 2024. Many of the 59 PBMs registered in Oregon were exempt from reporting for one of the following reasons:

- Employee Retirement Income Security Act (ERISA) self-funded plans only
- Workers' compensation plans only
- No covered lives in Oregon

For 2024, the program received reports from these 17 PBMs:

- A&A Drug Co. dba Sav-Rx Prescription Services
- AffirmedRx PBC
- Capital Rx Inc.
- CaremarkPCS Health LLC
- Cigna Health and Life Insurance Co.
- Drexi Inc.
- Express Scripts Administrators LLC
- FairScript LLC
- Magellan Rx Management LLC
- Mark Cuban Cost Plus Benefits LLC
- MedImpact Healthcare Systems Inc.
- Mitchell International Inc.
- Navitus Health Solutions LLC
- OptumRx Inc.
- Prescryptive Health Inc.
- Prime Therapeutics LLC
- True Rx Management Services Inc.

[31] ORS 735.530(11). https://www.oregonlegislature.gov/bills_laws/ors/ors735.html. Accessed Oct. 31, 2024.

[32] Senate Bill 192 (2023). https://olis.oregonlegislature.gov/liz/2023R1/Measures/Overview/SB192. Accessed Oct. 31, 2024.

Figure 20: According to ORS 735.537, the DPT Program has published the aggregate sum of each of the four data points:

Rebates and payments from manufacturer	Amount passed to insurers	Amount passed to enrollees	Amount retained as revenue
$287,479,362	$283,642,406	$2,236,218	$1,600,738

There are three categories where the manufacturer payment received was distributed: amount passed to insurers, amount passed to enrollees in the pharmacy program, and the amount retained by the PBM as revenue.

The vast majority (98.7 percent) of manufacturer payments received by the PBMs was passed back to insurance companies, $283.6 million.

Comparatively, very little of manufacturer payments ended up being passed to enrollees of the pharmacy program (0.8 percent, about $2.2 million). Similarly, only 0.6 percent, or $1.6 million, was kept as revenue by the 17 reporting PBMs.

Figure 21: Gross amount of manufacturer payments passed on to insurers or enrollees versus the amount retained

Amount passed to insurers	Amount passed to enrollees	Amount retained as PBM revenue
$283,642,406	$2,236,218	$1,600,738

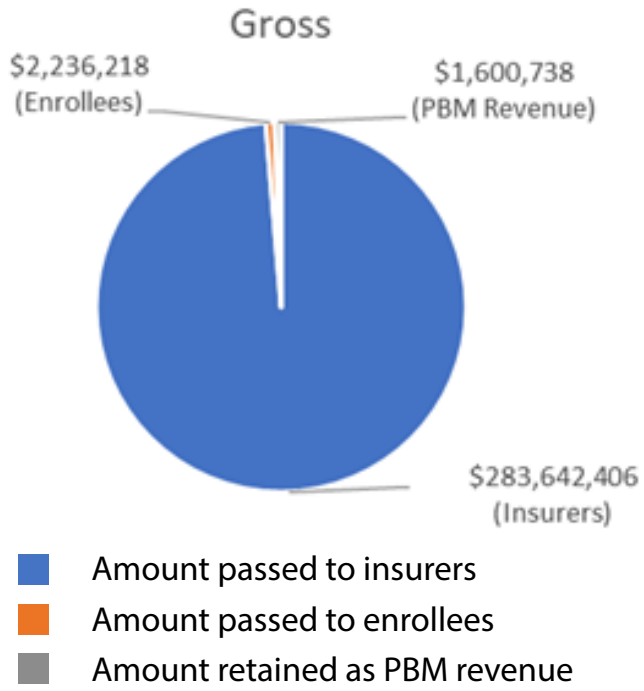
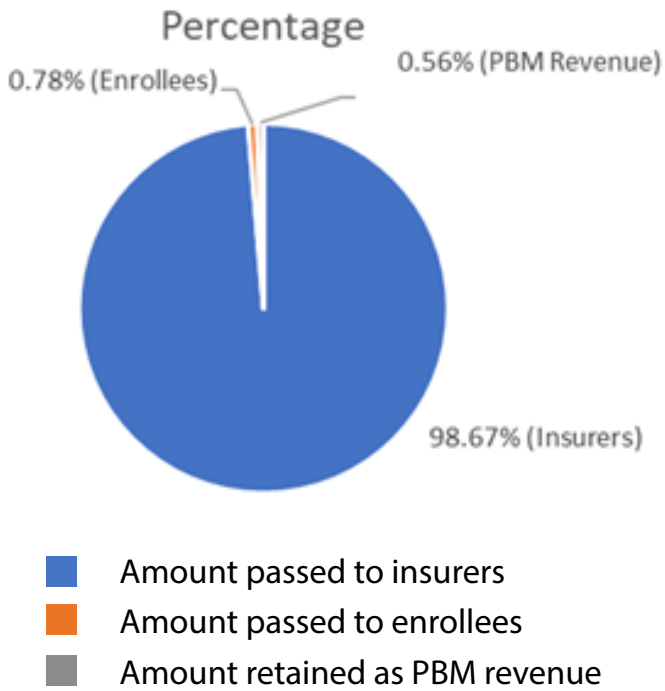
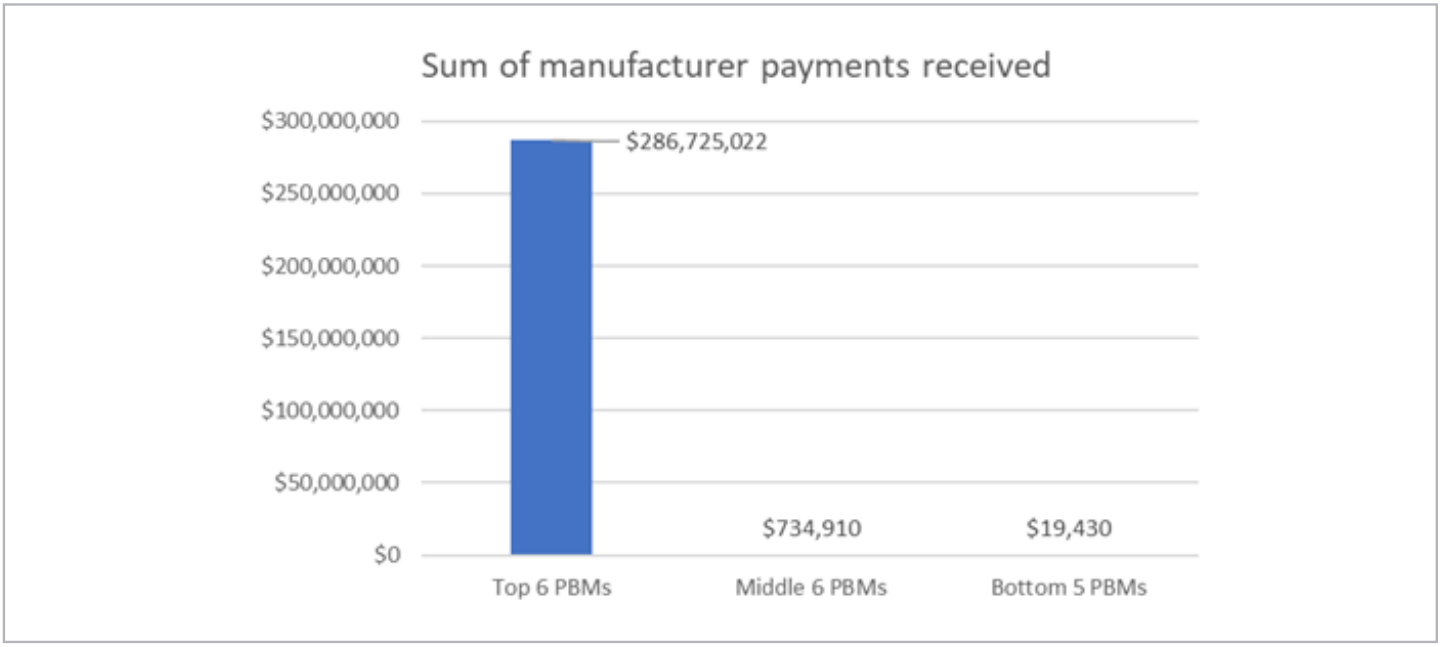


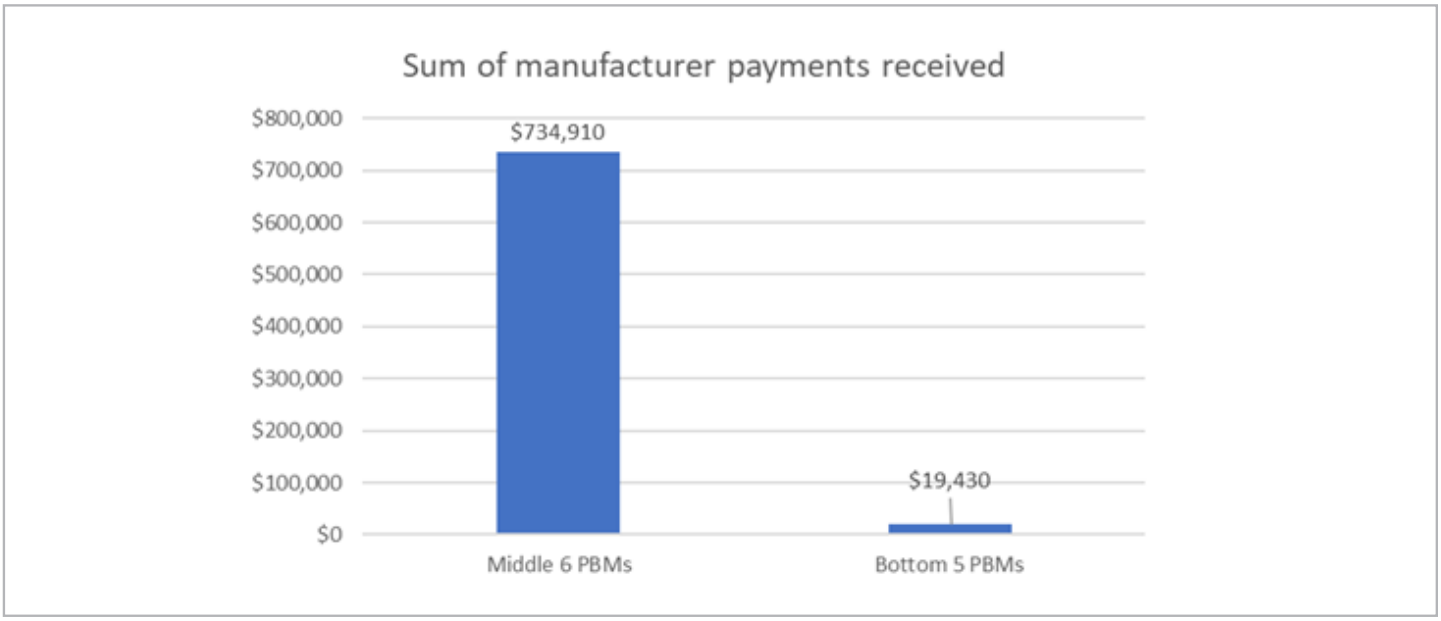
Figure 22: Percentage of manufacturer payments passed on to insurers or enrollees versus the amount retained

Amount passed to insurers	Amount passed to enrollees	Amount retained as PBM revenue
98.67%	0.78%	0.56%



Figures 23 and 24: Sum of manufacturer payments received by all PBMs (grouped by amounts of payments) and the two smaller groups





The PBMs that received the six-highest (top six) manufacturer payment amounts received a total of $286.7 million. The PBMs that received the next six-highest (middle six) manufacturer payment amounts received a total of $734,910 in rebates. Finally, the PBMs that received the five-smallest (bottom five) manufacturer payment amounts received a total of $19,430.

Eight out of 17 reporting companies reporting nonzero rebate amounts simultaneously reported zero in retained revenue.

Beginning in 2025, DCBS will also be collecting the following data points as required under House Bill 4149 (2023): (1) The total dispensing fees paid to the PBM and to pharmacies, (2) the total administrative fees obtained and retained from manufacturers and insurance companies, and (3) moneys obtained through spread-pricing, pay-for-performance, or similar means.

Health insurance companies

Each year many health insurance companies are required to report lists of the top 25 most prescribed drugs, the 25 drugs with the highest total health plan spending, and the 25 drugs with the greatest increase in year-over-year-plan spending. These reports are mandatory for health benefit plans in the small group, large group, and individual markets. Altogether, the data reported covers prescription drug claims for about 750,000 individuals, representing about a quarter of all Oregonians.

For 2024, the program received reports from these companies:

- Aetna Life Insurance Co.
- BridgeSpan Health Co.
- Cigna Health and Life Insurance Co.
- Health Net Health Plan of Oregon Inc.
- Kaiser Foundation Health Plan of the Northwest
- Moda Health Plan Inc.
- PacificSource Health Plans
- Providence Health Plan
- Regence BlueCross BlueShield of Oregon
- Samaritan Health Plans Inc.
- United Healthcare Insurance Co./United Healthcare of Oregon Inc.

Following program reporting guidance, insurance companies combine all claims for all drug products with the same name, including versions with different or modified release dosages. Then, they submit lists of the top 25 of the following:

- The number of prescriptions for those drugs in 2023
- The money spent by them and their policyholders on those drugs in 2023 after rebates or other price concessions
- The difference between the total amounts spent in 2022 and in 2023 (the year-over-year increase)

They submit separate lists for generic drugs, brand-name drugs, and specialty drugs. Generic and brand-name drugs are categorized as specialty drugs when they are priced at the same threshold used for new prescription drug reporting by manufacturers for the DPT Program. For this year's insurer reporting, the specialty drug threshold was $670 or more for a month's supply.

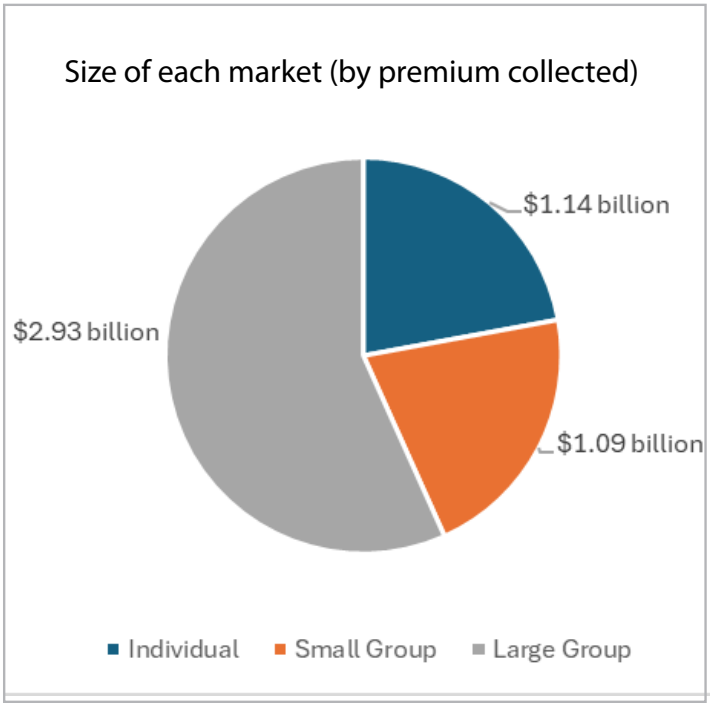
After combining the data, our final lists show the top-10 drugs in each category, aggregated from the data for all 11 insurers.

Plan spending on prescription drugs

Collecting information on drug spending compared to total premiums allows the DPT Program to measure the percentage of plan spending directed to prescription drugs versus all other costs – including all other medical claims, plan administration, profit, and financial reserves. The data presented in these charts represents prescription drug spending in the small-group, large-group, and individual-market segments.[33] It does not include data for the Public Employees' Benefit Board (PEBB), Oregon Educators Benefit Board (OEBB), Medicare, or Medicaid, because most insurers did not submit data for these plans, which are not required.

[33] Generally, under the Affordable Care Act, small-group plans are defined as those purchased by an employer with 50 or fewer enrollees; large-group plans are those purchased by an employer with 51 or more enrollees; and individual plans are plans purchased directly by the enrollee.

Figure 25: Premium amounts collected by individual, small-group, and large-group plans

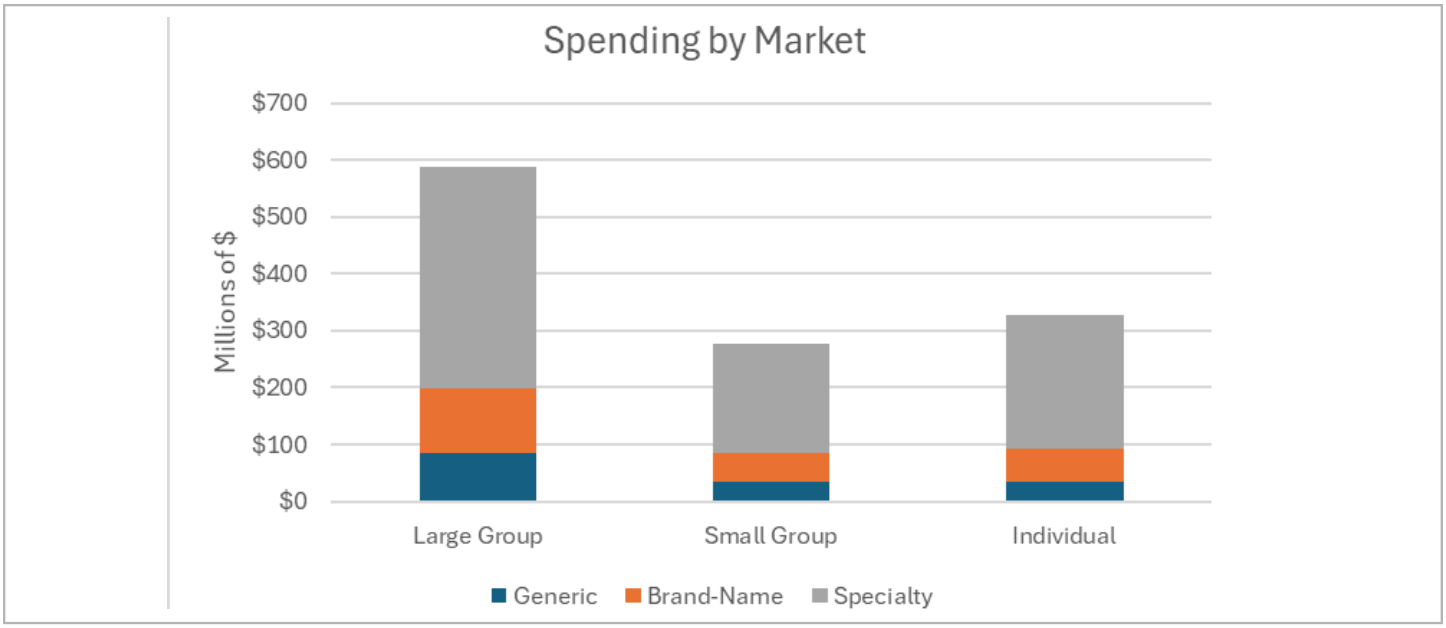


In terms of total premium collected, the large-group market was the largest by volume of premium collected, with $2.93 billion, followed by the individual market, with $1.14 billion. Small group was the smallest market among the three collected, with $1.09 billion in premiums collected. The comparison of those same groups (large group, individual, and small group) by spending on generic, brand-name, and specialty drugs is shown in the following graphs.

Across all insurance companies, the large-group market spent a total of $588.4 million ($85 million on generics, $114.7 million on brand-name drugs, and $388.7 million on specialty drugs). The small-group market spent a total of $277.4 million ($35.2 million on generics, $49.1 million on brand-name drugs, and $193.1 million on specialty drugs). The individual market spent a total of $328.4 million ($33.5 million on generics, $59.6 million on brand-name drugs, and $235.3 million on specialty drugs).

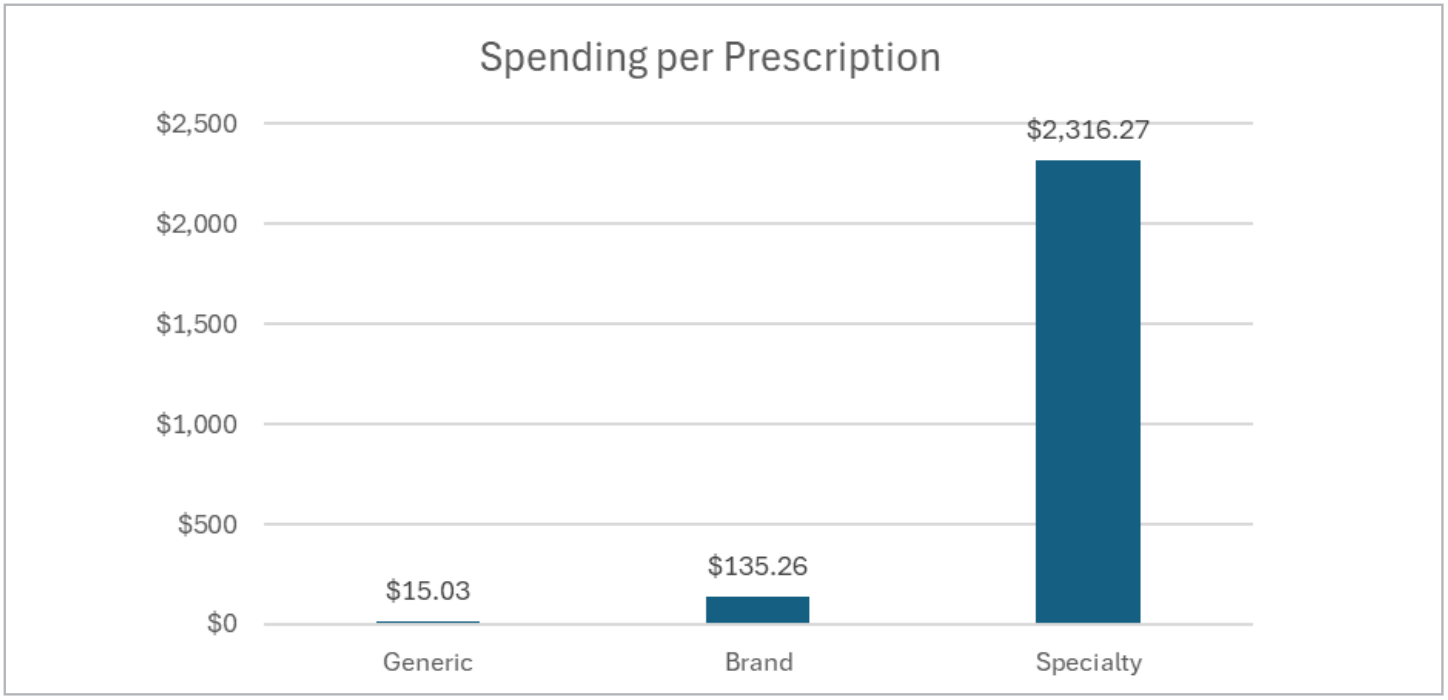
Figure 26: Prescription drug spending by types of policy and drug category

Drug category	Large Group	Small Group	Individual
Generic	$84,968,655	$35,213,552	$33,522,368
Brand name	$114,707,320	$49,106,697	$59,589,828
Specialty	$388,702,154	$193,105,850	$235,330,448



The following graphs represent the spending per prescription and spending per enrollee for all entries within the top 25 most-prescribed generic, brand-name, and specialty drugs. The average spending per prescription for generic drugs within those tables was $15.03, the average spending per prescription for brand drugs was $135.26, and the average spending per prescription for specialty drugs was $2,316.27. The average spending per enrollee for generic drugs was $42.29, the average spending per enrollee for brand-name drugs was $192.02, and the average spending per enrollee for specialty drugs was $7,296.15.

Figures 27 and 28: Insurer spending per prescription and per enrollee



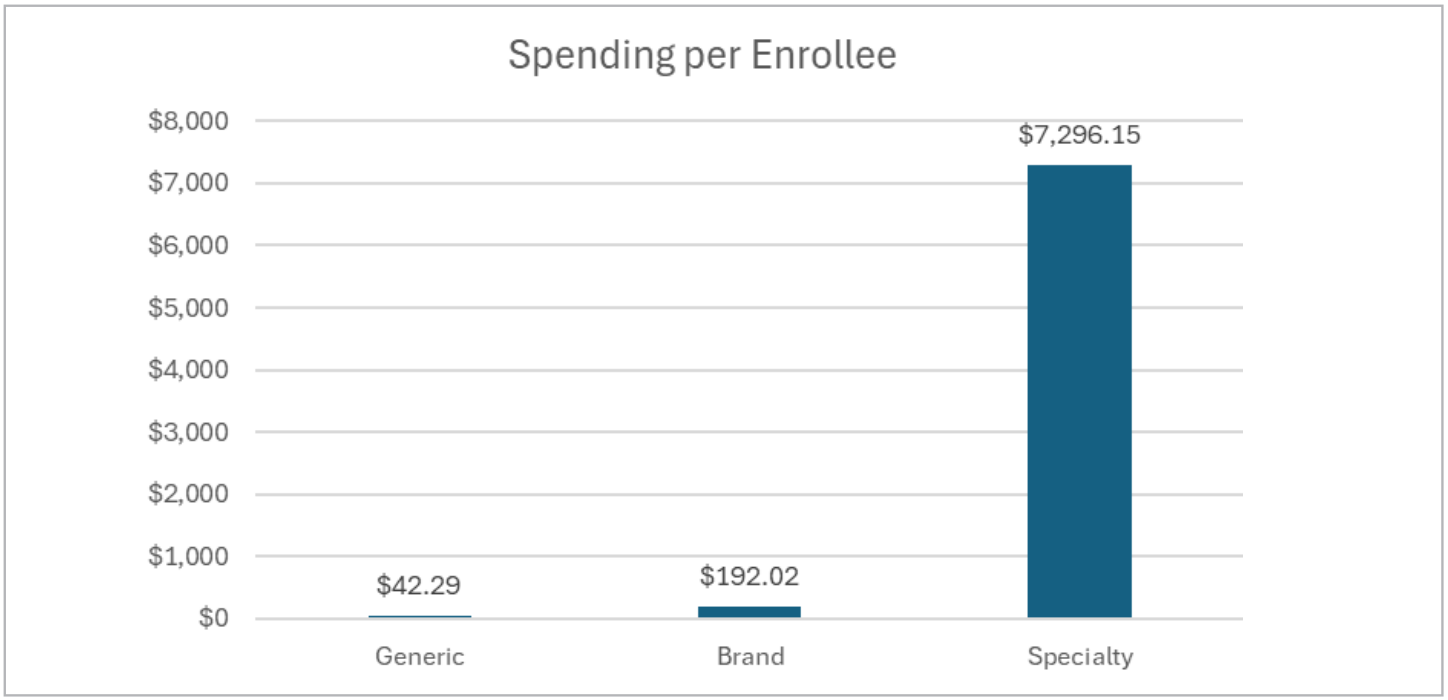


Figure 29 shows that plan spending on prescription drugs varies widely as a percentage of total premiums collected. BridgeSpan had the highest share of spending, with 47 percent of its total collected premium spent on pharmaceuticals. Cigna had the second-highest share of spending, at 31 percent. Kaiser and Health Net had the smallest amount of spending on pharmaceuticals with respect to the total premium collected, with 17 percent and 16 percent spent on pharmaceuticals, respectively.

Information about total premiums and the amount of member months covered was collected. Figure 30 shows the companies' premium collected per member per month. The insurance companies with the highest average premium per member per month was BridgeSpan and Moda, with $645 and $641 per member per month, respectively. The company with the lowest premium per member per month was Health Net at $489 per member per month.

Figure 29: Plan spending on prescription drugs as a percentage of premiums collected

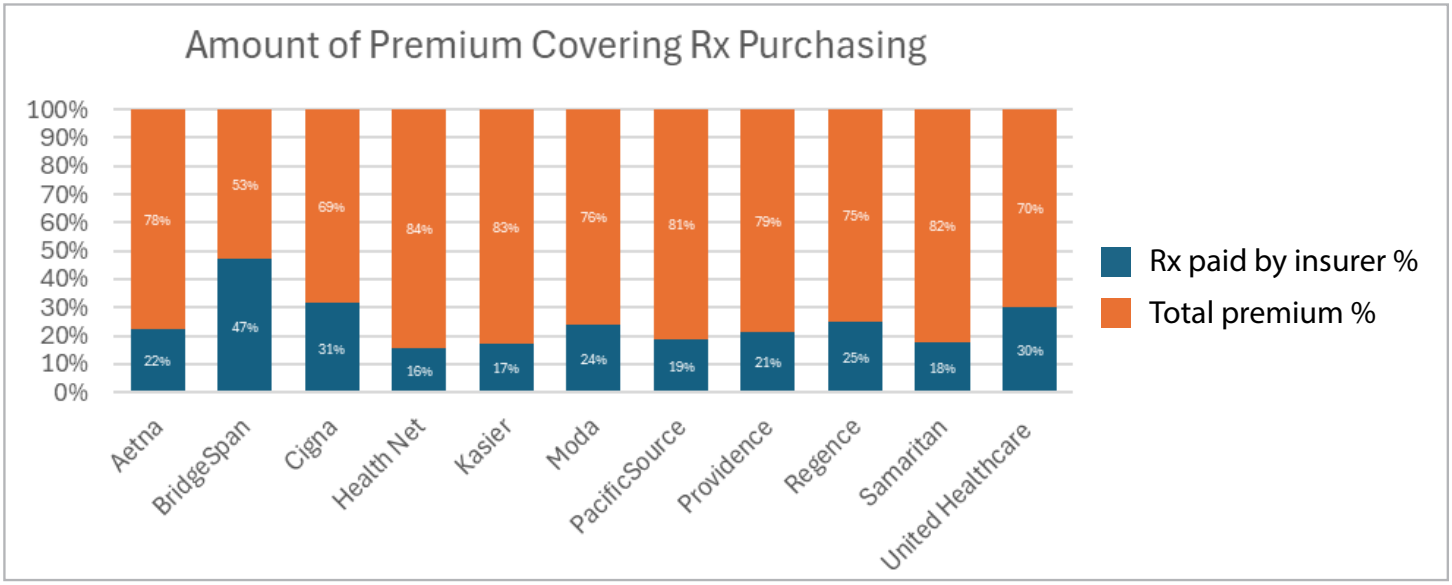


Figure 30: The average premium per member per month

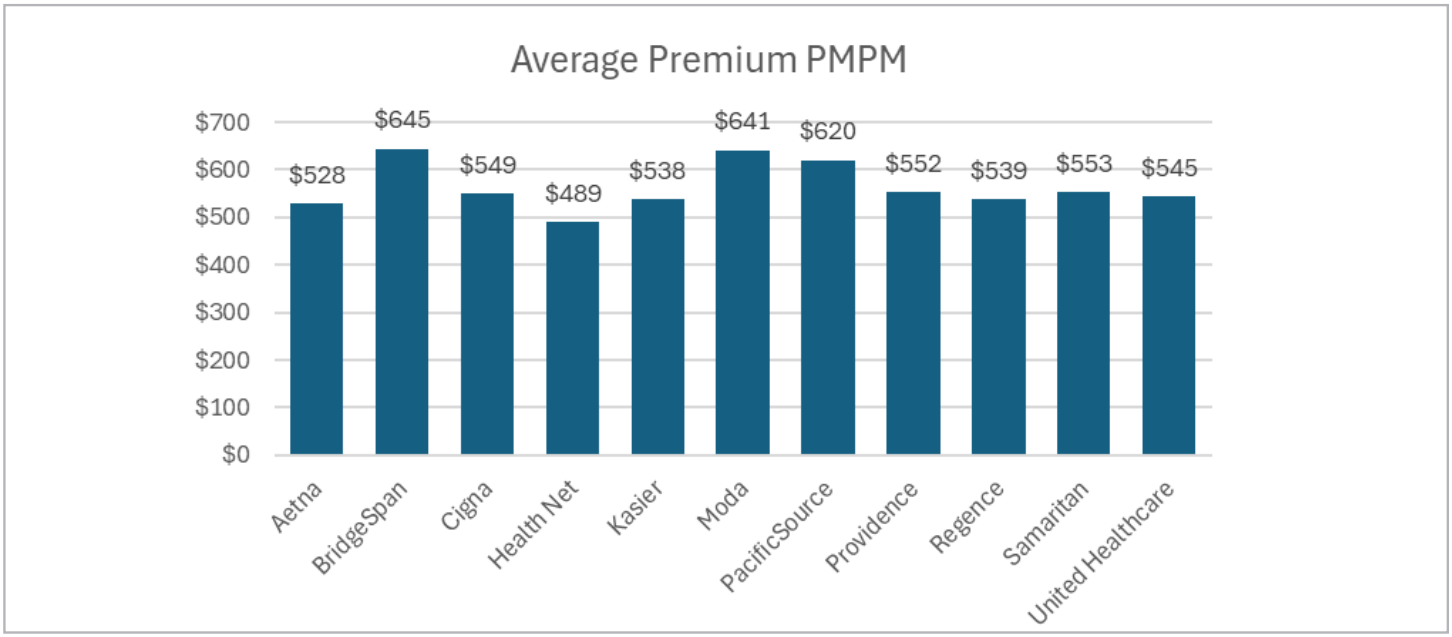


Figure 31 shows spending on each drug category as a percentage of total spending on prescription drugs. Across the board, all plans spent the most on specialty drugs and the least on generic drugs; however, this is opposite of the actual volume of prescriptions. Generic drugs constitute the vast majority of prescriptions written, while specialty drugs represent a fraction of prescriptions, despite driving the majority of spending. BridgeSpan was the company with the highest percentages of pharmaceutical spending on specialty drugs at 87 percent. PacificSource and Samaritan were the companies with the lowest percentages of spending on specialty pharmaceuticals with 56 percent and 58 percent, respectively.

Figure 31: Plan spending on prescription drugs by category (brand name, generic, and specialty)

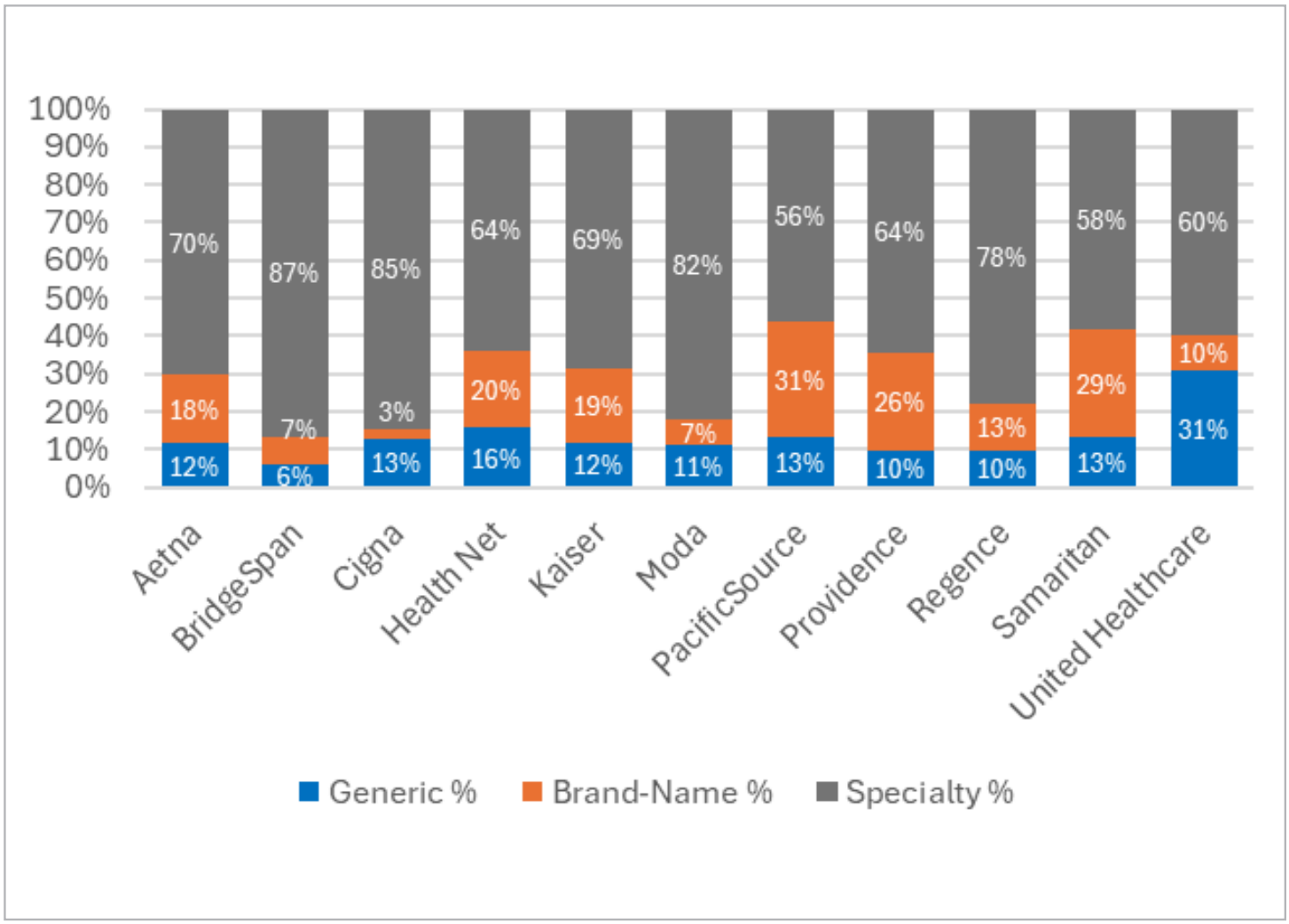
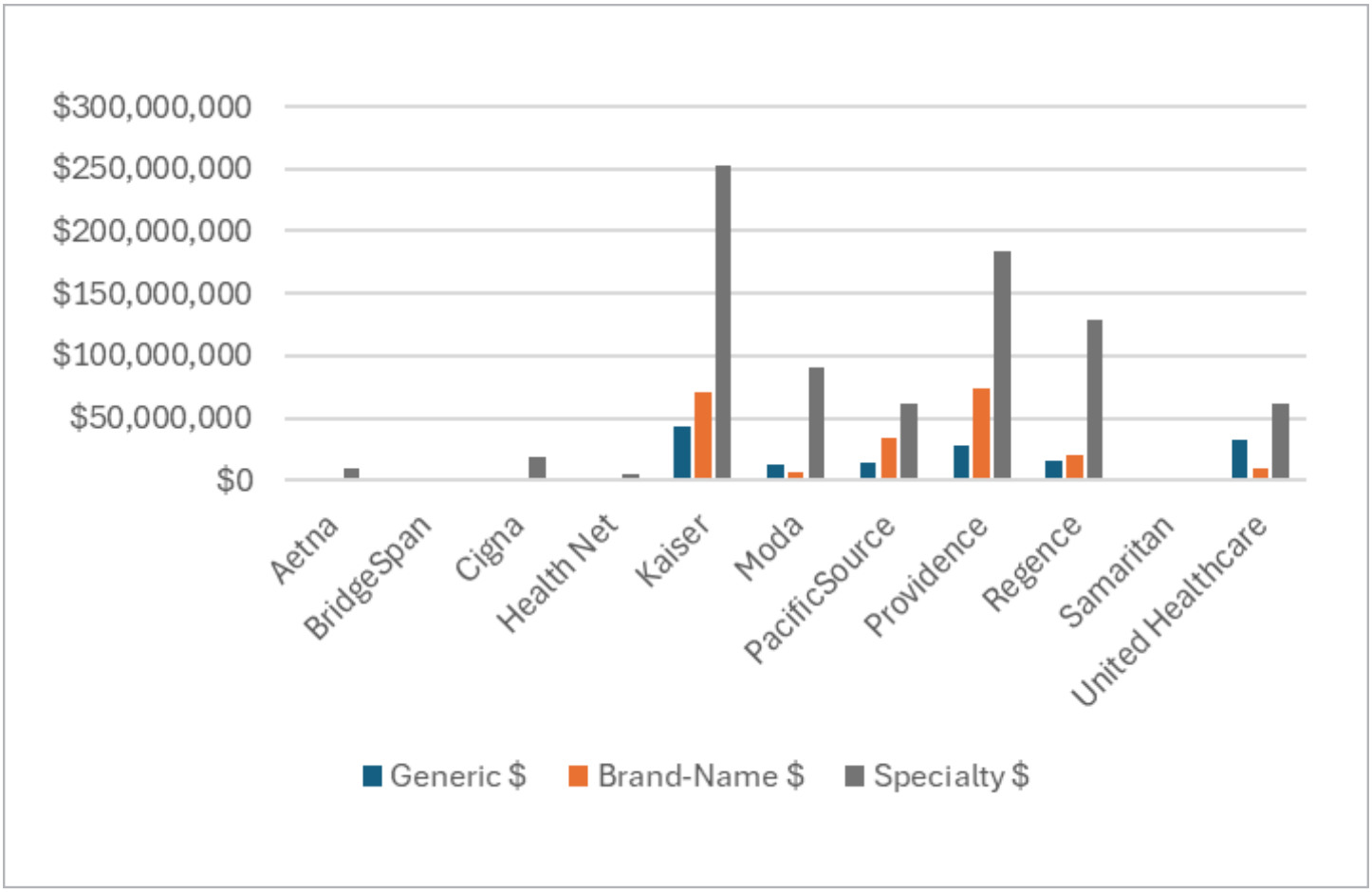


Figure 32 and 33: Amounts spent on prescription drugs by category (brand name, generic, and specialty) for all insurers and the five smallest insurers



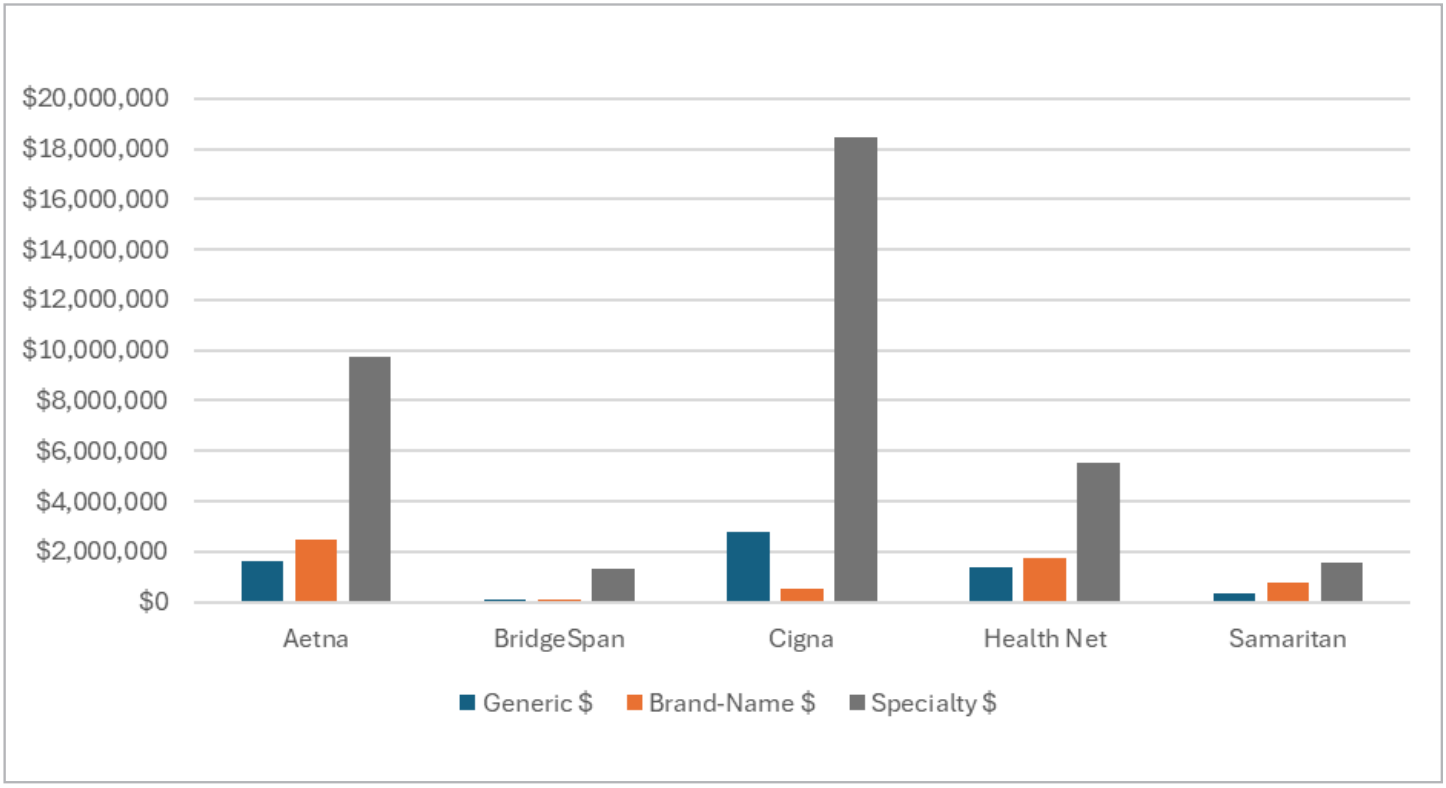


Figure 34: Amounts spent on prescription drugs by category (brand name, generic, and specialty) as shown in figures 32 and 33

Company name	Generic $	Brand-name $	Specialty $
Aetna	$1,625,713	$2,485,852	$9,751,154
BridgeSpan	$91,252	$115,478	$1,338,059
Cigna	$2,799,435	$549,953	$18,439,186
Health Net	$1,375,459	$1,743,754	$5,551,508
Kaiser	$43,693,262	$71,369,935	$253,120,362
Moda	$12,604,513	$7,235,715	$91,136,764
PacificSource	$14,442,586	$34,217,456	$61,753,557
Providence	$28,365,103	$74,064,425	$183,442,500
Regence	$16,090,693	$20,771,159	$128,705,681
Samaritan	$348,125	$764,337	$1,540,477
United Healthcare	$32,268,434	$10,085,782	$62,359,203

That said, there is at least one conclusion the program can draw from this data: High-cost specialty drugs present a significant financial risk for insurance companies with small enrollment.

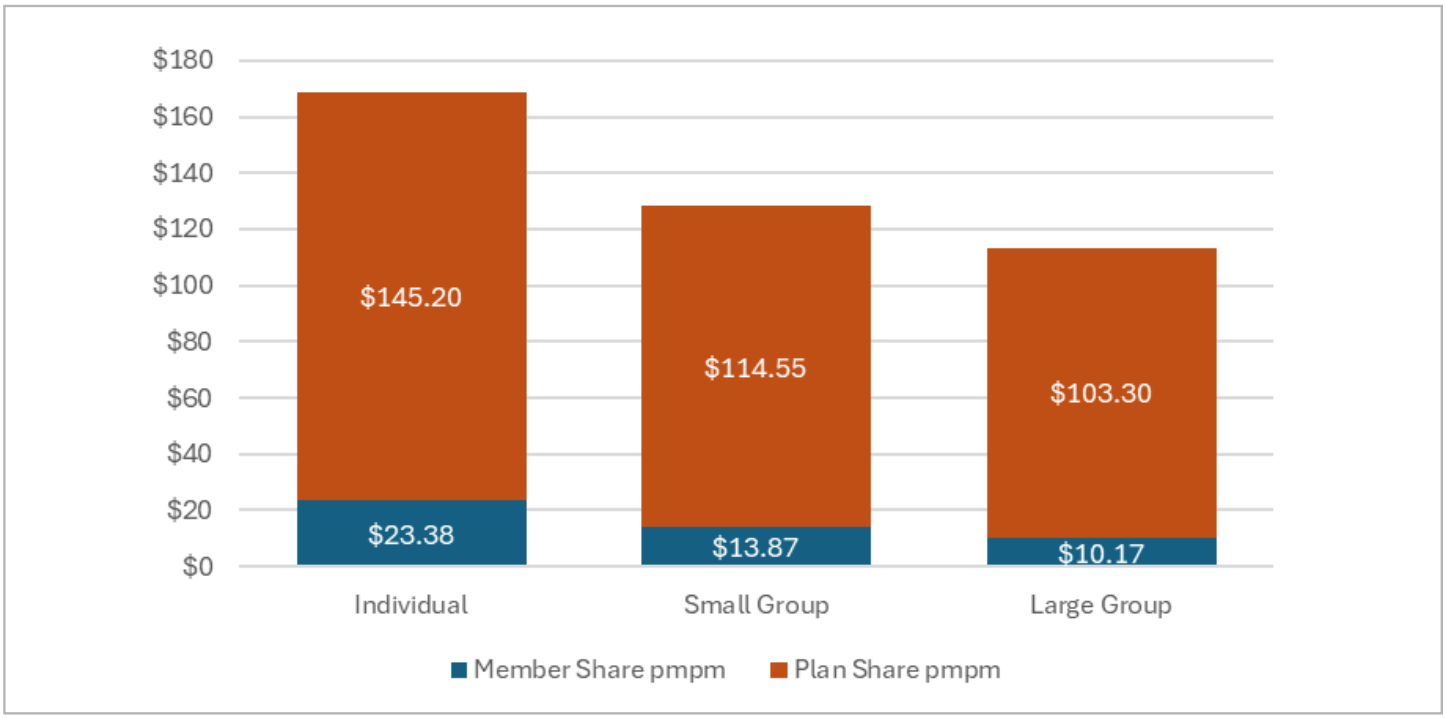
Consumer cost sharing

The data the program has collected on consumer cost sharing allows it to present an analysis regarding insured consumer cost burden for prescription drugs. Figures 35 and 36 show dollars spent on a per-member, per-month basis for individual, small-group, and large-group insurance plans across all nine insurers studied. This data shows the average monthly cost sharing for prescriptions paid by consumers (member share) and the average monthly amount covered by insurance (plan share). The program can compare the consumer burden per plan type in dollars and relative percentages as it did with its analysis of pharmaceutical spending by prescription type.

Overall, individual market plans spent the most per member, averaging $168.58 in total spending per member, per month. Of that amount, $23.38 was shouldered by the plan member and $145.20 was covered by the plan. Several factors may be contributing to the difference in spending between plan types. In general, employer-sponsored plans in the small- and large-group plans tend to have a larger number of young, healthy enrollees. As a result, claims costs for prescription drugs are likely to be lower in the group plans due to lower incidence of chronic conditions.[34] Individual plans may also have less market power, and thus have less ability to negotiate lower prices or higher rebates from manufacturers and wholesalers.

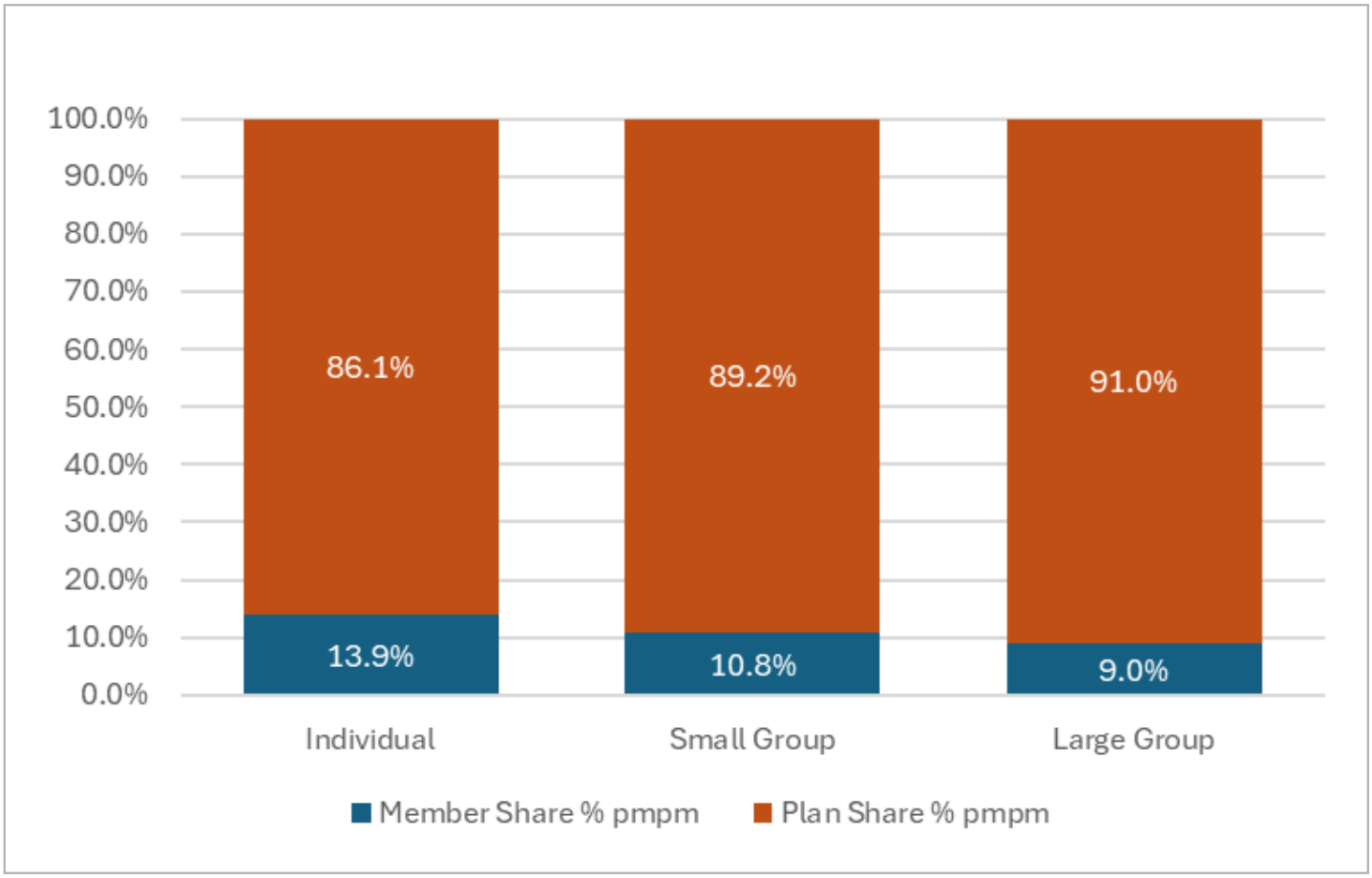
After comparing the member burdens between individual, small-group, and large-group market plans on an absolute basis in Figure 35, the program compares those values on a relative basis in Figure 36. Of the total spent on average for individual plans, 13.9 percent was shouldered by the member. Of the total spent on average for small-group plans, 10.8 percent was shouldered by the member. Of the total spent on average for large-group plans, 9 percent was shouldered by the member.

Figure 35: Average amount spent on prescription drugs per member per month



[34] Boersma, Peter et al. "Prevalence of Multiple Chronic Conditions Among US Adults, 2018." Centers for Disease Control and Prevention, Preventing Chronic Disease, vol. 17, Sept. 17, 2020. https://www.cdc.gov/pcd/issues/2020/20_0130.htm. Accessed Oct. 30, 2023.

Figure 36: Average percentage of prescription drug spending on prescription drugs per member, per month



Rebates

The price of a drug is influenced by many factors, but manufacturer rebates are one of the most significant. Typically, a manufacturer will pay a rebate for a portfolio of drugs, rather than on a drug-by-drug basis. Rebates are generally paid to insurers and negotiated by intermediary companies known as PBMs. Insurance companies use these rebates to lower premiums.

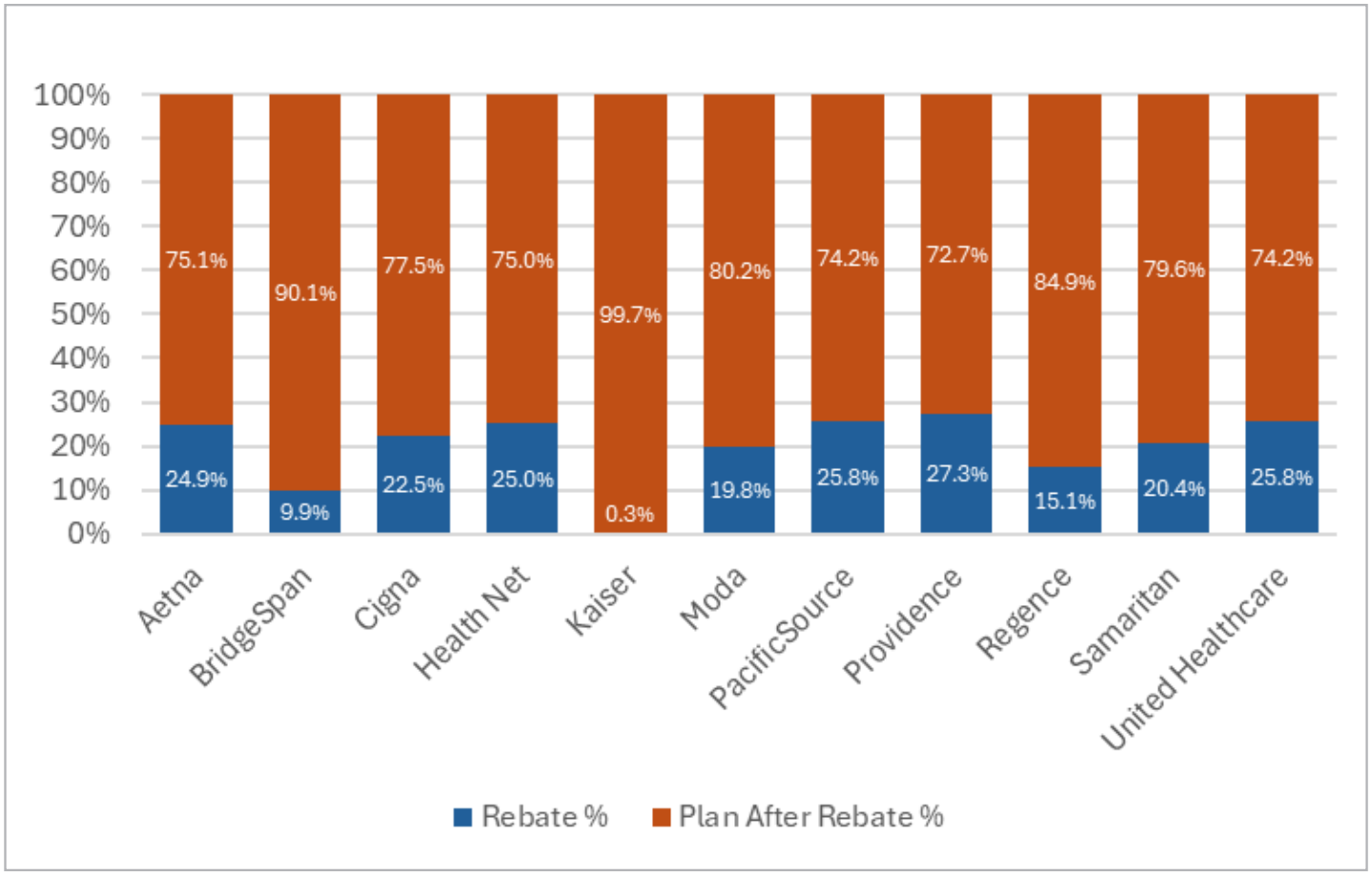
Specific rebate amounts are kept a closely guarded secret by PBMs. In many cases, PBMs do not share this information with their client insurance companies.

As a program, we gather cost information from insurers "net of rebates" to the maximum extent possible. We also collect data on the total amount of rebates received from each insurer and compare it to total spent on drugs.

In Figure 37, the blue bars represent the percentage of costs that were covered by rebates, while the orange bars represent the remaining cost paid by the insurance companies. Manufacturer rebates and other price concessions were reported by insurance companies as well as the total dollars paid by insurance companies after rebates. Amounts from individual, large-group, and small-group spending were added together.

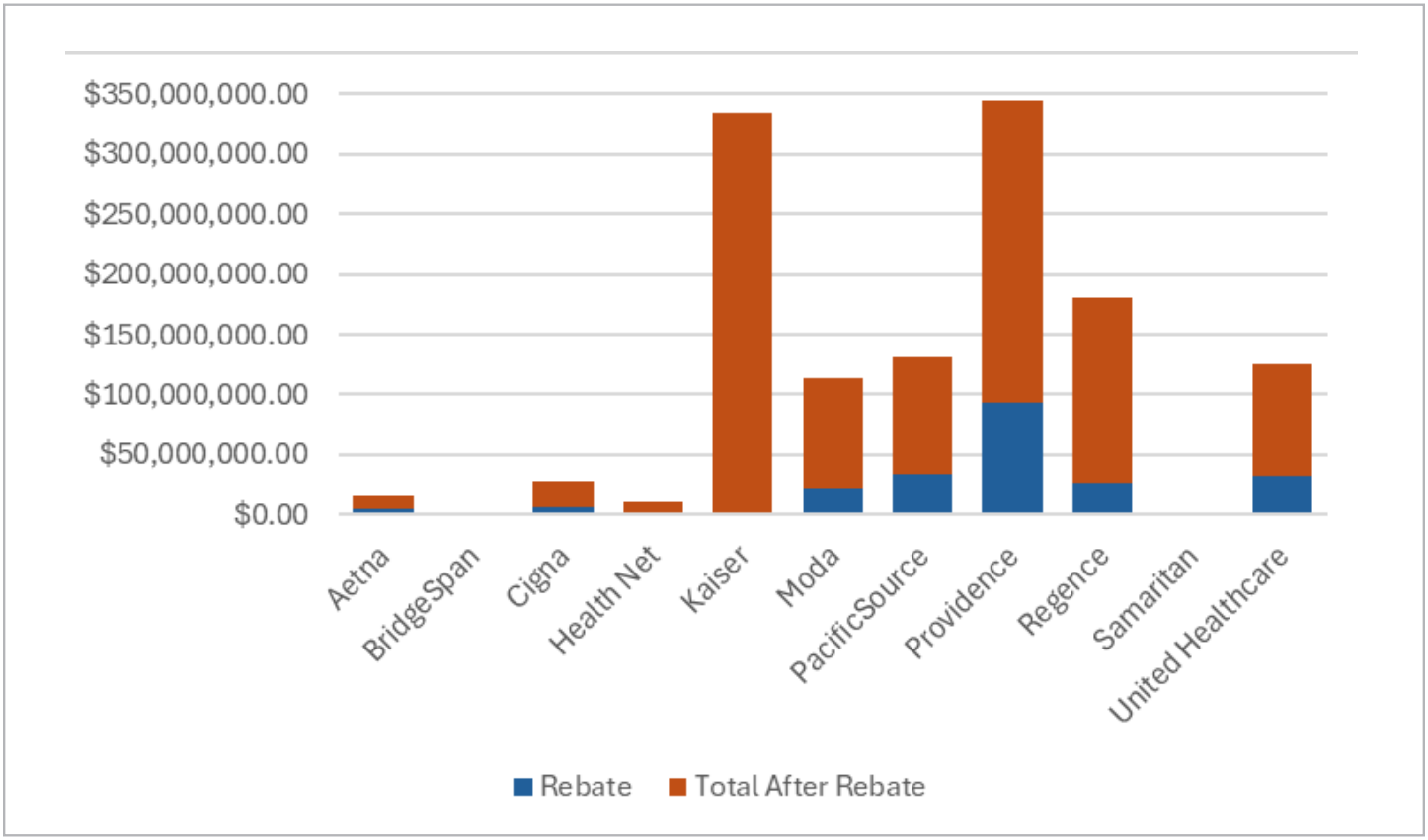
This year, Providence reported the highest percentage of rebates compared to total spent at 27.3 percent. United Healthcare and PacificSource came in at second and third place as both reported 25.8 percent of total spending being covered by rebates. Kaiser again reported the lowest amount of rebates, with 0.3 percent of spending covered by rebates.

Figure 37: Amount of prescription drug spending covered by rebates versus plan cost for all insurers



In Figure 38, the highest amount of rebate was from Providence with $94.1 million. The second-highest amount reported was from PacificSource at $33.9 million, and the third-highest amount reported was $32.5 million from United Healthcare. Figure 39 shows the amounts for the three smallest for better visibility. BridgeSpan had the lowest rebate amount reported at $163,290. Manufacturer rebates and other price concessions were reported by insurance companies, as well as the total dollars paid by insurers after rebates. Amounts from individual, large-group, and small-group spending were added together.

Figure 38: Amount of prescription drug spending covered by rebates versus plan cost for all insurers



Insurer	Rebate	Total spent after rebate
Aetna	$4,224,193	$12,708,798
BridgeSpan	$163,290	$1,486,084
Cigna	$6,312,709	$21,767,592
Health Net	$2,550,431	$7,642,900
Kaiser	$925,310	$333,707,725
Moda	$22,596,221	$91,775,281
PacificSource	$33,882,457	$97,431,016
Providence	$94,060,465	$250,452,728
Regence	$27,330,735	$153,680,224
Samaritan	$484,829	$1,887,431
UnitedHealthcare	$32,499,793	$93,452,857

Figure 39: Amounts of prescription drug spending covered by rebates versus plan cost for the three smallest insurers

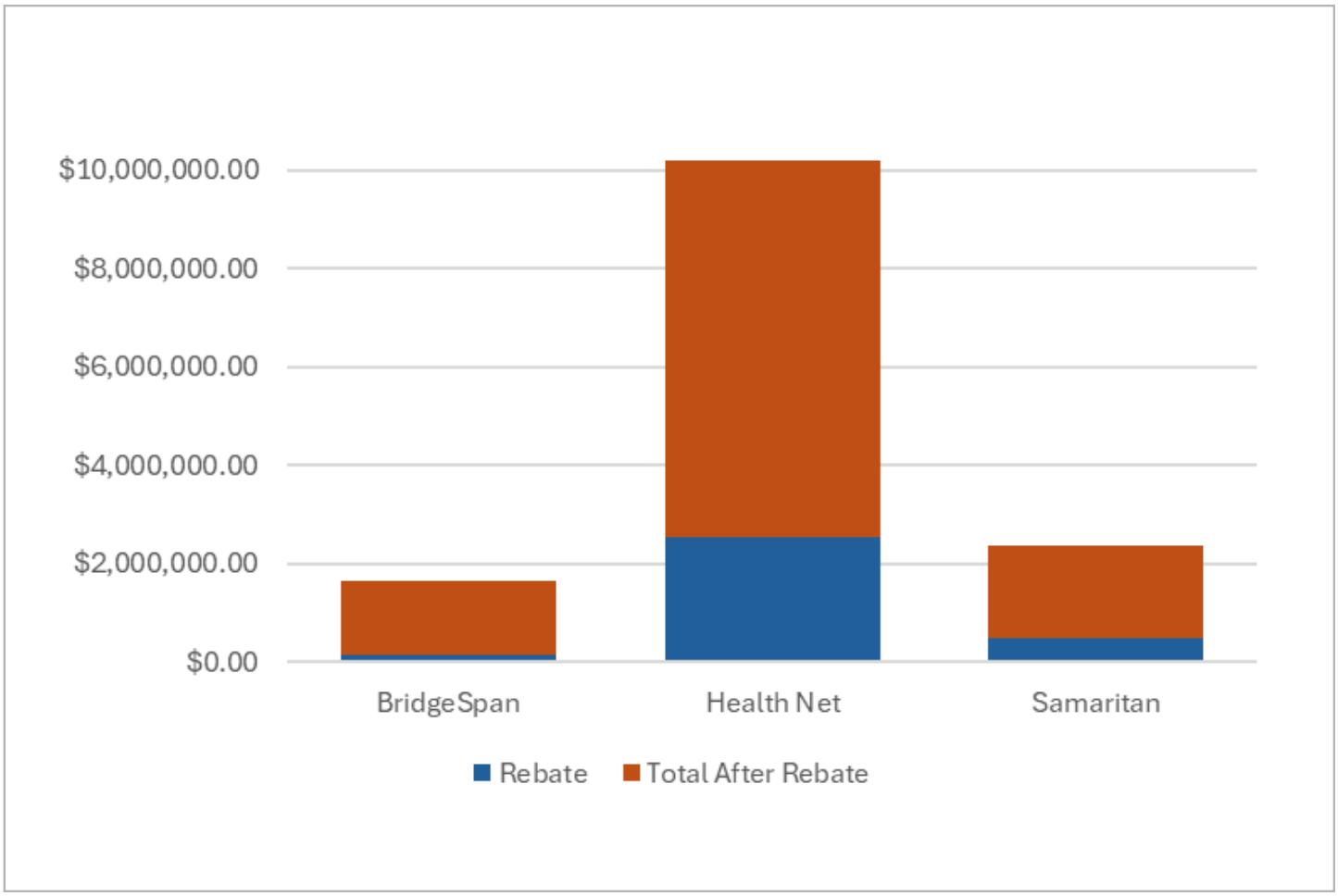


Figure 40: Top 10 most-prescribed drugs

Drug name	Therapeutic class	Prescriptions
Atorvastatin calcium	Antihyperlipidemics	185,385
Levothyroxine sodium	Thyroid agents	168,754
Lisinopril	Antihypertensives	164,576
Amphetamine-dextroamphetamine	ADHD / anti-narcolepsy/ anti-obesity/anorexiants	151,018
Metformin HCl	Antidiabetics	146,749
Bupropion HCl	Antidepressants	145,453
Fluzone	Vaccines	131,030
Sertraline HCl	Antidepressants	125,994
Losartan	Angiotensin receptor blockers	125,620
Albuterol sulfate	Anti-asthmatic/bronchodilator agents	119,330

Most prescribed drugs

We collected data from insurance companies. They were required to report the top 25 most prescribed generic, brand-name, and specialty drugs; the top 25 most-costly generic, brand-name, and specialty drugs; and the top 25 generic, brand-name, and specialty drugs with the greatest year-over-year spending increase. That data was reported across the insurers listed in the insurance company data section. The data was aggregated to create lists of the top 10 most-prescribed drugs, the top 10 most costly drugs, and the 10 drugs with the greatest year-over-year spending increase.

The 10 most frequently prescribed class of drugs reported for 2023 are shown in Figure 40.

Atorvastatin calcium, an antihyperlipidemic, had 185,385 prescriptions, the most this year. This is an 11.3 percent increase from last year. Levothyroxine sodium, a thyroid agent, was the second most prescribed drug with 168,754 prescriptions this year. This is a slight decrease (0.3 percent) decrease from last year. The combined prescriptions for two antidepressants, bupropion HCl and sertraline HCl, totaled 271,447, an increase of 10.3 percent from last year.

The drugs on this year's most-prescribed table that were also on last year's table are: atorvastatin calcium, levothyroxine sodium, lisinopril, amphetamine-dextroamphetamine, metformin HCl, bupropion HCl, Fluzone, sertraline HCl, and albuterol sulfate.

Figure 41: Top 10 most costly drugs

Drug name	Therapeutic class	Total annual plan spending
Humira	Analgesics/anti-inflammatory	$53,267,675
Keytruda	Antineoplastics and adjunctive therapies	$37,816,382
Stelara	Dermatologicals	$31,156,649
Biktarvy	Antivirals	$26,933,839
Skyrizi	Dermatologicals	$25,622,754
Entyvio	Gastrointestinal agent	$21,299,837
Enbrel	Analgesics/anti-inflammatory	$21,147,861
Cosentyx	Dermatologicals	$20,464,979
Ozempic	Antihyperglycemic	$18,232,971
Dupixent	interleukin inhibitors	$17,124,535

Most costly drugs

Insurer reporting of the costliest drugs reflects the drugs with the highest total payments made on behalf of covered members, including payments made by insurance companies and member cost sharing, such as copays and coinsurance. As has been the case for the prior three years, more money was reported spent on anti-inflammatory analgesics than on any other drug class. Most drugs in this therapeutic class are monoclonal antibodies and are used in the treatment of a variety of inflammatory auto-immune conditions, including arthritis, ankylosing spondylitis, Crohn's disease, ulcerative colitis, and plaque psoriasis.

Most of the spending was for Humira, which has been responsible for more plan spending than any other drugs for six years running. In 2023, companies reported $53.27 million, a decrease of $21.97 million from last year. The program does not have sufficient information to analyze the reason for this decrease, which could be a result of changing market conditions, or changes in the underlying population represented by this data set. Biosimilars for this drug became available in early 2024.

Another notable drug responsible for high levels of plan spending was Keytruda, an antineoplastic and adjunctive therapy that reported $37.82 million in plan spending, representing a 33.9 increase compared to last year. Stelara, a dermatological, reported $31.16 million in spending for 2023, a 7.6 percent increase from last year.

Drugs on this year's most costly table that were also on last year's table are Humira, Keytruda, Stelara, Biktarvy, Skyrizi, Entyvio, Enbrel, and Cosentyx.

Figure 42: Top 10 drugs with the greatest increases in plan spending[35]

Drug name	Therapeutic class	Year-over-year increase
Keytruda	Antineoplastics and adjunctive therapies	$13,569,234
Skyrizi	Dermatologicals	$10,452,298
Ozempic	Antidiabetics	$8,708,006
Comirnaty	Vaccine	$5,964,667
Prevnar	Vaccine	$4,735,807
Dupixent	Dermatologicals	$4,510,445
Stelara	Dermatologicals	$4,315,271
Verzenio	Antineoplastic and adjunctive therapies	$3,716,818
Jardiance	Antidiabetic	$2,666,754
Entyvio	Gastrointestinal agents – miscellaneous	$2,327,492

Drugs with the greatest increases in health plan spending

This list shows the 10 drugs with the largest year-over-year increase in plan spending, as well as the amount of that increase.

Keytruda was the drug with the highest gross increase in plan spending, $13.6 million. This increase is 14.6 percent higher than the increase in plan spending for this drug last year ($11.8 million), which was also the highest gross increase among drugs in 2022. Skyrizi was the drug with the second-highest-gross increase in plan spending, $10.5 million – 24.7 percent higher than last year's gross increase. Skyrizi was also reported as having the second-highest-gross increase in 2022.

The drugs on this year's greatest increase in plan spending table that were also on last year's table are Keytruda, Skyrizi, Ozempic, Dupixent, and Stelara.

Keytruda, Stelara, Skyrizi, Entyvio, Ozempic, and Dupixent appeared in both the top 10 most costly and greatest increase tables this year.

[35] Program had to remove 18.8 percent of listings from insurers because they represented new prescriptions. This list is representing prescriptions drugs that showed an increase in spending from the prior year. This has been corrected for next year's reporting to the program.

Policy recommendations

Prescription drug costs continue to be an issue for Oregonians. With the information reported, the program is learning several things about prescription drugs, such as the factors contributing to high costs, the drugs that are the costliest for health insurers, and what drugs are of most concern to Oregonians. The data received over the previous years of the program help identify areas for program improvements, and better understanding of drug pricing.

This report is required by the Prescription Drug Price Transparency Act, which also requires proposed recommendations for legislative changes to contain the cost of prescription drugs and reduce the effects of price increases. Some of this year's recommendations propose improvements to the program that would provide more quality data to better inform policy decisions. Refer to the appendixes for more details on these recommendations.

Recommendation 1: Expand patient assistance program reporting

Issue: Studies suggest that drug manufacturer financial assistance programs increase their own branded drug sales by 60 percent, mostly by reducing sales to generic competitors and increasing insurance costs for enrollees.[36] These programs, which benefit individual consumers, can also increase premium rates for all other consumers because of the insurer's increased coverage of expensive brand-name drugs instead of less costly generics and therapeutic alternatives.

Currently the Legislature only requires patient assistance program reporting from manufacturers that submit annual price increase reports. In 2024, this reporting captured 28 programs from 15 manufacturers, a small fraction of the estimated 200 programs available to Oregonians. Without more comprehensive reporting, not enough information is collected to conduct meaningful analysis to fully understand the benefits and the effect on the health care system. For example, robust analysis is needed to evaluate the effect of House Bill 4113 (2024) related to prescription drug affordability and determine potential revisions to meet its intent.[37]

Recommendation: As in previous reports, the program recommends the Legislature consider requiring all reporting manufacturers to report annually on all patient assistance programs they maintain, support, or fund.

Outcome: Collecting comprehensive patient assistance program information would greatly improve transparency for consumers. For example, most enrollment and financial benefits information is not publicly available. Additionally, collecting more complete data would allow for robust analysis, providing evidence to inform future policy decisions particularly regarding the relationship between patient assistance programs, prescribing patterns, drug costs to individual consumers, and insurance premiums.

Recommendation 2: Require insurers and PBMs to report on "copay accumulator" programs

Issue: In 2024, the Legislature passed House Bill 4113 requiring many health insurers to count outside financial assistance, such as manufacturer coupons or patient assistance programs, for certain prescription drugs toward a consumer's annual out-of-pocket cost sharing

[36] Feldman, Robin C. "Perverse Incentives: Why Everyone Prefers High Drug Prices -- Except for Those Who Pay the Bills." University of California, Hastings College of the Law, 57 Harv. J. on Legis. 3030 (2020). https://repository.uchastings.edu/faculty_scholarship/1770. Accessed Nov. 14, 2024.

[37] House Bill 4113 (2024), https://olis.oregonlegislature.gov/liz/2024R1/Measures/Overview/HB4113

requirements.[38] This legislation prohibits the use of "copay accumulator" programs for prescription drugs without a generic equivalent; in other words, outside financial assistance for these drugs counts toward a consumer's deductible, lowering the consumer's health care spending. All other prescription drugs with a generic equivalent may be subject to copay accumulator programs, which do not count outside financial assistance toward a consumer's out-of-pocket maximums.

Recommendation: As a companion to expanded reporting on patient assistance programs, the program continues to recommend the Legislature require insurers and PBMs to annually report data to the DPT regarding their copay accumulator programs in Oregon.

Outcome: Collecting information about copay accumulator programs would provide the data needed to shed light on this complex system. Collected data elements about copay accumulator programs could include (1) the applicable plans and drugs; (2) the amount of revenue generated; and (3) how revenue is allocated by insurers and PBMs. Analysis of newly reported data would improve our understanding of the effects these programs have on prescription drug costs across the health care system and provide analysis needed for evidence-informed policymaking.

Recommendation 3: Expand and strengthen Oregon's bulk purchasing authority

Issue: As shown by DPT's analysis of prescription drug costs and the featured consumer stories, prescription drugs remain unaffordable for many Oregonians. Recently, nonprofit and state-operated manufacturers have entered the generic pharmaceutical market to lead the charge in making prescription drugs more affordable and accessible for consumers. However, Oregon's state government does not have the statutory authority to develop its own bulk-purchasing program. Additionally, state health care entities are not required to take advantage of the prescription drug savings available under the Oregon Prescription Drug Program (OPDP).

Recommendation: As in previous annual reports, the program continues to recommend the Legislature establish a multistate purchasing authority on behalf of the state. The program also recommends that the Legislature require state entities purchasing prescription drugs to do so through OPDP, unless greater discounts and aggregate savings are available elsewhere. To enhance accountability and transparency, the program also recommends that OPDP be required to report to the Legislature annually regarding its programs, the number of Oregonians served, and savings generated.

Outcome: Granting the authority to adopt a direct bulk-purchasing model and requiring state entities to take advantage of those savings would open opportunities for Oregon to reduce state and consumer pharmaceutical spending. For example, California's state-run manufacturer recently released its over-the-counter naloxone nasal spray that will cost about 40 percent less than the branded version.[39] Since 2020, OPDP has saved Oregon and Washington $728 million in pass-through savings and, with more widespread use, the state's savings would increase substantially. Employing these proven models would allow Oregon to leverage its substantial purchasing power across public entities to reduce both consumer and government spending as well as strengthen access and availability of critical prescription drugs.

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[38] Ibid.

[39] "California to Purchase CalRx Branded Over-the-Counter (OTC) Naloxone for $24." CalRx, April 29, 2024. https://calrx.ca.gov//uploads/2024/04/CalRx-Webpage-Naloxone-Fact-Sheet.pdf. Accessed September 26, 2024.
"Poor Accountability and Transparency Harm Medicaid Patients and Independent Pharmacies." Oregon Secretary of State, Oregon Audits Division, August 2023. https://sos.oregon.gov/audits/Documents/2023-25.pdf. Accessed Nov. 14, 2024.

Recommendation 4: Centralize state Medicaid drug purchasing

Issue: Currently, the state Medicaid program delivery systems (fee-for-service and the 16 coordinated care organizations) separately purchase and manage prescription drug benefits. A 2023 Secretary of State audit of Medicaid's pharmacy benefits found that its current structure was too fragmented and complex for adequate accountability protections.[40] By continuing this policy, the state is missing a significant opportunity to reduce costs and increase program efficiency through consolidating state Medicaid drug purchasing. For example, for the 2023-25 biennium, prescription drugs (net of rebates) are estimated to make up nearly $2 billion[41] of the state's $26.3 billion Medicaid budget[42], demonstrating a potential focal point for managing state expenses.

Recommendation: The program recommends that the Legislature centralize state Medicaid drug purchasing to create administrative efficiencies, adequate oversight, cost savings, and equitable consumer experiences.

Outcome: Centralizing and leveraging state Medicaid prescription drug purchasing power would streamline administrative efforts as well as lower state spending without reducing benefits for consumers. This model would also realize other efficiencies including state supplemental rebates for a uniform preferred drug list and consistent pharmacy experiences for all Medicaid patients and providers.

Recommendation 5: Centralize pharmacy purchasing and analytics

Issue: Oregon spends well more than $1 billion annually[43] on medications across various state agencies and programs, including Medicaid, public employee benefits, the state hospital, and adult and youth corrections. However, there is no centralized resource for data and policy analysis, administrative services, and market monitoring. This fragmentation benefits the pharmaceutical industry by maintaining complex purchasing models and weakening Oregon's market position.

Recommendation: The program recommends the Legislature centralize pharmacy purchasing to provide coordination and oversight for all state prescription drug purchasing to ensure Oregon is leveraging the entirety of the state's position in the marketplace.

Outcome: Centralizing state pharmacy resources would provide guidance for informed, conflict-free decisions and facilitate the integration of pharmacy benefits across state programs. The creation of a centralized resource would streamline services, consolidate expertise and eliminate duplicate resources, and expedite analyses ultimately strengthening the state's purchasing power and producing state-wide savings.

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[40] "Poor Accountability and Transparency Harm Medicaid Patients and Independent Pharmacies." Oregon Secretary of State, Oregon Audits Division, August 2023. https://sos.oregon.gov/audits/Documents/2023-25.pdf. Accessed Nov. 14, 2024.

[41] Medicaid prescription drug costs, net of rebates, totaled $937.7 million for 2023. "Pharmacy Utilization Summary Report: January 2023 – December 2023: Total Amount Paid." Drug Use Research & Management Program, DHS Health Systems Division, Oregon State University College of Pharmacy, Page 3, July 18, 2024. CAREAssist program data provided from Oregon Health Authority. https://www.orpdl.org/durm/reports/utilization/2024/DUR_Utilization_2024_Q2.pdf. Accessed Oct. 17, 2024.

[42] Beitel, Amanda. "2023-25 Legislatively Adopted Budget Detailed Analysis." State of Oregon Legislative Fiscal Office, Feb. 16, 2024. https://www.oregonlegislature.gov/lfo/Documents/2023-25 LAB Detailed.pdf. Accessed Nov. 14, 2024.

[43] Medicaid pays nearly $1 billion alone in annual prescription drug costs. "Pharmacy Utilization Summary Report: January 2023 – December 2023: Total Amount Paid." Drug Use Research & Management Program, DHS Health Systems Division, Oregon State University College of Pharmacy, Page 3, July 18, 2024. CAREAssist program data provided from Oregon Health Authority. https://www.orpdl.org/durm/reports/utilization/2024/DUR_Utilization_2024_Q2.pdf. Accessed Oct. 17, 2024.

Drug policies in other states

The following section does not represent official recommendations from the department, but is rather an overview of what policies other states have pursued to reduce the cost of prescription drugs on consumers, businesses, and the state. These items provide additional considerations for the Legislature in continuing to build and shape the program.

State legislatures across the country have continued to work on policies aiming to control the cost of prescription drugs in their state. The topics addressed by state legislation over the past few years include:[44]

- **Drug affordability boards**: There are nine states (including Oregon) that review the affordability of specific drugs: Colorado, Maryland, Minnesota, Washington, Maine, New Hampshire, Ohio, and New Jersey.
- **Upper payment limits**: There are four states with authority to set upper payment limits on prescription drugs: Colorado, Maryland, Minnesota, and Washington.
- **Drug importation and bulk purchasing**: The eight states examining or establishing a drug importation program from Canada are Colorado, Florida, Maine, New Hampshire, New Mexico, Texas, Vermont, and Virginia. The U.S. Department of Health and Human Services has regulations for implementation of these programs. Some states are looking into or are in the process of setting up bulk purchasing for their state or in combination with other states, including Delaware, Nevada, and New Mexico.
- **Price transparency**: There are 24 states that require reporting on drug price information from specified pharmaceutical supply chain entities, such as pharmaceutical manufacturers, wholesale distributors, and PBMs.
- **Coupons and cost sharing**: There are 28 states regulating or prohibiting the use of discounts or coupons or limiting cost sharing on insulin drugs.
- **Pharmacy benefit managers**: All 50 states are regulating or providing additional transparency on the actions of PBMs, such as preventing discrimination against certain protected entities, or preventing PBMs from being able to hold a pharmacy or pharmacist responsible for any fees related to certain processes.

[44] Torrey, Zoe. "State Laws Passed to Lower Prescription Drug Costs: 2017-2024." National Academy for State Health Policy, Sept. 3, 2024. https://www.nashp.org/rx-laws/. Accessed Oct. 25, 2024.

Conclusion

Oregon's Prescription Drug Price Transparency Program has been collecting and analyzing information received from drug manufacturers, health insurers, and consumers for five years. The program is working to deepen the state's understanding of the factors that influence prescription prices and how drug prices affect Oregonians.

Based on the information collected, here are highlights of the data in this report:

- **Insurer rebates**: Most health insurers reported receiving rebates ranging from 9.9 percent and 27.3 percent of their total pharmaceutical spending. Providence reported the highest rebates received as a percentage of prescription spending at 27.3 percent. Kaiser reported the lowest rebates received at 0.3 percent.
  - The program does not have sufficient data to suggest whether there are any correlations between rebates and spending within the prescription drug data.
- **Drug with highest insurer spending**: Humira, manufactured by AbbVie Inc. to treat inflammatory conditions, continues to be the most costly drug contributing to increased plan spending – more than any other drug for six years running. In 2024, health insurance companies in Oregon reported more than $53.2 million in spending on Humira.
- **Most common new drug reporting**: Antineoplastics and adjunctive therapies, which are used to treat cancer, was again the most common category of new prescription drugs reported to the program by manufacturers.
- **Highest prices of new drugs reported**: The highest wholesale acquisition cost (WAC) reported for new prescription drugs were for the following hematological and hematopoietic agents (all three are brand-name prescription drugs):
  - $3.5 million for Beqvez™, a treatment for hemophilia B, manufactured by Pfizer
  - $3.1 million for Lyfgenia™, a treatment for sickle cell disease, manufactured by bluebird bio Inc.

- $2.2 million for Casgevy™, a treatment for sickle cell disease, manufactured by Vertex Pharmaceuticals Inc.

- **Manufacturer reporting quality and trade secret claims**: The quality of information submitted by manufacturers was extremely variable, ranging from initial refusals to provide information to generalized descriptions to detailed information of a company's reasons for determining the price of a drug. This variability continues to be an issue when attempting to determine the reasons why a drug is priced high when it comes to market.
  - For context, the program has received more than 2,500 reports that claimed one or more data elements as a trade secret since 2019. Within these 2,500 reports more than 11,500 data elements have been claimed as trade secrets. Of that total, 598 reports with 1,262 data elements claimed as trade secrets have been received since last year's report.
- **Manufacturer reporting compliance**: The program's compliance efforts have progressed to issuing noncompliance warning notices to manufacturers to address manufacturer behavior and the volume, variances, and complexities mentioned above. If the manufacturers do not come into compliance following our initial noncompliance notices, we will prepare a file to send to the division's enforcement unit. The department issued its first civil penalties totaling $75,000 in 2024.
- **PBM rebates and manufacturer payments**: The program received PBM reports in 2024 for the first time. These reports provided information about manufacturer payments collected, and whether that payment went back to the insurers, passed to enrollees of the pharmacy program, or was kept as revenue by the PBM. Across 17 PBMs not exempt to our reporting requirements, about $287.5 million was collected in manufacturer payments. Of this amount $283.6 million (98.7 percent of payments received) was passed to the insurers. $2.2 million (0.78 percent of payments received) was passed to enrollees, and $1.6 million (0.56 percent of payments received) was kept as revenue by the PBMs.

Information collected from this year and previous years continues to be valuable to further our understanding and contribute to ongoing efforts that address the effects of costly prescription drugs on Oregonians.

Resources

For more information about the Drug Price Transparency Program, visit https://dfr.oregon.gov/drugtransparency.

For information about the Prescription Drug Affordability Board, visit: https://dfr.oregon.gov/pdab/.

Health insurance issues and access

If you have issues with your insurance company about prescription drug coverage, contact the Division of Financial Regulation Consumer Advocacy Team at 888-877-4894 (toll-free) or email DFR.InsuranceHelp@dcbs.oregon.gov.

Oregonians can enroll for free into the ArrayRx Discount Card Program https://www.oregon.gov/oha/HPA/dsi-opdp/Pages/index.aspx and save on prescription drug costs when they are uninsured, underinsured, or their medication is not covered by their insurance. For more information, call 800-913-4146 (toll-free).

If you are uninsured, contact the Oregon Health Insurance Marketplace or the Oregon Health Authority for more information on the health insurance plans that may be available to you.

For information on a specific drug

- U.S. Food and Drug Administration – https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm
- U.S. National Library of Medicine – https://pubchem.ncbi.nlm.nih.gov/

For general information on prescription drugs

- U.S. Food and Drug Administration – https://www.fda.gov/drugs/drug-information-consumers/find-information-about-drug

Appendix A – Recommendation 1: Expand patient assistance program reporting (additional details)

Background

Patient assistance programs include manufacturer coupons and other payments, typically for expensive brand-name drugs, that reduce a patient's out-of-pocket cost to fill a prescription. While making select drugs more affordable for individual consumers, these programs can also increase costs for insurers because of the increased coverage of expensive brand-name drugs instead of less costly generics and therapeutic alternatives. Studies suggest that drug manufacturer patient assistance programs increase their own branded drug sales by 60 percent, mostly by reducing sales to generic competitors.[45] Increased costs to insurers often lead to increased premium rates for all other consumers.

Currently, the Oregon Legislature only requires patient assistant program reporting from manufacturers that submit annual price increase reports. In 2024, this reporting captured 28 programs from 15 manufacturers, a small fraction of the estimated 200 programs available to Oregonians. Collecting a larger amount of information would make it easier for DPT to report key findings and avoid trade secret concerns. With the complex dynamics surrounding patient assistance programs, more transparency is needed to fully understand and effectively evaluate their effect on individual and systemwide health care costs and prescription drug affordability.

Stakeholder perspectives

Drug manufacturers argue that patient assistance helps patients whose insurance does not fully cover the cost of a needed medication. Insurance companies argue that patient assistance undermines their efforts to control health care costs by incentivizing patients to use expensive brand-name drugs even when a therapeutic alternative is available. Patient advocates have also argued for a ban on "copay accumulators" (insurance plan designs that do not credit third-party payments, such as patient assistance, against an individual's deductible or out-of-pocket maximum). In 2024, Oregon House Bill 4113 banned copay accumulators in certain instances.[46]

Policy considerations

Patient assistance programs modify consumer behavior in ways that encourage the use of higher cost therapies that may not offer a meaningful improvement in health outcomes. This has the potential to increase costs without improving outcomes, and could contribute to higher premiums. However, isolating the effect of these programs on premiums would require additional data and advanced statistical modeling to estimate consumer behavior and remove the effects of other pricing-related factors. Requiring all drug manufacturers to annually report information about their patient assistance programs would provide policymakers and consumers with the data needed to make informed decisions. For example, policymakers could address the following types of questions:

- Which manufacturers offer patient assistance programs and which drugs and variations are included?
    - How many of these drugs have more affordable therapeutic alternatives?
    - How much is being spent by consumers and insurers on these drugs versus alternatives?

[45] Feldman, Robin C. "Perverse Incentives: Why Everyone Prefers High Drug Prices -- Except for Those Who Pay the Bills." University of California, Hastings College of the Law, 57 Harv. J. on Legis. 3030 (2020). https://repository.uchastings.edu/faculty_scholarship/1770. Accessed Nov. 14, 2024.

[46] House Bill 4113 (2024), https://olis.oregonlegislature.gov/liz/2024R1/Measures/Overview/HB4113

- How many Oregonians participate in patient assistance programs?
    - What are the patient eligibility requirements for these programs?
- What types of drugs are left out of patient assistance programs? What patient profiles are associated with these medical conditions?
    - What disparities may be present between the demographics of the medical conditions and the actual patients included in the program?
- How much financial assistance is provided to all Oregon patients?
    - How much do those patients pay versus patients not participating in the assistance program for the same drug?
- What is the estimated financial effect of patient assistance programs on health care costs at an individual and system level?
- Has health care affordability legislation, such as House Bill 4113, been effective in reducing costs for consumers?
- Do patient assistance programs offered to Oregonians affect overall premium rates?

Appendix B – Recommendation 2: Require insurers and PBMs to report on "copay accumulator" programs (additional details)

Background

Much of the recent discourse around manufacturer funded patient assistance has been driven by the increased use of "copay accumulator" programs nationally and in Oregon. This term refers to a practice in which an insurer will not count third-party payments, such as manufacturer coupons, against a consumer's annual cost-sharing limits. In other words, a patient who uses a manufacturer's patient assistance program to access a high-cost medication would still need to meet their deductible using personal funds after they would have otherwise met their deductible using patient assistance.

In 2024, the Oregon Legislature passed House Bill 4113, which prohibits the use of such copay accumulator programs for prescription drugs without a generic equivalent, including drugs that have a therapeutic alternative, drugs with a different chemical structure but similar treatment effects, which are typically less costly than the branded version.[47] All other prescription drugs with a generic equivalent may be subject to "copay accumulator" programs.

Stakeholder perspectives

Insurers argue that copay accumulators are an effective strategy to lower overall prescription drug spending and reduce premiums for their members, in part because manufacturer assistance may drive patients to continue using high-cost medications even when equally effective generic or therapeutic alternatives are available. From the insurer perspective, copay accumulators are a way to counteract this incentive, lower overall costs, and reduce premiums for the wider population of consumers. Patient advocates argue that accumulators impose steep financial burdens on patients – especially for patients who must meet their deductible before coverage begins – and may result in some going without needed medications.

Policy considerations

As a corollary to expanded reporting on patient assistance programs, the program recommends the Legislature explicitly require insurers and PBMs report data regarding their "copay accumulator" programs in Oregon. Increasing transparency of copay accumulators would give policymakers and consumers key insights into the following types of questions:

- Which insurance plans have the most affordable prescription drug plans for consumers with certain medical conditions?
- Which drugs with more affordable alternatives are currently subject to copay accumulators in Oregon?
- How do copay accumulators affect formulary development, including the drugs PBMs select and their tier level?
- How has House Bill 4113 changed consumer out-of-pocket health care expenses?
- How does revenue captured by copay accumulators affect premium rates?

[47] Ibid.

Appendix C – Recommendation 3: Expand Oregon's bulk purchasing authority (additional details)

Background

Frustrated by the lack of an adequate supply of fairly priced generic drugs, a number of novel types of drug manufacturers have recently entered the market. These include Civica Rx, a nonprofit generic manufacturer established by a coalition of philanthropies and health systems, and Cost Plus Drug Co., a public-benefit corporation online pharmacy that also plans to begin manufacturing drugs. In 2020, California became the first state to authorize the creation of a state-operated generic drug manufacturer, CalRx. While most of these entities are commonly described as drug manufacturers, their activity is more in line with bulk purchasing and relabeling of drugs.

The Oregon Prescription Drug Program (OPDP) is a statutorily defined program operated by the Oregon Health Authority (OHA) that participates in a regional drug purchasing consortium. However, OPDP does not have authority to establish its own multistate purchasing entity. If the Oregon Legislature granted this authority, OPDP could further expand its ability to leverage purchasing power for prescription drugs and decrease costs and ensure accessibility for consumers as well as government and commercial insurance entities.

Stakeholder perspectives

State-funded health care programs stand to realize substantial financial savings, particularly as the costs and demands for expensive prescription drugs increase. For example, in 2024 more than 1.7 million Oregonians received health coverage through Medicaid or state employee benefit programs. Oregon's Medicaid program spent about $937.7 million, net of any rebates, on prescription drugs alone in 2023[48], leaving a large opportunity for savings. These savings would benefit government budgets and consumers in terms of out-of-pocket spending and potentially lower premiums. Once the program becomes established, there is also the option of expanding products to commercial insurance as well, similar to California's plan.

Generic drug manufacturing companies are key industry stakeholders because any new generic drug manufacturer entering the market would be direct competition. There also could be future opportunities for contracting with the new state entity to produce drugs on the state's behalf. In California, the generic drug industry did not oppose the legislation that created CalRx. Instead, the manufacturers remained neutral on the legislation and a trade association representing generic manufacturers said the industry welcomed competition.[49]

Policy considerations

Granting the authority to adopt a direct bulk-purchasing model would open opportunities for Oregon to reduce state and consumer pharmaceutical spending while ensuring access to critical prescription drugs. As policymakers consider this recommendation, below are some important questions to analyze while developing potential legislation:

[48] "Pharmacy Utilization Summary Report: January 2023 – December 2023: Total Amount Paid." Drug Use Research & Management Program, DHS Health Systems Division, Oregon State University College of Pharmacy, July 18, 2024. CAREAssist program data provided from Oregon Health Authority. https://www.orpdl.org/durm/reports/utilization/2024/DUR_Utilization_2024_Q2.pdf. Accessed Oct. 17, 2024.

[49] Dembosky, April. "California Governor Signs A Bill To Allow State To Develop Generic Drugs." NPR All Things Considered (KQED), Sept. 29. 2020. https://www.npr.org/2020/09/29/918317455/california-governor-signs-a-bill-to-allow-state-to-develop-generic-drugs. Accessed Nov. 14, 2024.

- How could Oregon leverage its existing infrastructure and partnerships with other states to efficiently accomplish the goals of increased drug access and affordability?
- Where and how should a bulk purchasing entity be structured within state government?
- How would drugs be prioritized and selected for bulk purchasing?
    - Which drugs would generate the most savings and for whom?
    - Which drugs face supply issues?
    - Which consumers and medical conditions face the most severe consequences of drug costs and shortages?

Appendix D – Recommendation 4: Centralize state Medicaid drug purchasing (additional details)

Background

The state Medicaid program delivery systems, fee-for-service and the 16 coordinated care organizations (CCO), separately purchase and manage prescription drug benefits. This means that, for example, if a consumer switches from one CCO to another, access to their prescription drugs may change. It also means that each CCO must have the infrastructure to negotiate and manage individual prescription drug plans, which are complex and costly. Additionally, having 16 different drug plans makes it challenging to provide proper oversight.

A 2023 Secretary of State audit of Medicaid's pharmacy benefits found that its current structure was too fragmented and complex for adequate accountability protections.[50] The audit recommendations included items that could be accomplished by centralizing pharmacy benefits such as implementation of a fee-for-service approach, a universal preferred drug list, and a uniform and fair pharmacy reimbursement policy for CCOs. As of July 2023, eight other states[51] (California, Missouri, New York, North Dakota, Ohio, Tennessee, Wisconsin, and West Virginia) had consolidated Medicaid pharmacy benefits, experiences that could prove useful if Oregon follows this path.

Stakeholder perspectives

People with Medicaid coverage would be significantly affected by this shift. Consumers would likely have access to a larger pharmacy network, which would improve access to prescription drugs particularly in rural areas of the state. Additionally, the standardization of benefits would provide consumers with consistency in prescription drug coverage and costs regardless of which CCO they select; moving or switching CCOs would no longer result in a change in prescription drug benefits.

The 16 CCOs are the primary industry stakeholder and would have decreased funding under this recommendation. The CCOs would also have decreased obligations but would likely see lower overall revenue from this change in business structure. Additionally, eligible safety net providers that currently get revenue from selling drugs purchased at 340B discounted prices would have a reduction in funding as the entire CCO drug purchasing structure would change. Depending on the structure for centralization, the CCO provider tax could also be reduced. Policymakers should carefully consider these issues and potentially work to mitigate these funding changes.

Drug manufacturers are unlikely to be substantially affected. Pharmacy benefit managers may be affected depending on the current CCO contracts and the state's future contracting decisions.

Policy considerations

Implementing this recommendation would require considerable stakeholder engagement and administrative effort. As policymakers study this

[50] "Poor Accountability and Transparency Harm Medicaid Patients and Independent Pharmacies." Oregon Secretary of State, Oregon Audits Division, August 2023. https://sos.oregon.gov/audits/Documents/2023-25.pdf. Accessed Nov. 14, 2024.

[51] Hinton, Elizabeth, et al. "Amid Unwinding of Pandemic-Era Policies, Medicaid Programs Continue to Focus on Delivery Systems, Benefits, and Reimbursement Rates: Results from an Annual Medicaid Budget Survey for State Fiscal Years 2023 and 2024." KFF, Nov. 14, 2023. https://www.kff.org/report-section/50-state-medicaid-budget-survey-fy-2023-2024-pharmacy/. Accessed Nov. 14, 2024.

recommendation, there are a number of important considerations to keep in mind:

- What mechanisms for centralizing drug purchasing would mitigate concerns about changes in revenue?
- How can policymakers balance CCO autonomy and consumer choice with cost savings and accountability improvements from centralizing drug purchasing?
- How do the potential consumer benefits (e.g., consistency of experience, equity, and cost savings) compare with the potential costs?
- What are the administrative challenges and advantages of consolidating Medicaid prescription drug purchasing?
  - What existing resources can Oregon leverage for this transition?
  - What partnerships can Oregon develop or enhance to support this transition?
- How does centralized Medicaid drug purchasing and benefit management align with the future of coordinated care in Oregon, including the CCO 3.0 procurement, the next 1115 waiver in 2027, and OHA's 2030 Health Equity goal?
  - How could implementation of this recommendation aid other state policy goals, such as increasing pharmacy access?

Appendix E – Recommendation 5: Centralize pharmacy purchasing and analytics (additional details)

Background

The U.S. pharmacy supply chain is a complex and continually changing industry, involving various stakeholders such as pharmaceutical manufacturers, pharmacy benefit managers, and drug wholesalers. Over the last five years, Oregon has established the Drug Price Transparency Program, pharmacy benefit manager licensing, and the Prescription Drug Affordability Board to collect data for informed decision-making and regulatory oversight.

However, given the number of agencies and programs operating pharmacy programs, such as the Oregon Department of Corrections, Oregon State Hospital, and Medicaid, pharmacy policies and purchasing practices remain fragmented. This fragmentation benefits the pharmaceutical industry by maintaining complex purchasing models and weakening Oregon's market position. With Oregon spending more than $1 billion annually on medications across various agencies, building a centralized resource for data analysis, recommendations, and market monitoring would bring much needed administrative and financial efficiency across the state's prescription drug programs.

Stakeholder perspectives

Establishment of a centralized pharmacy resource would be a significant structural change within state government, which may pose concerns to existing pharmacy programs. Concerns may include loss of autonomy, unnecessary oversight, lack of understanding of program-specific needs, and reduced funding. Agencies and their existing pharmacy programs would need to be consulted throughout the development and implementation phases to capitalize on their expertise and address their specific concerns. Thoughtful, sincere involvement throughout the process would likely ease existing programs' apprehension and build trust that a centralized resource would be beneficial.

The pharmaceutical industry, particularly drug manufacturers and pharmacy benefit managers, stands to lose funding as Oregon pharmacy purchasing improves coordination and efficiency across the state. In anticipation of this, the industry may try to change its policies or structures to maximize its revenue, however, the centralized pharmacy resource will be well-positioned to mitigate this potential industry reaction.

Policy considerations

- What statutory authority should a centralized pharmacy resource be granted? For example:
  - Providing and implementing recommendations for statewide pharmacy policies and purchasing?
  - Oversight of state-contracted pharmacy benefit managers?
  - Collecting and analyzing statewide pharmacy data from all payers and purchasers?
  - Maintaining collaboration between the various state pharmacy programs?
  - What positions would be needed to appropriately staff these roles and responsibilities?
  - What level of funding is needed to support different levels of authority?
- Where should a centralized resource be located within state government?
  - What are the advantages and disadvantages of locating it within an agency as compared to a central service location?
  - What existing state pharmacy resources can be leveraged or consolidated?
  - What is the appropriate reporting structure for this new resource?

Appendix F – Average annual price increase formula

A net increase percentage compares the average price of a drug from one year to the average price the next year.

Suppose the list price of a brand-name prescription drug was $500 for the first 100 days of 2020, and then it rose in price to $600 on the 101st day and remained at that price for the remaining 266 days of the year. The drug's average list price in 2020 is the average of these list prices, $500 and $600, considering how much time the drug spent at each price. So, this drug's average list price in 2020 is

$$\frac{100 \times \$500 + 266 \times \$600}{366} = \$572.68$$

Suppose the drug had another price increase on Jan. 25, 2021, from $600 to $640, and then remained at that list price for the remaining 341 days of the year. The drug's average list price in 2020 is

$$\frac{24 \times \$600 + 341 \times \$640}{365} = \$637.37$$

Note: 2020 was a leap year with 366 days. We counted every one of those days and we divided by all 366 here instead of 365. Since 2021 was not a leap year, we divided by 365 when computing the drug's average list price in 2021.

To find the 2021 net increase percentage, we compare the average price in 2020 to the average price in 2021. The drug's average list price in 2021, $637.37, is 11.3 percent higher than its average list price in 2020 – $572.60:

$$\frac{\$637.37 - \$572.68}{\$572.68} \times 100 \quad 11.3\%$$

So, the 2021 net increase percentage for this drug is 11.3 percent, and the reporting manufacturer is required to file an annual price increase report for this prescription drug. In general, the formula for computing a 2021 net increase percentage is

$$\frac{\$(\text{average 2021 list price}) - \$(\text{average 2020 list price}}{\$(\text{average 2020 price list}}$$

Appendix G – Types of plans for insurer reports received in 2024

The program received reports from these companies that included the types of plans listed for each:

- Aetna Life Insurance Co.
  - Large group
- BridgeSpan Health Co.
  - Individual
- Cigna Health and Life Insurance Co.
  - Large group
- Health Net Health Plan of Oregon Inc.
  - Large group
  - Small group
- Kaiser Foundation Health Plan of the Northwest
  - Individual
  - Large group
  - Small group
- Moda Health Plan Inc.
  - Individual
  - Large group
  - Small group
- PacificSource Health Plans
  - Individual
  - Large group
  - Small group
- Providence Health Plan
  - Individual
  - Large group
  - Small group
- Regence BlueCross BlueShield of Oregon
  - Individual
  - Small group
- Samaritan Health Plans Inc.
  - Large group
  - Small group
- United Healthcare Insurance Co. / United Healthcare of Oregon Inc.
  - Large group
  - Small group