Prescription Drug Price Transparency Program results and recommendations – 2025

(As required by ORS 646A.689)

DCBS | Department of Consumer and Business Services

Nov. 25, 2025

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 United States, not including any price reductions, sometimes referred to as the "list price." This term is defined in federal law in 42 U.S.C. 1395w-3a(c)(6)(B).

Refer to additional pharmaceutical terms in the glossary on our website.

Additional report information:
This report is based on all data for 2024, and consumer survey responses received before the finalization of the report. This is a change from prior reports that had information from various time periods. Now manufacturer, insurer, and PBM information all reference the same calendar year.

Throughout our report we also reference drug prices and therapeutic class information extracted from the Medi-Span drug database. Descriptions of therapeutic classes used in this report can be found in Appendix H.

Acknowledgments

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

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Introduction

This seventh 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 information
- Special topic: Review of Humira and Stelara and biosimilar products
- Prescription drug manufacturer data, including compliance and enforcement efforts and 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

Throughout our country, people are having trouble affording necessary medications. Prescription drugs help many Oregonians live longer and have an improved quality of life.

The ever-increasing prices of drugs lead to Oregonians not being able to afford needed medications. This causes harm to patients and their families and further burdens our health care system. Some can only afford prescriptions by doing without other needs, while others cannot afford them at all. This 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.

Oregon's Prescription Drug Price Transparency Act, passed in 2018 (House Bill 4005), created the Drug Price Transparency Program.[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 Drug Price Transparency Program was affected by a federal court ruling in 2024 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 (PhRMA) v. Stolfi*, issued a declaratory judgment that section 2(3) of the act violates the First Amendment to the U.S. Constitution. The court's order suspended the requirement under ORS 646A.689(3) for drug manufacturers to report annual price increases. DCBS appealed the case to the U.S. Court of Appeals for the Ninth Circuit. In August 2025, a three-judge panel of the appellate court ruled in favor of the program and reversed the district court's ruling. The court held that the Act does not violate the First or Fifth Amendments to the U.S. Constitution. In October 2025, the Ninth Circuit court denied PhRMA's request for a rehearing.

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

Following the court order in February 2024, receiving such limited data for the last two years of reporting meant the program was 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 collect information to inform the annual public hearing and legislative report. This report summarizes the findings from 2024 data collected from insurers, PBMs, and pharmaceutical manufacturers, as well as 2024 and 2025 data collected from consumers.

1 House Bill 4005 (2018). https://olis.oregonlegislature.gov/liz/2018R1/Measures/Overview/HB4005. Accessed Oct. 21, 2025.

In 2025, the program will hold its seventh 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 since 2019, 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 reported for 2024 and analyzed in this report:

- **Insurer rebates**: With only one exception, health insurers reported receiving rebates ranging from 15.4 percent to 30.1 percent of their total pharmaceutical spending. United Healthcare reported the highest rebates received as a percentage of prescription spending (30.1 percent) with Aetna (26.5 percent) and Providence (25.2 percent). Kaiser again reported the lowest percentage of rebates received compared to other insurers, at 0.5 percent of total pharmaceutical spending. Note: The program does not have sufficient data to suggest whether there are any correlations between rebates and spending within the prescription drug data.
- **Drugs with highest insurer spending**: In 2025, health insurance companies in Oregon reported the drugs with the highest total spending (most costly) during 2024 for each market segment. We aggregated the data and found that the highest overall spending, more than $37 million, was on Skyrizi (risankizumab), manufactured by AbbVie and used to treat autoimmune and other disorders, such as psoriasis and Crohn's disease. The second highest spending, more than $36 million, was on Keytruda (pembrolizumab) made by Merck Sharp & Dohme, which is a type of immunotherapy used to treat several types of cancer. The third highest spending – more than $35 million – was on Stelara (ustekinumab) made by Janssen Biotech and used to treat autoimmune and other disorders.
  - For the first time in seven years of reporting, Humira, manufactured by AbbVie Inc., was not the drug with the highest total annual spending by insurers. Humira (adalimumab) is a medication used to treat inflammatory conditions such as rheumatoid arthritis, psoriasis, and Crohn's disease. This year, Humira dropped to seventh on the list with total spending of $23 million in 2024, down from more than $53 million in 2023, a 55.9 percent decrease.
- **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 three highest wholesale acquisition costs (WAC) reported for new prescription drugs were for:
  - $3.5 million for Beqvez™, a treatment for hemophilia B, manufactured by Pfizer (this product was discontinued by Pfizer[2])
  - $3.1 million for Lyfgenia™, a treatment for sickle cell disease, manufactured by bluebird bio Inc.
  - $2.3 million for Zolgensma™, a treatment for spinal muscular atrophy, manufactured by Novartis Gene Therapies 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

2 Santhosh, Christy. "Pfizer stops commercialization of hemophilia gene therapy Beqvez." Reuters, Feb. 21, 2025. https://www.reuters.com/business/healthcare-pharmaceuticals/pfizer-says-it-will-end-global-development-gene-therapy-beqvez-nikkei-reports-2025-02-20/. Accessed Oct. 21, 2025.

detailed information about 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 3,500 reports that claimed one or more data elements as a trade secret since 2019. Within these 3,500 reports, more than 10,000 data elements have been claimed as trade secrets. During 2024, the program received 1,120 reports and 535 (47.8 percent) of those made a trade secret claim on at least one data element (1,086 data elements in total). Program staff reviewed 300 new prescription drug reports with 608 data elements claimed as trade secret. Of those 300 reports, 39.3 percent were processed as claimed, and the remaining 60.7 percent were determined to have information not conditionally exempt from disclosure, and some or all of the claimed data was published.

- **PBM payments and revenues**: PBMs reported information about payments collected and kept as revenue by the PBM. All but 15 licensed PBMs were exempt from reporting. For 2024, the 15 PBMs that were required to report data, collected more than $377 million in manufacturer payments. Of this amount, more than $369 million (97.8 percent of payments received) was passed to the insurers, and $7.7 million (2.0 percent of payments received) was kept as revenue by the PBMs, with the remaining $432,204 (0.1 percent) going to health plan enrollees. PBMs received and retained almost $34 million in administrative fees.

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 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 recommends 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.

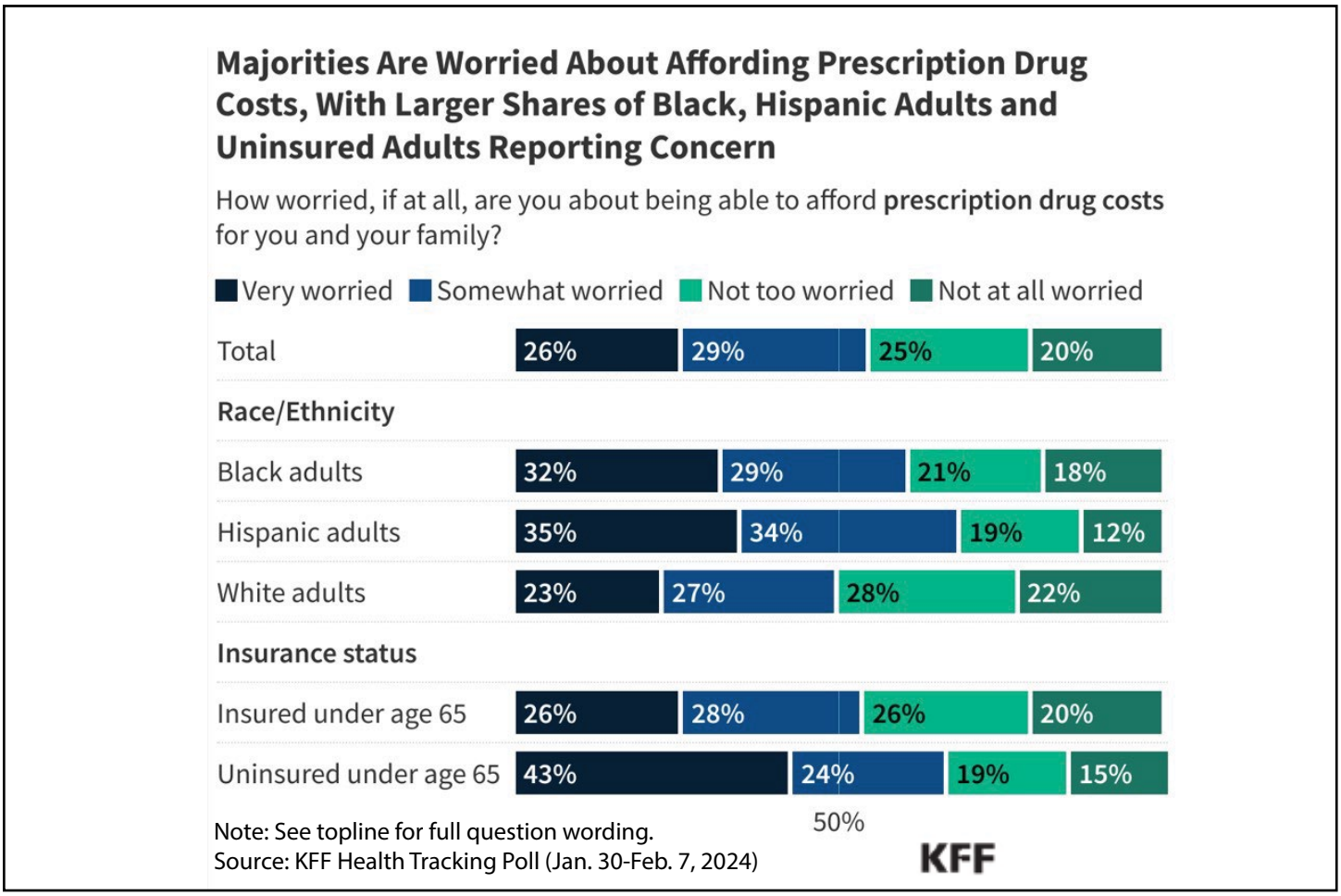
Section 1: Oregon drug prices and transparency

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 2024 Kaiser Family Foundation (KFF) poll, 26 percent of respondents were very worried about affording prescription drugs.[3] That KFF poll also found that people identifying as Black and Hispanic had a higher percentage who were very worried about affording prescription drugs.[4]

The ever-increasing prices of drugs lead to Oregonians not being able to afford needed medications. This causes harm to patients and their families and further burdens our health care system. Some can only afford prescriptions by doing without other needs, while others cannot afford them at all. This 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.

Figure 1: KFF poll of concerns about affording prescription drugs



3 Source: KFF Health Tracking Poll (Jan. 30-Feb. 7, 2024).

4 Sparks, Grace, et al. "Public Opinion on Prescription Drugs and Their Prices." KFF, Oct 4, 2024. https://www.kff.org/health-costs/public-opinion-on-prescription-drugs-and-their-prices/. Accessed Oct. 23, 2025.

Oregon's Prescription Drug Price Transparency Act, passed in 2018 (House Bill 4005), created the Drug Price Transparency Program.[5] 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.

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.[6] A prescription drug can be either a brand-name drug or generic drug. Brand-name prescription drugs are the first of their kind and 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.[7] Generic drugs typically cost less than brand-name drugs and are used more frequently due to their reduced cost. Some generics are branded generic drugs using their own distinguishing name and are often at a higher cost than other generics.

Most drugs can also be described as either small molecule or biologic drugs. Small molecule drugs are generally manufactured through a controlled chemical reaction, while biologics are generally manufactured through the manipulation of living cells.[8] 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.[9] Biologics generally refer to a drug that is the first of its kind, while biosimilars are a version of a reference biologic. Like small molecule generic drugs, biosimilars can be branded biosimilars with their own distinguishing name and are often at a higher cost than other biosimilars.

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 most of the actors involved in the pharmaceutical supply chain.

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5 House Bill 4005 (2018), https://olis.oregonlegislature.gov/liz/2018R1/Measures/Overview/HB4005. Accessed Oct. 21, 2025.

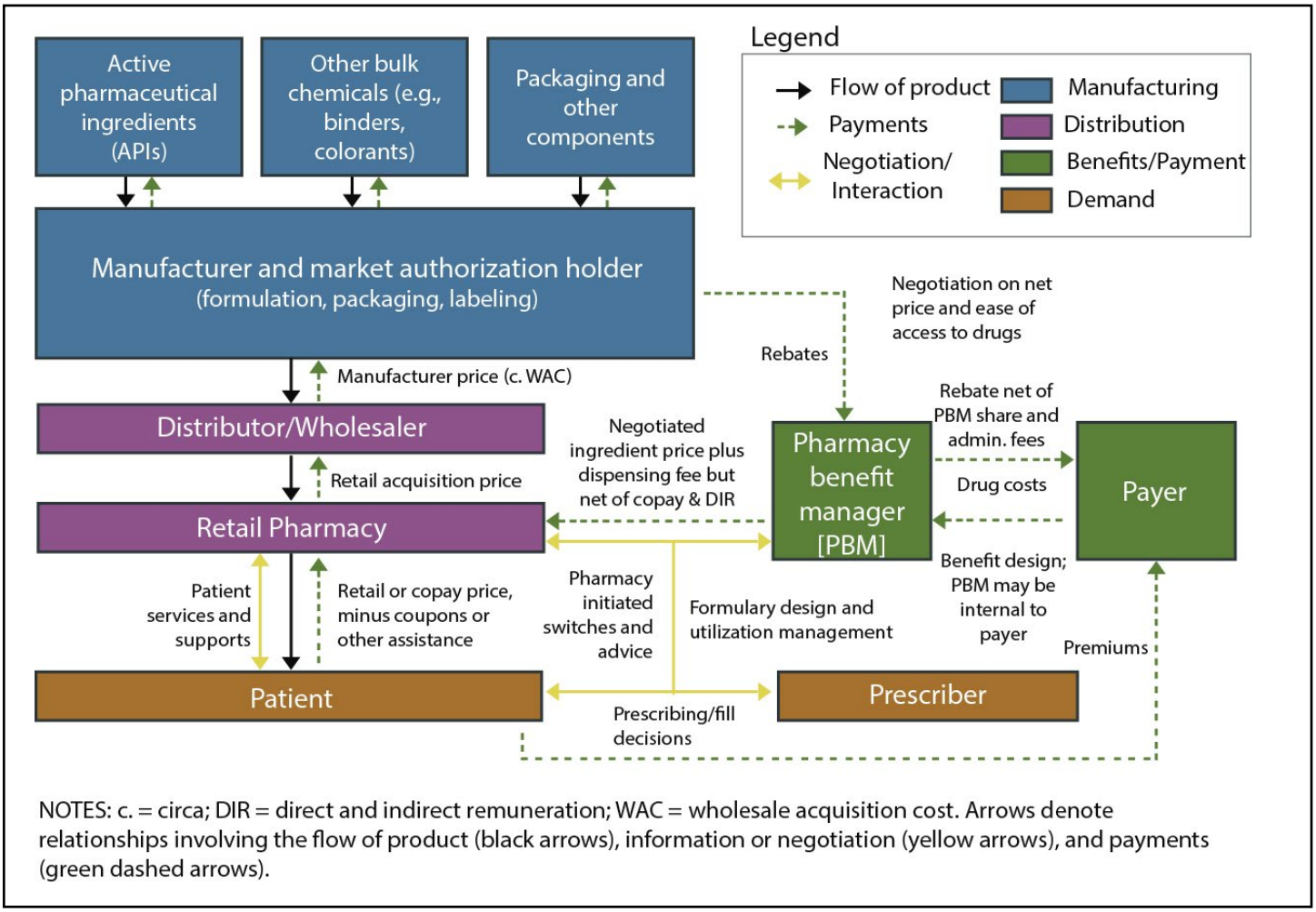
6 "Prescription Drugs and Over-the-Counter (OTC) Drugs: Questions and Answers." U.S. Food & Drug Administration, Nov. 13, 2017. https://www.fda.gov/drugs/questions-answers/prescription-drugs-and-over-counter-otc-drugs-questions-and-answers. Accessed Sept. 24, 2025.

7 "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 Sept. 24, 2025.

8 "Biological Product Definitions." U.S. Food & Drug Administration. https://www.fda.gov/files/drugs/published/Biological-Product-Definitions.pdf. Accessed Sept. 24, 2025.

9 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 Sept. 24, 2025.

Figure 2: Pharmaceutical supply chain for brand-name drugs dispensed through retail pharmacies[10]



NOTES: c. = circa; DIR = direct and indirect remuneration; WAC = wholesale acquisition cost. Arrows denote relationships involving the flow of product (black arrows), information or negotiation (yellow arrows), and payments (green dashed arrows).

The price a consumer pays at the pharmacy can be influenced by 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 with insurance. People who are uninsured typically pay the list price of the drug, which can be changed by the drug manufacturer and may include costs from others in the supply chain. Both insured and uninsured people can also use a discount card program such as Oregon's ArrayRx to receive a lower cost.[11]

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 out-of-pocket cost for the consumer. Removal from the formulary limits access to that drug. Many health insurance companies will require a copay or coinsurance payment when the consumer pays for the prescription drug at the pharmacy. A

10 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 Sept. 24, 2025.

11 "Lower the cost of you prescription with ArrayRx." Oregon Prescription Drug Program. Oregon Health Authority. https://www.oregon.gov/oha/hpa/dsi-opdp/Pages/index.aspx. Accessed Sept. 24, 2025.

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

There are several ways prescription drugs can be categorized: based on the conditions or diseases they treat (one or more therapeutic classes[12]); the 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.

In 2023, U.S. national health expenditures reached $4.9 trillion, a 7.5 percent growth from the prior year, and $449.7 billion (9.2 percent) of that was retail prescription drug spending.[13] For 2023, prescription drug expenditures grew by 11.4 percent. Figures 3 and 4 show the U.S. increase in prescription drug expenditures from 2014 through 2023 along with the amount of out-of-pocket costs for consumers and the view over a longer span of time. Calendar year 2023 data are the most recent data available.

The percentage of Americans who can afford and access prescription drugs and quality health care stands at a new low of 51 percent in 2024, a 10-point decline since 2022, according to the West Health-Gallup Healthcare Affordability Index. Forty-nine percent of American adults report struggling to cover their medical bills and are either cost insecure or cost desperate.[14]

According to the recently released West Health-Gallup 2024 Survey on Aging in America, an estimated 72.2 million – or nearly 1 in 3 – American adults did not seek needed health care in the prior three months due to cost, including an estimated 8.1 million Americans aged 65 and older. Nearly one-third (31 percent) were concerned about their ability to pay for prescription drugs in the next 12 months, up from 25 percent in 2022.[15]

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 and lung conditions. These stories illustrate the effects prescription drug costs have on households around the country and in Oregon.

12 Refer to Appendix H for descriptions of therapeutic classes used in this report.

13 "NHE Fact Sheet: Historical NHE, 2023." Centers for Medicare & Medicaid Services. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet. Accessed Sept. 24, 2025.

14 Witters, Dan and Maese, Ellyn. "In U.S., Inability to Pay for Care, Medicine Hits New High: Rates among Hispanic, Black adults and those with lower incomes worsen markedly since 2021." Gallup, April 1, 2025. https://news.gallup.com/poll/658148/inability-pay-care-medicine-hits-new-high.aspx. Accessed on Oct. 21, 2025.

15 Yu, Tiffany. "New Study Reveals More Struggling to Afford Healthcare." Westhealth, July 17, 2024. https://westhealth.org/news/new-study-reveals-more-struggling-to-afford-healthcare/. Accessed Oct. 20, 2025.

Figure 3: Estimated total expenditures and consumer out-of-pocket costs on prescription drugs in the U.S. from 2014 to 2023[16]

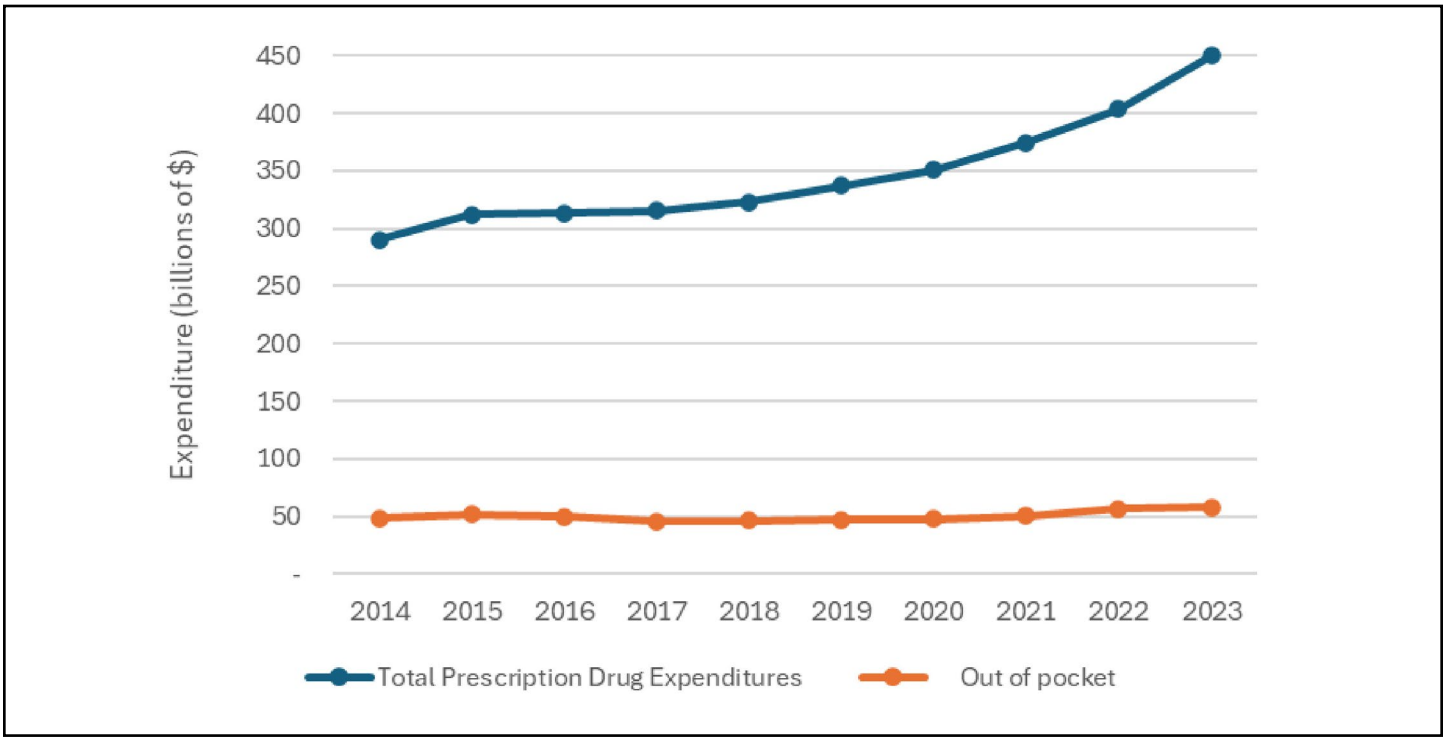
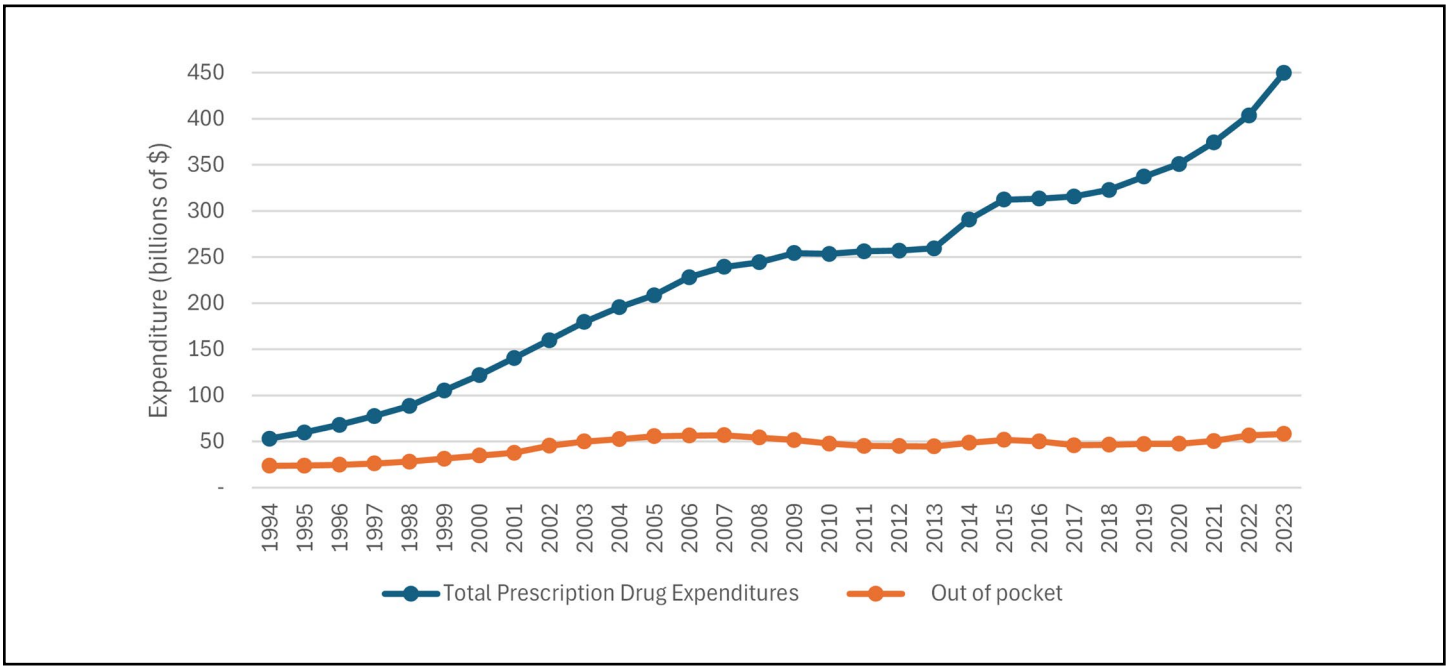


Figure 4: Estimated total expenditures and consumer out-of-pocket costs on prescription drugs in the U.S. from 1994 to 2023 to show the longer view[17]

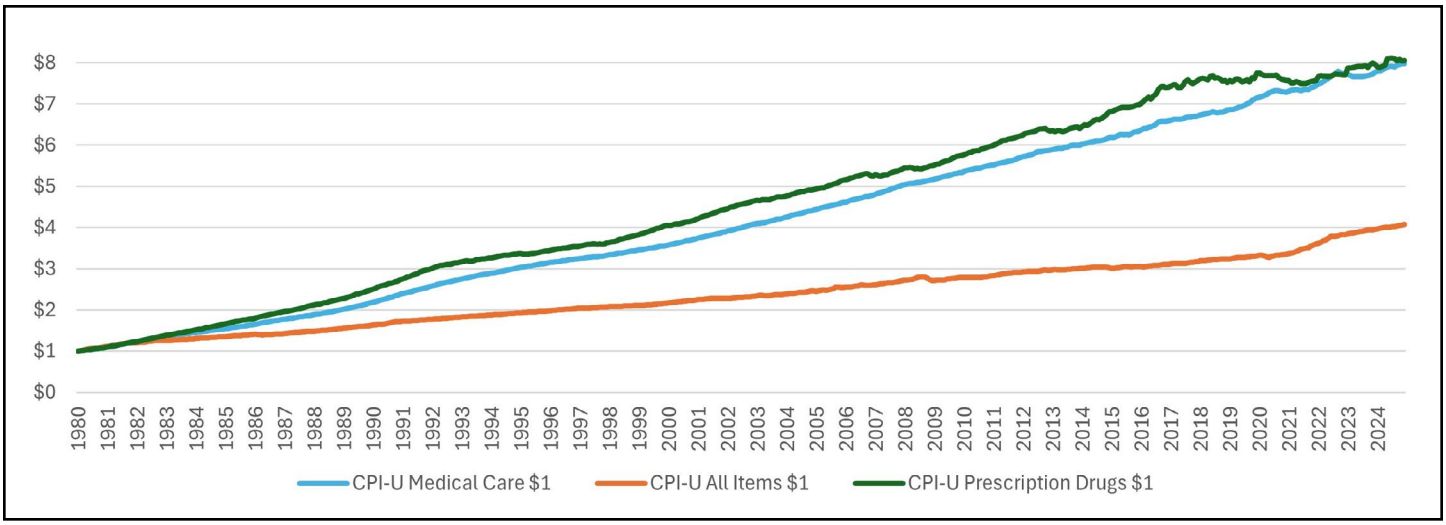


16 "Historical." Centers for Medicare and Medicaid, National health expenditure data, Dec. 18, 2024. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical. Accessed Sept. 24, 2025.

17 Ibid.

Starting in 1980 and ending in 2024, Figure 5 shows that prices for prescription drugs inflated 98 percent more than the rate for all items in the Consumer Price Index for All Urban Consumers (CPI-U).[18] The chart shows that the prices of medical expenses and prescription drugs have increased faster than general inflation during the last 35 years.

Figure 5: Overall inflation compared to the increases for prescription drugs and medical expenses from 1980 through 2024



Oregon prescription drug spending

Prescription drug spending and the effects of costs on Oregonians have 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 and direct purchases for Oregonians.

Reports show that the Oregon Health Authority (OHA) spent more than $1.04 billion, after rebates, between January and December 2024 on prescription drugs for the more than 1.2 million people enrolled in the Oregon Health Plan.[19] The total prescription drug spending expectation for 2024 was more than $16 million for the CAREAssist program (Oregon's AIDS Drug Assistance Program – ADAP) and is expected to be more than $15 million for 2025.[20]

Prescription drug spending by the Public Employees' Benefit Board (PEBB) was $145 million in paid pharmacy costs after rebates for 2024 for 135,678

18 "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. Also refer to "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. Also refer to "BLS Data View." U.S. Bureau of Labor Statistics. https://data.bls.gov/dataViewer/view/timeseries/CUSR0000SEMF01;jsessionid=95E7085FC504B86A4B4ED23DFB016957. Accessed Sept. 24, 2025.

19 Total payments before rebates for 2024 were more than $1.55 billion. Refer to "Pharmacy Utilization Summary Report: January 2024 – December 2024: Total Members; Total Amount Paid; Estimated Net Drug Costs." Drug Use Research & Management Program, DHS Health Systems Division, Oregon State University College of Pharmacy, Page 1, Aug. 28, 2025. https://www.orpdl.org/durm/reports/utilization/2025/DUR_Utilization_2025_Q2.pdf. Accessed Oct. 17, 2025.

20 CAREAssist program data provided from Oregon Health Authority. https://www.oregon.gov/oha/ph/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/CAREAssist/Pages/index.aspx.

members.[21] The Oregon Educators Benefit Board (OEBB), with 132,077 members, recorded $102 million in paid pharmacy costs after rebates for the 2023-24 plan year (October 2023 to September 2024).

For youth in the Oregon Youth Authority's close-custody facilities, pharmacy spending for 2024 was $411,000 with projected pharmacy spending expected to remain even at $411,000 for 2025, which is a projection and subject to multiple variables. The Oregon State Hospital's drug spending for 2024 was approximately $6.1 million, which includes inpatient prescription and over-the-counter drugs, as well as discharge medication vouchers. (Note that Oregon State Hospital's numbers reflect what that office currently shows; a review of the records could show a slight variation.) The Oregon Department of Corrections spent at least $18 million on prescription drugs in 2024 and – with changes to the federal 340B program, the cost of medications for opioid use disorder treatment, and expanding services for Hepatitis C – expenses are expected to increase significantly in future years.[22]

In total, the state of Oregon spent more than $1.3 billion on prescription drugs in 2024 through direct purchases and health insurance drug purchase costs, based on figures compiled for this report.

Oregon has a prescription drug assistance program called the ArrayRx Discount Card Program. ArrayRx is a partnership between the states of Oregon, Arizona, Connecticut, Nevada, Ohio, and Washington, serving more than 860,000 people. The discount card program helps Oregonians and residents of the other states (more than 111,000 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 six states, these include almost 725,000 group-insured people, managed Medicaid programs serving about 77,000, and vouchers serving more than 23,000. ArrayRx has resulted in more than $40 million in savings to Oregon and the other participating states through these programs during 2022 through 2024.[23]

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.

21 "Oregon Public Employees' Benefit Board, September Utilization Review." Mercer presentation to the Oregon Health Authority and Public Employees' Benefit Board, Page 39, Sept. 16, 2025. https://www.oregon.gov/oha/PEBB/MeetingDocuments/09-2025-PEBB-Board-Attachments.pdf#page=39. Accessed Oct. 17, 2025.

22 Oregon Educators Benefit Board (OEBB), Oregon Youth Authority, Oregon State Hospital, and Oregon Department of Corrections data provided from Oregon Health Authority. https://www.oregon.gov/oha/Pages/index.aspx.

23 Oregon Prescription Drug Program and ArrayRx data provided from Oregon Health Authority in 2025. https://www.oregon.gov/oha/hpa/dsi-opdp/Pages/index.aspx. Accessed Oct. 17, 2025.

Oregon's Drug Price Transparency (DPT) Program

The program continues to engage consumers, prescription drug manufacturers, insurers, and PBMs and collect information to inform the annual public hearing and legislative report. In December 2025, the program will hold its seventh 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.

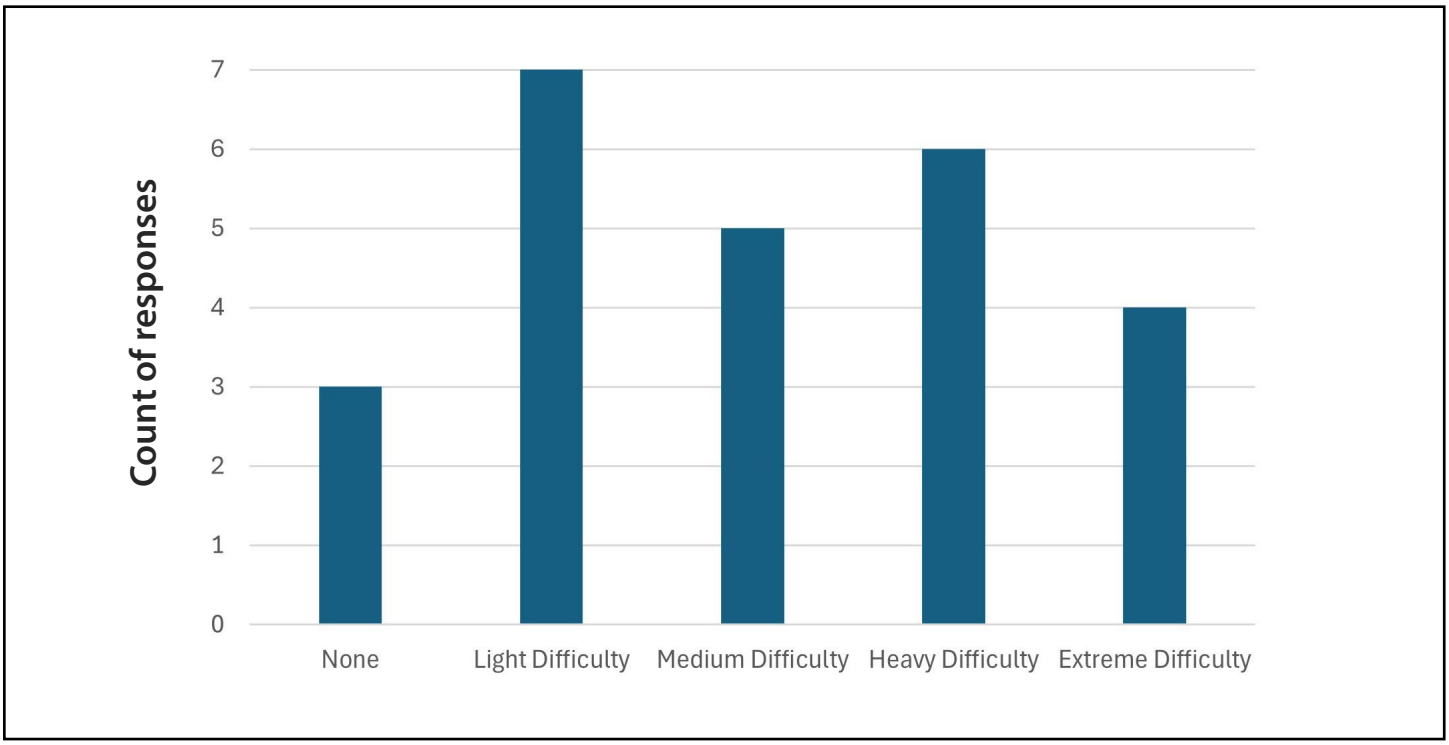
Data from consumers, pharmaceutical manufacturers, PBMs, and insurers is collected and analyzed by program staff members throughout the year.

This report summarizes the findings from data collected during 2024 and 2025 for the 2024 calendar year. As noted in the trade secret section, the program carefully analyzes all information claimed as trade secret and does not immediately release it. Any directly identifiable information in this report was not claimed as a trade secret in the manufacturer's submission or is not a trade secret based on a final determination notice DCBS issued to the manufacturer. Some data have been aggregated to protect trade secrets and still provide as much information to the public as possible.

Consumer notifications for high and increased drug prices

To improve consumer notifications, the program created an online Qualtrics survey in 2024 allowing consumers to report whatever information they had available. While this doesn't always result in enough detail to help us determine which drugs are causing the most burden or financial hardship, it has improved reporting. One of the optional questions we ask is the amount of financial difficulty prescription drug prices are causing people who report. Figure 6 illustrates the responses we have received since 2024 with 88 percent of respondents reporting at least some financial difficulty.

Figure 6: Consumer-reported financial difficulty ratings[24]



In 2025, we received 27 consumer notifications. Of those, 14 reported that the drug was a high cost, 10 reported a price increase, and three reported that the drug was a high cost and there was an increase.

Most notifications (15) were from the Portland metro area. The remaining were from southern Oregon, Salem, coastal areas, or rural areas.

All 27 consumers indicated they had insurance; 17 had insurance through their employer and five were on Medicaid, Medicare, or purchased a plan on the marketplace. Five others had purchased individual insurance policies from insurers or didn't specify their insurance.

Not all notifications identified the drug. For those that did, these therapeutic classes[25] were included:

- Attention-deficit/hyperactivity disorder (ADHD)/ anti-narcolepsy/anti-obesity/anorexiant agents
- Cardiovascular agents
- Endocrine and metabolic agents
- Gastrointestinal agents
- Ophthalmic agents

24 Figure 6 information is from the 25 people who responded to this question in the Qualtrics survey June 2024 through September 2025.

25 Refer to Appendix H for descriptions of therapeutic classes used in this report.

Here are some consumer comments about high priced drugs:

> *"Previous co-pay for same drug/ same dosage/same insurance was $31.46. … $178.60 on 2/4/25 … $419.60 on 7/31/25." [1,234% increase for a generic drug that is in multiple therapeutic classes]*

> *"My insurance copay would be $230. If I pay cash, it's $27. Thankfully my local independent pharmacy was willing to share the details. Insurance pharmacy benefits programs only exist to save insurance companies money and extract higher copays for their shareholders. An inappropriate extraction layer for consumer's hard-earned dollars." [752% increase when using insurance versus paying cash for this drug, therapeutic class: Gastrointestinal agents]*

> *"The cost increased from my order to when delivered. I have a screenshot to prove it. On my checkout screen and submitted order it totaled to $9.91 but the actual charge I saw after receiving the meds was $49.56." [400% increase for this drug, therapeutic class: ADHD/Anti-narcolepsy /Anti-obesity/ Anorexiant agents]*

Refer to all consumer notification comments and stories in a separate exhibit to this report.

Remember that anyone can provide notification of an increase in the cost of prescription drugs to the DPT Program through phone, email, or an online notification form in English or Spanish. We also have a downloadable form available in English, Spanish, Russian, Vietnamese, and Chinese.

We hope to receive more consumer notifications 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 notifications, 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 reusing vials to save money by refilling less often:

> *"I have dry eyes and use Restasis eye drops, in addition to getting tear duct plugs every 6 months. Restasis is an old generic drug, but Restasis puts it in small dropper vials and somehow must still have a patent for that. I have a Medicare Advantage plan, but even with that my copays are $250 per month (40% of the cost, which would otherwise be $625 per one month supply). I called the insurance company, Providence, about this and was told, although there is a generic available in some form, the cost to me would be even higher than for the brand name, Restasis vials. So, I save the vial each night and use it twice even though the directions say not to do that, and can usually get by with getting my prescription every other month. I have been using the Restasis for probably about 25 years and the cost was initially high, but not nearly as high as it is now. It is unbelievable that the chemical in this drug which apparently is some kind of immune suppressant, his existed for a long time yet this drug is so expensive just because it is in little vials. I don't know how anyone with less income than I have could possibly afford it. I am told that without adequately treating my dry eyes, I would get corneal damage since I already have Fuchs' dystrophy."*

Here is a story about insurance not covering a medication:

> *"My cost for NP Thyroid, which is a generic desiccated thyroid medication (desiccated thyroid meds were developed a good century + ago) has gone from less than $30 for a 90 day supply to $144 this year. Regence will no longer cover any desiccated thyroid medications at a more affordable price point. Generic synthetic thyroid medications are the only ones they cover on tier 1 (Armour and NP Thyroid are tier 3 now). The price with insurance is the same as without insurance. In fact in some cases with insurance is more expensive now. Synthetic thyroid medications do NOT work for me, they were less effective and caused intolerable side effects. There is no rational justification for the cost increase. The medication was developed over a century ago. The brand I use is considered a generic. This is purely Regence trying to dictate how I'm treated via financial stress. I don't have the choice to switch to their "preferred treatment", I used it in the past and it was ineffective and caused horrible side effects. They do not cover any other options of the same type of medication (natural desiccated thyroid) at a better price point."*

Here is a story about the different costs the consumer pays at different pharmacies:

> *"Last night I called my Aetna insurance and spoke to the pharmacy staff. I asked what my meds would cost me next year. This year for 3 month supply of Repatha was $432 at Fred Meyer (Kroger) which I picked up. The Aetna pharmacist looked up and said transfer your prescription to Walgreens, it will cost you $249 there. She verified it was also 3 months' worth. That's $183 difference! WOW!!! How can Fred Meyer get away and over charge like that!"*
>
> *[**Note**: Insurance and PBM pharmacy networks may have different levels or there could be other factors that lead to a difference in patient costs.]*

Special topic: Review of Humira and Stelara and biosimilar products

During the last six years, Humira, a biologic manufactured by AbbVie Inc. to treat inflammatory conditions, was the drug with the highest total annual spending by insurers. With the introduction of biosimilars in recent years, Humira has now dropped to seventh on total spending by insurers reported for 2024. Here, we will observe how many biosimilars for Humira entered the market and when. To show another example of a drug with biosimilars now on the market, we will also do the same for Stelara, a brand-name biologic drug that treats skin conditions, and its biosimilars. These analyses are based on biosimilar applications as of August 2025.

Figure 7 shows the number of drugs (different products) in the marketplace that are similar to Humira, quarter by quarter. Figure 8 shows the WAC history for Humira in Medi-Span.

Figure 7: Count of Humira biosimilars on the market

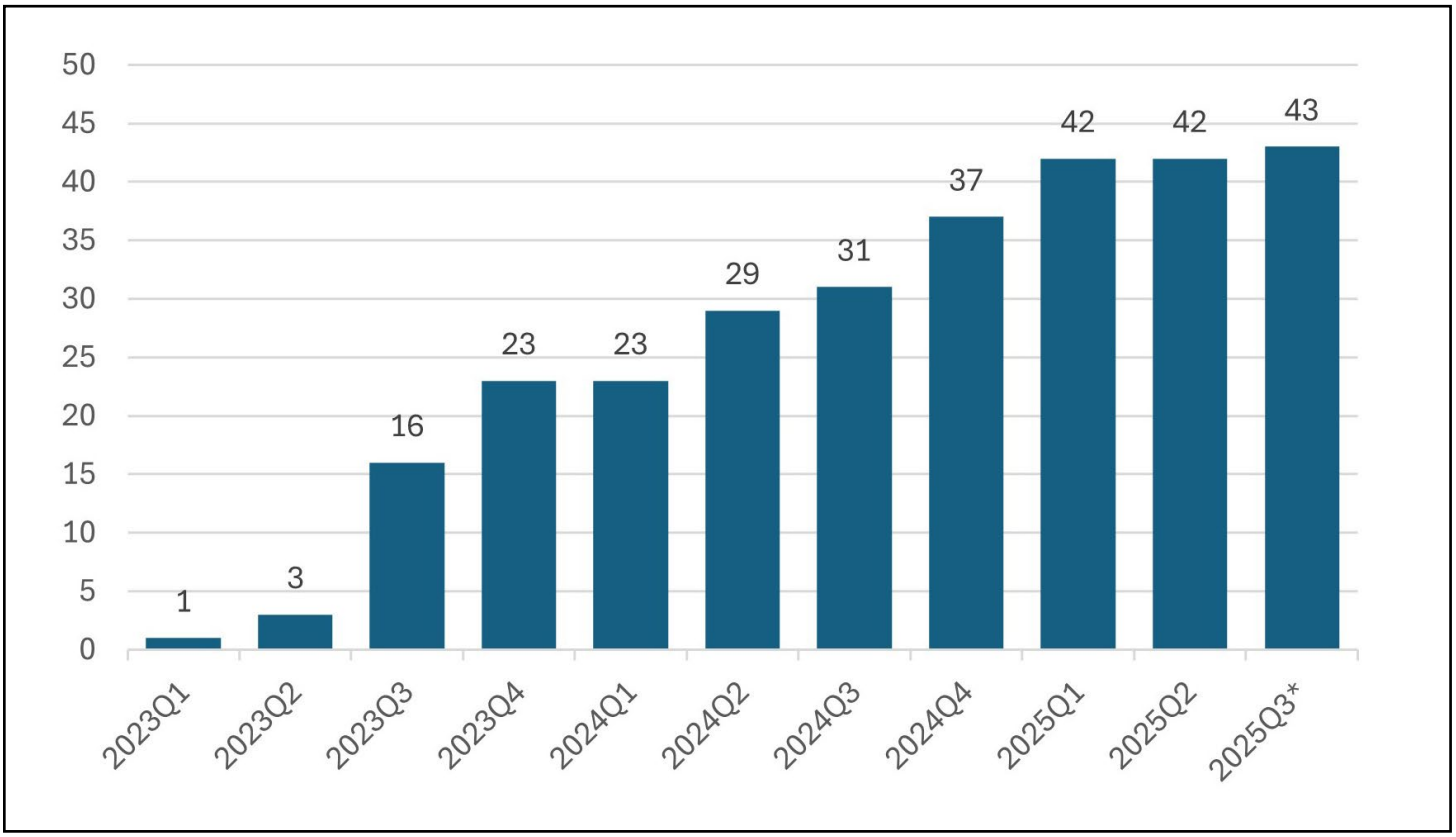


Figure 8: This shows the WAC history from Medi-Span for the oldest NDC for Humira (NDC 0074-3799-02 – two single-dose, prefilled syringes 40mg/.8mL each).

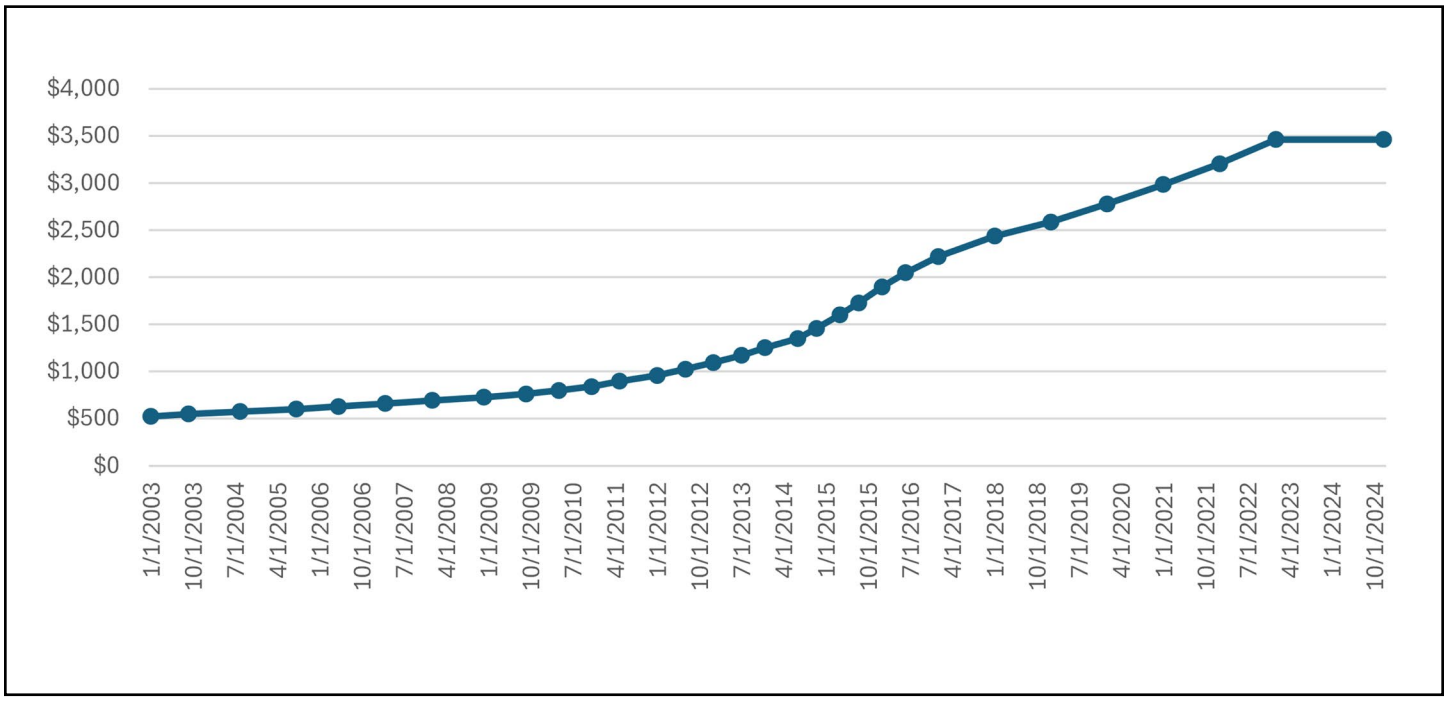
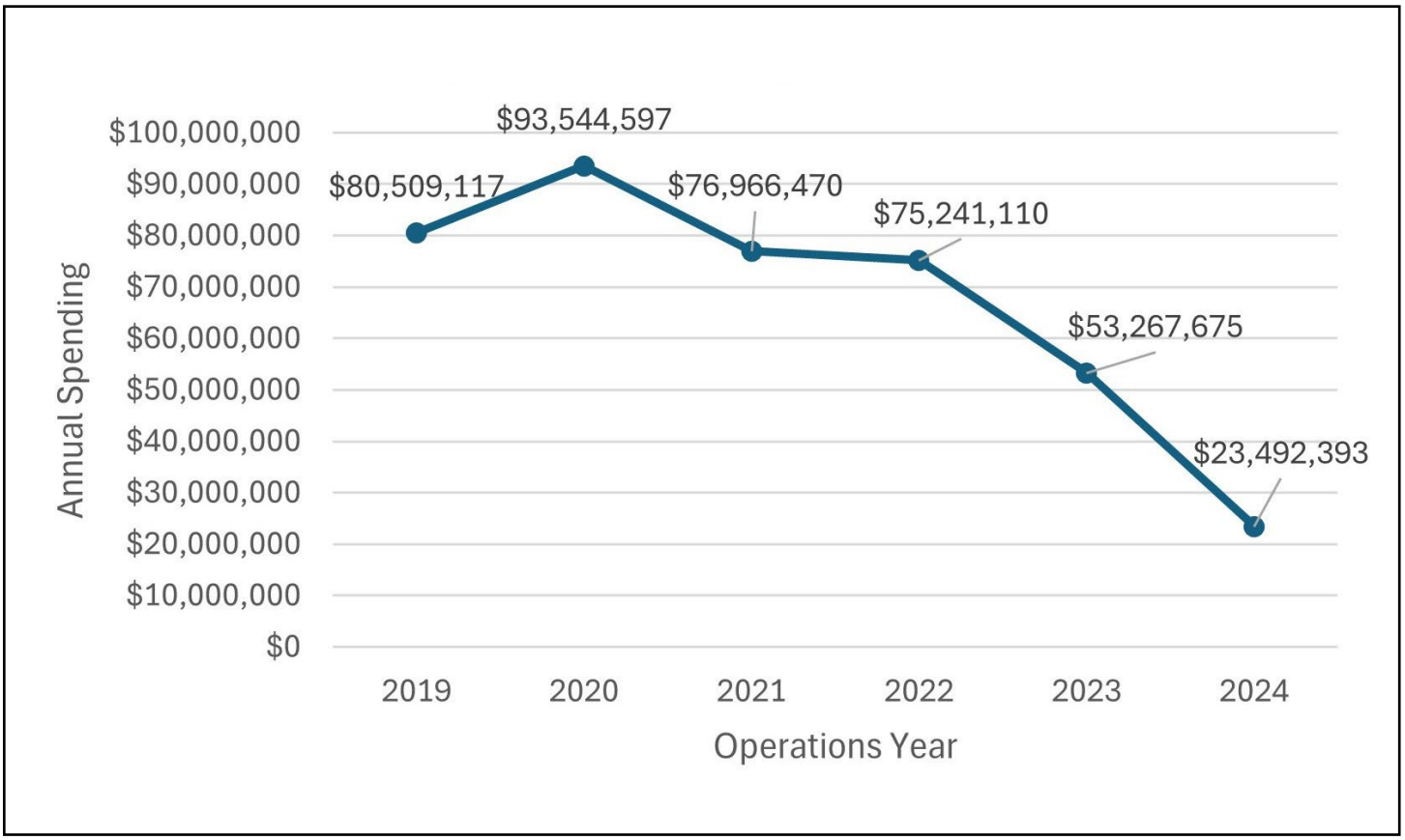


Figure 9: Oregon insurer-reported spending on Humira as reported to DPT starting in 2019.



In the 2023 calendar year data (and all previous years in this program's history), Humira was reported the No. 1 most costly drug (highest total annual spending by Oregon insurers who report data) with total spending at $53,267,675 as reported in the 2024 DPT report. In the 2024 calendar year data, Humira dropped to the seventh-most costly drug, with total spending of $23,492,393. This is a gross decrease of $29,775,282, or a 55.9 percent decrease.

Information from the All Payers All Claims (APAC) database managed by OHA allows us to study the utilization of new Humira biosimilar NDCs for the year 2023. Available APAC data includes medical, pharmacy and dental claims, demographic data, monthly insurance coverage data, and provider information. APAC includes up to 98 percent of the Oregon population annually, though about 1 percent of the people in APAC are not Oregon residents.[26] The dates compared in the images are based on each NDC "marketing start date" in the FDA directory. This is the date the company indicates when it started marketing the packaged product.[27]

Within the APAC database, Humira biosimilar NDCs had 5,737 entries, most being pharmacy claims. The sum of reported copay, coinsurance, and deductible amounts add to the "total patient contribution," that is, the amount a given patient pays, which might be zero in many instances. These NDCs had a total spending of $156,741 in 2023. The asterisk on the third quarter 2025 data (Q32025) is to indicate the partial quarter data (data pulled Aug. 25, 2025).

In Figure 9 (Oregon insurer-reported spending on Humira), we display the total annual spending for Humira reported to us by insurers each year in their Top 25 annual reporting. Refer to the insurer data in Section 4 of this report for more details. We can observe sharp declines in spending for Humira around reporting years 2024 and 2025 (operation years 2023 and 2024), when biosimilars became available.

In figures 10 through 12 we have similar graphs for Stelara. This graph shows the number of drugs (different products) in the marketplace that are biosimilars for Stelara, quarter by quarter.

26 Evans, Mary Ann, Grusing, Sara and APAC team. "APAC data limitations." Oregon All Payer All Claims Database (APAC).Data User Guide 2011-2022 Claims & Insurance Coverage, Data from HSRI Release 20. Oregon Health Authority, All Payer All Claims (APAC), November 2024, Page 35. https://www.oregon.gov/oha/HPA/ANALYTICS/APAC%20Page%20Docs/APAC-Data-User-Guide-2024.pdf#page=35. Accessed on Oct. 21, 2025.

27 NSDE. U.S. Food & Drug Administration, Aug. 5, 2024. https://www.fda.gov/industry/structured-product-labeling-resources/nsde. Accessed Oct. 24, 2025.

Figure 10: Count of Stelara biosimilars on the market [28]

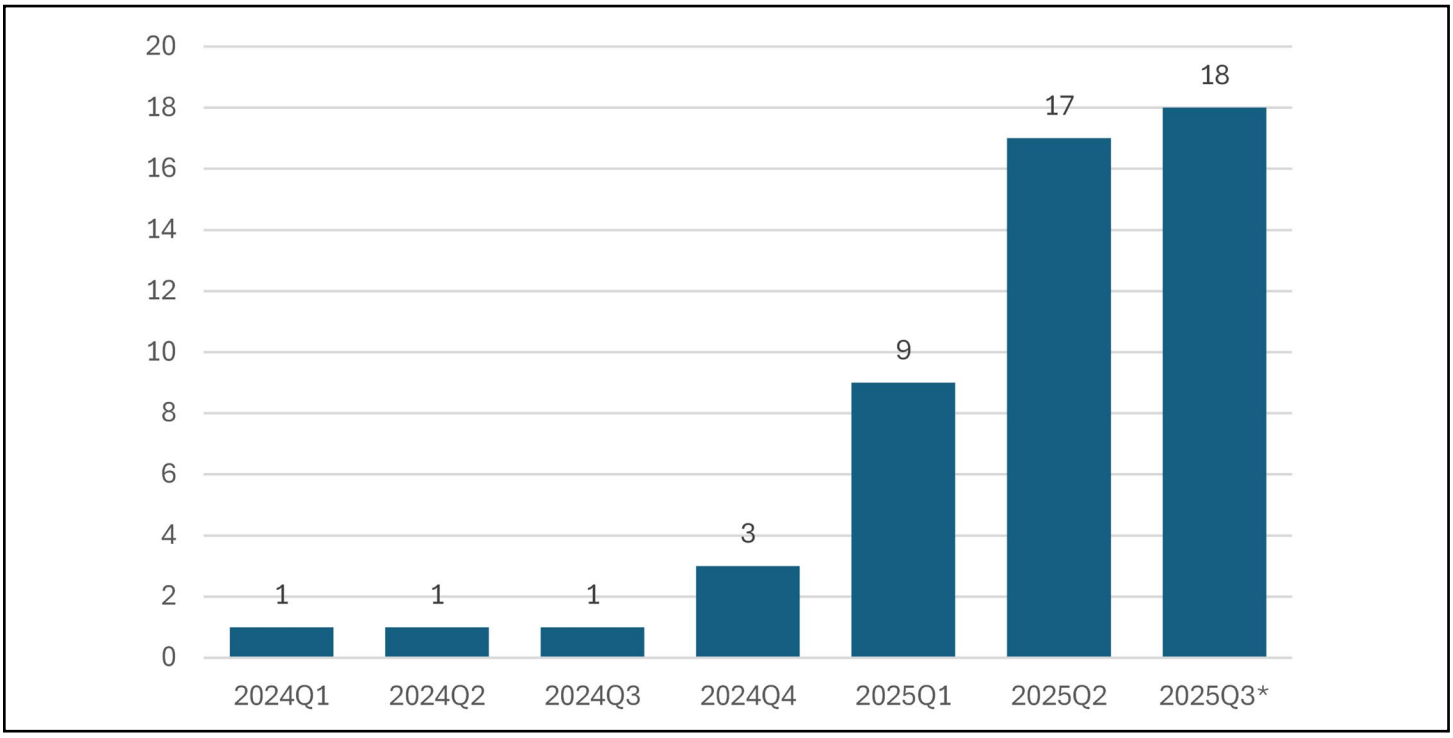
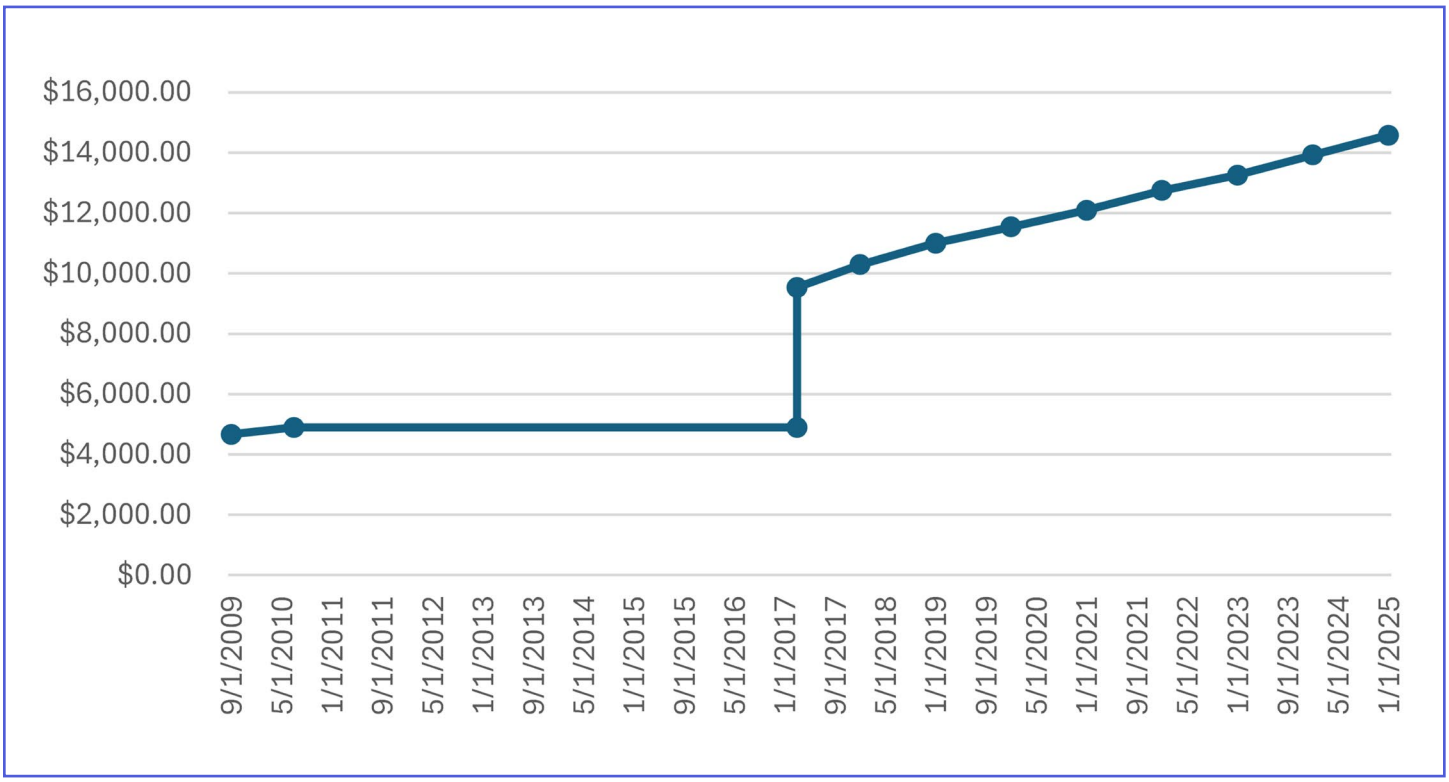


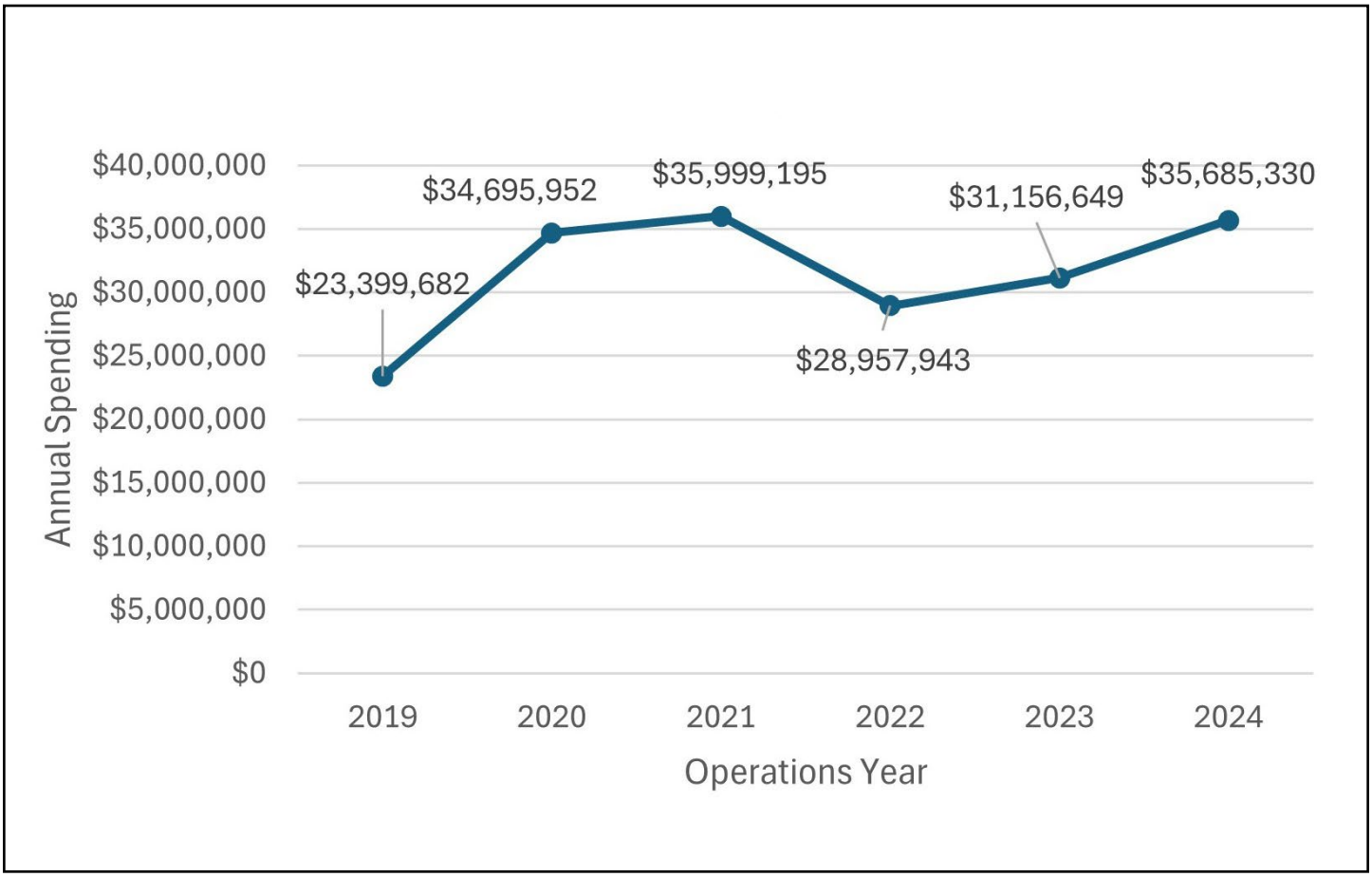
Figure 11: This shows the WAC history from Medi-Span for the oldest NDC for Stelara (NDC 57894-060-02 – one single-dose, prefilled syringe 45 mg/.5 mL).[29]



28 Based on approved biosimilars in the FDA Purple Book (https://purplebooksearch.fda.gov/) and the FDA NDC directory (https://www.accessdata.fda.gov/scripts/cder/ndc/index.cfm). Accessed September 2025.

29 Note that Medi-Span showed no price changes between 7/7/2010 and 3/17/2017. https://www.wolterskluwer.com/en/solutions/medi-span/medi-span.

Figure 12: Oregon insurer-reported spending on Stelara.



We did not see utilization of NDCs that are biosimilar to Stelara in the 2023 APAC data, which tracks well with the timeline indicating the first of these biosimilars started marketing in the first quarter of 2024 (Q12024).

In the 2023 data, Stelara was reported the third-most costly drug and the seventh-greatest increase (based on the increase in total annual spending year over year from 2022 to 2023), with total spending in 2023 of $31,156,649, and a year-over-year increase of $4,315,271 in the 2024 report. In the 2024 data, Stelara remained the third-most costly drug, with total spending of $35,685,330, and reported the fifth-greatest increase, with a year-over-year increase of $5,370,053. Total spending on Stelara had a gross increase of $4,528,681 (14.54 percent) from 2023 to 2024.

Section 2: Prescription drug manufacturers

This section of the report is based on new drug reports submitted from Jan. 1, 2024, through Dec. 31, 2024 and 2024 price increases that were reported in 2025. 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. This threshold changed to $950 or more for a 30-day supply for drugs introduced on or after Jan. 1, 2025 (OAR 836-200-0520).
- **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 and 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.[30]
- **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 aggregate data 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.

New prescription drug reports

From Jan. 1, 2024, through Dec. 31, 2024, the program received 547 new prescription drug reports. These reports were submitted by 136 different manufacturers, and each report is for a single NDC. Some reports were for a different NDC of the same drug.

Note:
The reporting period changed to calendar year for new drug reports. Last year's report used the range of Sept. 1, 2023, through Aug. 31, 2024, for new drug reports. This change means all data from manufacturers, insurers, and PBMs in this legislative report relates to the prior calendar year (Jan. 1, 2024, to Dec. 31, 2024).

30 "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 Oct. 20, 2025.

The types of reports received between Jan. 1 and Dec. 31 each calendar year are compared in the figure below.

We received 289 new prescription drug reports for generic drugs that came from 66 manufacturers. We also received 258 new prescription drug reports for brand-name drugs that came from 85 manufacturers. Some drugs have multiple reports to reflect different strengths or package sizes. This information is displayed year to year in Figure 13.

In Figure 14, the most common therapeutic class[31] of drugs in these reports were antineoplastic and adjunctive therapy drugs used to treat cancer, with 117 drug reports falling into this category. Among those 117 reports, 56 were for generic versions, and 61 were for brand-name versions of antineoplastic drugs. The second-most common class of drugs in these reports were analgesics/anti-inflammatory drugs, with 60 reports. Of these 60 reports, 27 were for generics and 33 were for brand-name drugs. The third-most common class was anticonvulsants with 30 reports, 19 for generic drugs of this category and 11 for the brand-name drugs. Figure 14 shows the six most common drug classes.

Figure 13: Report counts for generic and brand-name new prescription drugs for each calendar year from 2019 to 2024

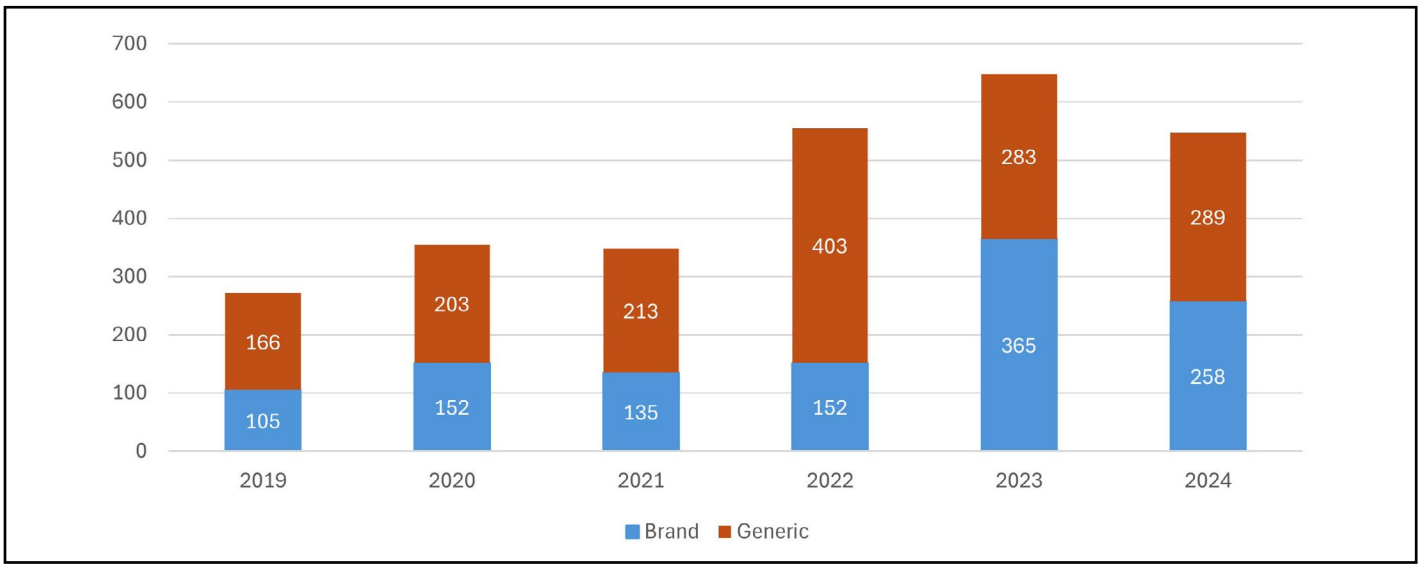
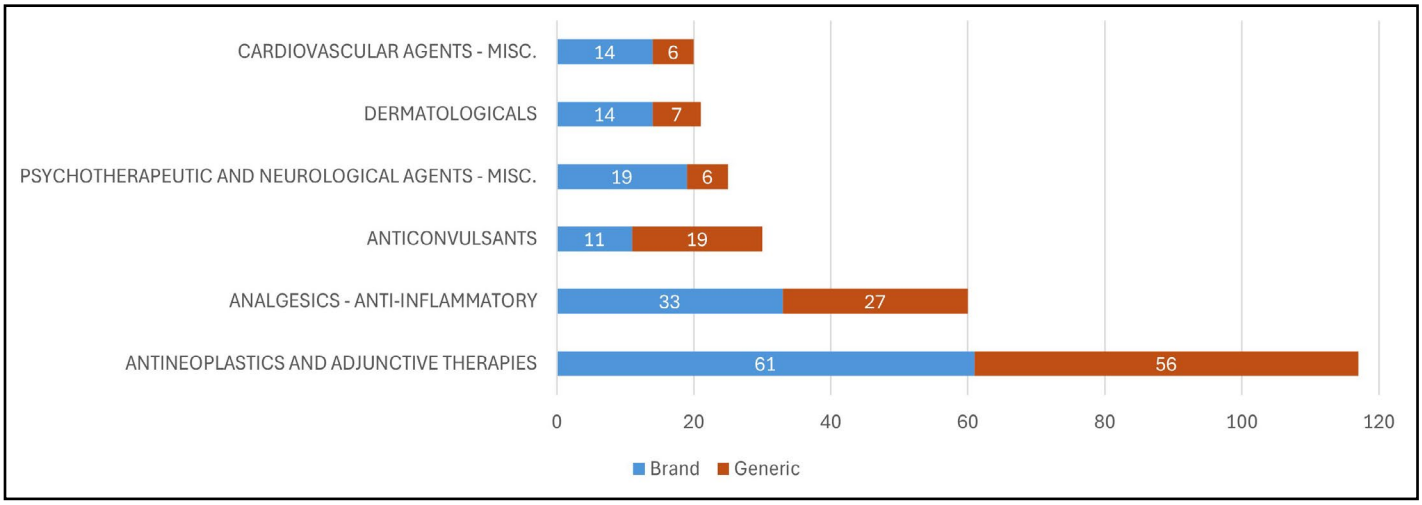


Figure 14: Distribution of brand-name and generic new prescription drugs by most common therapeutic classes



31 Refer to Appendix H for descriptions of therapeutic classes used in this report.

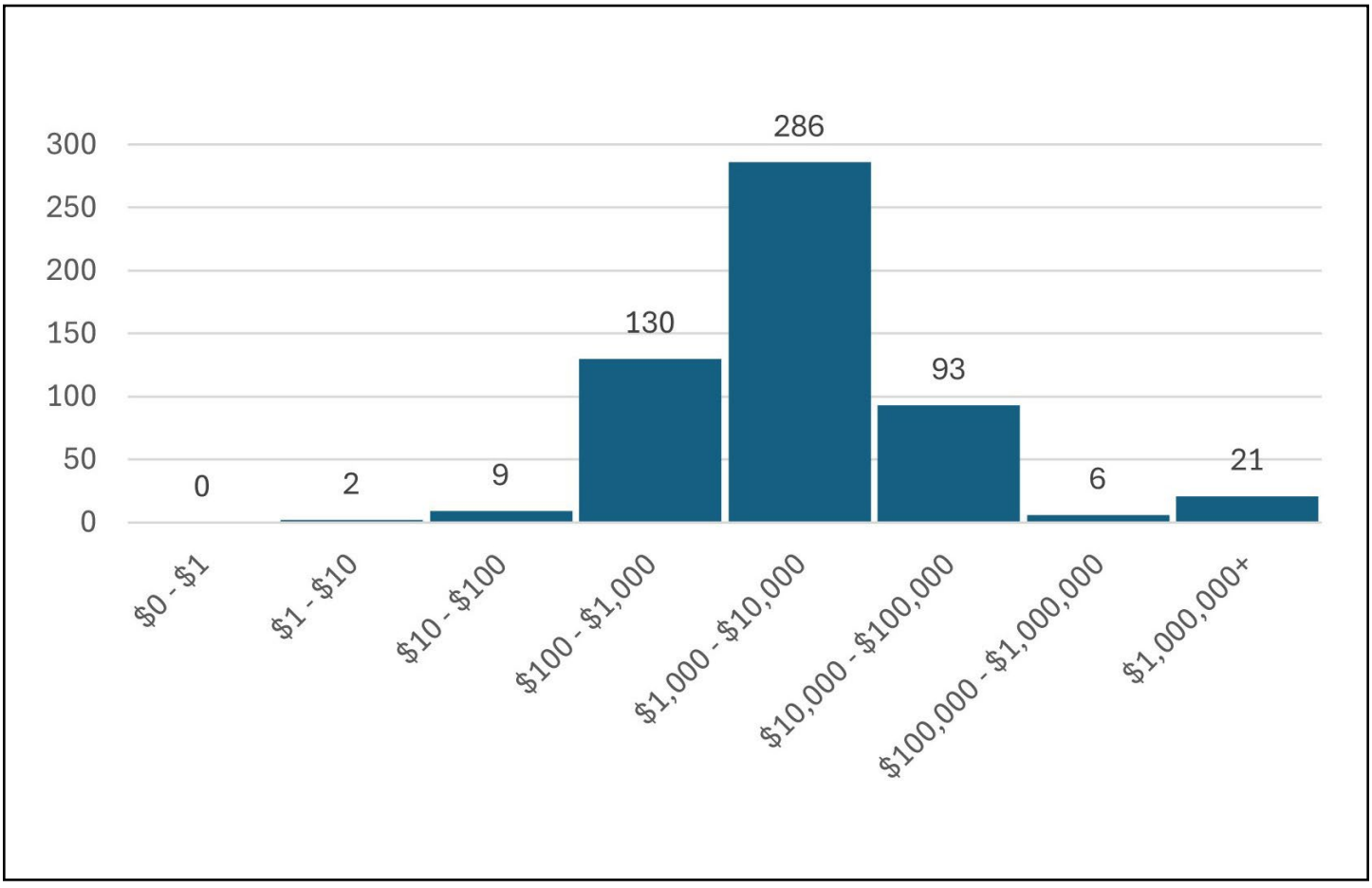
Finally, in Figure 15, we show the WAC price ranges in these reports. There were 286 entries with a reported WAC between $1,000 and $10,000, 130 entries with a reported WAC between $100 and $1,000, and 93 entries with a reported WAC between $10,000 and $100,000. Additionally, there were 21 entries whose WAC exceeded $1 million.

Highest WAC prices in new prescription drug reports

The program received new prescription drug reports for drugs with WAC prices ranging from a low of $5.61 to a high of $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 16 shows the 10 highest WAC prices for new brand-name drugs reported to the program that were reported in 2024. 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, typically calculated as a set percentage of a drug's WAC.

Figure 15: WAC price ranges for new prescription drug reports received in 2024, count of reports [32]



32 To make the histogram easier to read, we grouped the reports in categories by price using a base 10 logarithmic scale.

Figure 16: 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.
Zolgensma	$2.3 million	Neuromuscular agents	Novartis Gene Therapies, Inc.
Casgevy®	$2.2 million	Hematopoietic agents	Vertex Pharmaceuticals
Tecelra®	$727,000	Antineoplastics and adjunctive therapies	Adaptimmune LLC
Aucatzyl	$525,000	Antineoplastics and adjunctive therapies	Autolus, Inc.
Amtagvi™	$515,000	Antineoplastics and adjunctive therapies	Iovance Biotherapeutics Inc.
Livmarli	$106,800	Gastrointestinal agents – miscellaneous	Mirum Pharmaceuticals
Miplyffa	$106,020 – 79,515	Psychotherapeutic and neurological agents – miscellaneous	Acer Therapeutics, Inc.
Rivfloza™	$62,880	Genitourinary agents – miscellaneous	Novo Nordisk Inc.

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.[33]

The second-highest reported WAC was for a hematopoietic agent, Lyfgenia, at $3.1 million. Lyfgenia (lovotibeglogene autotemcel) is a one-time gene therapy that is given as an intravenous suspension to treat adults and children ages 12 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.[34]

Figure 17 shows the 10 highest WAC prices for new generic drugs reported to the program that were reported in 2024. Again, these are manufacturer prices and are generally not the prices billed to patients or insurance.

33 "U.S. FDA Approves Pfizer's BEQVEZ™ (fidanacogene elaparvovec-dzkt), a One-Time Gene Therapy for Adults with Hemophilia B." April 26, 2024. https://www.pfizer.com/news/press-release/press-release-detail/us-fda-approves-pfizers-beqveztm-fidanacogene-elaparvovec. Accessed Sept. 24, 2025.

34 Pope, Carmen. "Lyfgenia." Drugs.com, Jan.4, 2024. https://www.drugs.com/lyfgenia.html. Accessed Sept. 24, 2025.

Figure 17: Highest-reported WACs for new generic drugs

Drug	WAC (package)	WAC per unit	Therapeutic class	Manufacturer
Mifepristone (280 tablets at 300 mg)	$170,435	$609 / tablet	Endocrine and metabolic agents - miscellaneous; progesterone receptor antagonists (abortifacient)	Corcept Therapeutics Inc.
Nitisinone (60 capsules from 20 to 2 mg)	$38,580 – $3,858	$643 - $64 / capsule ($32 / mg)	Endocrine and metabolic agents – miscellaneous	Eton Pharmaceuticals Inc.
Mifepristone (28 tablets at 300 mg)	$16,734	$598 / tablet	Endocrine and metabolic agents – miscellaneous; progesterone receptor antagonists (abortifacient)	Teva Pharmaceuticals
Lenalidomide (28 capsules from 2.5 to 10 mg; 21 capsules from 15 to 25 mg[35])	$15,172 – $10,908	$541 – $519 / capsule	Miscellaneous therapeutic classes (Immunomodulators)	Exelan Pharmaceuticals, Inc.
Dasatinib (60 tablets from 50 to 70 mg)	$14,173 – $13,849	$236 – $231 / tablet	Antineoplastics and adjunctive therapies	Prasco LLC and Apotex Corp
Dasatinib (30 tablets from 80 to 140 mg)	$12,772 – $12,480	$426 – $416 / tablet	Antineoplastics and adjunctive therapies	Prasco LLC and Apotex Corp
Pazopanib (120 tablets at 200 mg)	$11,349	$95 / tablet	Antineoplastics and adjunctive therapies	Avkare, Inc.
Indomethacin (30 suppositories at 50 mg)	$10,314	$344 / suppository	Analgesics / anti-inflammatories	Zydus Pharmaceuticals USA Inc.
Pazopanib (120 tablets at 200 mg)	$8,900	$74/tablet	Antineoplastics and adjunctive therapies	Novugen Pharma USA LLC
Tiopronin delayed release (DR) (300 tablets at 100 mg)	$8,463	$28 / tablet	Genitourinary agents – miscellaneous	Torrent Pharma Inc.

35 The reports received for Lenalidomide from Exelan show that the lower doses are priced higher for this drug (also confirmed in Medi-Span).

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 547 new prescription drug reports received, six reports for four drugs showed public funding amounts that totaled more than $14 million.

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

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

An entry for Fabhalta (NDC 0078-1189-20), a hematological agent manufactured by Novartis Pharmaceuticals, reported $4,815 in national and state public funding with this 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 more than $4.4 million in national public funding with this 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."*

An entry for Promacta® (NDC 0078-0972-61), a blood disorder treatment manufactured by Novartis Pharmaceuticals, reported $841,094 in national and state public funding with this description:

> *"All States Public Funds Project dates from 2/21/2022 to 12/31/2022, Study Name: Open Label single arm prospective pilot trial of eltrombopag in patients 1 year to 18 years of age undergoing intensive chemotherapy for malignant solid tumors, located at the University of California. USA Federal Public Funds Project began in 5/24/2018, Study Name: Eltrombopag for patients with Fanconi anemia, located at the National Heart, Lung, and Blood Institute."*

Marketing spending and descriptions from new prescription drug reports

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

- Advertising on TV, social media, and in magazines
- Paying for endorsements and reviews
- Peer-to-peer communications, such as sponsored speakers at medical seminars
- Employing sales representatives

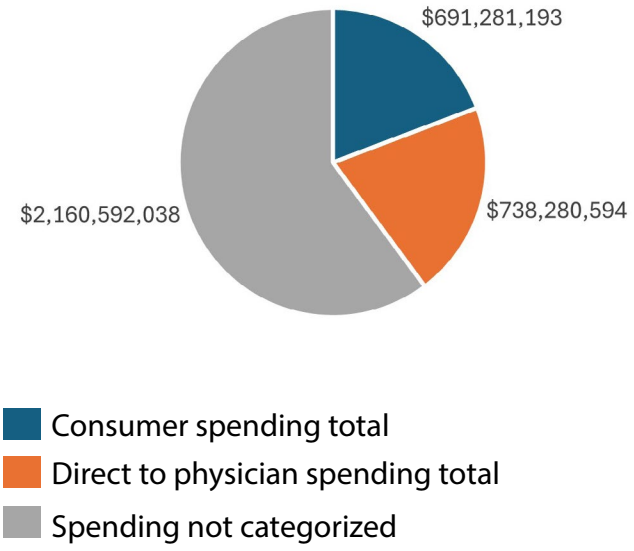
Many manufacturers claim marketing strategies and costs are trade secrets, so we used aggregated data to show spending and nontrade secret examples of marketing descriptions. Additional marketing information can be found on the program's data transparency webpages at https://dfr.oregon.gov/drugtransparency/data/Pages/new-drug-reports.aspx#drug.

Marketing spending reported

As illustrated in Figure 18, manufacturers of brand-name drugs reported more than $3.6 billion in total marketing spent in reports received from January to December 2024. The amounts for marketing usually represent spending during the first year a drug is on the market. Manufacturers did not classify more than 60 percent – $2.16 billion – of their total marketing spending amounts. The remaining 40

percent of the spending was classified as direct-to-consumer marketing ($691 million) and health care professional marketing ($738 million). Almost one-quarter (23.5 percent) of the marketing was associated with antineoplastics and adjunctive therapies. Analgesics/anti-inflammatory was the next highest therapeutic class[36] with 7.8 percent of the reported marketing spend.

Figure 18: New prescription drug reported marketing expenses



Marketing descriptions

A recent trend in marketing spending amounts reported to us shows more brand-name drugs with no consumer marketing spending. Instead, all planned spending goes to health care professionals.

Here are samples from submissions in 2024 with the marketing description data element. Some were not claimed as a trade secret. For those that did claim a trade secret, published information only shows the information we determined was not conditionally exempt from disclosure. Any information not disclosed after a trade secret review is identified in [brackets] with the original information replaced by a description of the information.

JAZZ PHARMACEUTICALS, INC

"$10,700,000. With the introduction of Ziihera, Jazz's marketing is focused on communication with Health Care Providers who currently treat biliary tract cancer, as well as providing appropriate education for biliary tract cancer patients. All materials are based on data in the Ziihera package insert. $7.7 Million (Promotional Material Development, Printed Promotional Materials, HCP Media (Display Media, Paid Search, Print & Email), HCP Email Marketing, HCP Speaker Programs, HCP Advisory Boards, Meetings, Account Management Fees, Brand Consultant Support and Brand Medicaid Education Agency Support). $3.0 Million (Promotional Educational Material Development, Direct to Consumer (DTC) Print Promotional Materials, DTC Medica (Paid Search, Paid Social, Display and Point of Care), DTC Email Marketing, Patient Promotional Webinars and Brand Printing Expenses." (Ziihera®)

NOVO NORDISK, INC

"At Rivfloza's™ launch on February 19, 2024, Novo Nordisk Inc. (NNI) intends to focus marketing efforts on pediatric and adult nephrologists and urologists and their support staff primarily, who are likely to manage a significant population of patients that are likely to benefit from Rivfloza™. NNI also will market Rivfloza™ for patients with Primary Hyperoxaluria Type 1 aged 9 and older with intact renal function, as per Rivfloza™ label.

NNI educates health care practitioners (HCPs) about Rivfloza™ through in-office detailing visits, … conferences and conventions … does not provide any gifts to health care providers … distributes educational materials to health care providers ... NNI also offers product information as well as product starter kits through HCPs for patient use.

… allocated budget to marketing Rivfloza™ to consumers by:

- *Paying the salary and related employment costs … to educate and promote to consumers in Oregon.*

36 Refer to Appendix H for descriptions of therapeutic classes used in this report.

• *Spending to … develop targeted online advertising to consumers.*

• *Providing patient starter kits for patients ...*

• *Providing Patient Support Programs …*

{similar actions for HCPs have been omitted in this excerpt}

… In connection with the introduction of Rivfloza™ to market, Novo Nordisk will spend approximately [monetary number] on marketing Rivfloza™ to consumers and HCPs in the United States in the manner provided above. That amount is less than [monetary number] per resident of Oregon based on United States Census Bureau population estimates for July 2023, the last data available. This figure does not include the internal administrative costs (e.g., home office facility costs)." (Rivfloza)

PHARMACEUTICAL ASSOCIATES, INC (PAI)

"*PAI Holdings LLC d/b/a PAI Pharma markets to hospitals and clinics, contracts with group purchasing organizations and wholesalers, and generally distributes products using the wholesaler channels. PAI Holdings LLC does not market direct to consumers. The planned marketing budget is approximately $40,000.*" (Lidocaine hydrochloride - generic)

VERTICAL PHARMACEUTICALS

"*RELEXXII is a central nervous system (CNS) stimulant indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD). Vertical Pharmaceuticals plans to spend to initially market the drug to physicians and other health care professionals an amount of $500,000.00. There are no marketing plans to advertise directly to consumers through TV, magazines, social media, blogs, billboards, mobile applications or other web-base media. Relexxii will be promoted/ detailed to physicians and other health professionals by 24 sales professionals across the US. Vertical offers to direct-to-consumer for Relexxii a Co-pay Assistance Card offer (only for eligible commercially insured patients that may pay as little as $15 per month). Relexxii commercial launch date is December 11, 2023.*" (RELEXXII®)

While the program collects this information for all new prescription drug reports, both generic and brand name, it has 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, branded generics and biosimilars (biologic drugs similar or equivalent to an original biologic drug), tend to be marketed more like a brand name.

Pricing methodology

Manufacturers are required to submit the methodology used to establish the price of the new prescription drug, including an explanation of all major financial and nonfinancial factors that influenced the initial price. The program has received a wide variety of explanations, some are minimal and others are more detailed. Many manufacturers claim this information is a trade secret. Reviews of these claims tend to show that it is not trade secret and often shows common industry practices.

While most brand-name manufacturers described a holistic multifactor analysis of economic and clinical factors, the program has found that most generic drugs instead determine a discounted price from the brand-name drug or a comparative price to other generics.

Here are samples from submissions in 2024 for the pricing methodology data element that were not claimed as or determined not to be a trade secret:

ASCEND LABORATORIES LLC

"*Ascend continues to keep affordability and patient access at the forefront of its company adjustives. We are committed to providing high quality and cost-effective generic drug products that address a number of health issues within multiple therapeutic areas. Utilizing multiple data platforms, Ascend conducts research of the competitive landscape while assessing the needs of patients to determine pricing for its product portfolio inclusive of Topiramate. At the time of launch, compared to other generic equivalent to the RLD offered in this class, Ascend's Topiramate is priced approximately .01% below competition.*" (Topiramate)

BOEHRINGER INGELHEIM PHARMACEUTICALS INC

"*Specific Marketing and Pricing Plans for adalimumab-adbm are not in the public domain or publicly available. Boehringer Ingelheim considered several factors in determining the price of our medicines. These factors include: the life transforming value that is delivered to patients, investments made with research and development and beyond, the patient population size, manufacturing, the risks undertaken, consideration for access to patients and the continued need for scientific innovation for generations to come. Boehringer Ingelheim invests up to 22.5% of its net sales into research and development, including clinical trials. A marketplace comparison to other Humira biosimilar equivalents (Sandoz, adalimumab-adaz) was used to determine WAC price for adalimumab-adbm. WAC price for adalimumab-adbm is an 81% discount to Humira.*" (adalimumab-adbm – this is a biosimilar to Humira)

MERCK SHARP & DOHME LLC

"*Merck considers several factors in determining the price of our medications. … Our pricing of WINREVAIR reflects consideration of these factors in the following ways:*

- *Unmet need: The U.S. price of WINREVAIR reflects the significant innovation that this medicine represents as … the first biologic approved by the U.S. FDA for Pulmonary Arterial Hypertension (PAH), a rare and progressive disease …*
- *Value to patients and the health care system: Based on … STELLAR trial in which WINREVAIR was added … WINREVAIR demonstrated clinically meaningful improvements for patients … and reduced the risk of clinical worsening events.*
- *Access and affordability needs for patients: Merck also considered supporting access to appropriate patients who may benefit, balancing the other factors described here.*
- *R&D sustainability: Merck took into account the need to ensure that we can continue the risky and capital-intensive biopharmaceutical research and development needed to bring forward medically-important breakthroughs for patients across a wide range of therapeutic areas. The price of WINREVAIR also reflects Merck's commitment to researching WINREVAIR in additional patient populations and for additional uses …*
- *Competitive landscape: Merck considered prices of existing products in the marketplace ...*" (WINREVAIR™)

MIRUM PHARMACEUTICALS

"*LIVMARLI is an orphan drug with a small patient population. The cost of research and development, marketing and commercialization for the rare disease is a contributing factor to the cost of the drug.*" (LIVMARLI®)

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.[37]

For the current reporting year (2024 data was reported in 2025), as displayed in Figure 19, the program received a total of four price increase reports with at least some voluntary data included. This represents a 98 percent decrease in reports received since the changes effective Feb. 21, 2024. 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

37 "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. 25, 2025.

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

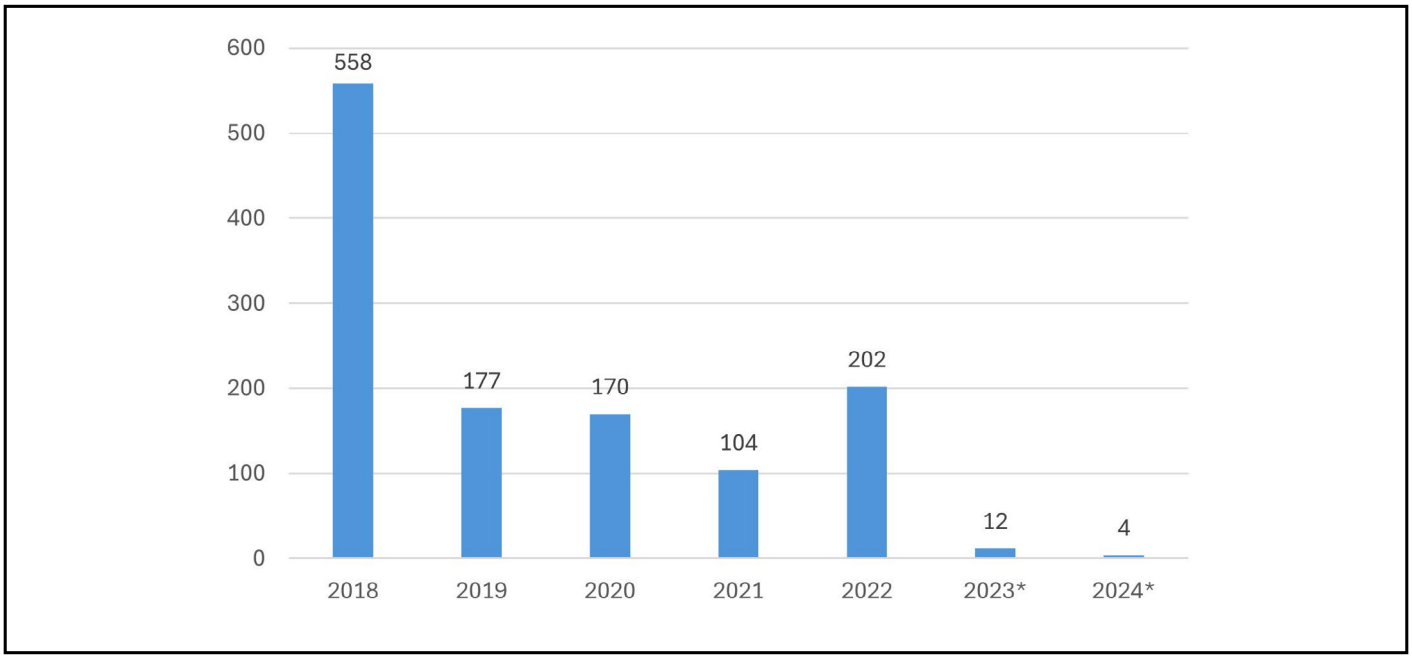
Reports are filed for price increases that occurred over the preceding calendar year, so reports received in 2025 reflect increases from the average price of the drug in 2023 to the average price of the drug in 2024.[38] Because most data are voluntary for reports received in 2024 and 2025 (increases that occurred in 2023 and 2024), the program will limit its analysis to the patient assistance program information it received.

Patient assistance data from annual increase reports

The program received patient assistance data for drugs that had a price increase of at least 10 percent between 2023 and 2024. Several reports had no Oregon participants. Reports came from 14 manufacturers, covering 2,074 Oregon patients totaling a value of $3,807,145 during 2024. This is an average of about $1,836 per patient (ranging from $139 to $136,800 per patient), and a decrease of about $12.8 million from last year's total assistance for Oregonians.

There were 33 unique patient assistance programs reported with 19 unique drugs, and all were brand-name drugs.

Figure 19: Counts for annual price increase reports based on the year of the data being reported for 2018 to 2024 (*2023 and 2024 only include those with voluntary data)



38 Note that in prior years, this chart referenced the year the reports were received. The current chart now reflects the data year, that is, the year the drug price increase occurred, which is reported in the following calendar year.

One of the 12 therapeutic classes[39] , was anti-asthmatic and bronchodilator agents, which reported the highest total patient assistance program spending. Data on patient assistance programs received this year not claimed as trade secret is shown in Figure 20.

Figure 20: Average patient assistance by therapeutic class

Therapeutic class	Average patient assistance amount per Oregon patient received in 2024
Diuretics	$136,800 / patient
Endocrine And Metabolic Agents – Miscellaneous	$14,196 / patient
Estrogens	$139 / patient
Ophthalmic Agents	$3,183 / patient

The program also received data claimed as trade secret about the therapeutic classes[40] that are not shown in Figure 20: analgesics – nonnarcotic, anti-asthmatic and bronchodilator agents, diagnostic products, gastrointestinal agents, genitourinary agents, and psychotherapeutic and neurological agents.

60-day price increase notices

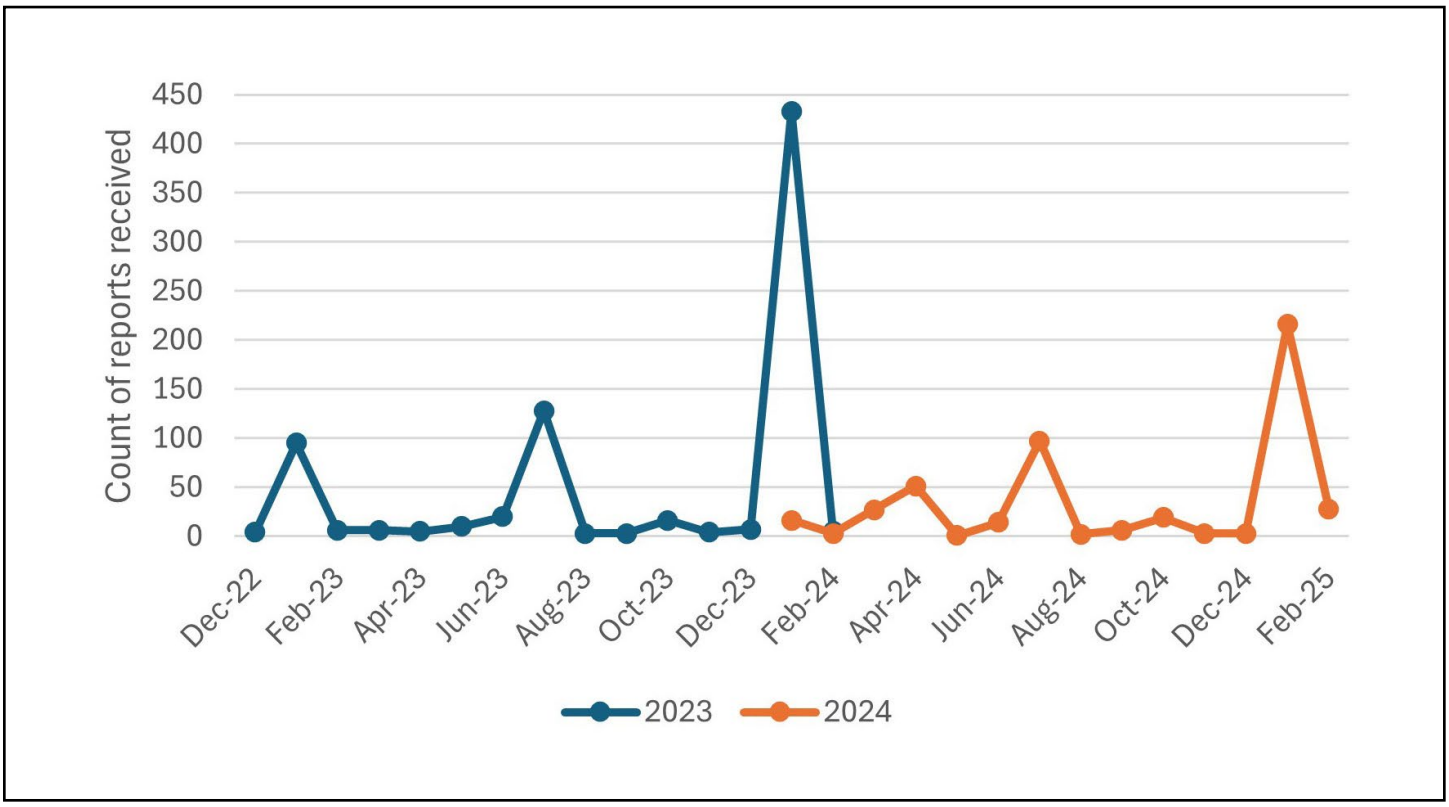
Manufacturers are required to submit a price increase notice 60 days before a planned price increase takes effect when the threshold is met. A report is required for a brand-name prescription drug when the cumulative price increase is at least 10 percent or $10,000 within a 12-month period. A report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

Here, we illustrate the effective date of the planned increase from reports submitted with filing dates between Jan. 1 through Dec. 31 for the years 2023 and 2024. In Figure 21 below, we represent the effective increase dates reported in 2023 as blue, and the effective increase dates reported in 2024 as orange.

For both years, most of these price increases come at the beginning of each year (433 NDCs in January 2024 and 216 NDCs in January 2025). Smaller spikes occurred in July, halfway through the year (128 NDCs in July 2024 and 97 NDCs in July 2025).

39 Refer to Appendix H for descriptions of therapeutic classes used in this report.
40 Ibid.

Figure 21: Number of 60-day price increase notices received based on the month of the planned increase, received in the years 2023 and 2024



Figures 22: Companies with the most 60-day price increase notices

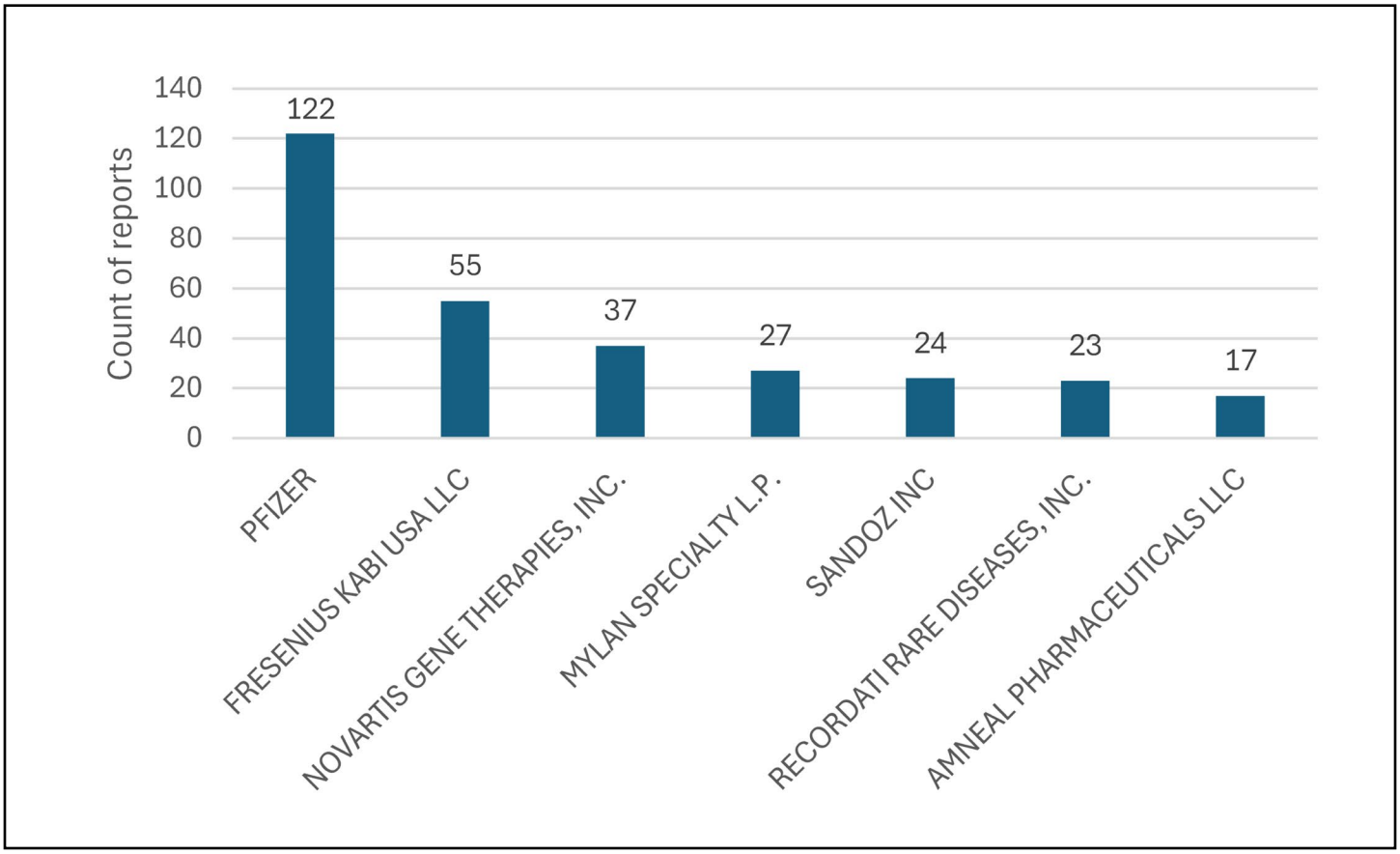
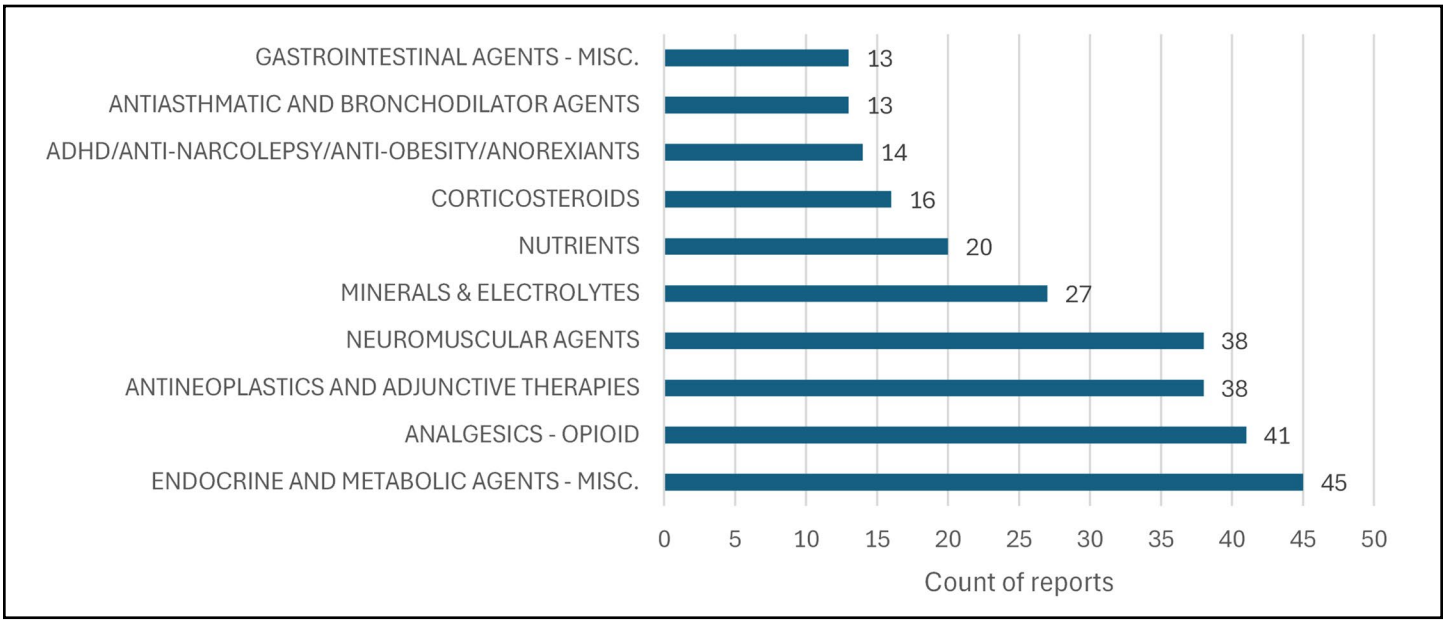


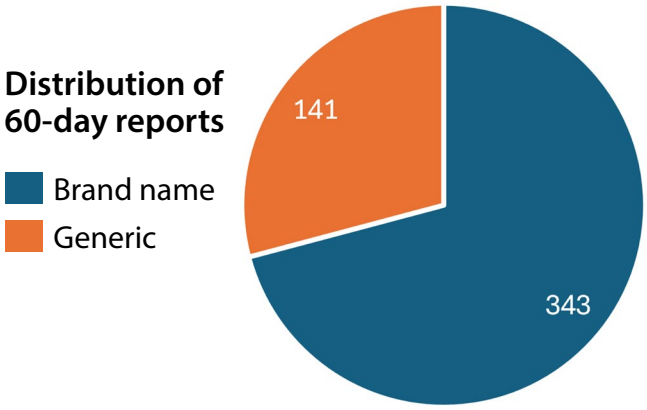
Figure 23: Drug categories with the most 60-day price increase notices



Pfizer submitted the most price increase notices in 2024 with 122. Fresenius Kabi USA LLC was next with 55 notices.

The 10 most reported by therapeutic class[41] are represented here. Endocrine and metabolic agents – miscellaneous had 45 price increase notices. Next was analgesics – opioid with 41 price increase notices.

Figure 24: Counts of 60-day price increase notices for generics versus brand-name drugs



Of the 484 price increase notices the program received in 2024, 141 (about 29 percent) were for generic drugs and 343 (about 71 percent) were for brand-name drugs.

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 life cycle. The program shifted to a more assertive approach to compliance insufficiencies. The new approach enables the program to address trade secrets and compliance issues with less time-lapse. As a result, all new drug reports filed in 2024 have been reviewed and trade secret claims resolved. To improve manufacturer reporting, the program completed rulemaking earlier this year to clarify expectations and is updating the manufacturer reporting system.

The program has the authority to impose civil penalties on manufacturers who fail to file required reports or respond to program correspondence. The program regularly reaches out to manufacturers and attempts to help them understand the requirements

41 Refer to Appendix H for descriptions of therapeutic classes used in this report.

to resolve their compliance issues. When manufacturers are not receptive, the program issues noncompliance warning notices. If the manufacturer still does not come into compliance following our initial noncompliance notices, we prepare the file for the division's enforcement unit. During 2024, program compliance was able to resolve issues without the need for enforcement intervention.

To monitor that all prescription drugs are reported accurately, the department contracted for access to Medi-Span, a database of WAC pricing data. The program 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. The program did further analysis to identify which NDCs should be reported and then notified the manufacturer to come into compliance or provide documentation that a report is not required.[42] Education efforts and noncompliance warnings have increased compliance and improved reporting and clarified trade secret claims for many manufacturers.

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 amounts spent on marketing) as trade secrets. This prevents the 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:

1. An evaluation of manufacturer-provided justification for the trade secret claim
2. A review of common industry practice and knowledge
3. Research 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, the program issues a trade secret determination to the manufacturer identifying where we disagree and what part of the data will be published. If the manufacturer does not appeal within 15 days, the determination becomes final. If the manufacturer appeals, the information provided in the appeal is reviewed and the program issues a final determination. After a 21-day waiting period, the information determined not conditionally exempt from disclosure per the final determination is published to the program's transparency site.

Reports with invalid or unexplained trade secret claims have been reduced by compliance education and outreach to manufacturers over the past year. While some representatives who work for third-party entities previously stated they were instructed by the manufacturer to provide as little information as possible and claim trade secrets on all data elements where allowed, this practice has also improved with the program's active compliance education.

Across the 547 new prescription drug reports the program received in calendar year 2024, manufacturers claimed 608 individual data elements as trade secrets on 300 reports. All 300 reports received in 2024 with trade secret claims were reviewed, with 182 (60.7 percent) having information determined not conditionally exempt from disclosure and some or all of the claimed data was published. The remaining 118 (39.3 percent) were processed as claimed after their review. 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

42 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.

With the decrease in invalid trade secret claims, increased education, and updated program rules, we expect a smaller percentage of reports to require a trade secret determination in the future.

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.

Section 3: Pharmacy benefit managers (PBMs)

Pharmacy benefit managers are entities that contract with pharmacies on behalf of health insurers, coordinated care organizations, as well as the Oregon Prescription Drug Plan.[43] Some of their tasks include:

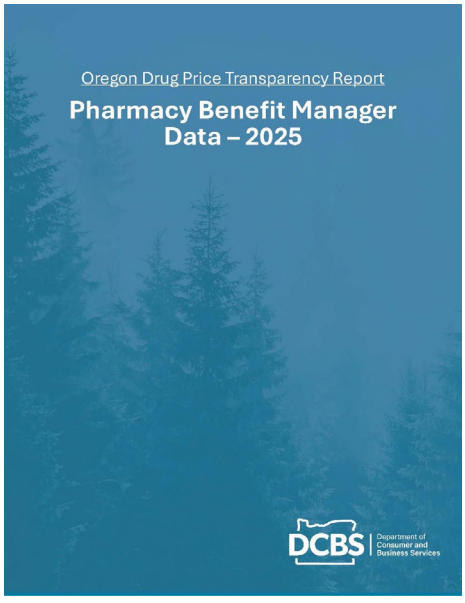
- Processing claims for prescription drugs and medical supplies dispensed by pharmacies
- Processing payments and negotiating rebates between drug manufacturers, pharmacies, and health insurers
- Creating prescription drug lists (formularies)
- Managing retail pharmacy networks

Since 2024, Oregon law[44] requires licensed pharmacy benefit managers (PBMs) to report information to the Drug Price Transparency (DPT) Program each year. PBMs licensed in Oregon are required to provide payment and revenue information for the preceding calendar year. This includes various payments (rebates, fees, etc.) received from manufacturers and carriers. Licensed PBMs are also to report revenue from retaining payments and through spread pricing and pay-for-performance arrangements. They must also report dispensing fees received and paid to others.

In 2025, 57 PBMs were licensed in Oregon at the time of reporting. Of those 57, 15 reported having business subject to the reporting requirements of this program. Those 15 PBMs are:

- A&A Drug Co. dba Sav-Rx Prescription Services
- AffirmedRx PBC
- Amwins Group Benefits LLC
- Capital Rx Inc.
- CaremarkPCS Health LLC
- Cigna Health and Life Insurance Co.
- DST Pharmacy Solutions Inc.
- Express Scripts Administrators LLC
- Interchange Rx, LLC
- MedImpact Healthcare Systems Inc.
- Navitus Health Solutions LLC
- OHSU PBM Services
- OptumRx Inc.
- Prime Therapeutics LLC
- True Rx Management Services Inc.

This report contains excerpts from the program's 2025 PBM report, which can be accessed on the program's website at https://dfr.oregon.gov/drugtransparency/Pages/DPT-pharmacy-benefit-managers.aspx. Refer to the full report for notes, exclusions, limitations, and assumptions concerning the PBM data.



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

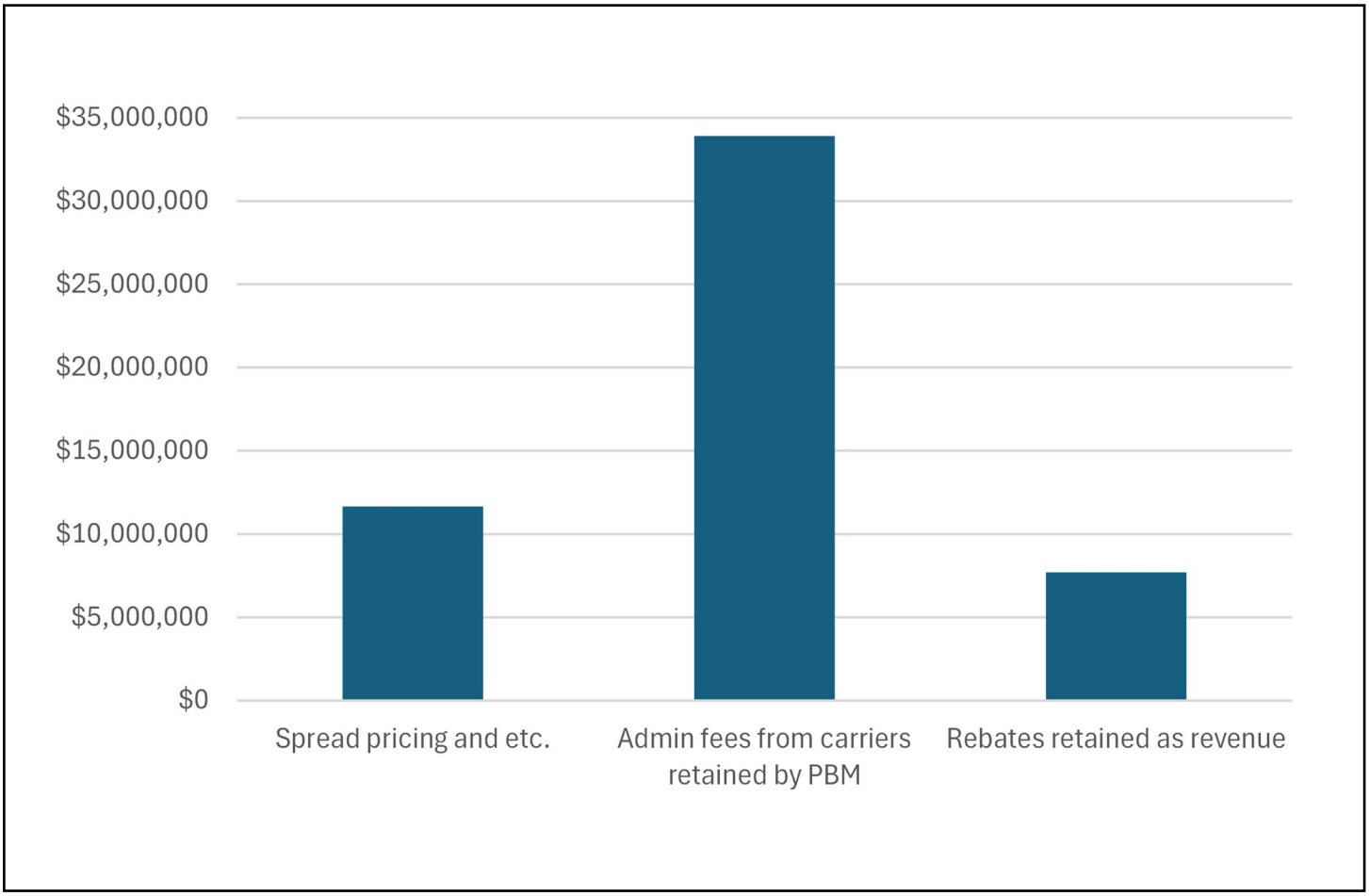
44 ORS 735.537 and OAR 836-200-0418. https://www.oregonlegislature.gov/bills_laws/ors/ors735.html and https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=3795. Accessed Oct. 20, 2025.

Figure 25: Aggregated data per ORS 735.537 shows reported data in an aggregated manner that does not disclose confidential PBM information.

Reporting element:	Aggregated data	Average	Number of PBMs[45]
(1) Total rebates, fees, price protection payments, and any other payments received from manufacturers related to managing pharmacy benefits for carriers issuing health benefit plans in Oregon:	$377,273,218	$31,439,435	12
Amount of (1) passed to carriers issuing health benefit plans in Oregon:	$369,134,168	$33,557,652	11
Amount of (1) passed to enrollees of health benefit plans in Oregon:	$432,204	$144,068	3
Amount of (1) retained by the PBM as revenue:	$7,706,846	$1,284,474	6
The total dispensing fees paid to the PBM in this state from carriers, coordinated care organizations, and the Oregon Prescription Drug Program:	$15,599,279	$1,559,928	10
The total dispensing fees paid to pharmacies in this state by the PBM:	$17,765,746	$1,268,982	14
The total administrative fees received from carriers:	$33,919,368	$5,653,228	6
The total administrative fees from carriers that were retained by the PBM:	$33,919,368	$5,653,228	6
The total amount of revenue received by the PBM through spread pricing, pay-for-performance arrangements, or similar means:	$11,654,515	$1,664,931	7

45 While there were 15 PBMs considered nonexempt from our reporting requirements this year, not every PBM reported dollar amounts for all of the fields requested. Many had $0 reported in spending or other data elements. Including zeroes in the average calculation would artificially deflate each of the metrics, reducing its accuracy and usefulness. Thus, we tabulated how many PBMs reported non-zero amounts in each data field requested and calculated the averages based on those amounts.

Figure 26: Sources of revenue



Fee type	Spread pricing and etc.	Administration fees from insurer retained by PBM rebates	Rebates retained as revenue
Retained as revenue	$11,654,515	$33,919,368	$7,706,846

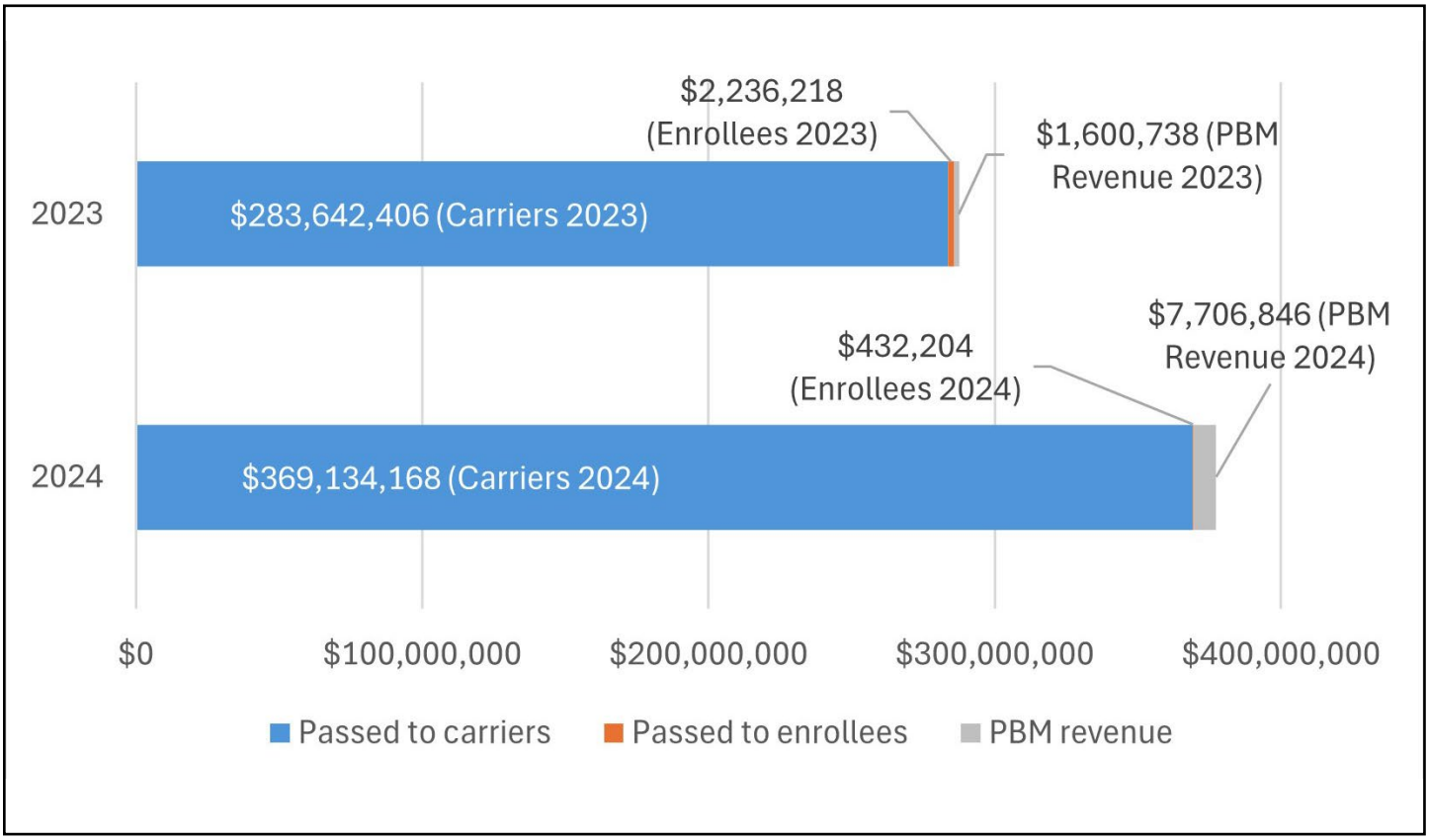
This table illustrates the sources of revenue for the reporting PBMs.

Notably, the bulk of revenue PBMs receive in Oregon comes from administration fees – 97.8 percent of manufacturer rebates are passed through to carriers.

Figure 26 aggregates and tabulates various categories of fees received and compares them to the reported amount of these fees retained by the PBMs. The total dispensing fees represent a net cost, with no amount of that fee retained as revenue.

Aggregate fees from spread pricing and etc., administration fees from manufacturers and carriers, and rebates had amounts reported to be retained as revenue. Of the 15 reporting PBMs, seven reported revenue from spread pricing, pay-for-performance arrangements, or similar means. The aggregate value reported was $11,654,515.The exact numbers in Figure 26 are found in the table below the chart.

Figure 27: Rebate amounts and distribution compared for data years 2023 and 2024 (reporting years 2024 and 2025)



Data year	Passed to carriers	Passed to enrollees	PBM revenue
2024	$369,134,168	$432,204	$7,706,846
2023	$283,642,406	$2,236,218	$1,600,738

In 2024, there were 17 PBMs considered nonexempt from the reporting requirements; in 2025, there were 15. Despite the decrease of two entities, there was an $89,793,856 gross increase in total rebates reported in 2025 (data year 2024) as compared to rebates reported in 2024 (data year 2023), a 31.2 percent increase year over year. Figure 27 below illustrates these figures.

Figure 27 also shows the distribution of the rebates received in both years. We aggregate the manufacturer payment amounts passed to carriers, enrollees, and retained as PBM revenue. The percentage figures for these statistics are also presented in the graph: $432,204 was passed to enrollees, a decrease of $1,804,014 (-80.7 percent) from data year 2023; $369,134,168 was passed to carriers, an increase of $85,491,762 (+30.1 percent) from data year 2023; $7,706,846 was kept by the PBMs as revenue, an increase of $6,106,108 (+381.5 percent) from data year 2023.

Additionally, we compare the total rebates received by both the top six and middle six PBMs, ranked by rebate received, from 2023 data to the 2024 data received this year. The rebates received by the top six PBMs increased by $89.5 million (+31.2 percent), and the rebates received by the middle six PBMs increased by $362,898 (+49.4 percent) during the same period.

Section 4: 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 850,000 people, representing about a quarter of all Oregonians.

For 2025, the program received reports from these 11 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.

The same 11 insurance companies reported aggregate data in 2025 and 2024 (about drugs purchased in 2024 and 2023, respectively). 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 2024
- The money spent by them and their policyholders on those drugs in 2024 after rebates or other price concessions
- The difference between the total amounts spent in 2023 and in 2024 (the year-over-year increase)

Insurers submit separate lists for generic drugs, brand-name drugs, and specialty drugs. Generic and brand-name drugs are those at or below the specialty threshold. For this year's insurer reporting, the specialty drug threshold was $670 for a one-month supply (aligning with DPT's threshold for new prescription drug reporting during 2024). A drug, generic or brand name, is categorized as a specialty drug when priced above the threshold for the reporting year.

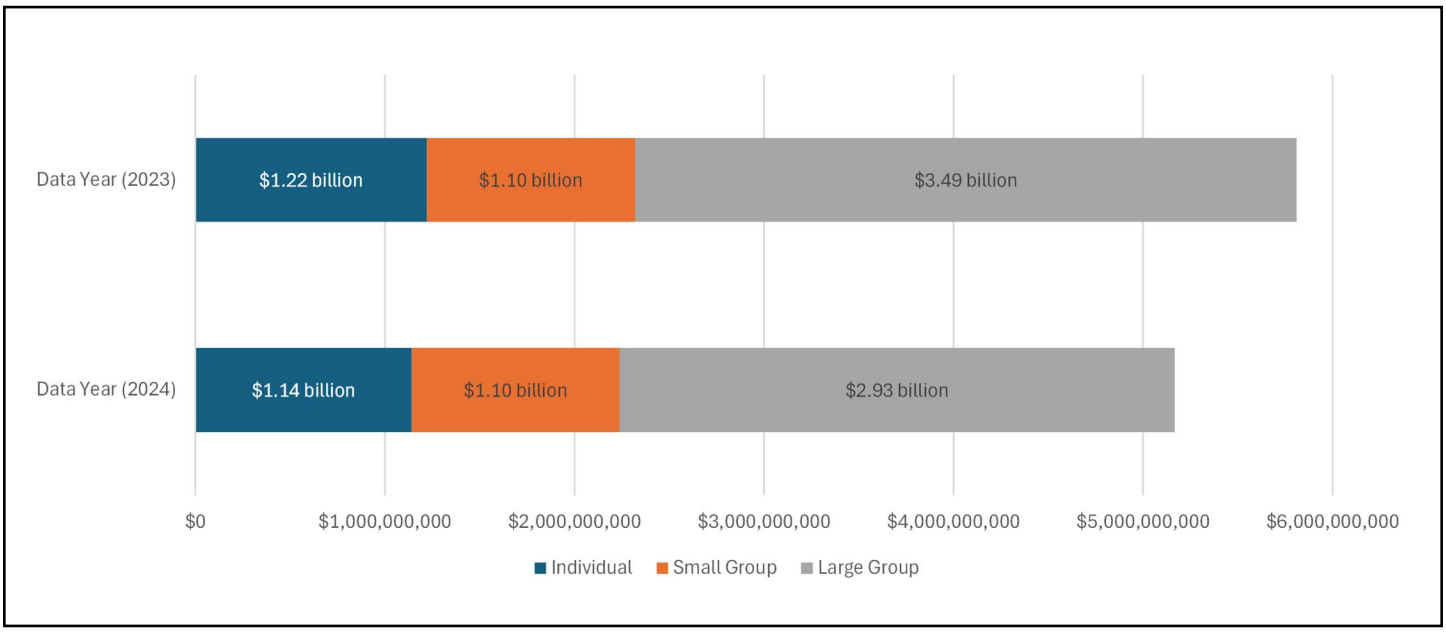
After combining the data, the final lists show the top-10 drugs in each category, aggregated from the data for all 11 insurers.

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.[46] 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.

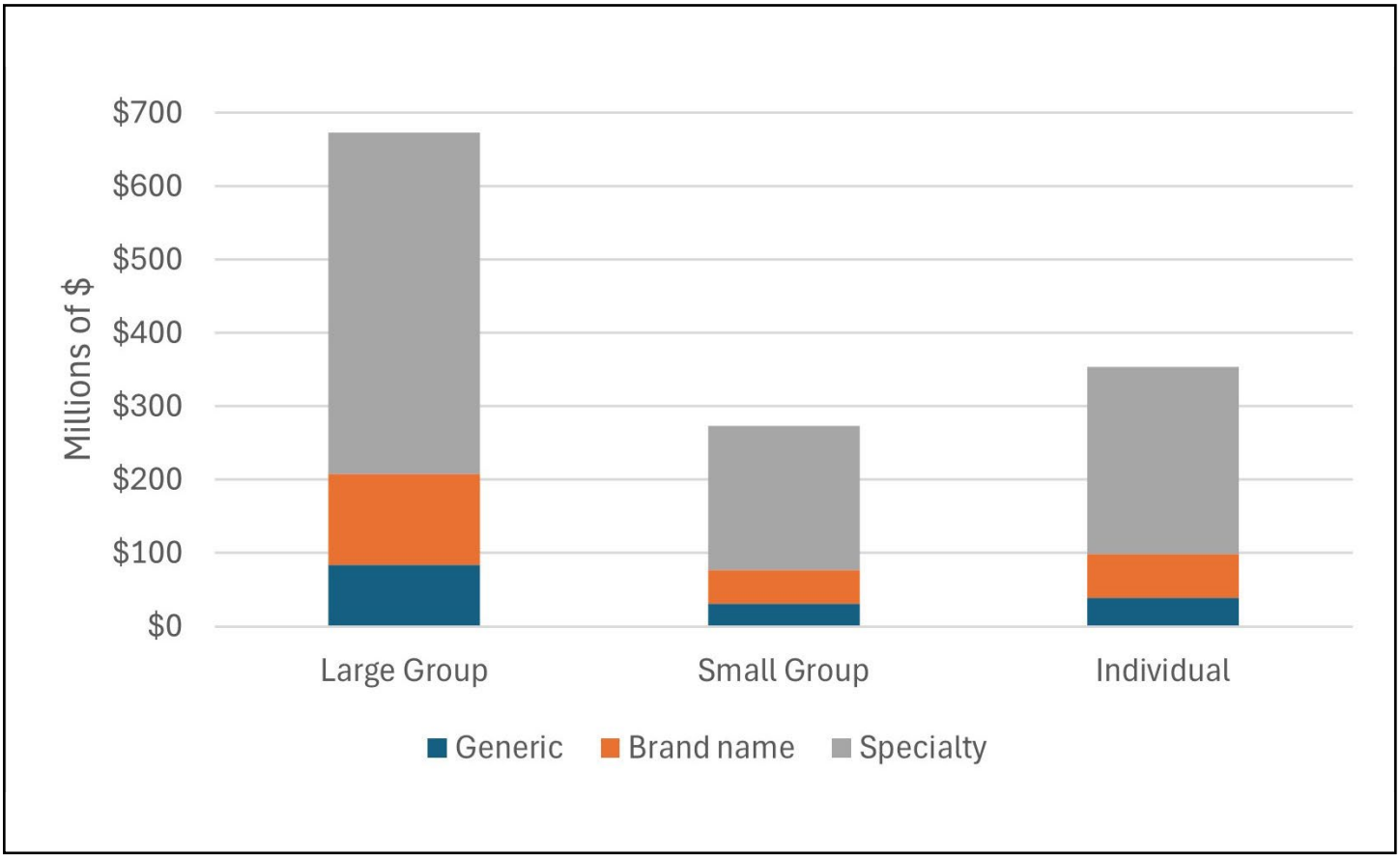
46 Generally, under the Affordable Care Act, small-group plans are defined as those purchased by an employer with 50 or fewer enrollees; large-group plans are those purchased by an employer with 51 or more enrollees; and individual plans are plans purchased directly by the enrollee.

Figure 28: Premium amounts indicating market size collected by individual, small-group, and large-group plans reported in 2024 (data year 2023) and 2025 (data year 2024)



Referencing Figure 28, in terms of total premium collected, the large-group market was the largest by volume, with $2.93 billion, a decrease of $562 million (-16.04 percent) from 2023 to 2024 data. The individual market was the second largest with $1.14 billion, a decrease of $80 million (-6.5 percent). Finally, small group was the smallest market among the three, with $1.10 billion in premiums collected, which is about the same in 2023 and 2024.

Figure 29: Prescription drug spending by markets and drug category



Drug category	Large group	Small group	Individual
Generic	$83,743,540	$31,531,617	$38,881,409
Brand name	$124,023,218	$45,278,956	$59,479,474
Specialty	$465,281,597	$197,012,515	$255,293,158
Total	$673,048,355	$273,823,088	$353,654,040

Figure 29 compares all three groups (large group, individual, and small group) by spending on generic, brand-name, and specialty drugs.

Across all insurance companies, they spent $1.3 billion on all drug types:

- Large-group spending of $673.0 million
  - $83.7 million on generics
  - $124.0 million on brand-name drugs
  - $465.3 million on specialty drugs
- Small-group spending of $273.8 million
  - $31.5 million on generics
  - $45.3 million on brand-name drugs
  - $197.0 million on specialty drugs
- Individual market spending of $353.7 million
  - $38.9 million on generics
  - $59.5 million on brand-name drugs
  - $255.3 million on specialty drugs

Shown below in Figure 30 is the spending per prescription for all entries in the top 25 most-prescribed generic, brand-name, and specialty drugs, reported in the 25 Most Prescribed (MP), 25 Most Costly (MC), and 25 Greatest Increase (GI) sections. The program aggregated the number of prescriptions and total annual spending across each category to get an average spending per prescription for each generic, brand name, and specialty table. For generic and brand-name drugs, drugs reported in the most prescribed tables tended to be slightly cheaper per prescription than the most costly and greatest increase tables, with drugs in the greatest increase tables costing the most per prescription among generic and brand-name drugs. Specialty drugs that reported the greatest spending per prescription were the ones reported in the most costly tables, at an average of $4,825. The specialty drugs in the most prescribed tables had an average of $2,093 per prescription.

Figure 30: Average insurer spending per prescription and per reporting category

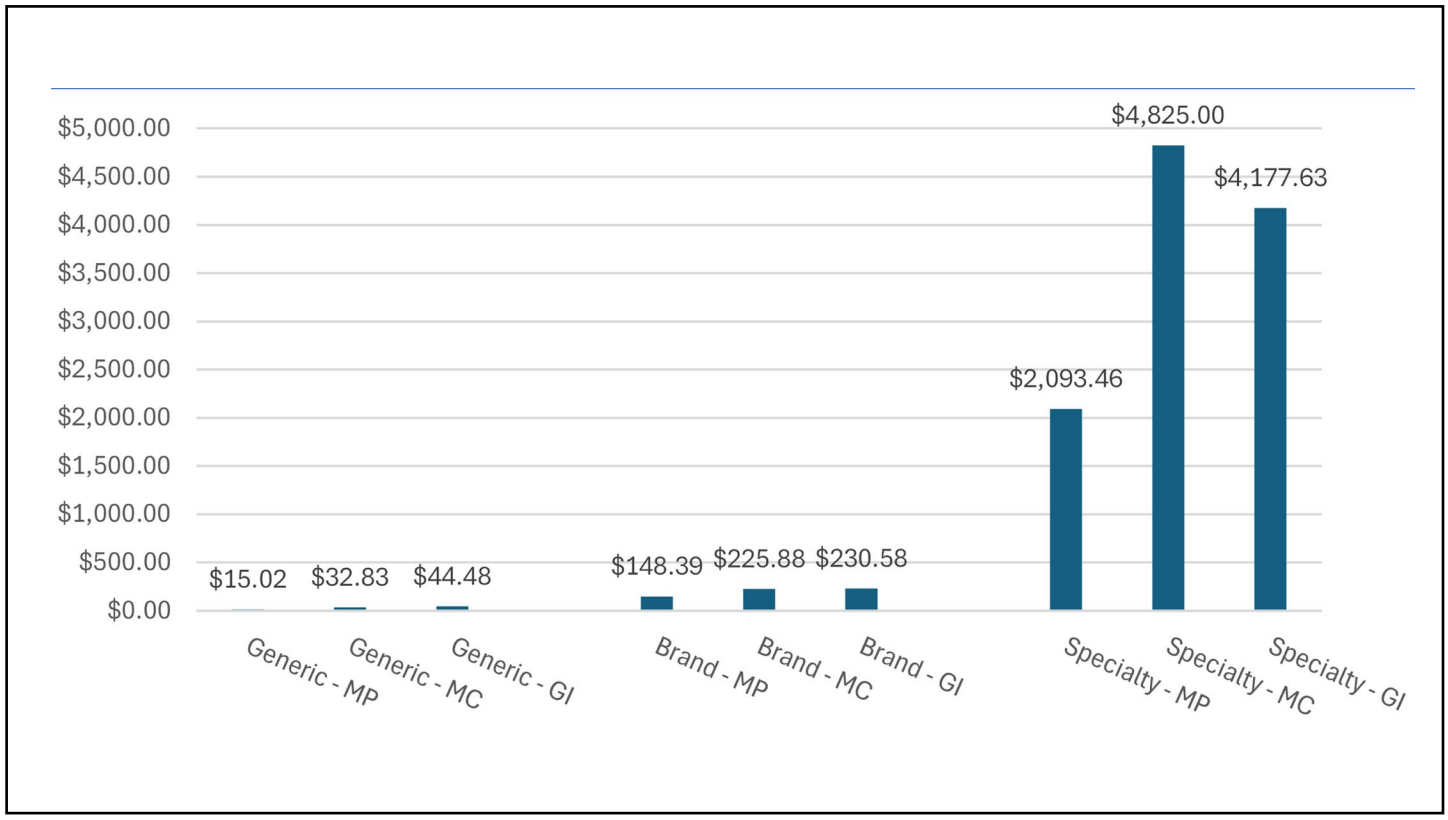


Figure 31 shows that plan spending on prescription drugs varies widely as a percentage of total premiums collected. BridgeSpan had the highest share of spending, reporting that 45 percent of its total collected premium was spent on pharmaceuticals. Cigna had the second-highest share of spending on pharmaceuticals with 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 18 percent spent on pharmaceuticals, respectively.

Insurers reported information about total premiums and the amount of member months covered. Figure 32 shows the companies' premium collected per member per month (PMPM). The insurance companies with the highest average premium per member per month were BridgeSpan and PacificSource, with $714 and $660 per member per month, respectively. The company with the lowest premium per member per month was United Healthcare at $513 per member per month.

Figure 31: Plan spending on prescription drugs as a percentage of premiums collected

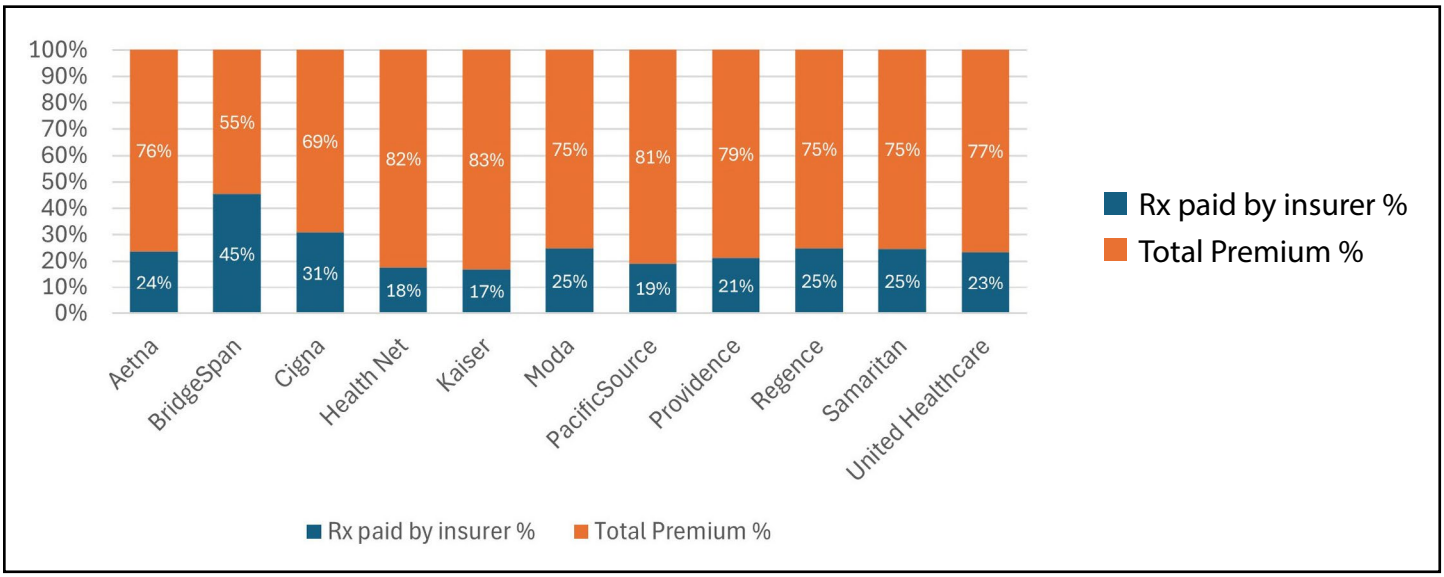


Figure 32: The average premium per member per month (PMPM)

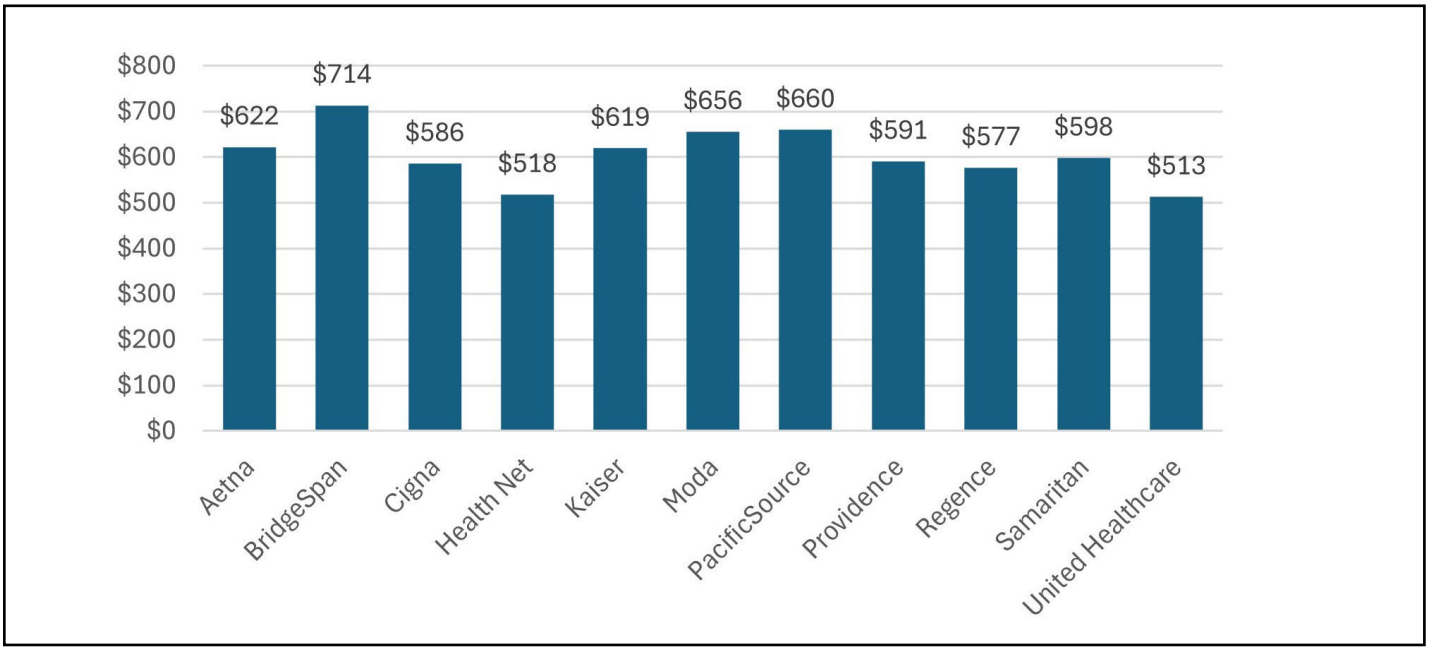
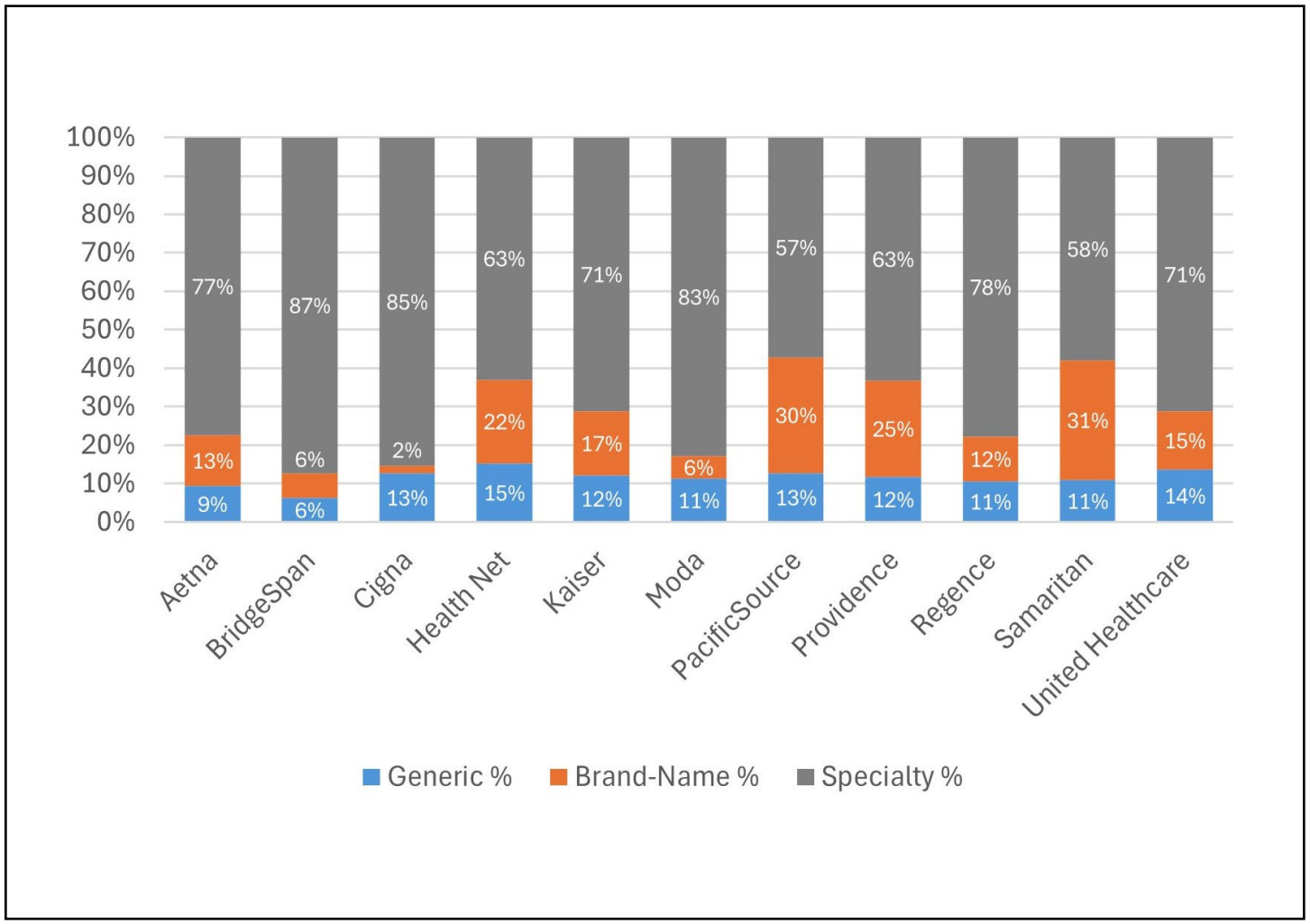


Figure 33 shows spending on each drug category as a percentage of total spending on prescription drugs. Across the board, all plans spent the most on specialty drugs and the least on generic drugs; however, this is opposite of the actual volume of prescriptions. Generic drugs constitute the majority of prescriptions written and filled, while specialty drugs (generic and brand-name drugs that cost more than $670 for a one-month supply) 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 57 percent and 58 percent, respectively.

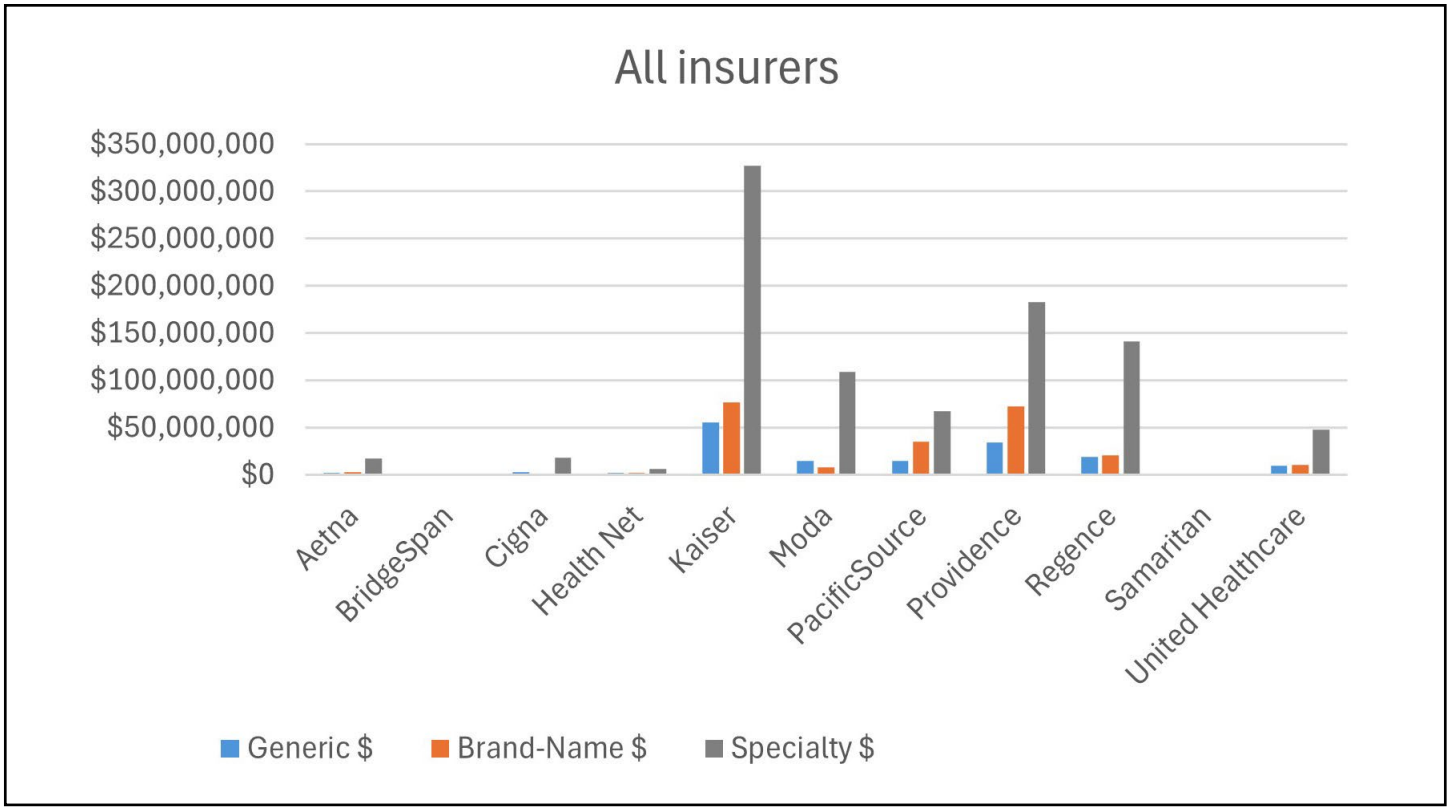
While Figure 33 shows spending in percentage terms, figures 34 and 35 show the gross spending on each category for the same companies.

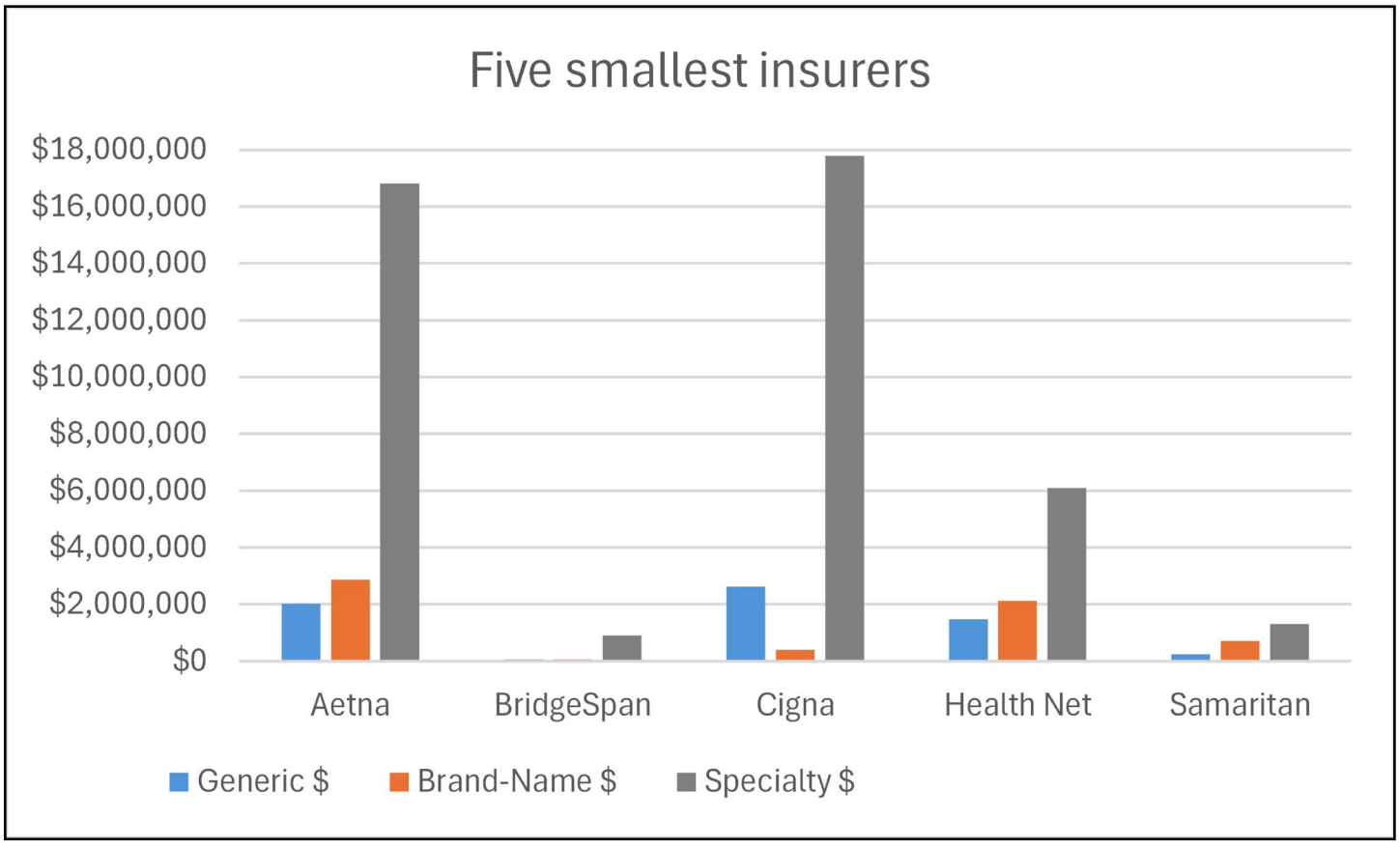
That said, there is at least one conclusion the program can draw from the data: High-cost specialty drugs represent a majority of drug spending reported by insurance companies.

Figure 33: Plan spending on prescription drugs by category (brand name, generic, and specialty)



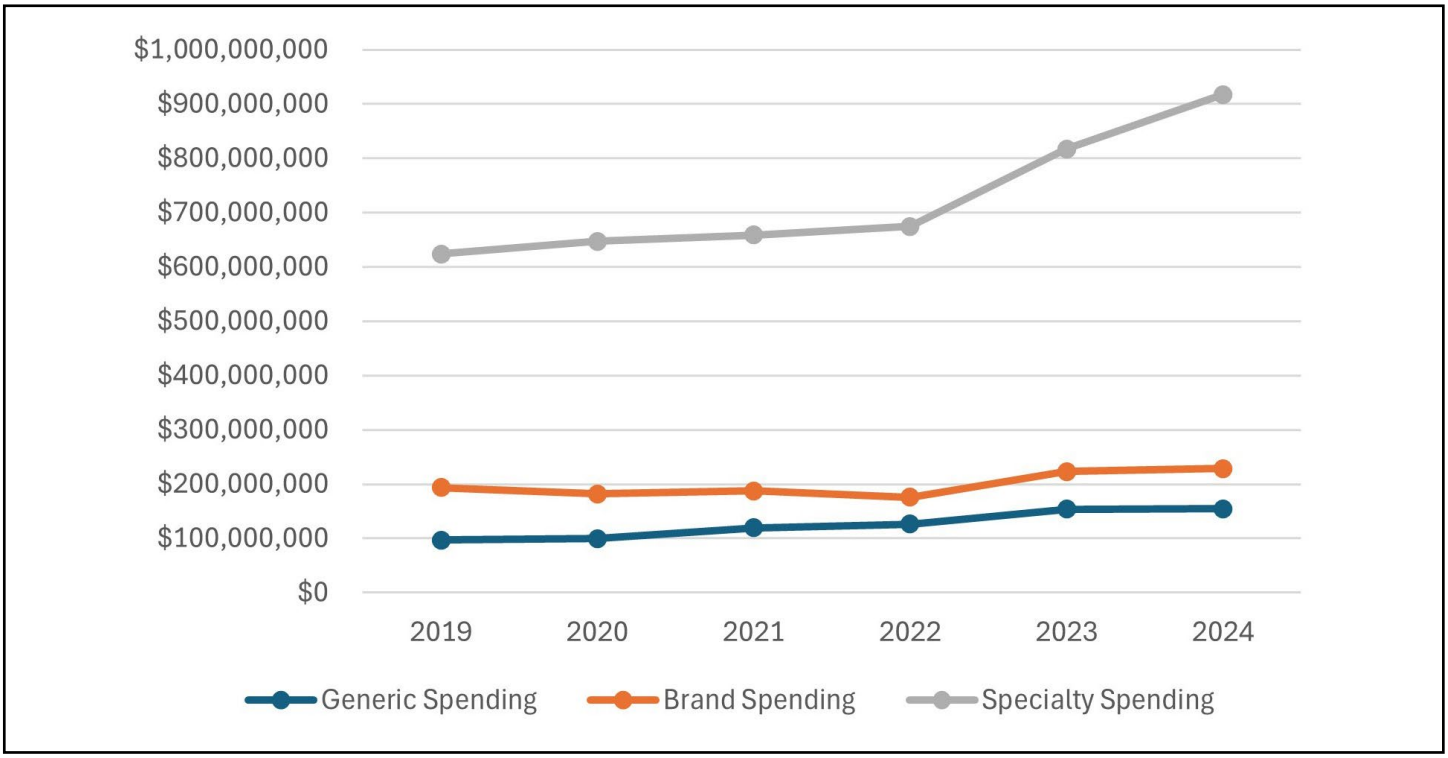
Figures 34 and 35: Amounts spent on prescription drugs by category (brand name, generic, and specialty) for all insurers and the five insurers with the smallest spending





Company name	Generic	Brand name	Specialty
Aetna	$2,029,696	$2,858,435	$16,810,814
BridgeSpan	$64,943	$66,669	$906,484
Cigna	$2,629,218	$399,140	$17,775,470
Health Net	$1,475,674	$2,115,639	$6,097,445
Kaiser	$55,624,373	$76,629,834	$327,495,081
Moda	$14,797,849	$7,648,980	$108,690,467
PacificSource	$14,952,859	$35,148,332	$66,969,612
Providence	$34,023,190	$72,129,310	$182,992,903
Regence	$19,167,343	$20,985,552	$140,813,669
Samaritan	$246,745	$702,356	$1,310,655
United Healthcare	$9,144,676	$10,097,400	$47,724,670

Figure 36: Total prescription drug spending by insurers from 2019 through 2024 (years being reported)



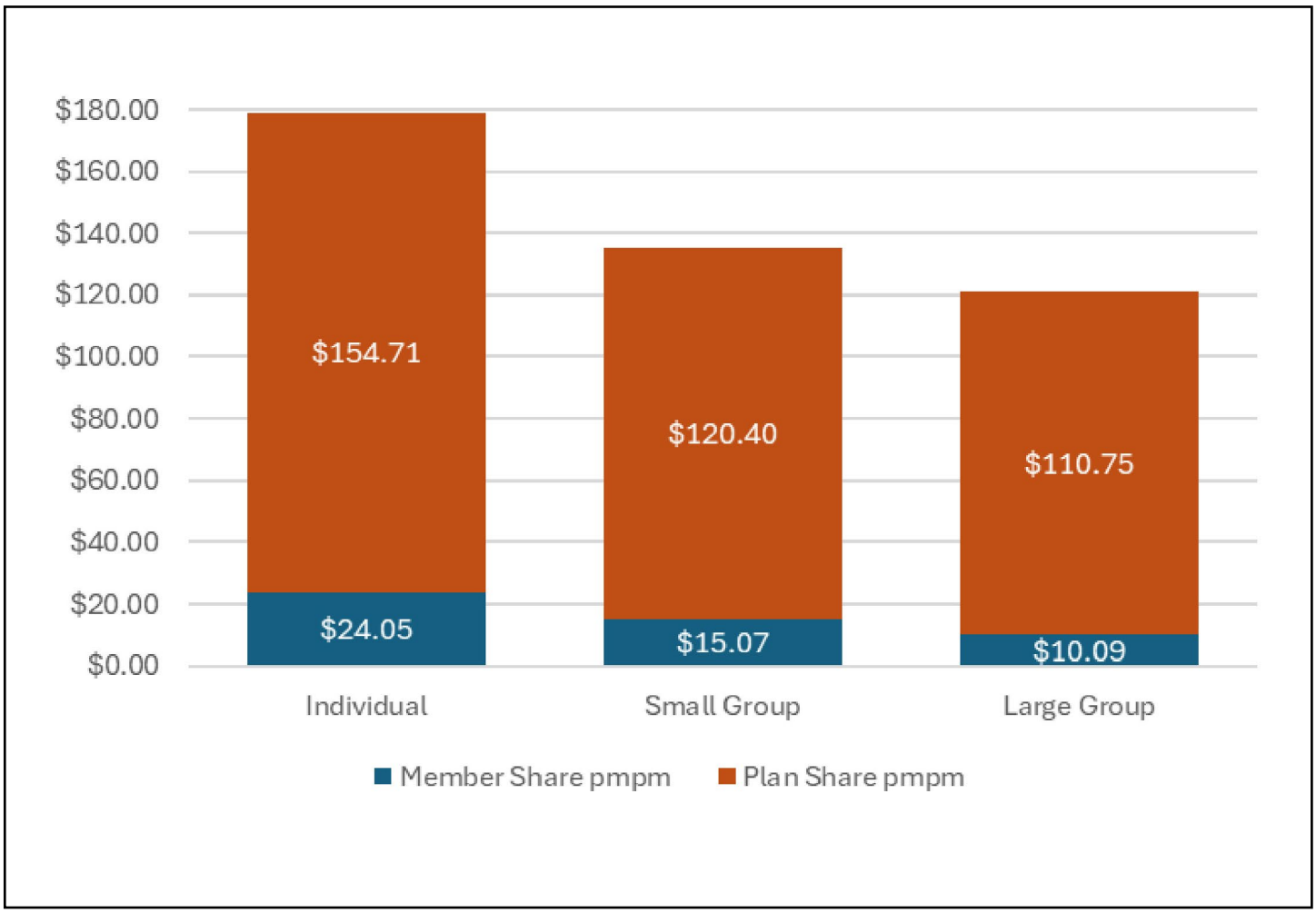
Year of operations	Generic spending	Brand spending	Specialty spending
2019	$96,571,550	$193,247,669	$623,461,129
2020	$99,560,804	$181,634,639	$647,307,246
2021	$119,725,433	$187,193,285	$658,555,860
2022	$126,355,982	$175,568,147	$674,167,000
2023	$153,704,575	$223,403,845	$817,138,452
2024	$154,156,565	$228,781,647	$917,587,270

Figure 36 shows spending on generic, brand-name, and specialty pharmaceuticals aggregated across all insurers and markets reported to us each year. This shows the data year being reported, which is submitted in the following calendar year. For 2022 spending the DPT Program received information from nine insurers while for 2023 and 2024 the program received information from 11 insurers.

Consumer cost sharing

Consumer cost sharing data collected by the program shows insured consumer cost burden for prescription drugs. Figures 37 and 38 show dollars spent on a per-member, per-month basis for individual, small-group, and large-group insurance plans across all 11 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 cost burden per plan type in dollars and relative percentages as we did with our analysis of pharmaceutical spending by prescription type.

Figure 37: Average amount spent on prescription drugs per member per month

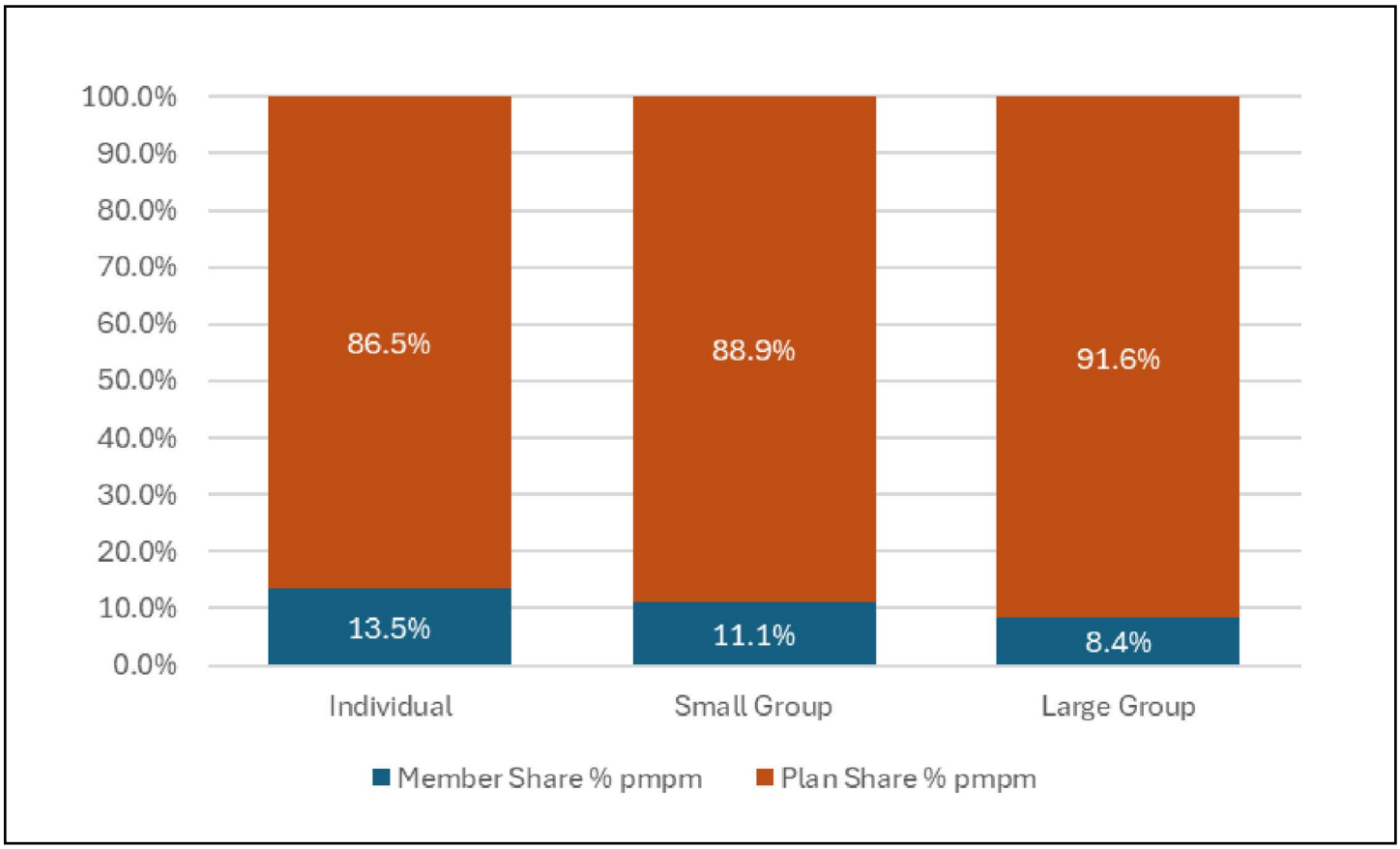


Overall, individual market plans spent the most per member, averaging $178.76 in total spending per member, per month. Of that amount, $24.05 was shouldered by the plan member and $154.71 was covered by the plan. Several factors may be contributing to the difference in spending between plan types. In general, employer-sponsored plans in the small- and large-group plans tend to have a larger number of younger enrollees with fewer medical conditions. As a result, claims costs for prescription drugs are likely to be lower in the group plans due to lower incidence of chronic conditions that are treated with medications.[47]

After comparing the member cost burden between individual, small-group, and large-group market plans on an absolute basis in Figure 37, the program compares those values on a relative basis in Figure 38. Of the total spent on average for individual plans, 13.5 percent was shouldered by the member. Of the total spent on average for small-group plans, 11.1 percent was shouldered by the member. Of the total spent on average for large-group plans, 8.4 percent was shouldered by the member. Across all three market segments, individual plan members had both the highest prescription drug costs and the highest share paid by the member.

47 Boersma, Peter et al. "Prevalence of Multiple Chronic Conditions Among U.S. 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 38: 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 the total spent on drugs.

In Figure 39, the blue bars represent the percentage of costs that were covered by rebates, while the orange bars represent the costs 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. While Figure 39 shows the rebates received as a percentage of costs, Figure 40 shows the gross amount of rebate received compared to the cost for each insurer.

This year, United Healthcare reported the highest percentage of rebates compared to the total spent at 30.1 percent. Aetna and Providence came in at second and third place as both reported 26.5 and 25.2 percent, respectively. Kaiser again reported the lowest amount of rebates, with only 0.5 percent of spending covered by rebates reflecting their plan design.

Figure 39: Percentage of prescription drug spending covered by rebates versus plan cost

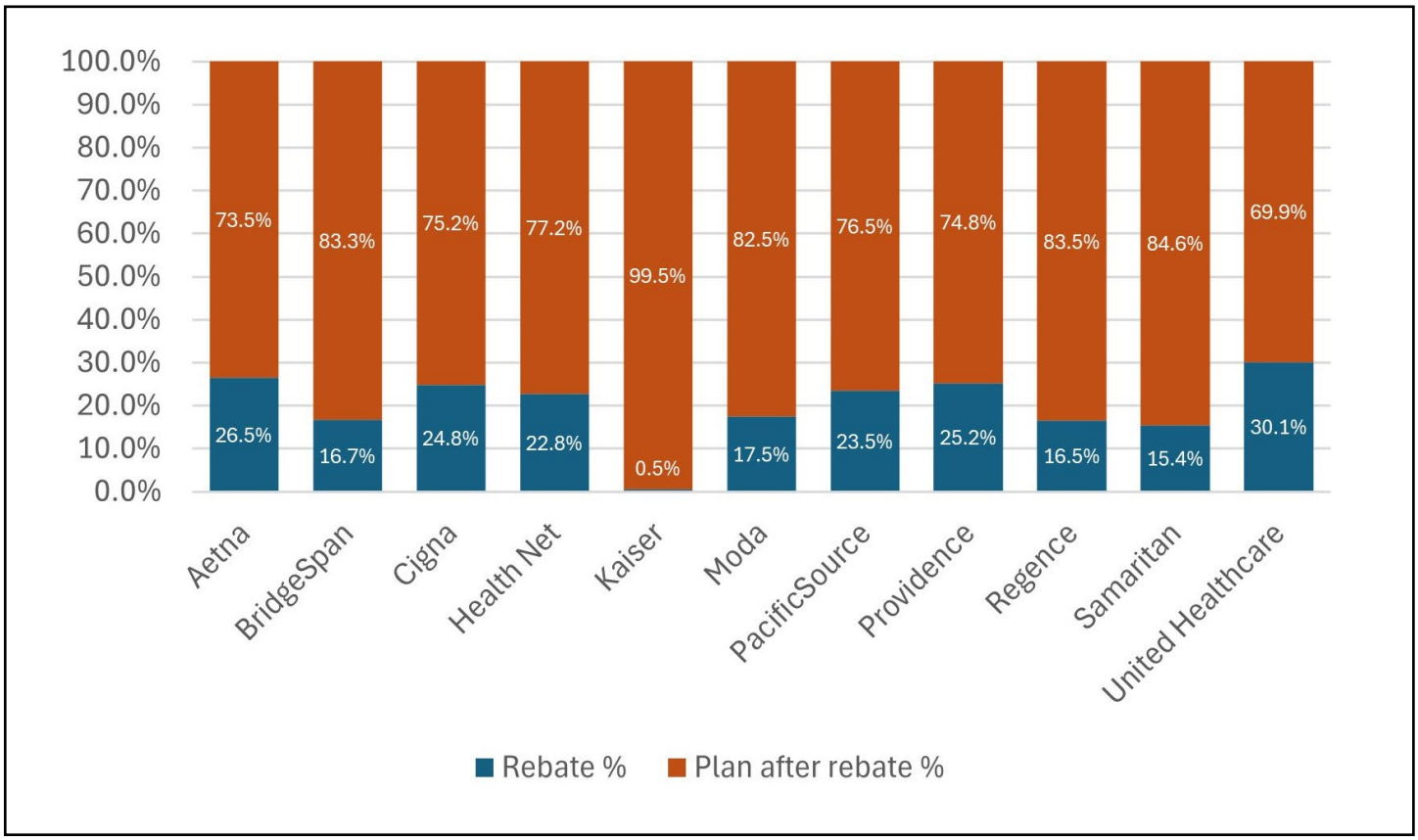
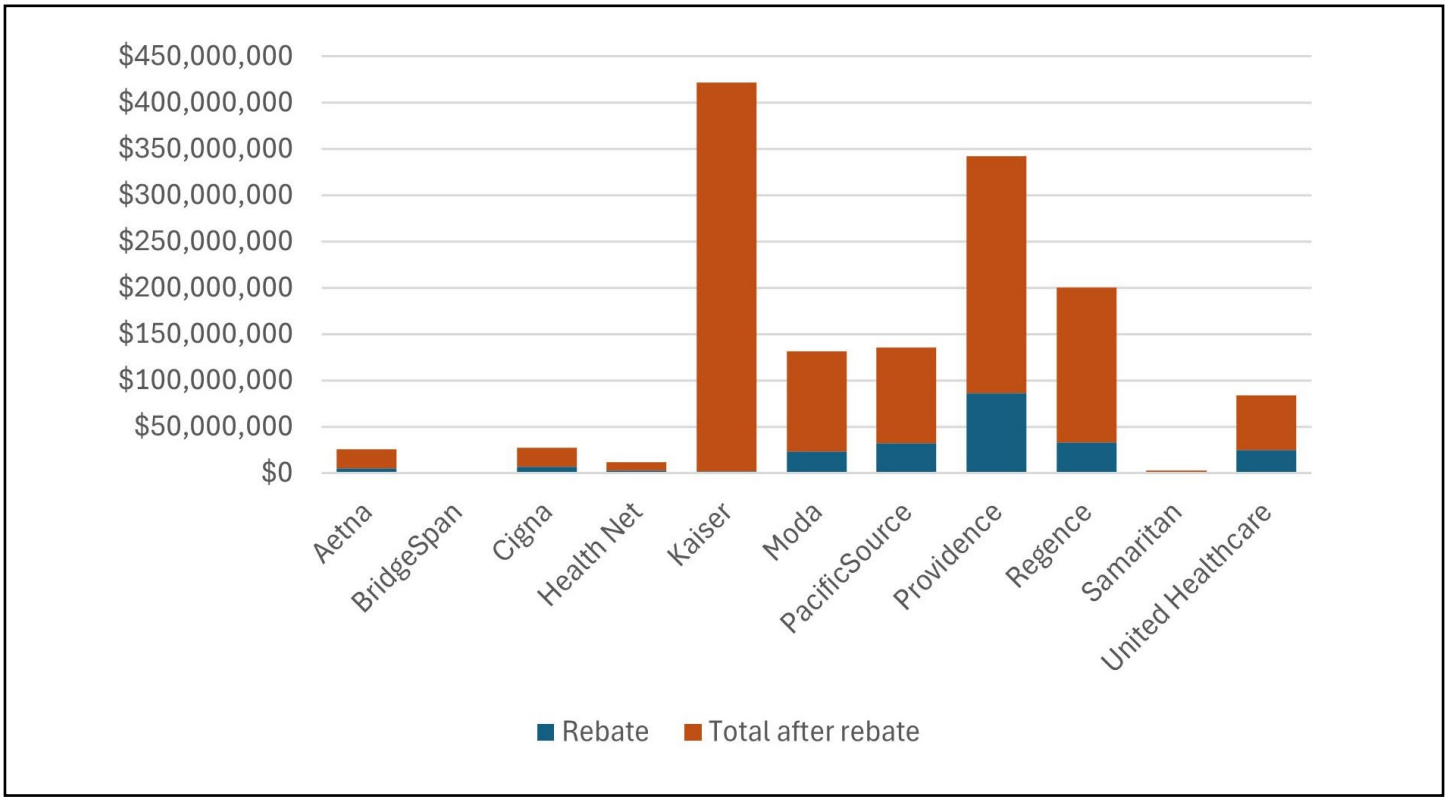


Figure 40: Amount of prescription drug spending covered by rebates versus plan cost for all insurers



Insurance company	Rebate	Total spent after rebate
Aetna	$5,337,267	$20,110,865
BridgeSpan	$199,072	$994,547
Cigna	$6,838,763	$20,702,748
Health Net	$2,567,063	$8,683,372
Kaiser	$1,986,514	$419,695,408
Moda	$23,069,805	$108,632,055
PacificSource	$31,797,075	$103,470,894
Providence	$86,325,190	$256,180,750
Regence	$32,966,183	$166,996,380
Samaritan	$449,945	$2,462,647
United Healthcare	$25,083,482	$58,329,372

In Figure 40, the highest amount of rebate was from Providence with $86.3 million. The second-highest amount reported was from Regence at $33 million, and the third-highest amount reported was $31.8 million from PacificSource. Figure 41 shows the amounts for the three insurers with smallest spending for better visibility. BridgeSpan again had the lowest total spending and the lowest rebate amount reported at $199,072. 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 41: Amounts of prescription drug spending covered by rebates versus plan cost for the three insurers with smallest spending

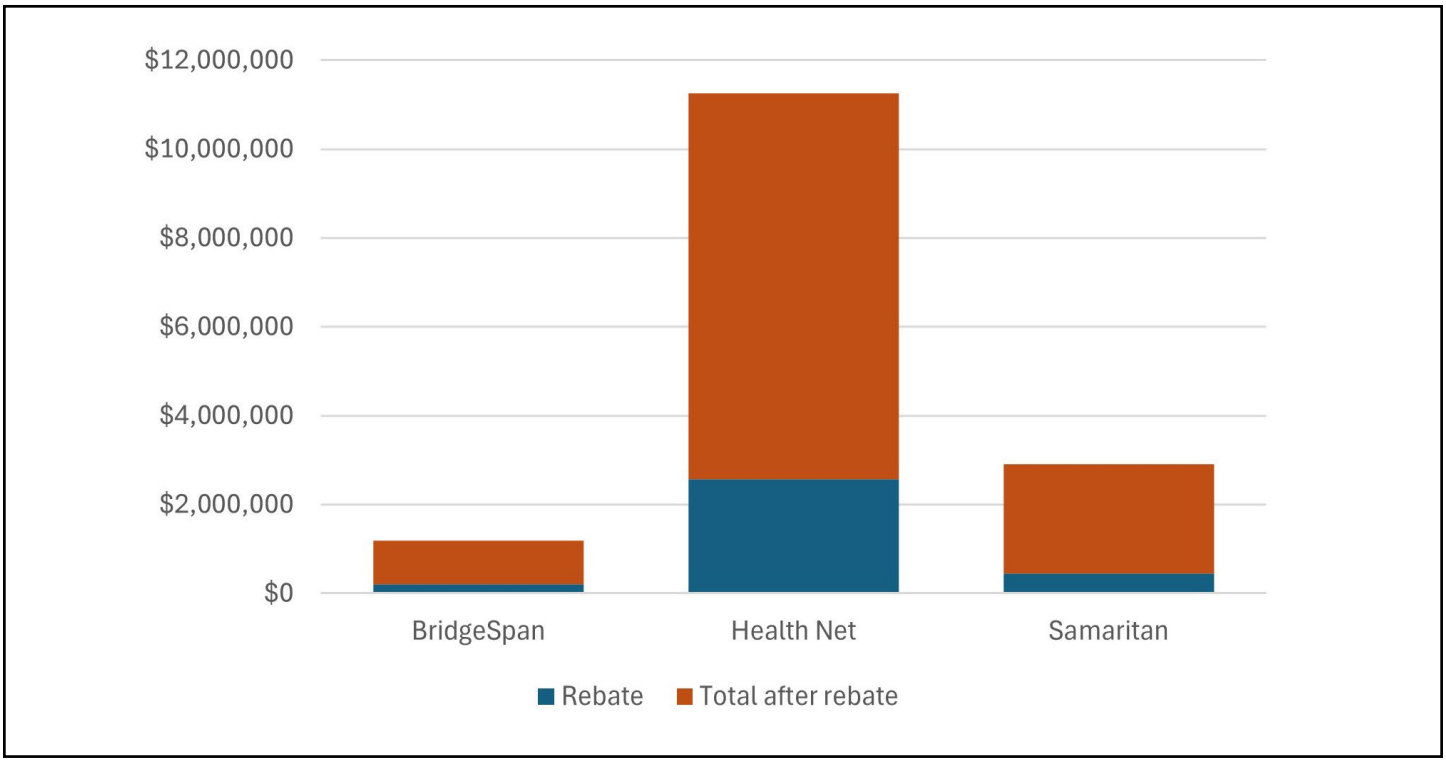
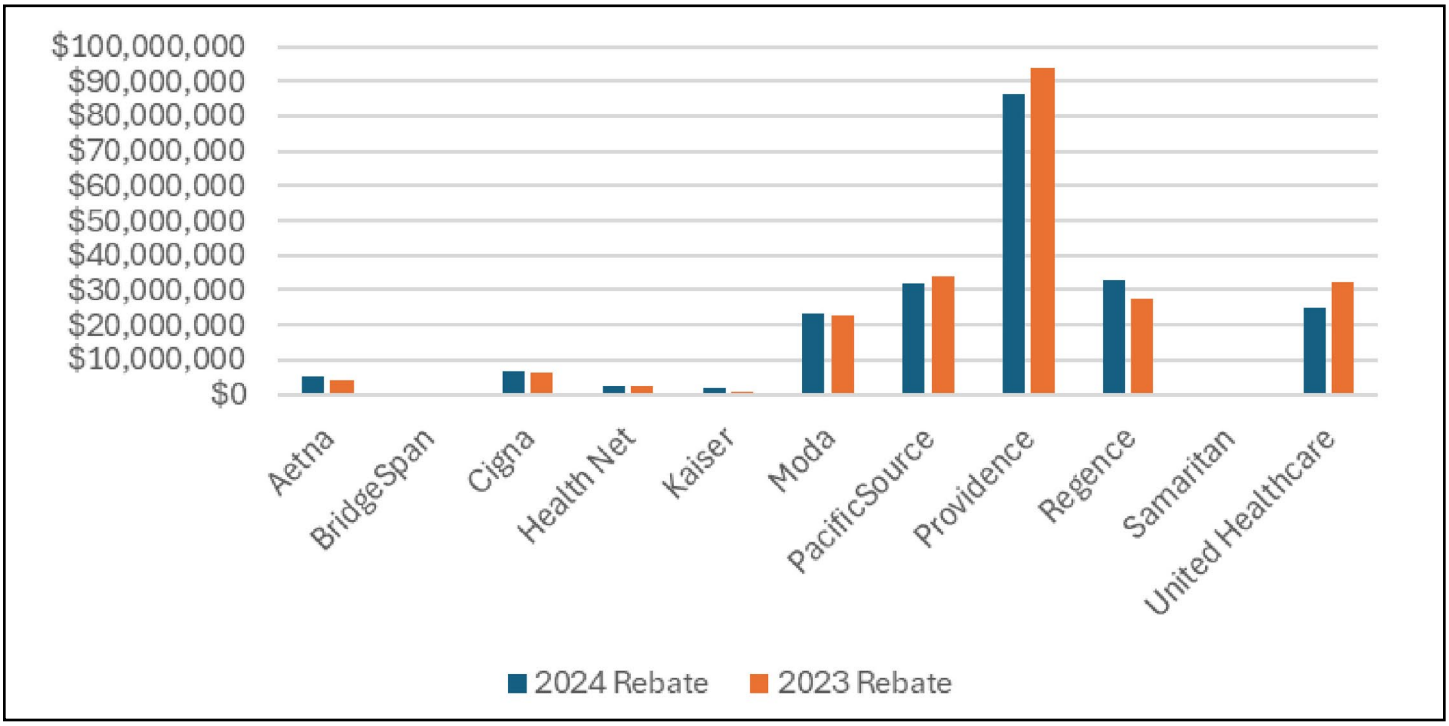


Figure 42: Amount of prescription drug rebates for data years 2024 and 2023 for all insurers followed by a chart with the details



For comparing last year to this year, here are charts showing the difference between 2023 and 2024, the data years being reported. Figure 42 and the table below compares the amounts each of the 11 insurers received in rebates from 2023 to 2024.

Insurance company	2024 rebate	2023 rebate	Gross change	Net increase percentage
Aetna	$5,337,267	$4,224,193	$1,113,074	26.3%
BridgeSpan	$199,072	$163,290	$35,782	21.9%
Cigna	$6,838,763	$6,312,709	$526,054	8.3%
Health Net	$2,567,063	$2,550,431	$16,632	0.7%
Kaiser	$1,986,514	$925,310	$1,061,204	114.7%
Moda	$23,069,805	$22,596,221	$473,584	2.1%
PacificSource	$31,797,075	$33,882,457	-$2,085,382	-6.2%
Providence	$86,325,190	$94,060,465	-$7,735,275	-8.2%
Regence	$32,966,183	$27,330,735	$5,635,448	20.6%
Samaritan	$449,945	$484,829	-$34,884	-7.2%
United Healthcare	$25,083,482	$32,499,793	-$7,416,311	-22.8%

Most prescribed drugs

The program collected data about prescription drug purchases reported in 2024 by 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. Those data were reported across the insurers listed in the insurance company data section. We aggregated the data from all 11 insurers 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 increases.

The 10 most frequently prescribed drugs reported for 2024 are shown in Figure 43. Amphetamine dextroamphetamine, an ADHD/anti-narcolepsy/anti-obesity/anorexiant, had 213,586 prescriptions, the most this year. This is a 41.4 percent increase from the data reported in 2024 (operations year 2023). Atorvastatin calcium, an antihyperlipidemic, was the second-most prescribed drug with 185,523 prescriptions this year. This is very close to the 2023 figure, with 185,385 prescriptions reported in 2024 (operations year 2023). The combined prescriptions for three antidepressants – bupropion, sertraline, and escitalopram) – totaled 420,597 prescriptions.

Nine of the drugs on this year's most-prescribed table were also on last year's table. These are amphetamine, atorvastatin, levothyroxine, bupropion, metformin, lisinopril, albuterol, losartan, and sertraline. Escitalopram is new to the 10 most-prescribed drugs, and Fluzone dropped off the top 10 most-prescribed list when the program analyzed the 2024 data.

Figure 43: Top 10 drugs with highest prescription counts from insurer-reported most prescribed lists for 2024

Drug name	Therapeutic class	Prescriptions
Amphetamine	ADHD/anti-narcolepsy/anti-obesity/anorexiants	213,586
Atorvastatin	Antihyperlipidemics	185,523
Levothyroxine	Thyroid agents	171,105
Bupropion	Antidepressants	166,146
Metformin	Antidiabetics	161,716
Lisinopril	Antihypertensives	159,183
Albuterol	Antiasthmatic and bronchodilator agents	157,926
Losartan	Antihypertensives	134,219
Sertraline	Antidepressants	132,611
Escitalopram	Antidepressants	121,840

Figure 44: Top 10 drugs with highest spending from insurer-reported most costly lists for 2024

Drug name	Therapeutic class	Total annual plan spending
Skyrizi	Dermatologicals	$37,536,013
Keytruda	Antineoplastics and adjunctive therapies	$36,481,289
Stelara	Dermatologicals/gastrointestinal agents – misc.	$35,685,330
Ozempic	Antidiabetics	$27,326,718
Trikafta	Respiratory agents – misc.	$25,747,283
Biktarvy	Antivirals	$24,080,914
Humira	Analgesics – anti-inflammatory	$23,492,393
Entyvio	Gastrointestinal agents – misc.	$23,070,291
Cosentyx	Dermatologicals	$20,562,420
Dupixent	Dermatologicals	$20,274,398

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. This information is shown in Figure 44.[48]

Insurers reported the highest total spending on Skyrizi, with $37,536,013 in annual spending in 2024. This is an increase of more than $11.9 million in annual plan spending compared to 2023 when insurers reported total spending of $25,622,754, which increased by 46 percent. Note that for the first time in the program's history, Humira was not the drug with the highest reported annual spending. In 2023, Oregon insurer spending on Humira, as reported in the most costly list, was more than $53.26 million, which decreased by 55.9 percent to $23,492,393 in 2024.

Nine of the drugs on this year's most costly table were also on last year's table. These are Skyrizi, Keytruda, Stelara, Ozempic, Biktarvy, Humira, Entyvio, Cosentyx, and Dupixent. Trikafta is new to the 10 most costly drugs, and Enbrel dropped off the 10 most-costly list when the program analyzed the 2024 data.

48 Note that Paxlovid's increase from the prior year was likely affected by the end of a federal government program that paid for this drug until late 2023. https://www.cms.gov/files/document/commercialcovid19oralantiviralsmemorevised20240220final.pdf. Accessed Oct. 20, 2025.

Drugs with the greatest increases in health plan spending

Figure 45 shows the 10 drugs with the largest year-over-year increase in plan spending, as well as the amount of that increase. This is based on the total increase in plan spending for the analyzed drugs; it is not based on changes in spending as a percentage of total spending.

Skyrizi was the drug with the highest gross increase in plan spending in 2024, at $15.7 million. This increase is 50.2 percent higher than the increase in plan spending for Skyrizi from 2022 to 2023 (about $10.5 million). Insurers also reported that Skyrizi had the second-highest gross increase in 2023.

Five of the drugs on this year's table showing the greatest increase in plan spending were also on last year's table. These are Skyrizi, Ozempic, Stelara, Keytruda, and Dupixent.

When the program analyzed the 2024 data for this report, Skyrizi, Keytruda, Stelara, Ozempic, Trikafta, and Dupixent appeared in both the top 10 most-costly and greatest-increase tables.

Figure 45: Top 10 drugs with the highest increases in plan spending from 2023 to 2024 from insurer-reported greatest increase lists for 2024

Drug name	Therapeutic class	Year-over-year increase in total spending
Skyrizi	Dermatologicals	$15,701,487
Ozempic	Antidiabetics	$8,934,850
Paxlovid	Antivirals	$7,566,764
Nexviazyme	Endocrine and metabolic agents – misc.	$5,674,528
Stelara	Dermatologicals/gastrointestinal agents – misc.	$5,370,053
Keytruda	Antineoplastics and adjunctive therapies	$5,332,555
Lisdexamfetamine	ADHD/anti-narcolepsy/anti-obesity/anorexiants	$5,121,695
Trikafta	Respiratory agents – misc.	$4,942,366
Mounjaro	Antidiabetics	$4,564,057
Dupixent	Dermatologicals	$4,463,941

Section 5: Policy recommendations

Prescription drug costs continue to be an issue for Oregonians. With the information reported annually, the program is learning more about usage and costs of prescription drugs, including 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 helps 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 higher 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.[49] These programs, which benefit individual consumers, can also increase premium rates for all other consumers because of the insurer's increased payment for 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 data reported for 2024, this requirement collected information on 33 programs from 14 manufacturers, a small fraction of the estimated 200 programs available to Oregonians. Without more comprehensive reporting, we do not collect enough information to conduct meaningful analysis to fully understand the benefits and the effect on the health care system. For example, robust analysis of the scope and use of patient assistance programs is needed to evaluate the effect of House Bill 4113 (2024) related to prescription drug affordability and determine potential revisions to meet its intent.[50]

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 or fund with participants in Oregon.

Outcome: Collecting comprehensive patient assistance program information would greatly improve transparency for consumers and legislators. For example, most enrollment and financial benefit 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

49 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 Oct. 20, 2025.

50 House Bill 4113 (2024). https://olis.oregonlegislature.gov/liz/2024R1/Measures/Overview/HB4113. Accessed Oct. 20, 2025.

out-of-pocket cost sharing requirements.[51] 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 and out-of-pocket maximum, lowering the consumer's health care spending when they have high annual costs. 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 recommends 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 increased out-of-pocket costs paid by consumers; and (3) how those payments are 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 information needed for evidence-informed policymaking.

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

Issue: As shown by the DPT Program'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 entities purchasing health care are not required to take advantage of the prescription drug savings available under the 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.[52] 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.

Recommendation 4: Centralize state Medicaid drug purchasing

Issue: Currently, the state Medicaid program delivery systems (fee-for-service and the 16 coordinated care

51 Ibid.

52 "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 Oct. 20, 2025.

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.[53] 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[54] of the state's $26.3 billion Medicaid budget[55] , 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 more than $1 billion annually[56] on medications across various 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 statewide savings.

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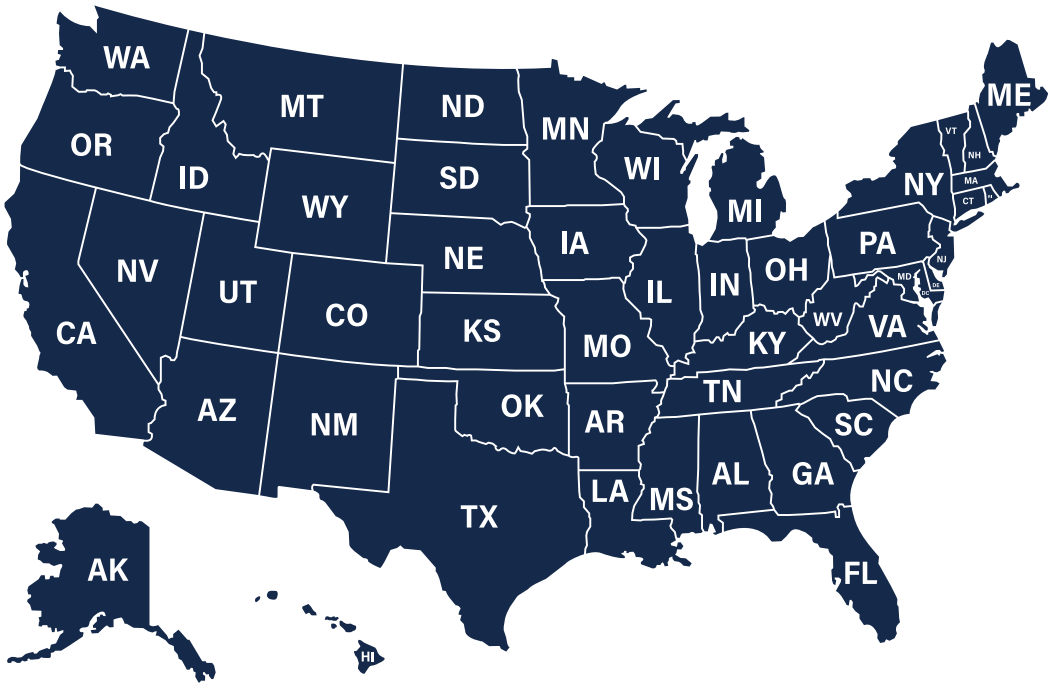
53 "Poor Accountability and Transparency Harm Medicaid Patients and Independent Pharmacies." Oregon Secretary of State, Oregon Audits Division, August 2023. https://sos.oregon.gov/audits/Documents/2023-25.pdf. Accessed Oct. 20, 2025.

54 Medicaid prescription drug costs, net of rebates, totaled $937.7 million for 2023 and $1.04 billion for 2024. "Pharmacy Utilization Summary Report: January 2023 – December 2023: Estimated Net Drug Costs." https://www.orpdl.org/durm/reports/utilization/2024/DUR_Utilization_2024_Q2.pdf. July 18, 2024;. and "Pharmacy Utilization Summary Report: January 2024 – December 2024; Estimated Net Drug Costs." Aug. 28, 2025. https://www.orpdl.org/durm/reports/utilization/2025/DUR_Utilization_2025_Q2.pdf. Drug Use Research & Management Program, DHS Health Systems Division, Oregon State University College of Pharmacy, CAREAssist program data provided by the Oregon Health Authority. Accessed Oct. 20, 2025.

55 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 Oct. 20, 2025.

56 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. https://www.orpdl.org/durm/reports/utilization/2024/DUR_Utilization_2024_Q2.pdf. Accessed Oct. 20, 2025.

Drug policies in other states



The following section does not represent official recommendations from the department, but is rather an overview of 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:[57]

- **Drug affordability boards**: There are 10 states that review the affordability of specific drugs: Colorado, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New York, Oregon, Vermont, 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 27 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.

57 Torrey, Zoe. "State Laws Passed to Lower Prescription Drug Costs: 2017-2025." National Academy for State Health Policy, July 23, 2025. https://www.nashp.org/rx-laws/. Accessed Oct. 6, 2025.

Conclusion

Oregon's DPT Program has been collecting and analyzing information received from drug manufacturers, health insurers, and consumers since 2019, and now also PBMs. 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 reported for 2024 and analyzed in this report:

- **Insurer rebates**: With only one exception, health insurers reported receiving rebates ranging from 15.4 percent to 30.1 percent of their total pharmaceutical spending. United Healthcare reported the highest rebates received as a percentage of prescription spending (30.1 percent) with Aetna (26.5 percent) and Providence (25.2 percent). Kaiser, again, reported the lowest percentage of rebates received compared to other insurers, at 0.5 percent of total pharmaceutical spending. Note: The program does not have sufficient data to suggest whether there are any correlations between rebates and spending within the prescription drug data.
- **Drugs with highest insurer spending**: In 2025, health insurance companies in Oregon reported the drugs with the highest-total spending (most costly) during 2024 for each market segment. The program aggregated the data and found that the highest overall spending, more than $37 million, was on Skyrizi (risankizumab), manufactured by AbbVie and used to treat autoimmune and other disorders such as psoriasis and Crohn's disease. The second-highest spending, more than $36 million, was on Keytruda (pembrolizumab) made by Merck Sharp & Dohme, which is a type of immunotherapy used to treat several types of cancer. The third-highest spending, more than $35 million, was on Stelara (ustekinumab), made by Janssen Biotech and used to treat autoimmune and other disorders.
    - For the first time in seven years of reporting, Humira, manufactured by AbbVie Inc., was not the drug with the highest-total annual spending by insurers. Humira (adalimumab) is a medication used to treat inflammatory conditions such as rheumatoid arthritis, psoriasis, and Crohn's disease. This year, Humira dropped to seventh on the list with total spending of $23 million in 2024, down from more than $53 million in 2023, a 55.9 percent decrease.
- **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 three highest wholesale acquisition costs (WAC) reported for new prescription drugs were for:
    - $3.5 million for Beqvez™, a treatment for hemophilia B, manufactured by Pfizer (this product was discontinued by Pfizer[58])
    - $3.1 million for Lyfgenia™, a treatment for sickle cell disease, manufactured by bluebird bio Inc.
    - $2.3 million for Zolgensma™, a treatment for spinal muscular atrophy, manufactured by Novartis Gene Therapies 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 about a company's reasons

58 Santhosh, Christy. "Pfizer stops commercialization of hemophilia gene therapy Beqvez." Reuters, Feb. 21, 2025. https://www.reuters.com/business/healthcare-pharmaceuticals/pfizer-says-it-will-end-global-development-gene-therapy-beqvez-nikkei-reports-2025-02-20/. Accessed Oct. 21, 2025.

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 3,500 reports that claimed one or more data elements as a trade secret since 2019. Within these 3,500 reports, more than 10,000 data elements have been claimed as trade secrets. During 2024, there were 1,120 reports received and 535 (47.8 percent) of those made a trade secret claim on at least one data element (1,086 data elements in total). DPT Program staff reviewed all 300 new prescription drug reports with 608 data elements claimed as trade secret. Of those 300 reports, 39.3 percent were processed as claimed, and the remaining 60.7 percent were determined to have information not conditionally exempt from disclosure, and some or all of the claimed data was published.

- **PBM payments and revenues**: PBMs reported information about payments collected and kept as revenue by the PBM. All but 15 licensed PBMs were exempt from reporting. For 2024, the 15 PBMs that were required to report data collected more than $377 million in manufacturer payments. Of this amount, more than $369 million (97.8 percent of payments received) was passed to the insurers, and $7.7 million (2.0 percent of payments received) was kept as revenue by the PBMs with the remaining $432,204 (0.1 percent) going to health plan enrollees. PBMs received and retained almost $34 million in administrative fees .

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 additional details: Expand patient assistance program reporting

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.[59] Studies suggest that drug manufacturer patient assistance programs increase their own branded drug sales by 60 percent, mostly by reducing sales to generic competitors.[60] Increased costs to insurers often lead to increased premium rates for all consumers.

Currently, the Oregon Legislature only requires patient assistance program reporting from manufacturers that submit annual price increase reports. For prescription drugs that had a price increase of at least 10 percent between 2023 and 2024, this reporting included 33 programs from 14 manufacturers, a small fraction of the estimated 200 programs available to Oregonians. Collecting a larger amount of information would make it easier for the DPT Program 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 less expensive generic or 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.[61]

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 insurance 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,

59 Therapeutic alternatives refer to drugs with a different chemical structure but similar treatment effects and typically less costly than the branded version.

60 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 Oct. 20, 2025.

61 House Bill 4113 (2024). https://olis.oregonlegislature.gov/liz/2024R1/Measures/Overview/HB4113. Accessed Oct. 20, 2025.

policymakers could address the following types of questions:

- Which manufacturers offer patient assistance programs and which drugs and formulations are included?
  - How many of these drugs have lower-cost therapeutic alternatives?
  - How much is being spent by consumers and insurers on drugs included in patient assistance programs versus alternatives?
- 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 the medical conditions treated by those drugs?
  - What disparities may be present between the demographics of people with these 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 out-of-pocket costs for consumers?
- Do patient assistance programs offered to Oregonians affect overall premium rates?

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

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.[62] 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 and less costly 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 prescription 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 drugs with less costly 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 consumer out-of-pocket payments required by copay accumulators affect premium rates?

62 House Bill 4113 (2024). https://olis.oregonlegislature.gov/liz/2024R1/Measures/Overview/HB4113. Accessed Oct. 20, 2025.

Appendix C – Recommendation 3 additional details: Expand and strengthen Oregon's bulk purchasing authority

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 Company, 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 all of these entities are commonly described as drug manufacturers, most of their activity is more in line with bulk purchasing and relabeling of drugs.

The 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 $1.04 billion, net of any rebates, on prescription drugs alone in 2024[63], 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.[64]

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:

- How could Oregon leverage its existing infrastructure and partnerships with other states to efficiently accomplish the goals of increased drug

63 "Pharmacy Utilization Summary Report: January 2024 – December 2024; Estimated Net Drug Costs (FFS & Encounter)." Drug Use Research & Management Program, DHS Health Systems Division, Oregon State University College of Pharmacy, Aug. 28, 2025. https://www.orpdl.org/durm/reports/utilization/2025/DUR_Utilization_2025_Q2.pdf. Accessed Oct. 17, 2025.

64 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 Oct. 20, 2025.

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 additional details: Centralize state Medicaid drug purchasing

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.[65] 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[66] (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 stakeholders 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 the effects of 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 recommendation, there are 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

65 "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 Oct. 20, 2025.

66 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 Oct. 20, 2025.

and consumer choice with cost savings and accountability improvements from centralizing drug purchasing?

- How do the potential consumer benefits (for example, 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 additional details: Centralize pharmacy purchasing and analytics

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. Since 2019, Oregon has established the DPT 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 $1.3 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

Establishing a centralized pharmacy resource would mean 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, a centralized pharmacy resource should 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 2024, 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 2024 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 2024 is

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

Suppose the drug had another price increase on Jan. 25, 2025, 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 2025 is

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

Note:
2024 was a leap year with 366 days. We counted every one of those days, and we divided by 366 instead of 365. Since 2025 was not a leap year, we divided by 365 when computing the drug's average list price in 2025.

To find the 2025 net increase percentage, we compare the average price in 2024 to the average price in 2025. The drug's average list price in 2025, $637.37, is 11.3 percent higher than its average list price in 2024, $572.68:

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

So, the 2025 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 2025 net increase percentage is

$$\frac{\$(\text{average 2025 list price}) - \$(\text{average 2024 list price})}{\$(\text{average 2024 list price})}$$

Appendix G – Types of plans for insurer reports received in 2025

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

Appendix H – Descriptions of therapeutic classes referenced

The following are general descriptions of therapeutic classes referenced in this report. While the therapeutic class names are from the Medi-Span drug database, Medi-Span does not provide definitions. The full FDA information on these are lengthy scientific explanations. These are basic descriptions to aid the reader in understanding the types of drugs being included in a therapeutic class.

- **ADHD/anti-narcolepsy/anti-obesity/ anorexiant agents**: These are medicines used to treat symptoms of ADHD (attention deficit hyperactivity disorder) such as hyperactivity and impulsiveness. They also help people with narcolepsy stay awake during the day (anti-narcolepsy medications) and can reduce appetite to support weight loss (anti-obesity medications).
- **Analgesics – nonnarcotic**: These are medicines used to relieve pain that are not addictive, such as acetaminophen or ibuprofen.
- **Analgesics – opioid**: These are strong medicines used to relieve pain, such as oxycodone or morphine, that can be addictive and have a high risk of dependence associated with them.
- **Analgesics/anti-inflammatory drugs**: These are medicines that reduce pain, swelling, and inflammation and are often used to treat arthritis or injuries.
- **Anti-asthmatic and bronchodilator agents**: These are medicines that help open airways, making it easier to breathe for people with asthma or other lung conditions.
- **Anticonvulsants**: These are medicines that help prevent or control seizures, often used to treat epilepsy.
- **Antidepressants**: These are medicines used to treat depression, anxiety, post-traumatic stress disorder (PTSD), and sometimes can help with chronic pain.
- **Antidiabetics**: These are medicines that help control blood sugar levels for people with diabetes.
- **Antihyperlipidemics**: These are medicines that lower cholesterol or fat levels in the blood to protect heart health.
- **Antihypertensives**: These are medicines used to lower blood pressure and reduce the risk of heart disease.
- **Antineoplastics and adjunctive therapies**: These are medicines used to treat cancer, including chemotherapy and drugs that support cancer treatment (adjunctive therapies).
- **Antivirals**: These are medicines that fight viruses, such as the flu, HIV, or hepatitis viruses.
- **Cardiovascular agents**: These are medicines used to treat medical conditions associated with the heart or the circulatory system (blood vessels).
- **Dermatologicals**: These are medicines applied directly to the skin to treat conditions such as acne, eczema, or infections.
- **Diagnostic products**: These are tools used to help diagnose health problems such as test strips or imaging agents.
- **Diuretics**: These are medicines that help the body get rid of extra fluid by increasing urination, often used for high blood pressure or swelling from heart failure.
- **Endocrine and metabolic agents – misc.**: These are medicines that help regulate hormones or support the body's metabolism, such as treatments for hormone imbalances or rare metabolic disorders.
- **Estrogens**: These are hormone medicines used to treat symptoms of menopause or other estrogen-related conditions.

- **Gastrointestinal agents – misc.**: These are medicines used to help stomach or digestion problems, such as acid reflux, constipation, or nausea.
- **Genitourinary agents – misc.**: These are medicines used to treat issues with the urinary tract or reproductive organs, such as bladder infections or prostate problems.
- **Hematological agents – misc.**: These are medicines that treat blood-related conditions, such as clotting disorders, or anemia.
- **Hematopoietic agents**: These are medicines that help the body make more blood cells. They are often used after chemotherapy or for anemia.
- **Miscellaneous therapeutic classes**: These are medicines that do not fit in another class. This report only includes one drug (lenalidomide) in this class. Lenalidomide is an immunomodulator, which helps the immune system work more effectively.
- **Neuromuscular agents**: These medicines relax muscles or block movement during surgery. They also treat nerve and muscle disorders.
- **Ophthalmic agents**: These are medicines used in the eyes, including eye drops for glaucoma, infections, or dryness.
- **Progesterone receptor antagonists (abortifacient)**: These are medicines that block the hormone progesterone and can be used to terminate a pregnancy.
- **Psychotherapeutic and neurological agents – misc.**: Psychotherapeutic medicines are used to treat serious mental health conditions such as schizophrenia. Neurological medicines are used to treat various neurological conditions affecting the brain, spine, and nervous system.
- **Respiratory agents - misc.**: These are medicines used to relieve, treat, or prevent breathing problems such as asthma, chronic bronchitis, chronic obstructive pulmonary disease (COPD), or pneumonia.
- **Thyroid agents**: These are medicines that replace or support thyroid hormones when the thyroid isn't making enough.