Oregon Prescription Drug Affordability Board

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Agenda

This is a draft agenda and subject to change.

Wednesday, **November 18, 2026 – 8 a.m.**

Register for meeting: **Zoom link**

Table 1 Board agenda details.

Subject	Presenter	Purpose
Call to order and roll call	Chair Shelley Bailey	*Informational and vote*
Board declarations of conflict of interest and meetings with entities or individuals related to board activities	Chair Shelley Bailey	*Informational*
Board review of 10/21/2026 minutes	Chair Shelley Bailey	*Review*
PDAB program update	Sarah Young, executive director	*Informational*
General public comment: limited to 3 minutes per speaker	Chair Shelley Bailey	*Informational*
Presentation on pharmacy benefit manager (PBM) market conduct oversight	Keith Turner, PBM compliance manager	*Informational*
Board review of draft 2026 annual report for the Oregon Legislature	Cortnee Whitlock, program and senior policy analyst	*Review and discussion*
The board will take a break around 10 a.m.	Chair Shelley Bailey	*Break*
Board discussion: drug review process	Cortnee Whitlock, program and senior policy analyst	*Discussion*
Board discussion: feedback form available all year	Sarah Young, executive director and Lou Savage, consumer engagement coordinator	Discussion
Announcements	Chair Shelley Bailey	*Informational*
Adjournment	Chair Shelley Bailey	*Vote*

Accessibility: Anyone needing assistance due to a disability or language barrier can contact Melissa Stiles at least 48 hours ahead of the meeting at pdab@dcbs.oregon.gov or 971-374-3724. American Sign Language will be available during the board meeting.

Oregon Prescription Drug Affordability Board

Oregon Prescription Drug Affordability Board Regular Meeting
Wednesday, October 21, 2026
Draft Minutes

Web link to the meeting video: https://youtu.be/HiQnNU4jWA8
Web link to the meeting materials: https://dfr.oregon.gov/pdab/Documents/20261021-PDAB-document-package.pdf

Call to order: Chair Shelley Bailey called the meeting to order at 8 a.m.
Roll call:
Present: Chair Shelley Bailey, Vice Chair Dan Hartung, Lauri Hoagland, Dan Kennedy, Michele Koder, Chris Laman and John Murray
Left early: Lauri Hoagland (10:15 a.m.)
Absent: Noelle Redmond

Board declarations of conflict of interest and meetings with entities or individuals related to board activities: John Murray, Chris Laman, and Shelley Bailey provided statements. View at video minute 00:00:59.

Approval of board minutes: Chair Bailey approved by consensus the Sept. 16, 2026, minutes as shown on Pages 2-3 of the agenda materials. View at video minute 00:03:40.

PDAB program update: Sarah Young, PDAB executive director, provided a program update. View at video minute 00:04:05.

General public comment: Public comment was received from the following individuals who signed up in advance: Dharia McGrew, PhRMA; Vanessa Lathan, EACH/PIC Coalition; Primo Castro, Biotechnology Innovation Organization; and Lorren Sandt, Caring Ambassadors. View at video minute 00:07:45. The board received 8 written comments, which are posted on the PDAB website.

Board discussion and vote on policy recommendations for annual report: Board members discussed the 2026 policy recommendations for the annual report. Board members voted to approve the following policy recommendations.

- Commercial health plan continuity of care
- Expand PDAB scope
- Orphan drug review refinements with alternative two
- Pharmacy benefit manager practices

View the slides in the agenda packet on **Pages 7-13**. See motions and votes below. View the discussion and votes at video minute **00:20:32**. Here are motions and vote counts for each policy recommendation.

MOTION to approve the policy recommendation for commercial health plan continuity of care requirement for prescription drugs as presented to the board today

Board Vote:
Motion: Shelley Bailey
Second: Dan Kennedy
Yes: Dan Kennedy, Michele Koder, Chris Laman, John Murray, Vice Chair Dan Hartung, Chair Shelley Bailey
No: None
Absent: Lauri Hoagland, Noelle Redmond
MOTION PASSED 6 in favor, 0 opposed, 2 absent

MOTION to approve the policy recommendation to expand PDAB scope beyond current affordability reviews for individual drugs as presented to the board today

Board Vote:
Motion: John Murray
Second: Dan Kennedy
Yes: Dan Kennedy, Michele Koder, Chris Laman, John Murray, Chair Shelley Bailey
No: Vice Chair Dan Hartung
Absent: Lauri Hoagland, Noelle Redmond
MOTION PASSED 5 in favor, 1 opposed, 2 absent

MOTION to approve the policy recommendation for orphan drug review refinements with amendments as discussed by the board today.

Note: The board voted for alternative two, to retain an exemption for orphan-only drugs. The board did not approve alternative one to remove the categorial exemption.

Board Vote:
Motion: John Murray
Second: Dan Kennedy
Yes: Dan Kennedy, Michele Koder, Chris Laman, John Murray, Chair Shelley Bailey
No: Vice Chair Dan Hartung
Absent: Lauri Hoagland, Noelle Redmond
MOTION PASSED 5 in favor, 1 opposed, 2 absent

MOTION to approve the policy recommendation to address key issues in pharmacy benefit manager practices as presented to the board today.

Board Vote:
Motion: John Murray
Second: Dan Kennedy
Yes: Dan Kennedy, Michele Koder, Chris Laman, John Murray, Vice Chair Dan Hartung, Chair Shelley Bailey
No: None
Absent: Lauri Hoagland, Noelle Redmond
MOTION PASSED 6 in favor, 0 opposed, 2 absent

Drug review public comment: The board held a second public comment period related to the drugs under review with one person signing up to speak, Scott Devine of Merck. View at video minute **02:40:51**. The board received two written comments about drugs under review. The letters are posted on the **PDAB website**.

Drug review of Skyrizi, Tremfya, and Keytruda. Potential vote on all drugs - Jardiance, Mounjaro, Ozempic, Humulin R U-500, Keytruda, Verzenio, Xeljanz, Ocrevus, Skyrizi, Tremfya, and Xolair: The board continued its 2026 drug review with a focus on Skyrizi, Tremfya, and Keytruda. Cortnee Whitlock, program and senior policy analyst, gave a presentation to the board. View the slides on **Pages 16-26**. Read the **drug reports** posted on the PDAB website. View at video minute **02:44:51**. The board voted on each of the 12 drugs under review and members provided justification for their votes. Motions for Keytruda and Skyrizi passed while the other motions failed. Here are motions, vote counts and video links to view board justification.

MOTION to identify Humulin R U-500 concentrated vial as a drug that may create affordability challenges pursuant to ORS 646A.694 due to high health care system and patient out-of-pocket costs in Oregon.

Note: The board voted a second time on this motion so they could begin providing justification.
Board Vote:
Motion: Michele Koder
Second: Dan Kennedy
Yes: None
No: Dan Kennedy, Michele Koder, Chris Laman, John Murray, Vice Chair Dan Hartung, Chair Shelley Bailey.
Absent: Lauri Hoagland, Noelle Redmond
MOTION FAILED 0 in favor, 6 opposed, 2 absent

View the board vote and justification at video minute **03:23:47**.

MOTION to identify Humulin R U-500 KwikPen as a drug that may create affordability challenges pursuant to ORS 646A.694 due to high health care system and patient out-of-pocket costs in Oregon.

Board Vote:
Motion: Michele Koder
Second: Dan Kennedy
Yes: None
No: Dan Kennedy, Michele Koder, Chris Laman, John Murray, Vice Chair Dan Hartung, Chair Shelley Bailey.
Absent: Lauri Hoagland, Noelle Redmond
MOTION FAILED 0 in favor, 6 opposed, 2 absent

View the board vote and justification at video minute **03:27:09**.

MOTION to identify Jardiance as a drug that may create affordability challenges pursuant to ORS 646A.694 due to high health care system costs in Oregon.

Board Vote:
Motion: Dan Hartung
Second: John Murray
Yes: None
No: Dan Kennedy, Michele Koder, Chris Laman, John Murray, Vice Chair Dan Hartung, Chair Shelley Bailey.
Absent: Lauri Hoagland, Noelle Redmond
MOTION FAILED 0 in favor, 6 opposed, 2 absent

View the board vote and justification at video minute **03:28:50.**

MOTION to identify Mounjaro as a drug that may create affordability challenges pursuant to ORS 646A.694 due to high health care system and patient out-of-pocket costs in Oregon.

Board Vote:
Motion: Michele Koder
Second: Dan Kennedy
Yes: Dan Kennedy
No: Michele Koder, Chris Laman, John Murray, Vice Chair Dan Hartung, Chair Shelley Bailey.
Absent: Lauri Hoagland, Noelle Redmond
MOTION FAILED 1 in favor, 5 opposed, 2 absent

View the board vote and justification at video minute **03:33:02.**

MOTION to identify Ozempic as a drug that may create affordability challenges pursuant to ORS 646A.694 due to high health care system and patient out-of-pocket costs in Oregon.

Board Vote:
Motion: John Murray
Second: Michele Koder
Yes: Vice Chair Dan Hartung
No: Dan Kennedy, Michele Koder, Chris Laman, John Murray, Chair Shelley Bailey.
Absent: Lauri Hoagland, Noelle Redmond
MOTION FAILED 1 in favor, 5 opposed, 2 absent

View the board vote and justification at video minute **03:26:22**.

MOTION to identify Keytruda as a drug that may create affordability challenges pursuant to ORS 646A.694 due to high health care system and patient out-of-pocket costs in Oregon.

Board Vote:
Motion: Michele Koder
Second: John Murray
Yes: Dan Kennedy, Michele Koder, Chris Laman, John Murray
No: Vice Chair Dan Hartung, Chair Shelley Bailey
Absent: Lauri Hoagland, Noelle Redmond
MOTION PASSED 4 in favor, 2 opposed, 2 absent

View the board vote and justification at video minute **03:41:07.**

MOTION to identify Verzenio as a drug that may create affordability challenges pursuant to ORS 646A.694 due to high health care system and patient out-of-pocket costs in Oregon.

Board Vote:
Motion: Dan Hartung
Second: Michele Koder
Yes: Dan Kennedy, Vice Chair Dan Hartung
No: Michele Koder, Chris Laman, John Murray, Chair Shelley Bailey
Absent: Lauri Hoagland, Noelle Redmond
MOTION FAILED 2 in favor, 4 opposed, 2 absent

View the board vote and justification at video minute **03:44:57**

MOTION to identify Xeljanz as a drug that may create affordability challenges pursuant to ORS 646A.694 due to high health care system and patient out-of-pocket costs in Oregon.

Board Vote:
Motion: Michele Koder
Second: Dan Kennedy
Yes: Dan Kennedy, Michele Koder
No: Chris Laman, John Murray, Vice Chair Dan Hartung, Chair Shelley Bailey.
Absent: Lauri Hoagland, Noelle Redmond
MOTION FAILED 2 in favor, 4 opposed, 2 absent

View the board vote and justification at video minute **03: 48:56**

MOTION to identify Ocrevus as a drug that may create affordability challenges pursuant to ORS 646A.694 due to high health care system and patient out-of-pocket costs in Oregon.

Board Vote:
Motion: Dan Kennedy
Second: Michele Koder
Yes: Michele Koder, John Murray, Vice Chair Dan Hartung
No: Dan Kennedy, Chris Laman, Chair Shelley Bailey
Absent: Lauri Hoagland, Noelle Redmond
MOTION FAILED 3 in favor, 3 opposed, 2 absent
View the board vote and justification at video minute **03:51:54**.

Note: In a tie vote, the motion fails, according to board policy.

MOTION to identify Skyrizi as a drug that may create affordability challenges pursuant to ORS 646A.694 due to high health care system and patient out-of-pocket costs in Oregon.

Board Vote:
Motion: Michele Koder
Second: Dan Kennedy
Yes: Dan Kennedy, Michele Koder, Chris Laman, John Murray, Vice Chair Dan Hartung, Chair Shelley Bailey
No: None
Absent: Lauri Hoagland, Noelle Redmond
MOTION PASSED 6 in favor, 0 opposed, 2 absent

View the board vote and justification at video minute **03:54:18**.

MOTION to identify Tremfya as a drug that may create affordability challenges pursuant to ORS 646A.694 due to high health care system and patient out-of-pocket costs in Oregon.

Board Vote:
Motion: Dan Kennedy
Second: John Murray
Yes: None
No: Dan Kennedy, Michele Koder, Chris Laman, John Murray, Vice Chair Dan Hartung, Chair Shelley Bailey.
Absent: Lauri Hoagland, Noelle Redmond
MOTION FAILED 0 in favor, 6 opposed, 2 absent

View the board vote and justification at video minute **03:56:21**.

MOTION to identify Xolair as a drug that may create affordability challenges pursuant to ORS 646A.694 due to high health care system and patient out-of-pocket costs in Oregon.

Board Vote:
Motion: Dan Kennedy
Second: John Murray
Yes: Dan Kennedy
No: Michele Koder, Chris Laman, John Murray, Vice Chair Dan Hartung, Chair Shelley Bailey
Absent: Lauri Hoagland, Noelle Redmond
MOTION FAILED 1 in favor, 5 opposed, 2 absent

View the board vote and justification at video minute **03:58:30**.

Announcements: Chair Bailey announced the board discussion on the year-round feedback form would be tabled until the next board meeting, which will be Nov. 18, 2026, at 8 a.m. View at video minute **04:01:54**.

Adjournment: Chair Bailey adjourned the meeting at 12:15 p.m. with all board members in agreement. View at video minute **04:02:12**.

Placeholder for
PBM market conduct oversight agenda item

Presentation materials were not available prior to the board material packet being published.

Oregon Prescription Drug Affordability Board

Prescription Drug Affordability Board

2026 Drug review roadmap

October 21, 2026

Drug review & annual report calendar (This is a rolling document and subject to change)

Workstream	Oct. 21 PDAB mtg.	Nov. 18 PDAB mtg.	Dec. 18 PDAB mtg.	Jan. 20, 2027 PDAB mtg.	Feb. 17, 2027 PDAB mtg.
2026 drug reviews and policy recommendations	Vote done for annual report				
2026 Annual report		Review draft annual report	Vote on final annual report		
2027 drug review			Review drug prelim list	Review drug prelim list	Discussion and vote on subset list

Oregon Prescription Drug Affordability Board

Web links to 2026 draft annual reports for the Nov. 18, 2026 board meeting:

- PDAB draft annual report Part 1
- PDAB draft annual report Part 2

PDAB annual report – Part 1

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Commented [CW1]: Comment provided by LH: I support the documents as written. My main comment is the absence of health inequity discussion. Part of our 0020 affordability review rule is to look at this. I realize this is due in part to a lack of good data for race and ethnicity. In addition there are evolving health care desserts in our state with pharmacies and specialty care. In Southern Oregon a recent loss of a pediatric oncologist means patients must travel north to receive oncology treatments. This situation affects care quality and affordability and likely impacts marginalized communities most but is also hard to capture with data.... I believe that somewhere in this report PDAB needs to mention the difficulty of looking at health inequities due to current data limitations.

Commented [CW2]: Comment provided by JM: My desire is more focused on PDAB changes than affordability evaluations. I think all reports were well prepared and thought out but as you might assume I would like the recommendations to take a more prominent place in the total report, especially highlighting Appendix A where the meat of them occur and how a legislator reading them could use the steps and information to act.
Thanks you again for your good work!

Commented [CW3]: Comment provided by DK: I have reviewed both reports and have no substantive edits to recommend. I had one small issue with the section on Medicaid spending which I'm now unable to locate. It stated that medication pricing may limit Medicaid Patient spending. There is no patient spending for Medicaid patients. Other than that, great job Cortnee and team in synthesizing out activities.

Commented [CW4]: Comment provided by NR: Overall, for the drugs themselves, these summaries feel thin relative to the underlying reviews and Part 2. Could we expand them to explain what the evidence showed and how it informed the determination?

I'm thinking for each product, identify the principal affordability concern, distinguish healthcare system spending from patient financial burden, and include the most relevant quantitative findings. Where members differed, summarize the competing interpretations. Anticipated competition or negotiated prices should also be distinguished from demonstrated savings, with any remaining concerns or monitoring needs stated clearly.

I'm attaching a separate document on what that could look like.

PDAB background and activities

The Oregon Legislature created the Prescription Drug Affordability Board (PDAB) through Oregon Senate Bill 844 (2021) and made amendments through Senate Bill 192 (2023), Senate Bill 289 (2025), and House Bill 4040 (2026). The legislation is codified in Oregon Revised Statutes (ORS) 646A.693 to 646A.697. The board's mission is to protect Oregonians, state and local governments, commercial health benefit plans, healthcare providers, pharmacies, and other Oregon stakeholders from the high costs of prescription drugs. PDAB is supported by staff in the Division of Financial Regulation in the Department of Consumer and Business Services (DCBS). The board conducts drug reviews to make affordability determinations and provides the Legislature with policy recommendations.

Board composition

The board is composed of eight members with expertise in healthcare economics, clinical medicine, pharmacy, and public health. Table 1 provides board member names, titles, and term dates. Read the **board member bios** on the PDAB website. PDAB will have two new members in January 2027, David Gross and Leah Hueser (terms of Jan. 1, 2027 to Dec. 31, 2030), replacing Lauri Hoagland and Michele Koder, who did not seek reappointment.

Table 1 Oregon PDAB members, title, occupation, and term dates

Board member	Title, occupation	Term dates
Shelley Bailey, MBA, chairperson	CEO of Famlee Fertility Inc. and former owner of Central Drugs in Portland	June 10, 2022, to Dec. 31, 2030 (2 terms)
Daniel Hartung, PharmD, MPH, vice chairperson	Tenured professor of pharmacy practice at the Oregon State University College of Pharmacy	June 10, 2022, to Dec. 31, 2029 (2 terms)
Lauri Hoagland, NP	Nurse practitioner for a school-based health center sponsored by La Clinica	Oct. 1, 2024, to Dec. 31, 2026
Daniel Kennedy, RPH	Retired pharmacist and outgoing president of the Oregon State Pharmacy Association	June 5, 2024, to Dec. 31, 2029 (2 terms)
Michele Koder, PharmD	Pharmacy director for the Multnomah County Health Department	Oct. 1, 2025, to Dec. 31, 2026

Board member	Title, occupation	Term dates
Christopher Laman, PharmD, MBA	Vice president of strategy, director of pharmacy and cancer center services at Columbia Memorial Hospital	Feb. 16, 2024, to Dec. 31, 2029 (2 terms)
John Murray, RPH	Pharmacist and co-owner of Murray's Drugs in Heppner, Condon, and Boardman	Sept. 28, 2022, to Dec. 31, 2028 (2 terms)
Noelle Redmond, PharmD	Former director of Clinical Pharmacy Services at Cambia Health Solutions/Regence Blue Cross Blue Shield	June 22, 2026, to Dec. 31, 2028

Governance and leadership

The board has highlighted the following milestones in its organizational growth.

- ✓ **Board established:** 2021 through Senate Bill 844.
- ✓ **First meeting held:** June 23, 2022.
- ✓ **Board authority:** Oregon Revised Statutes (ORS) 646A.693 to 646A.697 and Oregon Administrative Rules (OAR) 925-200-0010 and 925-200-0020.
- ✓ **Board policies:** The board adopted the following policies that govern its work: PDAB Policy; Delegation Policy; Conflict of Interest Policy; and Public Comment Policy.[1] PDAB policies provide the foundation for transparent decision-making, statutory compliance, and strategic direction.
- ✓ **Board meetings:** Board meetings are open to the public and held virtually on Zoomgov on the third Wednesday of the month. Meeting agendas include time for written and verbal public comments about general topics and drug review topics. The board has met twelve times in 2026 and 55 times since inception, as of December 2026.
- ✓ **Leadership**: Shelley Bailey was elected chairperson on Feb. 21, 2024, and Dr. Daniel Hartung was elected vice chairperson on November 19, 2025.
- ✓ **Accumulated total of board members:** Thirteen Oregonians have served on the board between 2022 and present, offering a wide range of expertise, skills, and perspective.

[1] Division of Financial Regulation, Department of Consumer and Business Services. *Oregon Prescription Drug Affordability Board*. State of Oregon. https://dfr.oregon.gov/pdab/Pages/index.aspx.

Board members have included physicians, health insurance company representatives, pharmacists, nurse practitioners, and university professors.

Board accomplishments

PDAB's work is centered on advancing its mission through strategic actions, data-driven reviews, and meaningful stakeholder engagement. Since its inception, the board has continued to meet its statutory responsibilities to review prescription drug costs affecting Oregon.

- ✓ **Annual reports for the Oregon Legislature:** The board has provided an annual report with policy recommendations to the Legislature each year since 2022 as required by ORS 646A.696. The annual reports can be found on the **PDAB website**.
- ✓ **Generic drug analysis:** For 2026, the generic drug analysis is included in the annual report to inform state policymakers. Previously, the board produced individual reports about the generic drug market. House Bill 4040, passed by the Oregon Legislature in 2026, provided statutory changes for PDAB's annual report structure and the number of drugs selected for affordability review each year.
- ✓ **Drug reviews**: The board has completed two prescription drug review cycles since its inception. In 2025, the board reviewed 23 medications and determined the following medications may create affordability challenges: Vraylar, a treatment for schizophrenia and bipolar disorder; Cosentyx, a treatment for plaque psoriasis; Trulicity, a treatment for diabetes; and Lantus SoloStar, an insulin product for treating diabetes. PDAB's **2025 Drug Review Report** for the Oregon Legislature is available on the PDAB website. In 2026, the board reviewed medications throughout the summer and fall to determine affordability challenges for Oregonians and the healthcare system. This report contains results of the 2026 review.

Public comments and community engagement

The board encourages public involvement in its decision-making process. Public comment opportunities are provided at each board meeting, and additional comment periods are offered during drug review sessions.

As part of the 2026 drug review process, PDAB hosted four in-person and three online community forums in April and May, with an extended public comment period during the May board meeting. The meetings held in Salem, Portland, Redmond, and Beaverton, and on Zoomgov, provided an opportunity for the board to hear from patients, caregivers, and others about how medication costs affect their daily lives, finances, and communities. Fifty-seven people attended the in-person and online events and 95 attended the May board meeting. Patients who spoke were primarily concerned about insurance denials of prescription drug

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coverage or changes in their health insurance policies that limited their prescription drug choices. All board members participated in the community forums. At each of the in-person and online events, board members engaged with patients who spoke and offered ideas and resources. The **Consumer Outreach Report 2026**, published by the Oregon PDAB on June 17, 2026, provides details of the board's outreach efforts.[2]

Also, for the 2026 drug reviews, the board posted on its website five feedback forms about the drugs under review targeted to five groups: individuals with scientific or medical training; patients, caregivers, and advocacy groups; pharmaceutical manufacturers; health insurers; and safety net providers. The board received 64 responses using the feedback forms, including 33 from patients, caregivers, and advocacy groups. Summaries from the questionnaires are posted on the **drug review page**, in the drug review reports, and in the **Consumer Outreach Report 2026**.

Table 2: 2026 community outreach: public comments for general and drug review topics and survey responses

Category	Speakers	Letters	Survey responses
Scientific/medical professionals	1	7	12
Patients, caregivers, advocates	29	56	33
Pharmaceutical manufacturers	15	40	7
Health insurers	4	4	1
Safety net providers	0	0	11
Pharmacy benefit managers	2	4	0
Trade associations	8	7	0
Total	**59**	**118**	**64**

[2] "Consumer Outreach Report." Oregon Prescription Drug Affordability Board, June 17, 2026. https://dfr.oregon.gov/pdab/Documents/reports/2026-consumer-outreach-report.pdf.

Drug review process

Overview of the 2026 review process

The 2026 drug review cycle began with the board's examination of prescription drug cost and utilization information reported to the Oregon Drug Price Transparency Program (DPT). The source data reflected plan year 2024 and were submitted in 2025, making them the most recent complete reporting-year data available when the 2026 review cycle began. The insurer reporting included each insurer's 25 most costly prescription drugs, 25 drugs with the greatest year-over-year increase in plan spending, and 25 most frequently prescribed drugs. The DPT program collects these annual reports as authorized by ORS 743.025 and described in OAR 836-053-1630.

DPT data provided the starting point for identifying products with significant spending, increasing costs, or high utilization in Oregon's fully insured commercial market. PDAB staff used the data to develop an initial statewide view of products with substantial spending, increasing costs, or high utilization. The preliminary list process was intended to identify drugs eligible for additional consideration. The process moved through successive stages of data preparation, eligibility screening, board prioritization, and collection of additional information for the selected products.

Development of the preliminary drug list

The PDAB data analyst, with support from the data researcher, consolidated insurer submissions and prepared the data for board review. Because the same product could appear in more than one insurer report and in more than one top-25 category, staff standardized and reconciled the records before counting products on the preliminary list. This work included:

- Standardizing proprietary and nonproprietary drug names and product identifiers.
- Reconciling duplicate entries across insurers, market segments, and reporting categories.
- Removing products outside the scope of the affordability review, including medical devices and diagnostic products.
- Aligning reporting fields and formats so products could be evaluated consistently across insurers.

After cleaning, standardization, and consolidation, staff produced a preliminary list of 137 unique prescription drug products for board consideration. This list provided the starting point for the board to apply the eligibility requirements and prioritization criteria.

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From the preliminary list to the subset list

The board reviewed the 137 products to identify those eligible to move forward for possible affordability review under ORS 646A.694 and OAR 925-200-0010. The screening removed products that did not meet the applicable statutory or rule-based requirements, for which lower-cost market competition was already available, or which the board determined should be excluded due to product characteristics and conditions treated. The exclusions documented during this stage included:

- 58 generic drugs
- 10 vaccines
- Three antiviral products
- Two toxoids
- Four drugs with marketed biosimilars, and
- Eight drugs with marketed generic equivalents.

After all board identified eligibility filters were applied, 49 prescription drugs remained on the subset list. The subset list represented the group of eligible products from which the board would prioritize drugs for full review. At this stage, the board considered the factors in OAR 925-200-0010, including frequency of appearance on insurer-reported top-25 lists, manufacturer price reports, historical and current wholesale acquisition cost trends, estimated treatment costs, availability of therapeutic equivalents or alternatives, market competition, utilization, and public input.

Board members were then surveyed individually and could identify up to six prescription drugs they were interested in advancing. Collectively, board members identified 22 drugs; 12 of those products were selected by more than one member. The board also identified four insulin products for consideration. This survey served as a prioritization tool and did not constitute the board's final selection.

At its April 2026 public meeting, the board reviewed the compiled survey results and discussed the products in the context of the available cost, utilization, clinical, and market information. From that discussion, the board selected ten prescription drugs and two insulin products for the 2026 affordability reviews.

Supplemental data collection and review packet development

Following the selection of the drugs for review, DCBS issued a data call to commercial health insurers to collect additional detailed information for each selected drug. Insurers provided information on health plan spending, rebates and other price concessions, enrollee out-of-

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pocket costs, claim and enrollee counts, utilization management policies, and other necessary claims information for analysis. Staff used insurer-reported information to calculate expenses and net costs after reported price concessions and other drug discounts.

Additionally, staff prepared aggregated, de-identified All Payer All Claims (APAC) data to assess utilization, gross spending, and patient out-of-pock costs across available commercial, Medicaid, and Medicare claims. Capturing insurer-reported information alongside APAC data allowed the board to consider both net commercial payer costs and broader gross spending and patient-cost measures. The different population and cost impacts were identified in the review packets. The measures were not treated as directly interchangeable because APAC data and commercial insurer data call data represent different populations.

Staff assembled standardized review packets that included therapeutic alternatives, wholesale acquisition cost trends, market competition, utilization and access information, patent and regulatory exclusivity context, stakeholder feedback, clinical information, and other available factors under ORS 646A.694 and OAR 925-200-0020. Sources included DPT data, Oregon Health Authority APAC data, information obtained through the insurer data call, and clinical and market research. Public comment and structured feedback from patients, caregivers, people with scientific and medical training, manufacturers, insurers, pharmacy benefit managers, and safety-net providers were incorporated when submitted.

The board reviewed the twelve selected prescription drug and insulin products in three groups during its June, July, and August 2026 public meetings. For each group, staff presented the drug review findings, and members discussed the available cost, utilization, clinical, and stakeholder information.

In September, the board revisited the twelve products and considered whether additional discussion was needed before making affordability determinizations. Members requested further discussion of Keytruda, Skyrizi, and Tremfya. In October, the board continued its review of the data for those three drugs. After completing discussion on those drugs, the board made individual motions and voted on each of the twelve products. The motions addressed whether each product may create affordability challenges for the Oregon healthcare system, patient out-of-pocket costs, or both.

Orphan indication methodology

The 2026 process also incorporated a method for products approved by the U.S. Food and Drug Administration (FDA) for both orphan and non-orphan indications. Keytruda and Skyrizi had designated orphan indications as well as broader non-orphan uses. Staff developed a claims-based methodology to identify and remove claims associated with orphan-designated indications, to the extent supported by the available diagnosis and claims data. The resulting

analysis was designed to focus the affordability review on utilization associated with non-orphan indications only while documenting the method and its data limitations.

Review tool

The drug scoring rubric developed in 2025 continued to provide PDAB members with an optional framework for supporting structured and transparent drug reviews. The rubric organizes consideration of key factors, including cost and utilization trends, therapeutic alternatives, and patient cost burdens. The rubric is not considered a formal scoring methodology. It is a tool that promotes consistent information for the selected drugs under review while maintaining board member discretion in determining review outcomes.

Results of prescription drug and insulin product affordability reviews

The table below lists the prescription drugs and insulin products selected for the 2026 affordability reviews, with votes for and against a motion to identify a product that may create affordability challenges due to high healthcare system costs and/or high patient out-of-pocket costs.

Table 3 Prescription drug and insulin products selected for 2026 affordability review by Oregon PDAB

Review grouping number	Therapeutic class	Proprietary name	Nonproprietary name	Vote for	Vote against	Identified
Group 1	Short acting insulin	Humulin R U-500 (Concentrated vial)	*insulin regular*	0	6	No
Group 1	Short acting insulin	Humulin R U-500 (KwikPen)	*insulin regular*	0	6	No
Group 1	Antidiabetics	Jardiance	*empagliflozin*	0	6	No
Group 1	Antidiabetics	Mounjaro	*tirzepatide*	1	5	No
Group 1	Antidiabetics	Ozempic	*semaglutide*	1	5	No
Group 2	Antineoplastics and adjunctive therapies	Keytruda	*pembrolizumab*	4	2	**Yes**

Review grouping number	Therapeutic class	Proprietary name	Nonproprietary name	Vote for	Vote against	Identified
Group 2	Antineoplastics and adjunctive therapies	Verzenio	*abemaciclib*	2	4	No
Group 2	Analgesics - anti inflammatory	Xeljanz	*tofacitinib citrate*	2	4	No
Group 3	Immuno modulatory agent	Ocrevus	*ocrelizumab*	3	3	No
Group 3	Dermatologicals	Skyrizi	*risankizumab-rzaa*	6	0	**Yes**
Group 3	Dermatologicals	Tremfya	*guselkumab*	0	6	No
Group 3	Antiasthmatic and bronchodilator agents	Xolair	*omalizumab*	1	5	No

Product-specific cost and affordability determination

Commented [CW5]: NR provided an updated review outcome section. See attached document *Proposed Review Conclusions Part 1-NMR*

On Oct. 21, 2026, the board voted on 12 drug and insulin products listed in Table 3. The board identified Keytruda and Skyrizi as drugs that may create affordability challenges due to high healthcare system and patient out-of-pocket costs in Oregon. Motions for the other products did not pass. A failed motion means the product was not identified through this review, and it does not establish that a drug is affordable for every patient or insurer.

Keytruda (*pembrolizumab*)[3]

Commented [CW6]: Edit and comment provided by DH: We use generic names more commonly in part 2

The board voted 4 in favor, 2 opposed and identified Keytruda as a drug that may create affordability challenges citing substantial insurer spending, price increases, and limited reported price concessions. Although the adopted motion addressed both system and patient costs, members differed in their assessment of system and patient affordability and the implications of the drug's multiple indications.

[3] Keytruda® (pembrolizumab) Version 3.1.Oregon Prescription Drug Affordability Board, Oct. 19, 2026. https://dfr.oregon.gov/pdab/Documents/Keytruda-2026.pdf.

Affordability effect on the Oregon healthcare system

Supporting members emphasized high treatment costs and use across multiple cancer indications. Board members cited upward price trends, minimal price concessions, and significant system and payer spending. Members questioned whether the very limited rebates reported for Keytruda reflected incomplete information. Staff confirmed that the commercial insurer data call requested medical and pharmacy spending, net costs, and rebates for every reviewed drug. Nearly all reported Keytruda spending was under the medical benefit. The data call did not ask insurers to explain why they reported few rebates for Keytruda.

Keytruda has both orphan and non-orphan indications. A claims-based method was applied to remove claims associated with orphan indication. Members discussed the difficulty of evaluating costs across Keytruda's many non-orphan indications and different dosing requirements.

Affordability effect on patient out-of-pocket costs

The board raised concerns about patient costs, but the discussion did not identify a uniform burden across patients. Several board members referenced the average out-of-pocket cost reported in the drug review report ($1,139 per enrollee for commercial and $3,195 per enrollee for Medicare), noting that it would be unaffordable for many patients. It was also mentioned that patient assistance programs mitigate affordability challenges, but this observation was based on external knowledge. Information on assistance programs or other patient cost-offset mechanisms was not included in the review report because the data were not available. The board further discussed that a low or zero median out-of-pocket cost can coexist with high costs for some patients, but available data could not quantify the extent to which these cases reflect people covered by Medicaid with no cost sharing, individuals reaching their annual out-of-pocket maximum, or other situations.

Skyrizi (*risankizumab- rzaa*)[4]

The board unanimously identified Skyrizi as a drug that may create affordability challenges due to high healthcare system and patient out-of-pocket costs. Board members cited sustained wholesale acquisition cost (WAC) increases, high insurer costs, and patient cost exposure.

Affordability effect on the Oregon healthcare system

Members noted that price growth was a central concern. Board members highlighted annual WAC growth exceeding seven percent in two years as shown in the drug report. WAC represents the manufacturer's list price before rebates and other price concessions.

Commented [CW7]: Note provided by NR: For what's it's worth, I can tell you this isn't incomplete information. Merck doesn't offer Keytruda rebates. They don't have to given its established market position.

Commented [CW8]: Note provided by NR: I'd state the time interval here, annual in this case, just to ground any numbers.

Alternatively just remove the numbers. This report seems really high level, and I don't see this level of detail elsewhere. I'd either consistently add it to each drug identified as concern or keep the narrative descriptive.

Commented [CW9]: Comment provided by NR: I don't want to oversell the assistance program stuff. It comes up a lot, but is not well understood and in my opinion can lead to mental dismissal of a real affordability issue. Maybe reframe as something like "The board also discussed the possible role patient assistance programs may play in mitigating affordability challenges, based on external knowledge. Because data about assistance programs or other patient cost-offset mechanisms was not available, it was not included in the review report. Assistance may reduce some patients' actual payments, but without uptake and eligibility data, we cannot quantify that offset or conclude it resolves the burden.

[4] Skyrizi® (risankizumab-rzaa) Version 2.0. Oregon Prescription Drug Affordability Board, Sept. 8, 2026. https://dfr.oregon.gov/pdab/Documents/Skyrizi-2026.pdf.

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Members considered costs remaining after reported price concessions. Other members stated that the remaining cost was meaningful and characterized the reported rebates (30.8 percent discount) as modest compared with other immunotherapies. It was also cited as the highest mean annual insurer cost per claim among the drugs and alternatives presented. Members considered the absence of a known near-term Medicare negotiated price or predictable biosimilar entry, according to the information available to the board.

Affordability effect on patient out-of-pocket costs

Members identified high patient out-of-pocket costs as an affordability concern citing patient costs and year-over-year WAC increases.

Other products reviewed

The following products were reviewed and were not identified as creating a significant affordability challenge at this time. A failed motion does not establish that a drug is affordable for every patient or insurer.

- **Humulin R U-500 concentrated (vial)**: Motion failed due to low utilization, low system spending, limited patient out-of-pocket costs, and a flat WAC trend.
- **Humulin R U-500 KwikPen**: Motion failed due to low utilization, low system spending, and low patient out-of-pocket costs.
- **Jardiance**: Members recognized high utilization and substantial spending, but the motion failed due to moderate price growth and reported price concessions. Board members considered Medicare price negotiation and potential generic competition among treatment alternatives. Several members attributed total spending primarily to widespread use rather than unusually high per-patient costs.
- **Mounjaro**: Motion failed due to low average annual WAC increase, reported price concessions, and spending relative to other reviewed products, although it was cited by a member that high volume and costs were a concern. It was suggested to consider the drug for future review due to the trend of spending and utilization growth.
- **Ozempic**: Motion failed due to moderate WAC growth, reported price concessions, and expected price reductions from Medicare price negotiations which take effect in 2027. Board members cited concern about the drug's high utilization, spending growth, and cost pressure on the healthcare system. Some members supported revisiting the drug or the therapeutic class due to continuing budget concerns.

Commented [CW10]: Comment provided by DH: High?

Commented [CW11]: Comment provided by NR: This term bothers me here. It's not wrong per se (anything working on the immune system can be called an immunotherapy) but it's not really accurate in the context we're using it. I'd use "targeted biologic therapy". Methotrexate could also be called an immunotherapy and we didn't include that as an alternative.

Commented [CW12]: Comment provided by NR: "mean annual insurer cost per claim" doesn't seem right... Maybe "highest mean annualized cost"? The per claim is what doesn't really work there.

Commented [CW13]: Comment provided by NR: No need to edit this, but in general when we consider MFP next year I'd really like to make more clear that MFP inclusion does NOT mean cheaper across the board. What we're observing so far in operation are manufacturer refunds to pharmacies for the delta for the MFP price vs acquisition/ insurer claim reimbursement. It commonly misunderstood that MFP means price dropped. Ozempic is a notable exception to this.

So overall, I think we need to distinguish a Medicare-specific negotiated price from an expected reduction for Oregon commercial plans.

Commented [CW14]: Comment provided by NR: I don't like this. Can be a conversation for another day, but PDAB is not just focused on PATIENT costs. The high total SYSTEM spending is relevant.

Commented [CW15]: Comment provided by NR: I like this addition

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- **Verzenio**: Motion failed due to moderate system spending, reported price concessions, costs of therapeutic alternatives, and anticipated effects of Medicare price negotiations which take effect in 2028. Concerns were mentioned about the drug's high patient out-of-pocket costs, price increases, and high spending relative to the number of users.
- **Xeljanz**: Motion failed due to moderate system spending, reported price concessions, and anticipated effects of Medicare price negotiations which take effect in 2028 and generic competition in 2026. Concerns were cited regarding high utilization and high patient out-of-pocket costs.
- **Ocrevus**: Motion failed due to a tied vote. Supporting members cited high system spending, moderate price concessions, and substantial patient out-of-pocket costs. Opposing members cited utilization, treatment setting, and costs relative to alternatives.
- **Tremfya**: Motion failed due to moderate system spending, reported price concessions, and costs below some of the reviewed therapeutic alternatives. Board members mentioned concern about patient out-of-pocket costs.
- **Xolair**: Motion failed due to moderate system spending, reported price concessions, and consideration of Medicare price negotiations which take effect in 2028 and biosimilar competition in 2026.

Commented [CW16]: Comment provided by NR: I know since I wasn't there you probably can't add this, but I do think this molecule gives up an opportunity to introduce conceptually that generic doesn't always equal cheaper, especially quickly. I think in my notes, I stated that data monitoring in the future would be good to ensure access, coverage, supply, etc. For specialty drug generics, it is really common for rebates to keep the brand "preferred".. which can essentially force patients to higher OOP option. On the flip side, the loss of big rebate generators in favor of a generic, can counter-intuitively mess up health plan finances leading to system spend issues.

Bottom-line, might be worth a line suggesting review of the molecule, including generic, next year.

Recommendations

The board approved four policy recommendations to the Oregon Legislature. The recommendations address continuity-of-care of prescription drug treatment when patients change commercial health plans, the scope of the board's work, the consideration of orphan indication in affordability reviews, and pharmacy benefit manager practices. See Appendix A for additional detail on each of the policy recommendations.

Recommendation 1: Commercial health plan continuity-of-care

The board recommends establishing continuity-of-care requirements for prescription drug coverage when an enrollee changes commercial health plans. The approach would provide a 90-day transition protection for treatment supported by a documented prior authorization or step therapy exception under the preceding plan, while the receiving plan reviews the authorization. The discussion recognized a covered-benefit safeguard; the proposal would not require a new plan to cover a drug or service excluded from its benefits although the new plan would still follow existing formulary exception policies.

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Board members discussed the importance of preventing interruptions in ongoing treatment and reducing repeated authorization work for patients, prescribers, and pharmacies. They also recommended that the receiving plan notify the dispensing pharmacy at the time a transition claim is processed so the pharmacy team can explain the temporary coverage and any next steps to the patient.

The board approved the recommendation by a vote of six in favor, zero opposed.

Recommendation 2: Expanded scope of PDAB reviews

The board recommends expanding the PDAB scope beyond individual prescription drug affordability reviews. The recommendation would allow broader examination of therapeutic classes of drugs, prescription drug market practices, purchasing arrangements, health plan design, and patient access concerns. Its purpose is to give the board greater flexibility to select work that examines the sources of prescription drug costs and informs legislative action.

Supporting members described opportunities to connect information held by different programs, identify missing data, and examine payments throughout the drug supply chain. Other members raised concerns about the breadth of the expanded work, limited staff and board capacity, and the need for a focused annual work plan.

The board approved the recommendation by a vote of five in favor, one opposed.

Recommendation 3: Orphan drug review refinement

The board recommends excluding from affordability review drugs that are approved solely for orphan indications and allowing review of drugs that have both orphan and non-orphan indications without separating claims by indication. The board also considered an alternative approach that would remove the orphan exemption entirely but did not support that approach due to the relatively small number of drugs that are approved for only orphan indications.

The proposed changes would allow the board to assess overall spending and patient costs for drugs with both orphan and non-orphan indications, while maintaining the affordability review exclusion for products with orphan-only indications. This change would permit review of all claims data for drugs that are approved to treat both orphan and non-orphan indications and remove the requirement to separate claims by indication for these drugs. The discussion also addressed affordability concerns for people with rare diseases, stakeholder concerns about access, and incentives for orphan drug development.

The board approved the recommendation as amended by a vote of five in favor, one opposed.

Commented [CW17]: Comment provided by NR: This is highly unrealistic for how stuff actually happens. Convo for another day.

More importantly, did any convo occur on my suggestion to require patient/ provider notification? To me that's the real ticket, and pharmacy notification is supplementary.

The highlighted suggestion is assumes an implementation technique that may or may not occur.

Commented [CW18]: Comment provided by NR: I would connect the flexibility to accountability: a public annual work plan, clear prioritization criteria, coordination with existing programs, and disclosure of data/resource gaps.

Opportunity to state that plainly here.

The practical test is whether a review can identify an actionable source of cost or access problems. Broader scope by itself does not provide additional analytic capacity or access to missing data.

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Recommendation 4: Pharmacy benefit manager practices

The board recommends additional pharmacy benefit manager (PBM) reporting and evaluation of the impact of PBM practices on prescription drug costs and pharmacy access. The framework includes an inventory of information already collected by Oregon agencies, identification of reporting gaps, and evaluation of pharmacy reimbursement practices, including payments to affiliated and non-affiliated pharmacies, maximum allowable cost list management, and reimbursement adequacy in relation to pharmacy acquisition costs. The recommendation also includes policy options and supporting information addressing PBM market practices, approaches used in other states, and concerns raised in the Secretary of State's August 2023 PMB audit.[5]

Members discussed patient receipt of rebates at the pharmacy counter, pass-through pricing, spread pricing, and separating PBM compensation from drug prices. They emphasized retaining these policy options alongside the recommended reporting and evaluation framework. Some members supported studying the potential benefits and unintended effects of regulating these practices before recommending policy changes. Members also noted the need to consider federal developments alongside state policy proposals. The board also removed statements in the supporting material that could imply savings had not been demonstrated in other states without sufficient support.

The board approved the recommendation as amended by a vote of six in favor, zero opposed.

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[5] "Poor accountability and transparency harm Medicaid patients and independent pharmacies." Oregon Secretary of State and Oregon Audits Division, August 2023. https://records.sos.state.or.us/ORSOSCMSearch/Search/RecordViewer.aspx?uri=9774904.

Appendix A

The Oregon PDAB provides the following policy recommendations for the Oregon Legislature. Click on the links below to read each policy recommendation.

Commercial health plan continuity of care requirement for prescription drugs

- This recommendation proposes prescription-drug transition protection for enrollees who change commercial health plans after receiving a prior authorization or step-therapy exception.

Expand PDAB scope beyond current affordability reviews for individual drugs

- This recommendation proposes options for expanding the board's examination authority beyond individual-drug reviews.

Orphan drug review refinements

- This recommendation proposes refining how the board reviews drugs with orphan indications.

Address key issues in pharmacy benefit manager (PBM) practices

- This recommendation proposes policy options addressing PBM conduct.

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Proposed report language for the identified products

Interpretation of the review outcomes

On October 21, 2026, the board identified Keytruda and Skyrizi as drugs that may create affordability challenges due to healthcare system and patient out-of-pocket costs. Motions to identify the remaining reviewed products did not pass. Members weighed total spending, costs after reported concessions, patient cost exposure, clinical and market context, and limitations of the available evidence differently. A failed motion does not establish that a product is affordable for every patient or payer. These determinations do not, by themselves, prescribe a coverage, payment, or pricing intervention.

Keytruda

The board voted 4–2 to identify Keytruda as a drug that may create affordability challenges. The 2024 APAC analysis used for the review included approximately $132 million in gross payer spending for 1,591 enrollees after the review's exclusions. Commercial insurers reported very limited price concessions. Members supporting identification cited substantial system spending, price increases, limited reported concessions, and patient costs, although they differed in the relative weight assigned to system and patient affordability.

Patient costs were unevenly distributed. The review reported mean annual enrollee out-of-pocket costs of $1,929, a median of $264, and a 95th percentile of $7,318. Members discussed how a low or zero cost on individual claims can coexist with substantial annual costs, including when patients reach an out-of-pocket maximum. The board also discussed the possible role of patient assistance programs in mitigating affordability challenges, drawing on members' external knowledge. Data on assistance programs and other patient cost offsets were unavailable and were not included in the review. Assistance may reduce some patients' actual payments, but without eligibility and uptake data, the review cannot quantify that offset or conclude that it resolves the burden.

Members opposing identification emphasized the difficulty of drawing a single conclusion across Keytruda's many indications and supported further examination. The limited reported concessions leave substantial costs with payers. The determination identifies an affordability concern without implying that other cancer treatments are interchangeable for every patient.

Skyrizi

The board unanimously identified Skyrizi as a drug that may create affordability challenges. Members emphasized sustained WAC growth, substantial spending remaining after reported concessions, and patient cost exposure. The review reported approximately $150 million in 2024 APAC gross payer spending and average annual WAC growth of 7.1 percent from 2021 through 2025. In the separate commercial carrier data, approximately $42.4 million remained in net spending after reported concessions reduced gross costs by 30.8 percent.

APAC mean annual enrollee out-of-pocket costs were $3,288, compared with a median of $500 and a 95th percentile of $12,112. These findings show that reported concessions and relatively low costs for some patients coexisted with substantial costs for others. Members also considered the absence of a scheduled near-term Medicare negotiated price or a predictable biosimilar entry at the time of the review. Comparisons with alternative targeted biologic therapies require attention to indication, dosing, route, and clinical appropriateness.

Proposed report language for other reviewed products

Humulin R U 500 vial and KwikPen

The board voted unanimously against identifying either Humulin R U-500 presentation. Members cited low utilization, relatively low total spending, and limited reported patient out-of-pocket costs; the vial discussion also noted a flat WAC trend. The reviewed evidence did not present a strong affordability signal relative to the other candidates. This outcome does not establish that all patients can obtain either presentation without financial difficulty.

Jardiance

The motion to identify Jardiance on the basis of healthcare system costs failed, with no votes in favor and six opposed. The review documented substantial utilization and total spending. Members opposing identification emphasized reported commercial concessions, moderate WAC growth, annual costs per patient, and anticipated effects of Medicare negotiated pricing and competition among treatment alternatives. High total system spending remains relevant to affordability even when it reflects widespread use or when patient out-of-pocket costs are relatively low. A Medicare-specific negotiated price does not establish a corresponding reduction for Oregon commercial plans. The vote should therefore be reported alongside the system-spending findings rather than as resolving that concern.

Mounjaro

The motion to identify Mounjaro failed, with one vote in favor and five opposed. The supporting member cited high volume and cost. Members opposing identification emphasized limited WAC growth, reported concessions, and spending relative to other reviewed products. However, the discussion also identified strong spending growth as a reason to revisit Mounjaro with more current data. The outcome reflects the evidence reviewed in this cycle and does not resolve concerns about its evolving budget impact.

Ozempic

The motion to identify Ozempic failed, with one vote in favor and five opposed. The supporting member emphasized high utilization, spending growth, and pressure on health system budgets. Opposing members cited moderate WAC growth, reported concessions, comparisons with other treatments, and anticipated price changes. Several members who voted no nevertheless expressed concern about budget effects and supported reviewing the drug or class again. The discussion therefore distinguished the current identification decision from the need to monitor spending and evaluate the class more broadly.

Proposed follow-up for board consideration: Revisit semaglutide and tirzepatide in the 2027 review cycle using updated utilization, spending, and coverage data. Assess net system spending and patient out-of-pocket costs across products and indications, including whether coverage restrictions affect access and continuity of treatment. Distinguish the effects of Medicare negotiated pricing from changes in commercial prices and rebates, and evaluate whether any savings offset continued spending growth.

A consistent interpretation across these outcomes

High utilization can create a substantial system-spending burden even when annual cost per patient is not the highest among alternatives. System affordability is a relevant concern in its own right. Conversely, lower total spending can coexist with substantial costs for individual patients. The board's decisions reflect how members weighed these different dimensions of affordability; the vote totals alone should not be interpreted as a ranking of clinical value or patient need.

Proposed report language for remaining products

Verzenio

The motion to identify Verzenio failed, with two votes in favor and four opposed. Supporting members cited high costs relative to the number of people treated, patient out-of-pocket costs, and price increases. Opposing members emphasized spending relative to alternatives, reported concessions, a zero median annual patient cost, and anticipated Medicare negotiated pricing. The zero median coexisted with mean annual APAC out-of-pocket costs of $2,381 and a 95th percentile of $12,967. The review therefore identified concentrated patient cost exposure even though the motion did not pass.

Xeljanz

The motion to identify Xeljanz failed, with two votes in favor and four opposed. Supporting members emphasized utilization and patient out-of-pocket costs. Opposing members cited moderate total spending, reported concessions, low median patient costs, and expected effects of generic competition and Medicare negotiated pricing. The decision reflected both historical cost findings and members' expectations of a changing market; it did not demonstrate that future savings or improved access had already occurred.

Proposed follow-up for board consideration: Revisit tofacitinib, including Xeljanz and generic products, in the 2027 review cycle. Assess net system spending, formulary placement, patient out-of-pocket costs, coverage, and supply to determine whether generic entry produces sustained savings and reliable access. This is a proposed next step, not an action adopted at the October meeting.

Ocrevus

The motion to identify Ocrevus failed on a 3–3 tie. Supporting members emphasized substantial patient out-of-pocket costs, system spending, and limited overall price concessions. Opposing members placed greater weight on spending and utilization relative to other reviewed drugs and alternatives; one member also raised site of care as a possible contributor to costs. The review reported mean annual APAC out-of-pocket costs of $3,703, a median of $1,186, and a 95th percentile of $18,060. The divided vote reflects differing assessments of this evidence rather than an absence of patient affordability concerns. Site-of-care effects were not separately quantified.

Proposed follow-up for board consideration: Revisit Ocrevus within a review of clinically appropriate multiple sclerosis treatments. Examine annual patient costs by coverage type, net system spending, and the contribution of administration and site-of-care costs. Assess whether lower-cost treatment or administration options are clinically appropriate and accessible without disrupting effective therapy.

Tremfya

The motion to identify Tremfya failed unanimously. Members emphasized spending and annual costs below some reviewed alternatives, reported commercial concessions, and a median annual patient cost of $25. Patient burden nevertheless remained part of the discussion: APAC mean annual out-of-pocket costs were $1,819 and the 95th percentile was $9,120. The outcome reflects the weight members placed on relative costs and concessions while recognizing that a low median did not describe every patient's experience.

Xolair

The motion to identify Xolair failed, with one vote in favor and five opposed. Members opposing identification cited spending relative to other reviewed drugs, reported concessions, anticipated Medicare negotiated pricing, and the prospect of biosimilar competition. These market developments influenced members' assessments but did not establish the extent of savings or improved access that patients would experience.

Suggested synthesis and additional feedback

Proposed addition for board consideration

Across the reviews, patient affordability and healthcare system spending did not always point to the same conclusion. Low median out-of-pocket costs sometimes coexisted with substantial costs for a smaller group of patients, and reported concessions did not eliminate all concerns about spending or access. Members also considered changes expected after the data period, including generic or biosimilar competition and Medicare negotiated pricing. These anticipated changes should be distinguished from savings demonstrated in the reviewed data. Medicare maximum fair prices apply within Medicare and do not, by themselves, establish a lower list price or a corresponding reduction in Oregon commercial plans' net costs.

Future reviews could assess clinically appropriate alternatives within a therapeutic area, separate patient costs by coverage type, and examine the distribution of annual patient costs alongside averages. They could also evaluate how benefit design, site of care, and reimbursement affect costs and access, and whether market changes produce sustained savings. Such work would help distinguish the existence of an affordability concern from the choice of an effective response.

Editorial note: this is proposed synthesis for the board to consider.

PDAB annual report – Part 2

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Price trends

Data sources, methodology, and assumptions

This section describes the data sources, reporting structure, and limitations of the Prescription Drug Affordability Board's (PDAB) price trend analysis. ORS 646A.696 instructs PDAB to report on price trends for the list of drugs identified by the Drug Price Transparency (DPT) data.[1] The data reported to DPT under ORS 743.025 reflects net insurer spending for fully-insured commercial market segments, representing about one-fifth of the Oregon population. The drugs analyzed in this report were selected from those reported to DPT for the 2025 data year. This analysis also incorporated APAC data from 2023 and 2024 for the selected drugs. APAC data allows examination of drug spending and utilization across a broader population, including Oregonians covered by fully-insured plans, Medicaid, Medicare, and some self-insured members, and across multiple years.[2] Insurers report total annual drug spending net of rebates or other price concessions to DPT while APAC data reflect gross prices before rebates as reported on the claim.

For the data year 2025, the DPT Program received reports from eleven insurers.[3] The 2026 DPT annual report lists the reporting insurers and the market segments included in their submissions.[4] Commercial insurers submit annual top 25 lists for the three categories of brand, generic, and specialty drugs, separately for their small group (SG), large group (LG), and individual (IND) markets. The reporting includes three metrics:

- **Greatest increase (GI):** The top 25 drugs with the largest increase in total annual spending year-over-year.
- **Most-costly (MC):** The top 25 drugs with the highest share of total annual spending.
- **Most prescribed (MP):** The top 25 drugs with the highest prescription claim counts.

Insurer submissions reflect net spending after rebates, discounts, price concessions, and other reimbursements. All submissions for data year 2025 were considered when selecting drugs for this price trend analysis.

[1] ORS chapter 646A (2025) https://www.oregonlegislature.gov/bills_laws/ors/ors646a.html.
[2] Oregon All Payer All Claims Database (APAC) Data User Guide, version 1.1 updated Nov 19, 2025. https://www.oregon.gov/oha/HPA/ANALYTICS/APAC%20Page%20Docs/APAC-Data-User-Guide.pdf.
[3] Data year 2025 refers to the period when health services were delivered and claims incurred. Insurers with health benefit plans issued in Oregon were required to submit reports by May 1, 2026, that reported on claims and associated drug spending that occurred from Jan. 1 to Dec. 31, 2025.
[4] "Prescription Drug Price Transparency Program results and recommendations – 2026." Oregon Drug Price Transparency Program. (Provide link once published)

The most-costly and greatest increase lists from each insurer and market segment were aggregated by non-proprietary name which identifies the active ingredient or molecule. Using aggregated data, the ten drugs with the highest reported annual spending from the most-costly drug list and the ten drugs with the largest year-over-year spending increases from the greatest increase in spending list were selected for in-depth analysis. Because some drugs appeared in the top ten on both lists, the final selected 14 unique non-proprietary names associated with 29 proprietary named drugs. See *Limitations and data considerations: Drug-name standardization* for additional details. The APAC data for the 14 selected drugs were then analyzed.

Top findings

- **Drugs with the highest spending differed in rank across data sources**. *Risankizumab* (Skyrizi) had the highest reported net insurer spending in the 2025 DPT data at $65 million, followed by *pembrolizumab* (Keytruda) and *semaglutide* (Ozempic, Rybelsus, Wegovy) at approximately $40 million each. In the 2024 APAC data *semaglutide* had the highest total payer and enrollee spending at $279 million, followed by *pembrolizumab* at $161 million and r*isankizumab* at $159 million. APAC data include significantly more individuals than DPT data.
- **Spending increases were concentrated in several drugs**. *Risankizumab* had the highest year-over-year increase in the DPT net insurer spending at $20 million, followed by *tirzepatide* (Mounjaro, Zepbound) at $13 million. In APAC, *semaglutide* had the largest spending increase from 2023 to 2024 at $63 million followed by *pembrolizumab* at $60 million and *tirzepatide* at $43 million.

Commented [CW1]: Comment provided by NR: I count 27 in table 1

Commented [CW2]: Edit provided by NR

Commented [CW3]: Comment provided by NR: Is the relevant finding that the rank was different… or that the top 3 were the same in both?

II think the rank is secondary especially since we're already acknowledging sample size differences.

I'd reframe to:
· **The same three drugs had the highest spending across both data sources.** Among the 14 drugs analyzed, risankizumab (Skyrizi), pembrolizumab (Keytruda), and semaglutide (Ozempic, Rybelsus, Wegovy) accounted for the highest spending in both datasets, although their order differed. Reported net insurer spending in the 2025 DPT data was approximately $65 million for risankizumab and $40 million each for pembrolizumab and semaglutide. In the 2024 APAC data, gross payer and enrollee spending was $279 million for semaglutide, $161 million for pembrolizumab, and $159 million for risankizumab. These totals are not directly comparable because the datasets differ in population coverage, reporting year, and treatment of rebates and other price concessions.

Commented [CW4]: Comment provided by MK: Covered lives

Commented [CW5]: Comment provided by NR: "Concentrated" implies to me that the highest % of total growth was in this drugs. I don't think that's the claim your making.

I'd reframe to:
Several drugs stood out for spending growth. In the DPT data, risankizumab (Skyrizi) had the largest increase in reported net insurer spending from 2024 to 2025, at $20 million, followed by tirzepatide (Mounjaro, Zepbound) at $13 million. In the APAC data, semaglutide (Ozempic, Rybelsus, Wegovy) had the largest increase in gross payer and enrollee spending from 2023 to 2024, at $63 million, followed by pembrolizumab (Keytruda) at $60 million and tirzepatide at $43 million. Tirzepatide was therefore among the drugs with the largest spending increases in both data sources, despite differences in the populations, reporting periods, and spending measures.

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- **Higher claim counts did not necessarily correspond to higher spending**. *Estradiol* (Climara, Dotti, Estradiol, Estring, Lyllana), *semaglutide*, and *tirzepatide* accounted for 88 percent of claims but only 21 percent of spending for the 14 selected drugs from the 2025 DPT data. In APAC, *estradiol* had the highest enrollee and claim counts in 2024, but the lowest total spending of the analyzed drugs.
- **Utilization increased for most selected drugs**. APAC enrollee and claim counts increased for 12 of the 14 drugs from 2023 to 2024. *Tirzepatide* had the largest percentage increase in both measures. *Elexacaftor-tezacaftor-ivacaftor* (Trikafta) and *etanercept* (Enbrel) had slight decreases in enrollee counts, claim counts, and spending.

Commented [CW6]: Comment provided by NR: I'd move this one to the end of the list and add a little more color. I'd also consider focusing on just estradiol. I understand the GLP including math-wise but it feels counterintuitive given the other spend findings we're stating. Their inclusion isn't really needed for the point anyway.

Suggestion:
The most widely used drug had the lowest total spending. Among the 14 drugs analyzed, estradiol had the highest enrollee and claim counts in the 2024 APAC data, with approximately 100,000 enrollees and 390,000 claims, but the lowest gross payer and enrollee spending, at $26 million. By comparison, pembrolizumab (Keytruda) accounted for approximately 1,800 enrollees and 11,400 claims but $161 million in spending. These differences underscore the importance of considering both utilization and spending when assessing drug affordability; neither measure alone establishes patients' financial burden.

Commented [CW7]: Comment provided by NR: I think this one could use some more color to match the others, most importantly some magnitude markers. The tirzepatide change is very notable, which sets up its inevitable selection next year again nicely.

Suggested rewrite:
Utilization increased for most selected drugs. APAC enrollee and claim counts increased for 12 of the 14 drugs analyzed from 2023 to 2024. Tirzepatide (Mounjaro, Zepbound) had the largest percentage increase in both measures: the number of enrollees receiving the drug rose from 4,299 to 10,800 (151%), while claims increased from 22,658 to 60,756 (168%). Elexacaftor-tezacaftor-ivacaftor (Trikafta) and etanercept (Enbrel) were the only drugs with declines in both measures. Trikafta enrollee counts decreased by 3% and claims by 15%, while Enbrel enrollee counts decreased by 13% and claims by 17%.

DRAFT

- **Spending growth varied across therapeutic class**. The combined dermatologicals and gastrointestinal agent therapeutic classes had the highest net insurer spending at $84 million in 2025. In APAC, the two classes of antidiabetic and anti-obesity agents containing *semaglutide* and *tirzepatide* had the highest total spending at $348 million in 2024 and the largest increase at $106 million.

These findings describe the drugs selected for in-depth analysis rather than the entire prescription drug market. DPT and APAC data include different years, populations, and spending measures, so their totals are not directly comparable. Changes in the total spending do not, by themselves, establish changes in the drug prices or financial impacts for enrollees.

DRAFT

Commented [CW8]: Comment provided by NR: The text focuses on spending rather that growth.

Suggested rewrite:
Different therapeutic groupings led spending and growth in each dataset. Among the selected drugs, guselkumab (Tremfya) and risankizumab (Skyrizi), grouped as dermatological and gastrointestinal agents, accounted for $84 million in net insurer spending and a $26 million annual increase in the 2025 DPT data. In the 2024 APAC data, semaglutide and tirzepatide, grouped as antidiabetic and anti-obesity agents, accounted for $348 million in gross payer and enrollee spending and a $106 million annual increase. Each grouping had the highest spending and largest increase within its respective dataset; these totals do not represent the entire therapeutic classes.

If you regroup as I suggest later, I'd use this instead:

Autoimmune and inflammatory drugs had the highest spending in both datasets, while the largest spending increases differed by dataset. Among the selected drugs, the autoimmune and inflammatory grouping (etanercept, upadacitinib, secukinumab, guselkumab, and risankizumab) accounted for $153 million in net insurer spending and a $38 million annual increase in the 2025 DPT data, the highest spending and largest increase of any grouping. This grouping also had the highest gross payer and enrollee spending in the 2024 APAC data, at $419 million. However, the diabetes and weight-management grouping, comprising semaglutide and tirzepatide, had the largest APAC spending increase, rising by $106 million to $348 million. These totals reflect only the selected drugs within each grouping, not all drugs used to treat these conditions.

Commented [CW9]: Comment provided by NR: Another bullet to consider adding--

Biologics as a grouping. In my experience, lay/ legislator understanding of the overall pharmaceutical shift is still limited. I like the idea of showing them that this broad type of drug classification drives significant spending.

Biologics accounted for just over half of spending among the selected drugs. The eight biologic groups analyzed accounted for approximately $731 million, or 53 percent, of gross payer and enrollee spending in the 2024 APAC data. The six non-biologic groups accounted for the remaining $639 million, or 47 percent.

Commented [CW10]: Comment provided by NR: I really like this. Might also consider adding. "High spending can reflect broad use, high treatment costs, or both; it does not establish clinical value or patient hardship."

Analysis of spending and utilization

Selected drugs

Table 1 lists the drugs selected using 2025 DPT insurer data, grouped by non-proprietary name, with their associated proprietary names and therapeutic classes.[5]

Table 1: Prescription drugs identified for analysis by non-proprietary name (based on 2025 commercial insurer reporting to DPT)

Non-proprietary name	Associated proprietary names	Therapeutic class(es)
bictegravir-emtricitabine-tenofovir alafenamide fumarate	Biktarvy	Antivirals
dupilumab	Dupixent	Dermatologicals
elexacaftor-tezacaftor-ivacaftor	Trikafta	Respiratory Agents - Misc.
estradiol	Climara, Dotti, Estradiol, Estring, Lyllana	Chemicals, Estrogens, Vaginal and Related Products
etanercept	Enbrel	Analgesics - Anti-Inflammatory
guselkumab	Tremfya	Dermatologicals, Gastrointestinal Agents - Misc.
immune globulin	Cuvitru, Gammagard, Gamunex-C, Hizentra, Octagam, Privigen, Xembify	Passive Immunizing and Treatment Agents
nivolumab	Opdivo	Antineoplastics and Adjunctive Therapies
pembrolizumab	Keytruda	Antineoplastics and Adjunctive Therapies
risankizumab	Skyrizi	Dermatologicals, Gastrointestinal Agents - Misc.
secukinumab	Cosentyx	Dermatologicals

[5] This report uses the therapeutic class assignment methodology established by the DPT Program. The Medi-Span drug database assigns a generic product identifier (GPI) to every product identified by National Drug Code (NDC). The highest level of the GPI is called the Drug Group (also called GPI02) and staff identify the assigned Drug Group for every NDC reported in the DPT insurer data. Some active ingredients may be found in products assigned to different Drug Groups in Medi-Span, for example Ozempic, Rybelsus, Wegovy all contain *semaglutide* and some *semaglutide* products are classified as antidiabetics while others are classified as anti-obesity products.

Non-proprietary name	Associated proprietary names	Therapeutic class(es)
semaglutide	Ozempic, Rybelsus, Wegovy	ADHD/Anti-Narcolepsy/Anti-Obesity/Anorexiants, Antidiabetics
tirzepatide	Mounjaro, Zepbound	ADHD/Anti-Narcolepsy/Anti-Obesity/Anorexiants, Antidiabetics
upadacitinib	Rinvoq	Analgesics - Anti-Inflammatory

DPT commercial insurer data

Table 2 presents the selected drugs in descending order of reported insurer annual net spending for 2025. The table aggregates all data reported by insurers on the top 25 lists for these drugs.

Table 2: DPT reported net insurer spending and utilization for 2025 by non-proprietary name

Non-proprietary name	Associated proprietary names	List types[6]	Markets	Number of claims	Number of enrollees	Annual net spending	YOY Increase
risankizumab	Skyrizi	GI, MC	IND, LG, SG	4,613	1,191	$64,989,889	$20,143,
pembrolizumab	Keytruda	GI, MC	IND, LG, SG	1,981	297	$40,151,845	$8,507,
semaglutide	Ozempic, Rybelsus, Wegovy	GI, MC, MP	IND, LG, SG	58,378	10,888	$40,023,207	$5,194,294
dupilumab	Dupixent	GI, MC, MP	IND, LG, SG	9,263	1,318	$33,558,861	$7,183,719
secukinumab	Cosentyx	GI, MC	IND, LG, SG	5,897	875	$27,257,990	$2,957,624
elexacaftor-tezacaftor-ivacaftor	Trikafta	GI, MC	IND, LG, SG	1,015	102	$26,801,481	$1,763,202

Commented [CW11]: Question provided by NR: % increase better?

Commented [DHA12R11]: This would have some challenges since the drugs are not reported from year to year by the same insurer/market combinations making them not wholly accurate if calculated by percent change. It would take some effort to bring this into code if we wanted to use it and disclose its caveats.

[6] Key: GI: Greatest increase; MC: Most-costly; MP: Most prescribed; IND: ~~Independent~~ Individual market; LG: Large group market; SG: Small group market.

Non-proprietary name	Associated proprietary names	List types[6]	Markets	Number of claims	Number of enrollees	Annual net spending	YOY Increase
bictegravir-emtricitabine-tenofovir alafenamide fumarate	Biktarvy	GI, MC	IND, LG, SG	3,998	781	$26,142,762	$1,595,
tirzepatide	Mounjaro, Zepbound	GI, MC, MP	IND, LG, SG	35,100	7,032	$25,199,904	$12,689,888
etanercept	Enbrel	GI, MC, MP	IND, LG, SG	4,694	605	$21,803,318	$2,515,711
upadacitinib	Rinvoq	GI, MC	IND, LG, SG	3,518	533	$20,113,351	$7,015,481
guselkumab	Tremfya	GI, MC	IND, LG, SG	2,227	488	$19,064,291	$5,547,659
estradiol	Climara, Dotti, Estradiol, Estring, Lyllana	GI, MC, MP	IND, LG, SG	207,616	70,498	$12,241,890	$4,005,346
nivolumab	Opdivo	GI, MC	IND, LG, SG	640	115	$9,659,121	$4,487,666
immune globulin	Cuvitru, Gammagard, Gamunex-C, Hizentra, Octagam, Privigen, Xembify	GI, MC	IND, LG, SG	1,998	277	$8,703,150	$4,002,472

Commented [CW11]: Question provided by NR: % increase better?

Commented [DHA12R11]: This would have some challenges since the drugs are not reported from year to year by the same insurer/market combinations making them not wholly accurate if calculated by percent change. It would take some effort to bring this into code if we wanted to use it and disclose its caveats.

All 14 selected drugs appeared in one or more DPT submissions for the individual, small group, and large group markets. All of these drugs appeared in the top 25 most-costly and greatest increase lists from one or more insurers. Five of the 14 drugs (36 percent) also appeared on the top 25 most prescribed list from one or more insurers, as shown in Table 2.

Figure 1 shows *risankizumab* had the highest reported annual net spending ($65 million) and the largest year-over-year increase ($20 million). *Tirzepatide* had the second-largest increase ($13 million), equivalent to about half of its 2025 annual spending ($25 million). *Pembrolizumab* had the second-highest annual spending ($40 million) and the third-largest increase ($9 million).

Only three of the 14 drugs had more than 10,000 claims per drug in 2025. Together, *estradiol*, *semaglutide*, and *tirzepatide* accounted for 301,094 claims (88 percent) and $77 million (21 percent) of annual spending for the selected drugs in 2025. The remaining 11 drugs accounted for 39,814 claims and $298 million in spending.

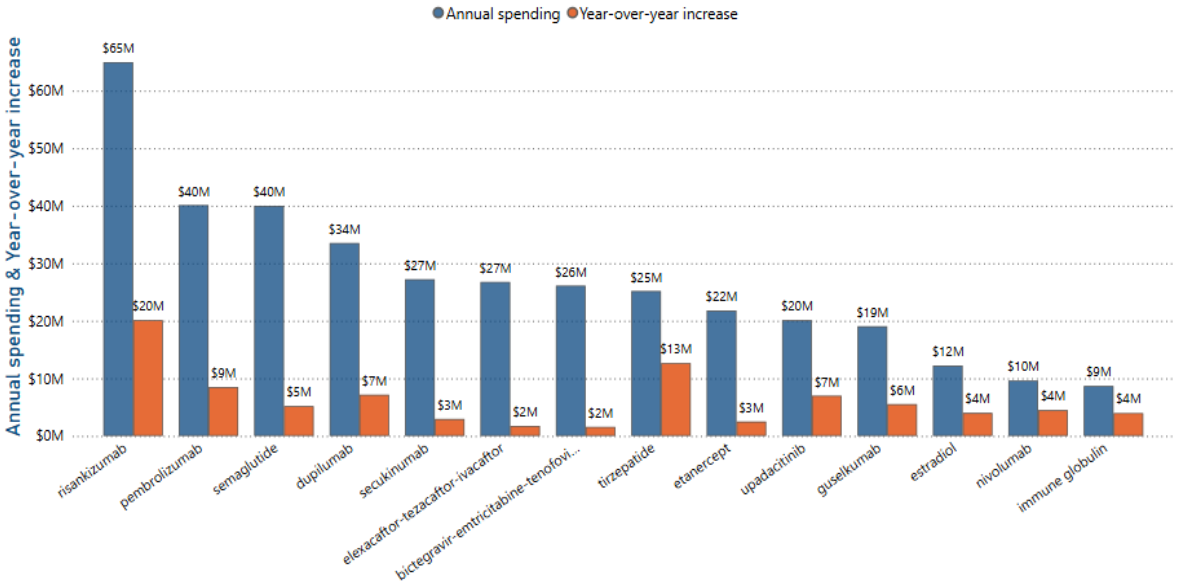


Figure 1: 2025 Annual spending and year-over-year increase by non-proprietary name as reported to DPT by commercial insurers

APAC Data

APAC data for the 14 drugs DPT-reported drugs presented in Table 3 shows *semaglutide* had the highest total system spending in 2024, defined here as payer plus enrollee spending, at $279 million. *Pembrolizumab* (Keytruda) and *risankizumab* (Skyrizi) followed in 2024 at $161 million and $159 million. These were also the three drugs with the highest annual spending in the 2025 DPT data, although their order differed. From 2023 to 2024 *semaglutide* had the largest APAC spending increase ($63 million), followed by *pembrolizumab* ($60 million) and *tirzepatide* ($43 million). Spending decreased for *elexacaftor-tezacaftor-ivacaftor* by $6 million and for *etanercept* by $15 million. The DPT and APAC results cover different years, populations, and spending measures as described in the methodology section.

Commented [CW13]: Comment provided by NR: could also consider a horizontal stacked bar. Prior, YOY. Total figure on top. I think it would communicate it more clearly. But I'm being really picky here.

Commented [DHA14R13]: A horizontal stacked bar is something that can be done but the prior YOY follows with difficulty as indicated in the last comment.

Commented [CW15]: Edit provided by DH

Commented [CW16]: Comment provided by NR: Throughout document, consider using "gross drug spending n APAC" or similar. Plan + patient isn't really the full cost of care. Semantics, but I think potentially important.

You define it, so not a deal breaker. Food for thought.

Table 3: APAC gross spending and utilization for 2023 and 2024, an asterisk (*) denotes a Small-molecule ~~biologic~~ drug

Data year	Non-proprietary name	Associated proprietary names	Therapeutic class	Total claims	Total enrollees	Total system spend (payer + enrollee)
2024	*bictegravir-emtricitabine-tenofovir alafenamide fumarate**	Biktarvy	Antivirals	30,062	3,498	$129,716,501
2023	*bictegravir-emtricitabine-tenofovir alafenamide fumarate**	Biktarvy	Antivirals	29,493	3,307	$122,729,486
2024	*dupilumab**	Dupixent	Dermatologicals	26,997	3,323	$96,881,647
2023	*dupilumab**	Dupixent	Dermatologicals	23,219	2,710	$78,343,822
2024	*elexacaftor-tezacaftor-ivacaftor**	Trikafta	Respiratory Agents - Misc.	3,755	307	$88,589,404
2023	*elexacaftor-tezacaftor-ivacaftor**	Trikafta	Respiratory Agents - Misc.	4,426	317	$95,072,611
2024	*estradiol*	Climara, Dotti, Estradiol, Estring, Lyllana	Chemicals, Estrogens, Vaginal and Related Products	390,250	100,027	$26,494,673
2023	*estradiol*	Climara, Dotti, Estradiol, Estring, Lyllana	Chemicals, Estrogens, Vaginal and Related Products	331,920	83,112	$22,711,176
2024	*etanercept**	Enbrel	Analgesics - Anti-Inflammatory	12,955	1,543	$87,695,488
2023	*etanercept**	Enbrel	Analgesics - Anti-Inflammatory	15,699	1,764	$102,410,774

Commented [CW17]: Edit provided by MK.

Commented [CW18]: Comment provided by MK: The biologic asterisks need correction. Biktarvy, Trikafta, and Rinvoq are not biologics; Immune globulin is a biologic.

Would also need to update the related narrative and math.

Commented [CW19]: Comment provided by DH: This table is challenging to interpret and could be made more informative. See attached excel that has changes from year to year as distinct columns and decomposition of changes in spending as mostly due to price (cost per claim) versus utilization.
The decomposition of spending is fairly straightforward. Basically, it models how much of overall spend change is attributable to changes in change in price holding utilization static, versus changes in utilization holding price static.

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Data year	Non-proprietary name	Associated proprietary names	Therapeutic class	Total claims	Total enrollees	Total system spend (payer + enrollee)
2024	*guselkumab**	Tremfya	Dermatologicals, Gastrointestinal Agents - Misc.	3,346	775	$38,016,590
2023	*guselkumab**	Tremfya	Dermatologicals, Gastrointestinal Agents - Misc.	3,170	681	$35,353,811
2024	*immune globulin*	Cuvitru, Gammagard, Gamunex-C, Hizentra, Octagam, Privigen, Xembify	Passive Immunizing and Treatment Agents	9,443	959	$54,264,049
2023	*immune globulin*	Cuvitru, Gammagard, Gamunex-C, Hizentra, Octagam, Privigen, Xembify	Passive Immunizing and Treatment Agents	5,603	615	$34,075,331
2024	*nivolumab**	Opdivo	Antineoplastics and Adjunctive Therapies	3,937	579	$45,440,787
2023	*nivolumab**	Opdivo	Antineoplastics and Adjunctive Therapies	2,873	435	$35,898,636
2024	*pembrolizumab**	Keytruda	Antineoplastics and Adjunctive Therapies	11,425	1,796	$161,366,970
2023	*pembrolizumab**	Keytruda	Antineoplastics and Adjunctive Therapies	6,479	1,254	$101,035,002
2024	*risankizumab**	Skyrizi	Dermatologicals, Gastrointestinal Agents - Misc.	8,807	2,357	$159,222,121

Data year	Non-proprietary name	Associated proprietary names	Therapeutic class	Total claims	Total enrollees	Total system spend (payer + enrollee)
2023	*risankizumab**	Skyrizi	Dermatologicals, Gastrointestinal Agents - Misc.	7,314	1,884	$123,415,158
2024	*secukinumab**	Cosentyx	Dermatologicals	12,702	1,595	$88,073,449
2023	*secukinumab**	Cosentyx	Dermatologicals	11,903	1,394	$77,196,058
2024	*semaglutide*	Ozempic, Rybelsus, Wegovy	ADHD/Anti-Narcolepsy/Anti-Obesity/Anorexiants	251,795	41,394	$279,071,674
2023	*semaglutide*	Ozempic, Rybelsus, Wegovy	ADHD/Anti-Narcolepsy/Anti-Obesity/Anorexiants	192,751	32,424	$216,099,507
2024	*tirzepatide*	Mounjaro, Zepbound	ADHD/Anti-Narcolepsy/Anti-Obesity/Anorexiants	60,756	10,800	$69,275,315
2023	*tirzepatide*	Mounjaro, Zepbound	ADHD/Anti-Narcolepsy/Anti-Obesity/Anorexiants	22,658	4,299	$26,491,942
2024	*upadacitinib**	Rinvoq	Analgesics - Anti-Inflammatory	7,057	999	$45,954,849
2023	*upadacitinib**	Rinvoq	Analgesics - Anti-Inflammatory	4,923	702	$30,580,259

Out of 14 drugs analyzed, 11 are biologics; they are responsible for $995 million in total system spending in 2024 which is about 73 percent of the total system spend of the selected drugs. The three remaining small-molecule drugs (*semaglutide, tirzepatide,* and *estradiol*) contributed to $375 million of total system spending. *Estradiol* only accounts for $26 million of spending as the drug with the lowest total spending in the group, shown in Figure 2.

Commented [CW20]: Comment provided by MK: 8? Biktarvy and Trikafta are synthetic small-molecule drugs

Commented [CW21]: Comment provided by DH: Confusing. Are you saying that biologics (n=11) are responsible for 73% of total spend for these 14 drugs.

Commented [CW22]: Comment provided by NR: Based on my biologic comment above, here's how I think this needs rewritten. I would call the remainder 'non-biologic drugs' to avoid grouping semaglutide and tirzepatide, which are peptide drugs, under an overly broad small-molecule label.

Of the 14 drug groups analyzed, eight were biologics, accounting for approximately $731 million, or 53 percent, of gross payer and enrollee spending in the 2024 APAC data. The six non-biologic groups [bictegravir-emtricitabine-tenofovir alafenamide (Biktarvy), elexacaftor-tezacaftor-ivacaftor (Trikafta), estradiol, semaglutide, tirzepatide, and upadacitinib (Rinvoq)] accounted for the remaining $639 million, or 47 percent. Estradiol had the lowest total spending among the selected drugs, at approximately $26 million, as shown in Figure 2.

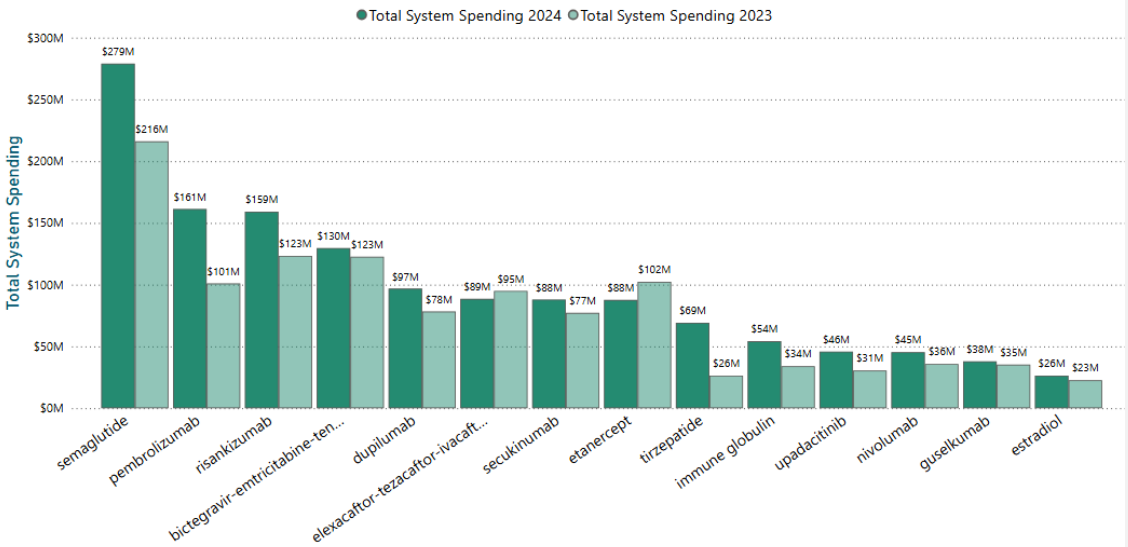


Figure 2: APAC total system spending by drug for 2023 and 2024, ordered by 2024 spending

Figure 3 compares APAC enrollee counts for the selected drugs in 2023 and 2024. *Estradiol* had the highest enrollee count in 2024, increasing from 83,112 to 100,027, followed by *semaglutide*, which increased from 32,424 to 41,394. *Tirzepatide* had the largest percentage increase, ~~which~~ with its enrollee count more than doubling from 4,299 to 10,800. These were also the three drugs with the highest enrollee counts in the 2025 DPT data. Enrollee counts increased for 12 of the 14 selected drugs; *etanercept* and *elexacaftor-tezacaftor-ivacaftor* had decreases. These trends show that more enrollees had claims for most of the selected drugs in 2024. A growing enrollee count can contribute to higher total spending, but the figure does not show how frequently each enrollee received treatment.

Commented [CW23]: Comment provided by DH: Can 2024 be the right of 2023? Is it possible to include % change on second axis?

Commented [CW24]: Comment provided by NR: I'd go horizontal here too. Would afford you more space between pairs

Commented [CW25]: Edit provided by MK

Commented [CW26]: Comment provided by NR: Kinda to this point, raw enrollee counts alone cannot show whether treatment became more common within a comparable population.

Could we distinguish growth in the number of treated enrollees from growth in the underlying covered population? Something like a utilization rate per 1,000 members or something.

DRAFT

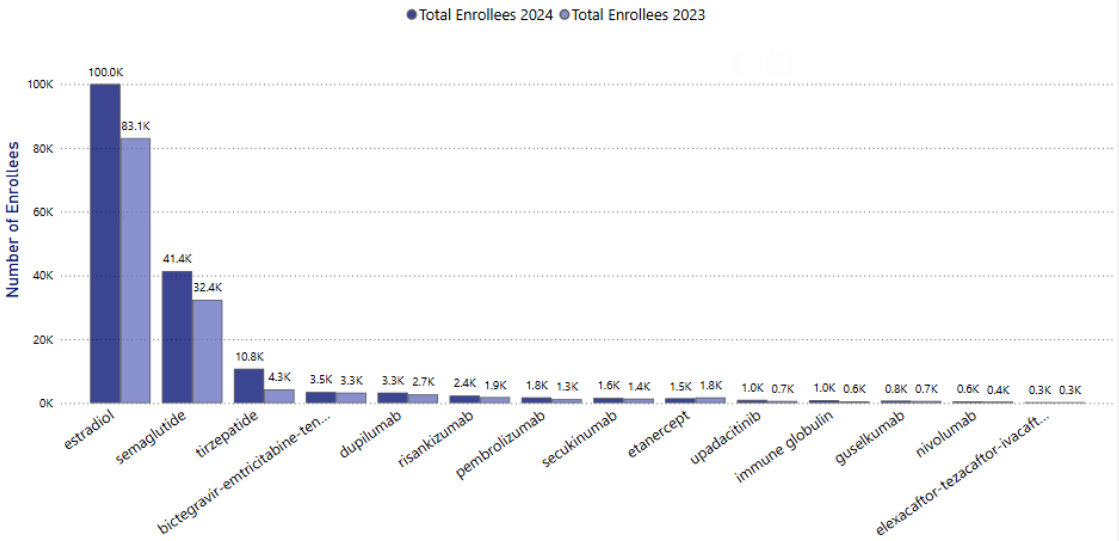


Figure 3: APAC enrollee counts by drug for 2023 and 2024, ordered by 2024 enrollees.

Figure 4 compares APAC claim counts between 2023 and 2024. *Estradiol* had the highest claim count in 2024 at 390,250, flowed by *semaglutide* at 251,795. *Semaglutide* had the largest increase in claims (rising from 192,751 to 251,795, a 23 percent increase), while *tirzepatide* had the largest percentage increase (63 percent increase from 2023 to 2024). Claim counts increase for 12 of the 14 selected drugs and decreased for *etanercept* and *elexacaftor-tezacaftor-ivacaftor*. The spending effect differed across drugs: *estradiol* had 58,330 additional claims and a $4 million spending increase, while *pembrolizumab* had 4,946 additional claims and a $60 million increase, as show in Figure 2. These comparisons show that claims growth alone does not explain the size of spending changes because cost per claim varies greatly for different drugs. Claim counts also do not establish whether growth reflects more enrollees, more frequent treatments per enrollee, or differences in how services were billed.

Commented [CW27]: Comment provided by NR: Title is confusing. Maybe "Number of enrollees receiving each selected drug, 2023 and 2024"?

I'd also consider horizontal bars here for similar reason as above.

More importantly, maybe create two panels so that you can deal with the massive scale difference?

Commented [CW28]: Comment provided by DH: 2024 should be right of 2023; the figure is difficult to interpret because first two data points are 5-10 fold higher magnitude. Either separate OR use log scale WITH second access to describe y to y changes.

Commented [CW29]: Comment provided by NR: I think the math on all these percentages might be wrong. Should be 2024-2023/ 2023.. so for example on this one that calculates to 31% increase. Wrong denominator maybe?

Commented [CW30]: Comment provided by DH: This is a 31% increase

Commented [CW31]: Comment provided by DH: Tirzepatitde claims increased 2.6 fold.

Commented [CW32]: Comment provided by MK: Claim counts are also influenced by benefit designs, e.g. quantity limits

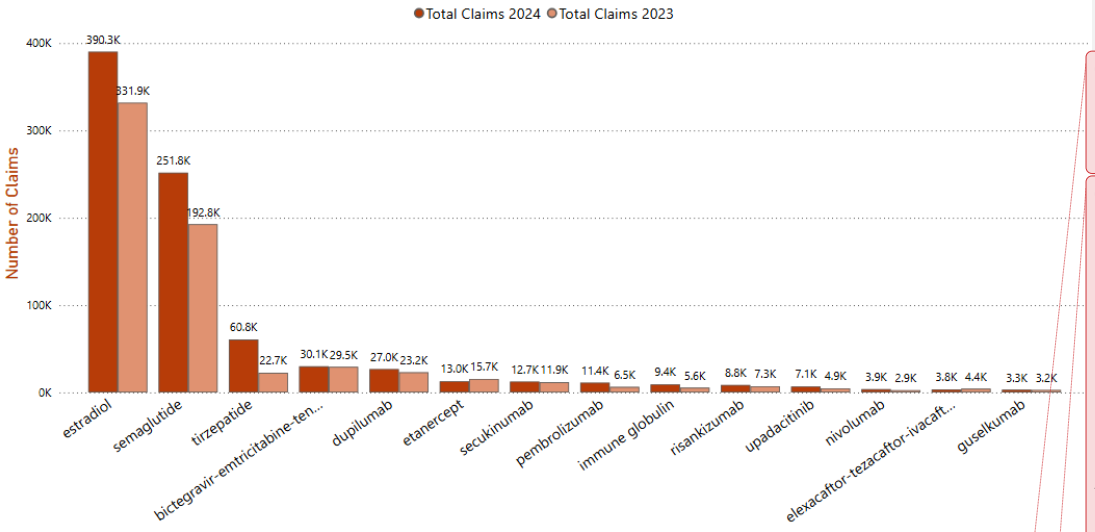


Figure 4: APAC claim counts by drug for 2023 and 2024, ordered by 2024 claims.

Key takeaways:

- *Semaglutide*, *pembrolizumab*, and *risankizumab* had the highest total system spend in the 2024 APAC data and the highest net insurer spending in the 2025 DPT data, although their rankings differed between the two datasets.
- Changes in utilization and spending differed across drugs. *Estradiol* claims increased by 58,330 and spending by $4 million, while *pembrolizumab* claims increased by 4,946 and spending by $60 million.

Therapeutic class trends

Among the selected drugs in the 2025 DPT data, Figure 5 shows the combined dermatologicals and gastrointestinal agent grouping had the highest annual net spending ($84 million) and the largest year-over-year increase ($26 million). The two-class grouping included two drugs, *guselkumab* (Tremfya) and *risankizumab*. The two-class grouping that included *semaglutide* and *tirzepatide*, ADHD/anti-narcolepsy/anti-obesity/anorexiants and antidiabetics, ranked second in spending ($65 million) and with the second-highest year-over-year spending increase of $18 million. The single-class dermatologicals-only grouping contained two drugs, *dupilumab* (Dupixent) and *secukinumab* (Cosentyx), and ranked third in spending ($61 million), with a $10 million increase. The single-class antineoplastics and adjunctive therapy grouping contained two drugs, *pembrolizumab* and *nivolumab* (Opdivo), and had $50 million in spending and a $13 million year-over-year increase. The single-class analgesics grouping contained two drugs,

Commented [CW33]: Comment provided by NR: Effectively same comment as Fig 3. "number of claim for each selected drug, 2023 and 2024"... consider horizontal bars. The rate comment could also apply here, but I think more important above.

Commented [CW34]: Comment provided by NR: Not sure your standard, but I'm really consider using plain language groupings. I understand where these are coming from, but they're not understandable and database categories are just weird sometimes (i.e., enbrel and rinvoq as analgesics).

I'd consider regrouping entirely. The finding would be more meaningful. Happy to help you do that. It would also set stage for next year's "class" reviews.

Here's how I would do that and how I'd rewrite--

Among the selected drugs in the 2025 DPT data, the autoimmune and inflammatory grouping had the highest reported net insurer spending, at approximately $153 million, and the largest increase from 2024, at $38 million (Figure 5). This grouping included etanercept (Enbrel), upadacitinib (Rinvoq), secukinumab (Cosentyx), risankizumab (Skyrizi), and guselkumab (Tremfya). Diabetes and weight management therapies, comprising semaglutide and tirzepatide, ranked second in both spending and annual growth, with $65 million in spending and an $18 million increase. Oncology therapies, comprising pembrolizumab (Keytruda) and nivolumab (Opdivo), ranked third, with $50 million in spending and a $13 million increase. Dupilumab (Dupixent), grouped separately under type 2 inflammatory conditions, accounted for $34 million in spending and a $7 million increase. These totals describe the selected drugs within each grouping, rather than all drugs used to treat these conditions.

Autoimmune and inflammatory conditions: Enbrel, Rinvoq, Cosentyx, Skyrizi, Tremfya

Diabetes and weight management: Ozempic, Rybelsus, Wegovy; Mounjaro, Zepbound

Oncology: Keytruda, Opdivo

Type 2 inflammatory conditions: Dupixent

HIV: Biktarvy
Cystic fibrosis: Trikafta
Immunoglobulin therapies
Estrogen therapies

Commented [CW35]: Comment provided by MK: Is it worth noting somewhere that biologics are more costly to manufacture? Or are we sticking to the data?

etanercept (Enbrel) and *upadacitinib* (Rinvoq) and had $42 million in spending and a $10 million year-over-year increase. These totals describe the drugs within each grouping that were selected for analysis in this report, rather than all drugs in each therapeutic class.

The remaining four groupings shown in Figure 5 each contained one drug analyzed in this report. See Table 1 for a complete list of the drugs and associated therapeutic classes.

Commented [CW36]: Comment provided by NR: I'm happy to pull this through to the full list if you want. I totally get it if using medispan class or whatever if what you want to stick with, it's just a lot less meaningful/ easy to understand

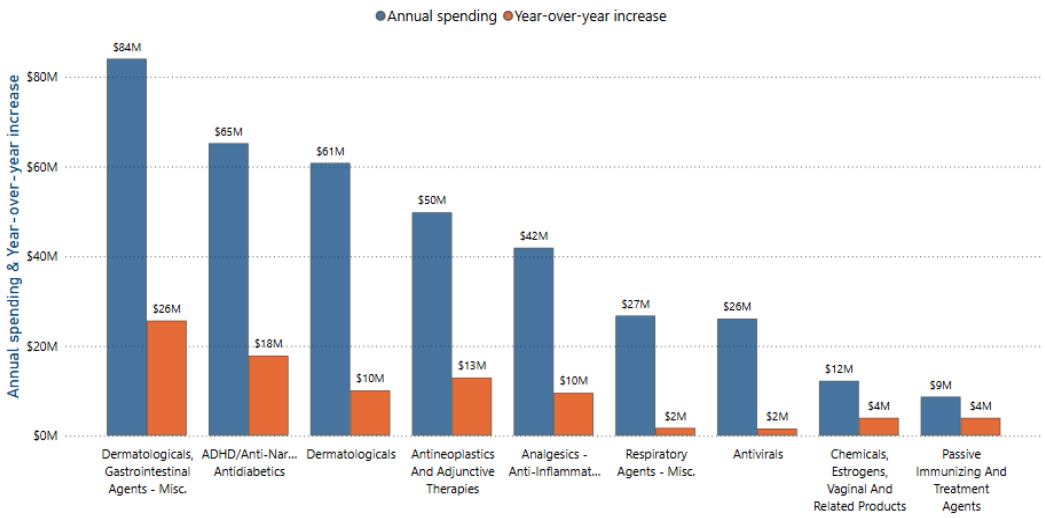


Figure ~~5~~5 DPT reported net spending by therapeutic class for 2025

Figure 6 compares APAC total system spending, including payer and enrolled spending, using the same therapeutic class grouping for the selected drugs in 2023 and 2024. The ADHD/anti-narcolepsy/anti-obesity/anorexiants and antidiabetics grouping had the highest spending in 2024 at $348 million and the largest year-over-year increase of $106 million. The antineoplastics and adjunctive therapies grouping followed at $207 million, an increase of $70 million. The combined dermatologicals and gastrointestinal agents grouping increased by $38 million to $197 million. Spending increase in eight of the nine groupings; respiratory agents, represented by *elexacaftor-tezacftor-ivacaftor*, decreased by $6 million from 2023 to 2024. These results identify where spending growth was concentrated among the analyzed drugs. They do not represent spending for all drugs in each therapeutic class or distinguish the effects of changes in utilization from changes in amounts paid.

Commented [CW37]: Comment provided by DH: This classification system is doing a lot of work. I suspect its mostly GLP-1 driven. Not sure if we have other classification systems available?

Commented [CW38]: Comment provided by NR: How'd I rewrite if regrouped:

Figure 6 compares gross payer and enrollee spending in the 2023 and 2024 APAC data using the same eight therapeutic groupings. The autoimmune and inflammatory grouping had the highest spending in 2024, at approximately $419 million, an increase of $50 million from 2023. Diabetes and weight management therapies ranked second in spending, at $348 million, but had the largest annual increase, at $106 million. Oncology therapies followed with $207 million in spending and a $70 million increase. Spending increased in seven of the eight groupings. Cystic fibrosis therapy, represented by elexacaftor-tezacaftor-ivacaftor (Trikafta), was the only grouping with a decline, decreasing by approximately $6 million to $89 million. These results describe spending patterns among the selected drugs, rather than all drugs used to treat these conditions. Changes in spending may reflect changes in utilization, amounts paid, or both.

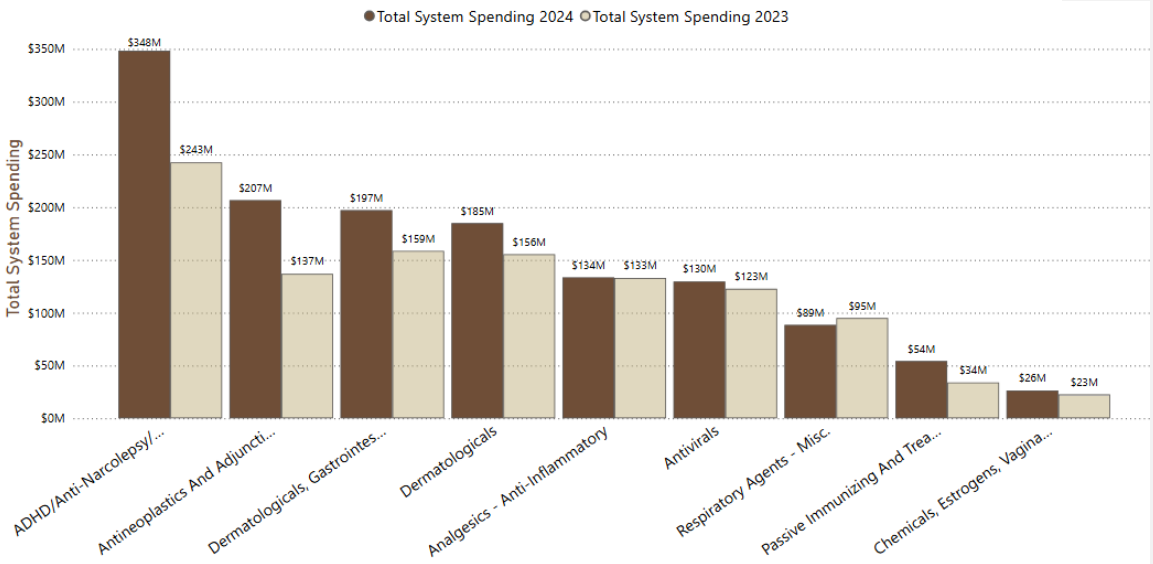


Figure 6: APAC total system by therapeutic class for 2023 and 2024, ordered by 2024 spending

Commented [CW39]: Comment provided by NR: APAC gross payer and enrollee spending for selected drugs by therapeutic grouping, 2023 and 2024

Market dynamics

The PDAB 2025 annual report identified utilization growth, negotiated payments, coverage arrangements, and the availability of new therapies as factors relevant to prescription drug spending. [7] It also identified concentrated spending in antidiabetics, dermatological, and anti-inflammatory drugs. The 2026 analysis shows similar patterns among the selected drugs, although differences in drug selection, reporting periods, and data sources limit direct comparisons between the reports.

Growth in utilization. APAC enrollee and claims counts increased for 12 of the 14 selected drugs from 2023 to 2024. *Tirzepatide* had the largest percentage increase in both measures, while *semaglutide* had the largest absolute increase in claim counts. These increases occurred alongside higher spending, indicating that growth in the number of people receiving treatment and the volume of claims are important considerations when assessing spending trends. The data do not establish whether these changes resulted from expanded indications, changes in coverage, prescribing practices, or other factors.

Commented [CW40]: Comment provided by NR: Could we add a small amount of descriptive analysis to separate the spending components: treated enrollees, claims per enrollee, and average spending per claim? That would help explain what changed without claiming causation. We should still note that average cost per claim can change with dose, days supplied, product mix, or site of care and is not a standardized unit price.

Concentration of spending. The current analysis continues to identify substantial spending among drug classified as antidiabetics and dermatologicals. In the 2025 DPT data, the combined

Commented [CW41]: Comment provided by DH: And cancer

[7] "PDAB Annual Report 2025. "Oregon Prescription Drug Affordability Board, December 2025. https://dfr.oregon.gov/pdab/Documents/archive/PDAB-Annual-Report-2025.pdf.

dermatologicals and gastrointestinal agents grouping, containing *guselkumab* and *risankizumab*, had the highest net insurer spending among the selected drugs at $84 million. In the 2024 APAC data, the ADHD/anti-narcolepsy/anti-obesity/anorexiants and antidiabetics grouping, containing *semaglutide* and *tirzepatide,* had the highest payer and enrollee spending at $348 million. These findings are consistent with the spending concentration described in the PDAB 2025 annual report. However, analysis in this report describes the selected products rather than all drugs in the analyzed therapeutic classes.

Different spending effects across drugs. High utilization, high per-enrollee spending, and high total spending represent different forms of financial exposure. *Estradiol* had the highest enrollee and claim counts in APAC but the lowest total spending among the selected drugs. *Pembrolizumab* and *risankizumab* had substantially fewer claims but ranked second and third in total spending in APAC in 2024. Consequently, spending assessments need to consider both the number of people receiving a drug and the amount paid for their treatment.

Negotiated payments and coverage arrangements. Rebates, formulary placement, and benefit design remain relevant when interpreting spending and patient affordability. A federal review of Medicare Part D found that rebates could reduce plan spending without reducing individual beneficiary payments and could influence formulary placements.[8] That finding provides context but does not establish the effects of these arrangements in Oregon's commercial market. DPT reports on net insurer spending, while APAC reports on gross payer and enrollee spending. Neither dataset, as presented, identifies whether changes in rebates, contract terms, or coverage requirements explain the observed spending and utilization changes.

The recurring pattern is that spending pressures reflect a combination of broad utilization of some drugs and substantial per-person spending on other products used by smaller numbers of people. The pattern does not establish changes in list prices, the causes of utilization growth, or the extent of patient affordability challenges.

Limitations and data considerations

The results presented in this report are subject to several important data considerations and limitations. While every effort was made to ensure data accuracy and consistency, certain factors inherently affect the interpretation of the trends over time. These should be considered when evaluating the analyses within this report.

- **Spending trends rather than list-price trends.** This report refers to price trends; however, the data supporting the analysis aligns with spending trends. ORS

[8] "Medicare Part D: CMS should monitor effects of rebates on plan formularies and beneficiary spending, GAO-23-105270." Government Accountability Office, Sept. 5, 2023. Medicare Part D: CMS Should Monitor Effects of Rebates on Plan Formularies and Beneficiary Spending | U.S. GAO.

Commented [CW42]: Edit provided by MK

Commented [CW43]: Comment provided by DH: Do you mean cost-sharing or premiums?

Commented [CW44]: Comment provided by DH: Seems like coupling the two (net cost per claim vs gross cost per claim) for commercial payers provides an opportunity to estimate rebates.

646A.689 defines price as "the wholesale acquisition cost as defined in 42 U.S.C. 1395w-3a(c)(6)(B)".[9] The data received from DPT is related to commercial insurer reporting on net spending rather than wholesale acquisition cost (WAC). APAC data reports gross spending before rebates or price concessions. Therefore, the analysis in this report is a review of spending and related trends.

- **Drug-name standardization.** Insurers reporting to DPT enter the drug's proprietary and non-proprietary names into an open text field. Manual text entry fosters multiple variations for drug names as entered by different insurers. To better conduct this analysis, the data team adopted a naming convention based on review of the insurer reporting, Medi-Span, and U.S. Food & Drug Administration (FDA) sources to associate all data lines at the prescription drug level.
- **Trends are not indicative of WAC.** Price trends represented in the market by the data received are not necessarily indicative of WAC. Refer to the bullet item above: "Spending trends rather than list-price trends." A WAC price may increase, decrease, or remain the same from one period to the next and may not align with trends seen in this report. The spending on a drug can be influenced by many factors, including negotiations, rebates, fees, and supply chain variances.
- **The number of reporting insurers and covered markets.** Insurers issuing health benefit plans, as defined in ORS 743B.005, are required to report data to DPT under ORS 743.025. Eleven insurers reported data for drug spend incurred in 2025 (reported in 2026) and reimbursed under health benefit plans. This report is not inclusive of all insurers in the state or in all markets. Roughly one-fifth of the Oregon population is represented by the reports received from these insurers. These reports only include individuals and employers that buy fully insured plans in Oregon. People with public insurance, including Medicare and Medicaid, and people with health insurance through a self-insured employer are not included in the data in these reports and the findings may not be generalizable to the entire Oregon population.
- **Net and gross values.** Net values reported by the insurers represent spending after all rebates, discounts, price concessions, and any other forms of reimbursement have been applied. APAC values are reported to OHA at gross spend.

Commented [CW45]: Comment provided by DH: Is this the same concept as the first bullet.

Commented [CW46]: Comment provided by DH: It's also varies by drug and aggregating across drugs may be a misleading snapshot of even this limited segment.

[9] "Use of average sales price payment methodology." Sec. 1847A. [42 U.S.C. 1395w–3a(c)(6)(B). https://www.ssa.gov/OP_Home/ssact/title18/1847A.htm.

DRAFT

Generic drug report

Background

Generic drugs account for 90 percent of U.S. prescriptions, and these medicines are an integral part of the health care system.[10] Generic drugs are also relatively inexpensive, accounting for roughly 12 percent of prescription drug spending in 2025.[11] Generic drugs are produced and sold by multiple companies after the end of patent protections and exclusivity periods on the original product.

Commented [CW47]: Comment provided by NR: picky comment- but I'd qualify this a little-- add "are typically produced"-- Not all generics are multi-source, and it's part of market trend pressure upwards towards higher spending. We see that especially as speciality drugs become generic.

While the terms branded and generic drugs are usually used to refer to small molecule medications made by chemical synthesis, another category of drugs called biologics, is made up of complex molecules from living organisms. Biologics have an increasing important role in treating diseases such as cancer and autoimmune disorders. At the same time these drugs can be very expensive, and the cost can be a barrier to patients accessing these treatments. Similar to generic small-molecule drugs, products called biosimilars are produced and sold after the end of patent and exclusivity periods for biologic drugs. Biosimilars are regulated by the FDA, and they must match the original product in the following ways: they must be made from the same types of sources, provide the same benefits when treating diseases or medical conditions, are given at the same strength and dosages, and are not expected to cause new or worsening side effects.[12]

Generic drugs and biosimilars can increase competition among manufacturers, lower cost, and increase access to medicines. Generic drugs enter the market when applicable patents and exclusivity protections permit. They use the same active ingredients as the brand-name product, but inactive ingredients may differ. Their approval pathway relies on the established safety and effectiveness of the brand-name product and generally avoids repeating extensive preclinical and clinical trials.[13] The FDA reviews generic drugs to ensure they are comparable to their brand-name, including the active ingredient, strength, dosage form, and route of

[10] Schulman, Kevin A., et al. "Ensuring Access To Generic Medications In The US." Health Affairs, Sept. 12, 2023. https://www.healthaffairs.org/content/forefront/ensuring-access-generic-medications-us.
[11] "*2026 U.S. Generic & Biosimilar Medicines Savings Report.*" Association for Accessible Medicines, Sept. 10, 2026. https://accessiblemeds.org/resources/reports/2026-savings-report/.
[12] "Biosimilars Basics for Patients." U.S. Food & Drug Administration, Aug. 1, 2024. https://www.fda.gov/drugs/biosimilars/biosimilars-basics-patients.
[13] Awasthi, Abhishek and Gupta, Mohit. "Generic Drug Development and Bioequivalence Study." International Journal of Pharmaceutical Sciences, June 1, 2026. https://www.ijpsjournal.com/article/generic-drug-development-and-bioequivalence-study.

administration.[14] Lower development costs of generic drugs can encourages market entry and competition. Greater generic competition can reduce prices for patients and insurers.[15]

Biosimilars can also lower health care costs by providing competitive alternatives to reference biologic products. Like generics, biosimilars can increase treatment options and competition among manufacturers.[16] The effects on patient access and patient and health system spending depend on product availability, coverage, and cost sharing.

Biologics and biosimilars

Biosimilars and generics have technical and regulatory differences that impact their uses. The Biologics Price Competition and Innovation Act of 2009 (BPCI Act) was signed into law as part of the Affordable Care Act in 2010. The BPCI Act creates an abbreviated approval pathway for biological products that are demonstrated to be "highly similar" (biosimilar) to or "interchangeable" with an FDA-approved biological product.[17] Interchangeable status indicates that biosimilars can be used in place of reference biologics but it does not mean that a product is safer or more effective than a biosimilar without that status. The FDA continues to encourage innovation and competition in the market for biological products.[18]

Legally, generics and biosimilars are treated differently by drug substitutions laws. In Oregon, pharmacists may substitute a "drug product with the same generic name in the same strength, quantity, dose and dosage form as the prescribed drug".[19] All states have similar laws allowing substitutions; substitutions are permitted in some states while mandated in others.[20] For biosimilars, the FDA allows pharmacists to substitute reference products with biosimilars without the approval of the prescriber.[21] However, laws regarding biosimilar substitution vary from state to state. Most state laws allow pharmacists to substitute biosimilars with the

Commented [CW48]: Comment provided by NR: I'd sharpen this. All approved biosimilars can be prescribed in place of their reference product. Interchangeability addresses pharmacy substitution without prescriber intervention under applicable state law; it is not a higher standard of clinical effectiveness.

Suggestion:
The interchangeable designation permits pharmacy-level substitution where state law allows; it does not mean the product is safer or more effective than other approved biosimilars.

[14] "Generic Drugs." U.S. Food & Drug Administration, Sept. 18, 2026. https://www.fda.gov/drugs/buying-using-medicine-safely/generic-drugs.
[15] Conrad, Ryan and Lutter, Randall. "Generic competition and Drug Prices: New Evidence Linking Greater Generic Competition and Lower Generic Drug Prices." U.S. Food & Drug Administration, December 2018. https://www.fda.gov/media/133509/download.
[16] Chan, Juliana and Chan, Anthony. "Biologics and biosimilars: what, why, and how?" ESMO Open, March 23, 2017. https://www.esmoopen.com/action/showPdf?pii=S2059-7029%2820%2932482-0.
[17] "Implementation of the Biologics Price Competition and Innovation Act of 2009." U.S. Food and Drug Administration, Feb. 12, 2026. https://www.fda.gov/drugs/guidance-compliance-regulatory-information/implementation-biologics-price-competition-and-innovation-act-2009.
[18] "Biosimilars Action Plan." U.S. Food and Drug Administration. https://www.fda.gov/drugs/biosimilars/biosimilars-action-plan.
[19] ORS 689.515. https://www.oregonlegislature.gov/bills_laws/ors/ors689.html.
[20] Rome, Benjamin, et al. "State Laws and Generic Substitution in the Year After New Generic Competition." Health Policy Analysis, October 2022. https://doi.org/10.1016/j.jval.2022.03.012.
[21] "Considerations in Demonstrating Interchangeability With a Reference Product: Update." U.S. Food & Drug Administration, June 20, 2024. https://www.fda.gov/media/179456/download.

interchangeable designation; some states require added communication from the pharmacists to the prescriber or permission from the prescriber to substitute products.[22]

Both generics and biosimilars lower drug costs for patients and payers, but the adoption of biosimilars has lagged behind their small-molecule counterparts. However, as product availability increases, patients, prescribers, and pharmacists may adapt to use biosimilar treatments.

Price of generic drugs on year-to-year basis

Annually, Oregon insurance companies report top 25 drug lists of the most-costly, most prescribed, and greatest increase in spending to the DPT Program. For the 2024 data provided by DPT, PDAB staff identified nine generic drugs that contributed to health care system costs in Oregon. The drugs were identified from the preliminary list that appeared on five or more most-costly, most prescribed, and greatest increase lists across all reporting insurers in Oregon. The selection was then narrowed to include only generics with therapeutic alternatives or equivalents. From this refined list, staff analysts selected the nine generic drugs with the highest total spending and used the most utilized National Drug Code (NDC) for each drug to obtain WAC data from the Medi-Span database. WAC data for the period 2021-2025 were compiled and analyzed for comparison with spending trends. A similar analysis was previously performed in the 2025 Generic Drug Report and has some of the same drugs, including *atorvastatin*, *gabapentin*, and *lisinopril*.[23] Most of these drugs showed no change in the package WAC from year to year. Two generic drugs with distinct trends were notable amongst the group: *atorvastatin* and *buprenorphine*.

Commented [CW49]: Comment provided by NR: The FDA sentence is too broad. The FDA does not give pharmacists blanket authority to substitute any biosimilar, its all state law (ORS 689.522)

Commented [CW50]: Comment suggested by NR: This doesn't reflect all the factors.

Suggested rewrite:
Generics and biosimilars can lower drug costs for patients and payers, but biosimilar adoption has lagged behind that of small-molecule generics. Greater product availability creates opportunities for competition, but uptake also depends on formulary placement, net prices after rebates, provider reimbursement, and the practical requirements of switching treatments. These factors, together with patient cost sharing, influence whether biosimilar competition translates into lower spending and improved access.

Commented [CW51]: Comment provided by NR: Why exclude generics without therapeutic alternatives or equivalents? Those may be particularly relevant to affordability and supply vulnerability. Please distinguish a therapeutically equivalent product from a different therapeutic alternative, explain the reason for this filter, and state what it leaves out of the analysis.

[22] "Decreasing drug costs through generics and biosimilars." National Conference of State Legislatures, Jan. 21, 2022. https://www.ncsl.org/health/decreasing-drug-costs-through-generics-and-biosimilars.
[23] "PDAB Generic Drug Report 2025." Oregon Prescription Drug Affordability Board, May 2025. https://dfr.oregon.gov/pdab/Documents/archive/PDAB-Generic-Drug-Report-2025.pdf.

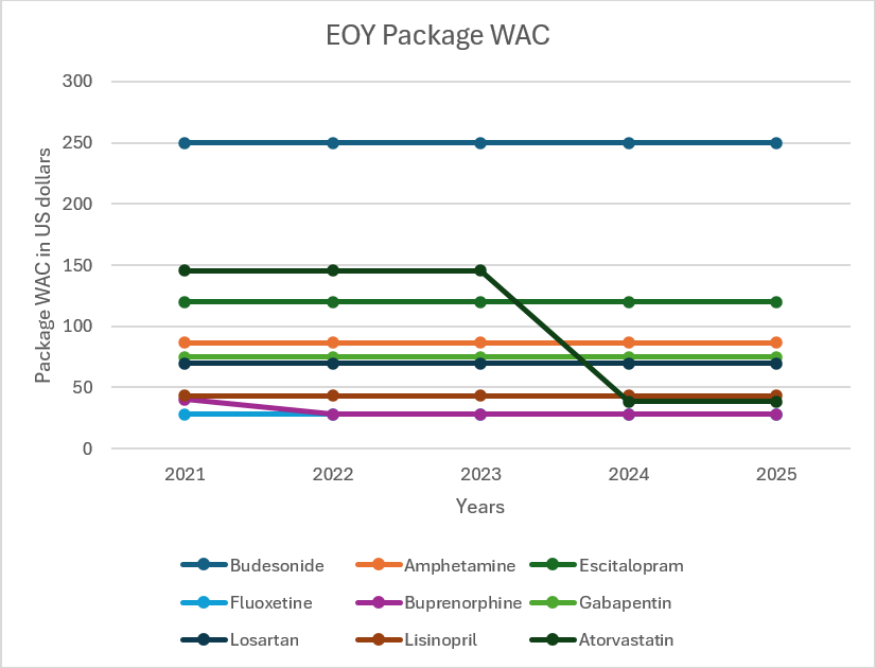


Figure 7: End-of-year generic drugs packaged WAC from 2021-2025

From 2023 to 2024, the end-of-year (EOY) WAC for *atorvastatin* dropped from $145.41 to $38.33. The FDA listed recall of *atorvastatin* starting September 19, 2025, and the recall is still ongoing.[24]

Buprenorphine is the other generic drug with price changes in this analysis. From 2021 to 2022, the EOY package WAC of *buprenorphine* dropped from $40.00 to $28.00. In June of 2018 (predating this time series), FDA approved *buprenorphine* and *naloxone* generics.[25] As more manufacturers enter the market, the WAC of *buprenorphine* may adjust and drop due to increased competition.

The other seven selected drugs had stable EOY package WACs over the period shown. For example, *gabapentin's* packaged WAC remained $75.00 from 2021 through 2025. These results describe the selected products and do not establish price trends for all generic drugs. WAC is a

Commented [CW52]: Comment provided by NR: I don't find this relevant to WAC pricing.

Commented [CW53]: Comment provided by NR: Can we clarify which buprenorphine product is being analyzed? We should distinguish products approved for pain from those approved for opioid use disorder. Single-ingredient buprenorphine can fall into either category depending on the formulation. The June 2018 approval cited here specifically concerns buprenorphine/naloxone sublingual film.

I would also remove the suggested explanation for the price decline unless we have product-specific evidence linking it to increased competition.

[24] "Enforcement Report." U.S. Food & Drug Administration, Sept. 19. 2025. https://www.accessdata.fda.gov/scripts/ires/?Event=97639.
[25] "2018 First Generic Drug Approvals." U.S. Food & Drug Administration, Jan. 11, 2019. https://www.fda.gov/drugs/first-generic-drug-approvals/2018-first-generic-drug-approvals.

list price before rebates or discounts and does not measure amounts paid by insurers or patients.

Cost sharing and insurance premiums

The relationship between generic drug prices and health insurance premiums is difficult to assess with the available information. Pharmacy benefit managers (PBMs) negotiate drug payments and help health plans manage formularies. Rebates and contract terms are often considered trade secret or confidential, limiting public assessment of how drug spending affects premiums.

Cost-sharing is the financial responsibility of a patient for medical services or items included in their health insurance. There are three main categories of cost-sharing charges with health insurance plans:

- **Deductibles**: The fixed amount that a policyholder must pay for health care services before their insurance coverage commences.
- **Copayments (copays)**: A predetermined fee that individuals are required to pay each time they access a specific service or item, such as a medical consultation or a prescription refill, even after fulfilling their deductible.
- **Coinsurance**: A percentage of the cost of a covered service that individuals are obliged to pay each time they access a specific service or item, after fulfilling their deductible, thus signifying a shared cost arrangement between the insurance provider and the insured.

The amounts, requirements, and services subject to each form of cost sharing vary by health plan benefit design.

Patient out-of-pocket drug costs depend on benefit design, including deductibles, copayments, and coinsurance. The amount or rate for these charges is often set by formulary placement. Rebates and discounts can reduce net insurer spending, but they do not necessarily reduce patient costs at the pharmacy.[26] Health plans often place generic drugs in tiers with lower cost sharing than brand-name drugs to encourage use of lower-cost options. The relationship between list prices and patient payments depends on the plan and is not assumed to be the same across products.

[26] Yang, Eric J., et al. "Changes in Drug List Prices and Amounts Paid by Patients and Insurers." Health Policy, JAMA Network Open, Dec. 9, 2020. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2773825.

Commented [CW54]: Comment provided by NR: I'd add more color. WAC isn't actually reflective of much.

Suggested rewrite:
Seven selected NDCs had unchanged end-of-year package WACs over the period shown. For example, the selected gabapentin product's package WAC remained $75.00 from 2021 through 2025. These findings reflect list prices for specific products and package sizes, rather than price trends across their respective generic markets. Stable WAC does not necessarily indicate stable pharmacy acquisition costs, insurer payments, or patient costs. A companion analysis using a per-unit acquisition-cost measure, such as the National Average Drug Acquisition Cost (NADAC) where available, could provide additional insight into price changes not captured by WAC.

Commented [CW55]: Comment provided by NR: This is leaning on rebates pretty hard when that's not really a thing for generics.

Suggested rewrite:
This analysis does not estimate the effect of generic drug price changes on health insurance premiums. Assessing that relationship would require information on drug acquisition costs, pharmacy reimbursement, and health plan costs after applicable rebates and other price concessions. Premiums reflect expected total medical and pharmacy claims, administrative expenses, and other factors. Changes in the selected products' WACs alone therefore cannot establish whether or how generic drug prices affect premiums.

Commented [CW56]: Comment provided by NR: Picky but I recommend some semantic changes here, especially around deductible.

Suggestion:
Cost sharing is the portion of the cost of covered health care services or prescription drugs that a patient pays out of pocket. The three main types are:
- Deductible: The amount a patient must pay for covered services subject to the deductible before the health plan begins paying its share.
- Copayment (copay): A fixed amount a patient pays for a covered service or prescription, such as $20 per visit or refill.
- Coinsurance: A percentage of the allowed cost of a covered service or prescription that a patient pays. For example, with 20 percent coinsurance, a patient pays $20 when the allowed cost is $100.

How these charges apply depends on the health plan's benefit design. Some services and prescriptions are covered before the deductible is met, and copayments or coinsurance may apply before or after the deductible.

Drug shortages

This section examines shortages of two prescription drugs: stimulants used to treat attention-deficit/hyperactivity disorder (ADHD) and liquid *albuterol* used to treat bronchospasm caused by asthma and other lung diseases.

Shortages of stimulants used to treat ADHD have affected access since 2022.[27] Affected drugs include the branded and generic versions of *amphetamine/dextroamphetamine* (Adderall), *methylphenidate* (Ritalin), and *lisdexamphetamine* (Vyvanse). Shortage status varies by product and formulation.

Rising demand is one factor associated with stimulant shortages. A Centers for Disease Control and Prevention (CDC) analysis of commercially insured people aged 5 through 64 found that the percentage with one or more prescription stimulant fills increased from 3.6 percent in 2016 to 4.1 percent in 2021.[28] The study describes expanded telehealth access as a possible contributor to prescribing trends. Prescription-fill rates do not measure ADHD prevalence and do not establish why individual patients sought treatment.

Supply constraints are another factor. The Drug Enforcement Agency (DEA) regulates the manufacture and distribution of Schedule II controlled substances, including *amphetamine* and *methylphenidate*, and sets aggregate production quotas based on estimated needs. In October 2025, the DEA published a notice to raise the quota for both *d-amphetamine* and *methylphenidate*. [29] A quota adjustment permits additional production but does not establish whether manufacturers can produce and distribute enough medication to meet demand.[30]

Higher quotas alone may not solve shortages. A 2023 joint FDA and DEA letter reported that manufacturers sold approximately 70 percent of their allotted *amphetamine* quota in 2022,

Commented [CW57]: Comment provided by NR: two examples not two drugs (LOTS of stimulants on shortage). I also think connecting why this matters is important.

Suggestion:
This section examines two examples of prescription drug shortages: stimulants used to treat attention-deficit/hyperactivity disorder (ADHD) and albuterol inhalation solution used to treat bronchospasm associated with asthma and other lung diseases. These shortages can interrupt treatment, make it difficult to locate available supplies, and require changes in medication or formulation that may affect patients' out-of-pocket costs. These potential consequences were not measured in this analysis.

[27] "FDA drug shortages. Current and resolved drug shortages and discontinuations reported to FDA: Active Ingredient Details: Amphetamine Aspartate Monohydrate, Amphetamine Sulfate, Dextroamphetamine Saccharate, Dextroamphetamine Sulfate Tablet." U.S. Food and Drug Administration, Oct. 12, 2022. https://www.accessdata.fda.gov/scripts/drugshortages/dsp_ActiveIngredientDetails.cfm?AI=Amphetamine%20Aspartate%20Monohydrate%2C%20Amphetamine%20Sulfate%2C%20Dextroamphetamine%20Saccharate%2C%20Dextroamphetamine%20Sulfate%20Tablet&st=c.

[28] Danielson, Melissa L., et al. "Trends in Stimulant Prescription Fills Among Commercially Insured Children and Adults — United States, 2016–2021." CDC Morbidity and Mortality Weekly Report, March 31, 2023. https://www.cdc.gov/mmwr/volumes/72/wr/mm7213a1.htm?s_cid=mm7213a1_w.

[29] "DEA Releases 2026 Aggregate Production Quotas." United States Drug Enforcement Administration, Jan. 9, 2026. https://www.dea.gov/press-releases/2026/01/09/dea-releases-2026-aggregate-production-quotas.

[30] "Adjustment to the Aggregate Production Quota for d-Amphetamine (For Sale) and Methylphenidate (For Sale) for 2025 Pursuant to 21 U.S.C. 826(h)." National Archives Federal Register, Oct. 2, 2025. https://www.federalregister.gov/documents/2025/10/02/2025-19335/adjustment-to-the-aggregate-production-quota-for-d-amphetamine-for-sale-and-methylphenidate-for-sale#p-15.

leaving capacity equivalent to approximately 1 billion additional doses.[31] In 2026, researchers identified constraints involving active ingredients, imports, and backorders.[32] These constraints may have contributed to manufacturers producing below established limits; however, further research is required to better understand the causes of and potential solutions to the shortage.[33]

Albuterol shortages involved inhalation solutions through a nebulizer, rather than metered-dose inhalers. Akorn Pharmaceuticals discontinued its concentrated 0.5 percent inhalation solution after ceasing operations in February 2023.[34] The FDA subsequently listed the shortage of concentrated *albuterol sulfate* solution, 2.5 mg/0.5 mL, as resolved on August 27, 2026.[35]

Low-profit margins can limit investment in generic drugs production and make supply more vulnerable to disruption.[36] When a manufacturer exits the market, remaining suppliers may lack the capacity or financial incentive to expand production. The *albuterol* example illustrates why low prices alone do not ensure a reliable supply.

Lower drug prices do not always ensure access. The shortage of liquid *albuterol* demonstrates the need to consider both affordability and supply reliability when evaluating access to essential medicines.

Generic drug prices affecting annual spending in Oregon Medicaid

Oregon State University College of Pharmacy Drug Use Research and Management (DURM) Program collaborates with the Oregon Health Authority (OHA) to publish quarterly Medicaid

[31] Califf, Robert M. and Milgram, Anne M. U.S. Food & Drug Administration letter, Aug. 1, 2023. https://www.dea.gov/sites/default/files/2023-08/DEA%20and%20FDA%20Issue%20Joint%20Letter%20to%20the%20Public.pdf?utm_medium=email&utm_source=govdelivery.

[32] Currie, Janet and Malinovskaya, Anna. "Manufacturing Supply Chains and Imports in the ADHD Drug Shortage." JAMA Health Forum, March 20, 2026. https://pmc.ncbi.nlm.nih.gov/articles/PMC13005163/.

[33] Ibid.

[34] "UPDATE - Akorn Issues Voluntary Nationwide Recall of Various Human and Animal Drug Products Within Expiry Due to Company Shutdown." U.S. Food & Drug Administration, May 4, 2023. https://www.fda.gov/safety/recalls-market-withdrawals-safety-alerts/update-akorn-issues-voluntary-nationwide-recall-various-human-and-animal-drug-products-within-expiry. Jensen, L. (2024, Feb. 27). See also "Albuterol inhalation solution." American Society of Health-System Pharmacists, Feb. 27., 2024. https://www.ashp.org/drug-shortages/current-shortages/drug-shortage-detail.aspx?id=820.

[35] "FDA drug shortages. Current and resolved drug shortages and discontinuations reported to FDA: Albuterol sulfate solution." U.S. Food and Drug Administration, Aug. 27, 2026. https://www.accessdata.fda.gov/scripts/drugshortages/dsp_ActiveIngredientDetails.cfm?AI=Albuterol%20Sulfate%20Solution&st=r.

[36] Van Beusekom, Mary. "US liquid albuterol shortage expected to worsen after major supplier shuts down" University of Minnesota, March 10, 2023. https://www.cidrap.umn.edu/resilient-drug-supply/us-liquid-albuterol-shortage-expected-worsen-after-major-supplier-shuts-down.

Commented [CW58]: Comment provided by NR: Not wrong, but I think missing the unused capacity piece.

Suggestion:
Higher production quotas alone may not resolve shortages. In an August 2023 joint letter, FDA and DEA reported that manufacturers sold approximately 70 percent of their allotted amphetamine quota in 2022, leaving unused quota equivalent to approximately 1 billion doses. That estimate reflects production permitted under the quota; it does not establish that manufacturers had the ingredients or operational capacity to produce those doses. dea.gov A study published in 2026 found that production declines during the 2022–2023 shortage coincided with reduced imports of amphetamine and a key precursor, consistent with manufacturers' reports of active ingredient shortages. These findings suggest that addressing shortages requires attention to supply chain constraints as well as production quotas.

Commented [CW59]: Comment provided by NR: This needs a little something. I think some more explanation would help.

Suggestion:
Albuterol shortages illustrate how a manufacturer's exit can disrupt the supply of a specific formulation. The shortages discussed here affected inhalation solutions administered through a nebulizer, rather than metered-dose inhalers. Akorn ceased operations in February 2023 and discontinued its concentrated 0.5 percent albuterol inhalation solution, removing a source of supply.

As of [DATE, FDA listed the shortage of concentrated albuterol sulfate inhalation solution, 2.5 mg/0.5 mL, as resolved. This designation reflects FDA's assessment that national supply can meet demand; it does not establish that every strength or package size is available or that all local pharmacies and health care facilities can obtain it.

Commented [CW60]: Comment provided by NR: This is an important policy point. I would state explicitly that affordability work should evaluate whether savings are sustained while patients retain a reliable supply.

Suggestion:
Lower drug prices alone do not ensure access to essential medicines. The shortage of albuterol inhalation solution underscores the need to assess whether savings can be sustained while patients retain a reliable supply. Affordability efforts should consider supply continuity and supplier diversity alongside price, with success measured by both lower costs and dependable access to treatment.

drug utilization reports.[37] The reports describe medication use and spending across the Oregon Medicaid program.

The quarterly reports provide monthly rolling averages of pharmacy-paid claims, to monitor drug utilization trends. The fourth quarter report includes claims from July 2024 through June 2025 with information on generic drug costs and their utilization percentage.[38]

Table 4 shows the monthly average gross payment per generic multisource claim being $22.60 before rebates. Payments ranged from $15.24 for mental health carve-out drugs to $24.49 for encounter physical health drugs. The reported monthly average generic drug use percentage was 91.2 percent overall, with the highest percentage in mental health carve-out drugs at 97.2 percent.[39] These measures describe payments and utilizations but do not quantify savings attributed to generic drugs.

Table 4 Generic drug payments and use in Oregon Medicaid, July 2024-June 2025[40]

Reporting category	Gross amount paid per generic multisource claim, monthly average	Generic drug use, monthly average
Mental health carve-out drugs	$15.24	97.2%
FFS physical health drugs	$22.74	86.4%
Encounter physical health drug	$24.49	90.0%
Overall FFS and encounter	**$22.60**	**91.2%**

On July 4, 2025, the H.R. 1 budget reconciliation package was signed into law by President Trump.[41] The bill made significant changes to federal health care spending. States will feel the effects through the next ten years as Medicaid funding decreases and slows down. KFF estimates that through 2034, federal Medicaid spending will be reduced by $911 billion.[42] There are also additional provisions that decrease funding specifically for states, including Oregon, that have adopted the Affordable Care Act (ACA) expansion group by $526 billion. The

Commented [CW61]: Comment provided by DH: This digression on HR1 seems out of scope and potentially opens up discussions that don't need to be opened. For instance. Medicaid is already has high use of generics - one could argue that for some, expensive brands might be financially better for OHA because of the statutory base and inflationary rebates that were uncapped a few years ago because of 2021 American rescue plan.

[37] Pharmacy Utilization Summary Report: July 2024-June 2025. Oregon State University College of Pharmacy, Drug Use Research & Management Program, Jan. 17, 2026. https://www.orpdl.org/durm/reports/utilization/2025/DUR_Utilization_2025_Q4.pdf.
[38] Ibid.
[39] Ibid.
[40] Payments exclude rebates. Values reproduce the source's "Avg Monthly" column; they are not recalculated annual averages. DURM does not define the denominator for generic drug use.
[41] "H.R. 1—An act to provide for reconciliation pursuant to title II of H. Con. Res. 14." 119th Congress 1st Session, U.S. Congress., July 4, 2025. https://www.congress.gov/119/bills/hr1/BILLS-119hr1eh.pdf.
[42] Euhus, Rhiannon, et. Al. "Allocating CBO's Estimates of Federal Medicaid Spending Reductions Across the States: Enacted Reconciliation Package." KFF, July 23, 2025.https://www.kff.org/medicaid/allocating-cbos-estimates-of-federal-medicaid-spending-reductions-across-the-states-enacted-reconciliation-package/.

disproportionate budget cut means funding reductions will differ by state, and Oregon may be one of the most impacted, with 19% spending cuts.[43] The changes shift some financial burdens of Medicaid from the federal government to the states and patients.

Generic multisource drugs can help Oregon's Medicaid program, the Oregon Health Plan (OHP), manage prescription drug spending. Competition among suppliers can lower prices, but the effect on state spending also depends on utilization and rebates.

The role of generic multisource drugs in managing anticipated Medicaid funding reductions remain uncertain. The H.R. 1 changes were intentionally backloaded so 76 percent of the overall reductions in Medicaid spending will occur in 2030-2034.[44] In 2025, Governor Kotek convened an Advisory Group on Medicaid Sustainability to seek input on how the state might address the shortfall caused by H.R.1. The final report from the advisory group was presented to the Oregon Health Policy Board in July 2026.[45]

Commented [CW62]: Comment provided by NR: Could we close with what this analysis supports: generics remain an important cost-management tool, but the data do not quantify additional savings or their ability to address the funding gap? 'Scheduled to occur largely in 2030-2034' is also more neutral than 'intentionally backloaded.'

DRAFT

[43] Euhus, Rhiannon, et. Al. "Allocating CBO's Estimates of Federal Medicaid Spending Reductions Across the States: Enacted Reconciliation Package." KFF, July 23, 2025.https://www.kff.org/medicaid/allocating-cbos-estimates-of-federal-medicaid-spending-reductions-across-the-states-enacted-reconciliation-package/.

[44] Ibid.

[45] "Governor's Advisory Group on Medicaid Sustainability Final Report." Oregon Health Authority & Oregon Health Policy Board. https://www.oregon.gov/oha/OHPB/MtgDocs/4.%20Advisory%20Group%20on%20Medicaid%20Sustainability%20Report%20to%20Governor%20Kotek%20Final.pdf.

Decompose spending provided by DH sorted by highest total system spend 2024

Non-proprietary name	Associated proprietary names	Therapeutic class	Total claims 2023	Total claims 2024	Total enrollees 2023	Total enrollees 2024	Total system spend (payer + enrollee) 2023	Total system spend (payer + enrollee) 2024	Cost per claim 2023	Cost per claim 2024	Cost per enrollee 2023	Cost per enrollee 2024	Net change	% change in spending
semaglutide	Ozempic, Rybelsus, Wegovy	ADHD/Anti-Narcolepsy/Anti-Obesity/Anorexiants	192,751	251,795	32,424	41,394	$216,099,507	$279,071,674	$1,121	$1,108	$6,665	$6,742	$62,972,167	29.1%
pembrolizumab	Keytruda	Antineoplastics and Adjunctive Therapies	6,479	11,425	1,254	1,796	$101,035,002	$161,366,970	$15,594	$14,124	$80,570	$89,848	$60,331,968	59.7%
risankizumab	Skyrizi	Dermatologicals, Gastrointestinal Agents - Misc.	7,314	8,807	1,884	2,357	$123,415,158	$159,222,121	$16,874	$18,079	$65,507	$67,553	$35,806,963	29.0%
bictegravir-emtricitabine-tenofovir alafenamide fumarate	Biktarvy	Antivirals	29,493	30,062	3,307	3,498	$122,729,486	$129,716,501	$4,161	$4,315	$37,112	$37,083	$6,987,015	5.7%
dupilumab	Dupixent	Dermatologicals	23,219	26,997	2,710	3,323	$78,343,822	$96,881,647	$3,374	$3,589	$28,909	$29,155	$18,537,825	23.7%
elexacaftor-tezacaftor-ivacaftor	Trikafta	Respiratory Agents - Misc.	4,426	3,755	317	307	$95,072,611	$88,589,404	$21,480	$23,592	$299,914	$288,565	-$6,483,207	-6.8%
secukinumab	Cosentyx	Dermatologicals	11,903	12,702	1,394	1,595	$77,196,058	$88,073,449	$6,485	$6,934	$55,377	$55,218	$10,877,391	14.1%
etanercept	Enbrel	Analgesics - Anti-Inflammatory	15,699	12,955	1,764	1,543	$102,410,774	$87,695,488	$6,523	$6,769	$58,056	$56,834	-$14,715,286	-14.4%
tirzepatide	Mounjaro, Zepbound	ADHD/Anti-Narcolepsy/Anti-Obesity/Anorexiants	22,658	60,756	4,299	10,800	$26,491,942	$69,275,315	$1,169	$1,140	$6,162	$6,414	$42,783,373	161.5%
immune globulin	Cuvitru, Gammagard, Gamunex-C, Hizentra, Octagam, Privigen, Xembify	Passive Immunizing and Treatment Agents	5,603	9,443	615	959	$34,075,331	$54,264,049	$6,082	$5,746	$55,407	$56,584	$20,188,718	59.2%
upadacitinib	Rinvoq	Analgesics - Anti-Inflammatory	4,923	7,057	702	999	$30,580,259	$45,954,849	$6,212	$6,512	$43,562	$46,001	$15,374,590	50.3%
nivolumab	Opdivo	Antineoplastics and Adjunctive Therapies	2,873	3,937	435	579	$35,898,636	$45,440,787	$12,495	$11,542	$82,526	$78,481	$9,542,151	26.6%
guselkumab	Tremfya	Dermatologicals, Gastrointestinal Agents - Misc.	3,170	3,346	681	775	$35,353,811	$38,016,590	$11,153	$11,362	$51,915	$49,054	$2,662,779	7.5%
estradiol	Climara, Dotti, Estradiol, Estring, Lyllana	Chemicals, Estrogens, Vaginal and Related Products	331,920	390,250	83,112	100,027	$22,711,176	$26,494,673	$68	$68	$273	$265	$3,783,497	16.7%

Oregon Prescription Drug
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Preliminary list data elements

Preliminary List

- Certain data elements are available from insurer reporting to the DPT program or Medi-Span database and require no additional research
  - Ex: Total amount paid (DPT), therapeutic class (Medi-Span)

- Other data elements require more research and analysis from additional sources
  - Ex: patent/exclusivity expiration, CMS list
  - Some research-intensive data elements that are less integral to the board in the preliminary list filtering process can be deferred to the subset list.
  - Which data elements should be considered for later research?

Data elements that require additional research

- Previous drug review list
  - Source: PDAB website
  - Appearance of drug on previous preliminary or subset lists
- Most utilized NDC
  - Source: DPT report
  - For each drug, the NDC with the most prescriptions as reported by insurers in 2025.
- WAC/WAC % change
  - Source: Medi-Span
  - 2025 end-of-year (EOY) WAC of the most utilized NDC
- Orphan designation/Orphan designated conditions
  - Source: FDA
  - Current FDA approved orphan designated conditions of drug

3

Data elements that require additional research

- Orphan tiers
  - Source: PDAB
  - Tiers for orphan drugs based on FDA-labeled indications and the relative contribution of orphan vs non-orphan indications to both utilization and spending. Tier 3 orphan drugs can be analyzed.
- FDA license application
  - Source: FDA Orange/Purple book
  - Type of license application (BLA/ANSA)
- TA/TE/Biosim
  - Source: Clinical consultant
  - Number of TA/TE/Biosim products available for drug
- Physician administered drug
  - Source: FDA labels/clinician consultant
  - If a drug is physician administered

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Data elements that require additional research

- Earliest FDA approval
  - Source: FDA Orange/Purple book
  - First FDA approval date of drug
- Approval through expedited pathway
  - Source: FDA Orange/Purple book
  - If the drug was approved through Fast Track, Breakthrough Therapy designation, Accelerated Approval, Priority Review
- Patent expiration
  - Source: FDA Orange/Purple book
  - If the patent expiration date is available and set to expire soon (within 18 months)
- CMS MFP list/MFP effective year
  - Source: CMS
  - If the drug was selected by CMS for MFP negotiations and when the MFP takes effect for Medicare

5

Oregon Prescription Drug
Affordability Board

Prescription Drug Affordability Board
Update on board outreach 2026

Lou Savage, Consumer Engagement Coordinator
Division of Financial Regulation, Department of Consumer and Business Services (DCBS)

Staff recommendations June 2026

- Provide a limited number of online community forums.
- Partner with community organizations, state and local agencies to identify opportunities to engage Oregonians throughout the year.
- Creation a speaker's bureau with the PDAB executive director and board members.
- Continue to engage with pharmacists, medical clinics, and advocacy groups.
- View consumer feedback as a year-round process.



Board recommendations June 2026

- Speak at medical associations or professional meetings related to arthritis, dermatology, diabetes, neurology, depending on the PDAB medications under review.
- Create a simple, year-round feedback form for board review.
- Partner with university students to help with community outreach.
- Ask advocacy groups to help with PDAB outreach efforts.
- Engage with those who help people enroll in marketplace plans or switch plans due to affordability challenges.
- Purchase stand-alone signs with a QR code pointing to PDAB feedback forms to place in pharmacies where customers wait in line.
- Send self-addressed, stamped postcards so people can fill it out easily and mail it back to PDAB staff.



What we have accomplished so far

- Announced the speaker's bureau.
- Met with Vice Chair Dan Hartung and two other OSU professors.
- Met with Chair Shelley Bailey and Board Member Michele Koder.
- Partnering with the DFR Outreach team.
- Created a PDAB tri-fold brochure in English and Spanish.
- Created a year-round feedback form.
- **Created a brochure for printing and posting online**.



Future outreach strategy

- Continue to promote the speaker's bureau.
- Engage with those who help people who struggle with health insurance access.
- During the 2027 drug reviews:
  - Continue to engage with community members.
  - Ask advocacy groups to help us with outreach.
  - Host online community forums in the spring.
- Meet with the DFR Outreach team quarterly to find events PDAB can participate in.



Oregon Prescription Drug
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Questions?

How to contact us:

Sarah Young, executive director
pdab@dcbs.oregon.gov

Oregon Prescription Drug Affordability Board

Year-round feedback for the Oregon Prescription Drug Affordability Board

The Oregon Prescription Drug Affordability Board wants to hear from Oregonians about your experiences with prescription drug costs and access. Your feedback helps us understand real-life challenges and can inform our future work.

Participation is voluntary and anonymous. We do not collect names or contact information in this feedback form. We may share information from this feedback publicly in our reports or through public records requests.

Important: *Please do not include personal information you do not want shared publicly, such as names, contact details, medical record~~s numbers~~, or other information that could identify you or another person.*

This form does not replace formal public comment at board meetings. Sharing feedback does not guarantee that a particular drug or issue will be selected for review.

To submit testimony for a board meeting, please see our public comment instructions. If you have other questions about the board, please contact us.

Draft version 1.3 – updated Oct. 22, 2026

Note for reviewers: The purpose of this feedback form is to provide an easy-to-use way for consumers to share input with the board on an ongoing basis. It won't be as precise or detailed as the specific drug feedback forms. This feedback form should be short and easy for consumers to fill out. The form will be set up with branching logic, based on Q2, so users see one of four question sets depending on the type of feedback they want to share.

We have updated version 1.2 based on public and board member comments. Suggested edits are in dark red, underlined text.

Updated version 1.3 includes additional edits from board members in dark purple, underlined text.

Oregon Prescription Drug Affordability Board

Introduction questions for everyone

About you

Q1) [required] What best describes your role or point of view? Select all that apply:

- Patient or consumer
- Family member or caregiver
- Health care professional
- ~~Member of an advocacy group~~
- Representative of a patient organization
- Representative of a drug manufacturer or industry association
- Representative of a health insurance company, employer, or other organization that pays for health care
- Other: [text entry box]

Q2) [required] What would you like to tell us about today? Select one:

1. A personal experience with prescription drug costs or access
2. A prescription drug you think the board should review
3. Feedback on the board's current or past work
4. Something else ~~Other: [text entry box]~~

Oregon Prescription Drug Affordability Board

Branching logic – if #1 selected show the following set:

You are sharing a personal experience with prescription drug costs or access

If you are a caregiver sharing someone else's experience, please answer from the patient's perspective.

Q3) What is the name of the drug?

[text entry box]

Q4) What condition or conditions do you use the drug to treat?

[text entry box]

Q5) How often do you refill your prescription for the drug or receive a treatment?

If you get the drug through an infusion or another way, describe how you get the treatment and how often you need it.
[text entry box]

Q6) How much do you pay each time you refill your prescription or receive a treatment?

Include any out-of-pocket payments ~~cost sharing~~ you pay yourself such as copays or coinsurance. Do not include costs paid on your behalf by someone else such as your health insurance or a financial ~~patient~~ assistance program.
[text entry box]

Q7) Do you use a financial ~~patient~~ assistance ~~or discount~~ program to help pay for the drug?

These programs that help patients with out-of-pocket payments may be called many things including discount program, patient assistance program, copay coupon, or other names.

- Yes, always
- Yes, sometimes
- No
- Not sure

[show if yes, will be skipped if no/unknown]
Q8) How much does the program pay each time?

Share your best guess or write not sure if you do not know.
[text entry box]

Q9) What cost or access problems have you experienced? Select all that apply:

- High copay or coinsurance

- High deductible
- The price increased
- My out-of-pocket payment increased
- Prior approval required from my insurance before receiving the drug
- Insurance required me to try a different drug to treat my condition
- Insurance did not cover the drug
- Insurance changed and I had to get a new approval
- The drug was not available at my pharmacy
- Difficulty getting to a pharmacy to pick up the drug
- Could not find a clinic or infusion center where I could get the treatment
- Other: [text entry box]

Q10) Please describe your experience.

[long text entry box]

Q11) In the last 12 months, have you stopped taking this medication or taken less of it because you could not afford it?

- Yes, I was prescribed the drug but never filled the prescription due to the cost
- Yes, I took less of the drug or delayed refills due to the cost
- Yes, I stopped taking the drug due to the cost
- No
- Not sure

[show if yes, skip if no or not sure]

Q12) Please explain what happened to make the medication unaffordable for you.

[text entry box]

Q13) Has your health insurance changed in the last 12 months?

- Yes
- No
- Not sure

[show if yes, skip if no]

Q14) What changed about your health insurance?

[text entry box]

Q15) Do you currently have health insurance?

- Yes

- No
- Not sure

[show if yes, skip if no or not sure]

Q16) What type of health insurance do you have? Select all that apply:

- Coverage through a job
- Coverage through the Oregon Health Insurance Marketplace (also called OregonHealthCare.gov)
- Coverage you or someone purchases directly (not through the Oregon Health Insurance Marketplace)
- Medicare
- Oregon Health Plan (also called OHP or Medicaid)
- Military, Veterans, TRICARE, or CHAMPVA
- Indian Health Services
- None
- Prefer not to answer
- Other: [text entry box]

[go to final questions]

Oregon Prescription Drug Affordability Board

Branching logic – If #2 selected, show the following set:

You are suggesting a prescription drug you think the board should review

Q17) What is the name of the drug you want to suggest?

Providing a drug's name does not guarantee that it will be selected for affordability review.
[text entry box]

Q18) Why should the board consider reviewing this drug?

Describe the cost or access problems. Explain who is affected. Include anything else you would like the board to consider.
[long text entry box]

[go to final questions]

Oregon Prescription Drug Affordability Board

Branching logic – if #3 selected show the following set:

You are sharing feedback on the Prescription Drug Affordability Board's current or past work

Q19) What PDAB work or decision are you commenting on?

Please be specific.
[long text entry box]

Q20) What would you like the board to know?

Explain what you did or did not like about the board's work or decision making.
[long text entry box]

Q21) Do you have suggestions for what we could do differently?

The board may or may not choose to act on suggestions provided through this feedback form.
[long text entry box]

[go to final questions]

Oregon Prescription Drug Affordability Board

Branching logic – if #4 selected show the following set:

You are sharing other feedback with the Prescription Drug Affordability Board

Q22) What would you like to share with the board?

We do not collect names or contact information in this feedback form. If you would like a response, please email us at pdab@dcbs.oregon.gov.

[long text entry box]

[go to final questions]

Oregon Prescription Drug Affordability Board

Final questions – show all respondents the following:

These final questions will help us understand you better.

Q23) [required] Do you live in Oregon?

This question is required.

- Yes
- No
- Other [text entry box]

[the following three questions are optional]

Q24) **City or town you live in**: [text entry box]

Q25) **Your ZIP code:** [text entry box]

Q26) **What is your age?** [Drop-down box with five categories]

- Under 18
- 18 – 25
- 26 – 64
- 65 or older
- Prefer not to answer

Thank you for sharing your feedback.

Click here to sign up for updates from the board.