PDAB annual report – Part 2

Table of contents

Price trends 2

Data sources, methodology, and assumptions 2

Top findings 3

Analysis of spending and utilization 4

Market dynamics 15

Limitations and data considerations 16

Generic drug report 18

Background 18

Biologics and biosimilars 19

Price of generic drugs on year-to-year basis 20

Cost sharing and insurance premiums 22

Drug shortages 23

Generic drug prices affecting annual spending in Oregon Medicaid 24

DRAFT

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 propriety 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.
- **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.
- **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.

DRAFT

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.

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

[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)
risankizumab	Skyrizi	Dermatologicals, Gastrointestinal Agents - Misc.
secukinumab	Cosentyx	Dermatologicals
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	$20,143,470
pembrolizumab	Keytruda	GI, MC	IND, LG, SG	1,981	297	$40,151,845	$8,507,366
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

[6] Key: GI: Greatest increase; MC: Most-costly; MP: Most prescribed; IND: Independent 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	$1,595,938
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

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.

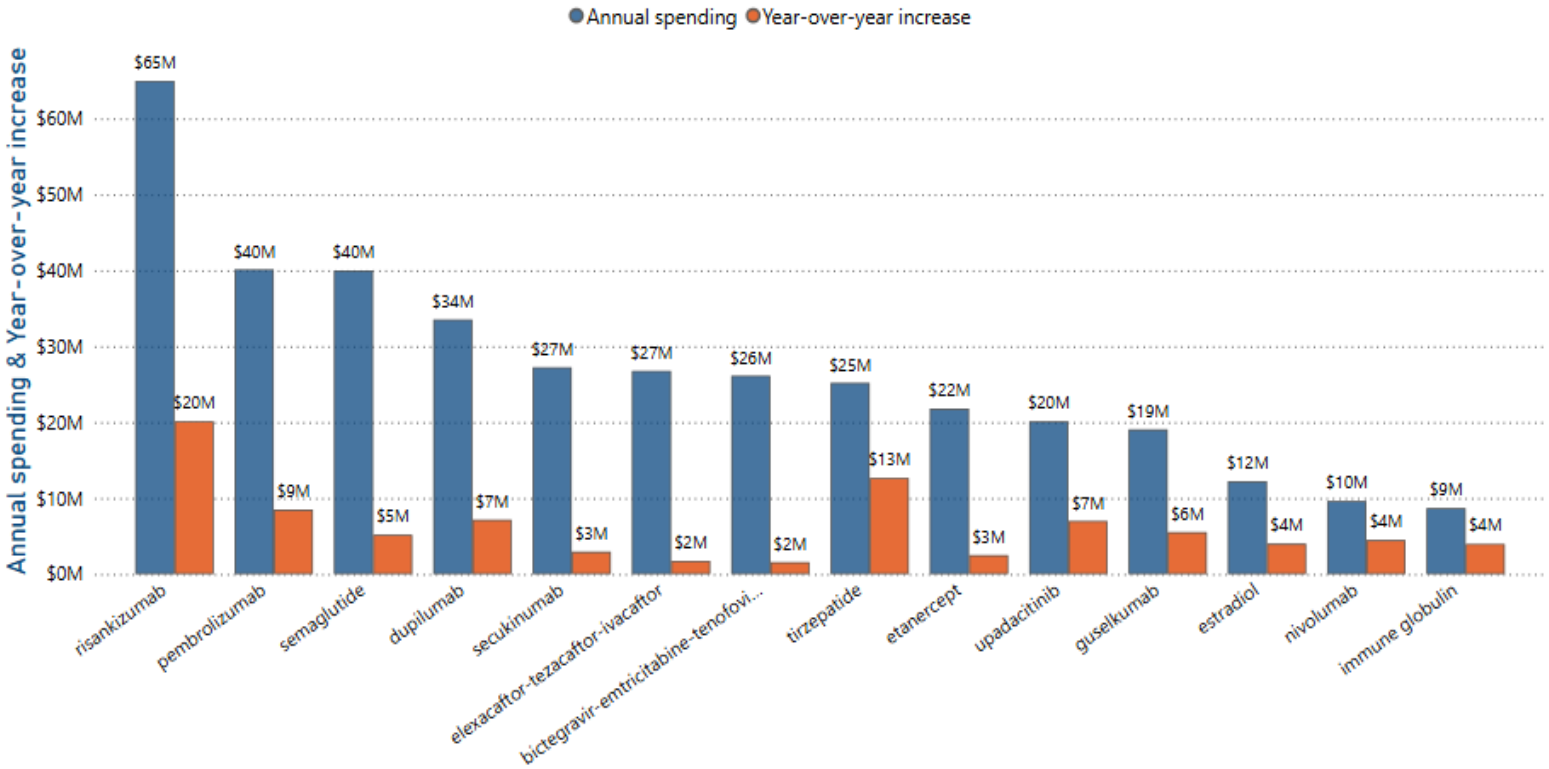


Figure 1: 2025 Annual spending and year-over-year increase by non-proprietary name as reported to DPT by commercial insurers

APAC Data

APAC data for the 14 drugs 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.

Table 3: APAC gross spending and utilization for 2023 and 2024, an asterisk (*) denotes a 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

DRAFT

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.

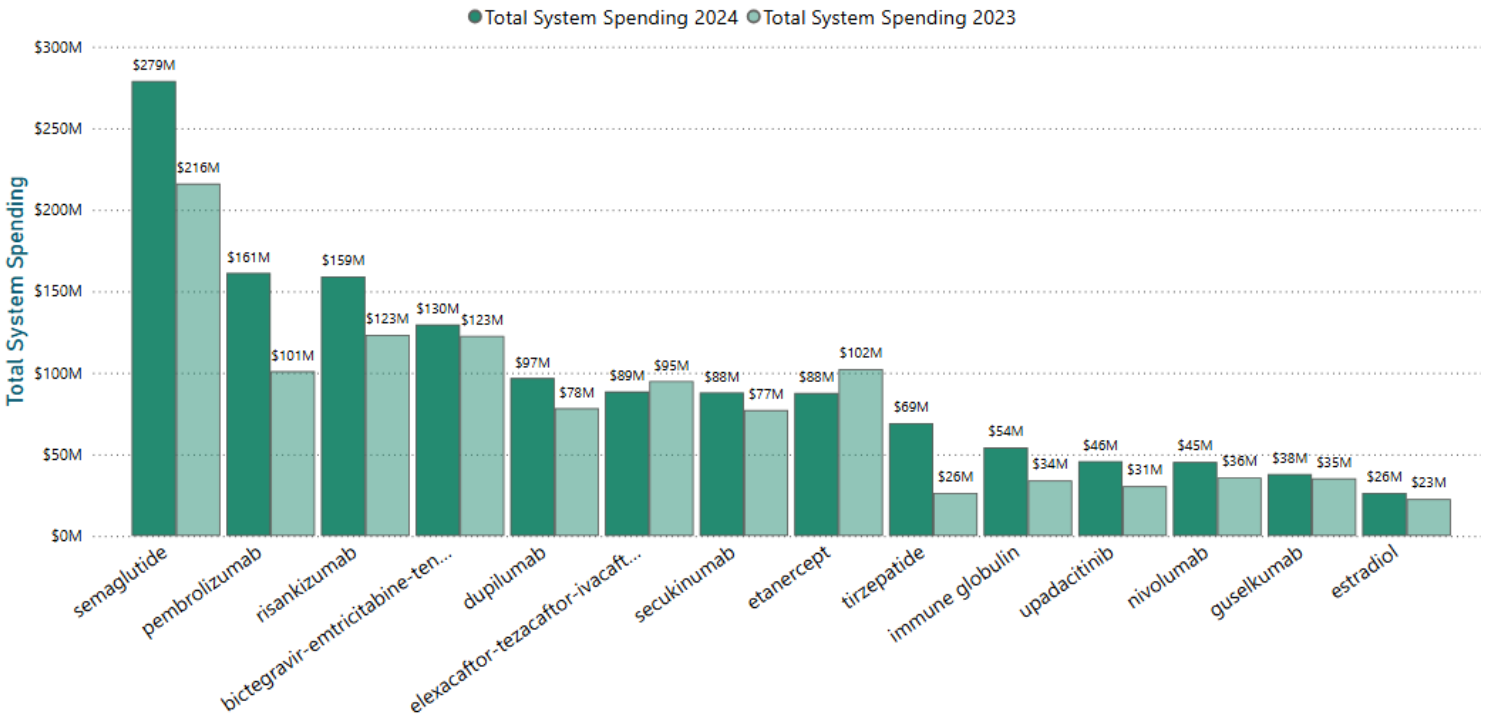


Figure 2: APAC total system spending by drug for 2023 and 2024, ordered by 2024 spending

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 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.

DRAFT

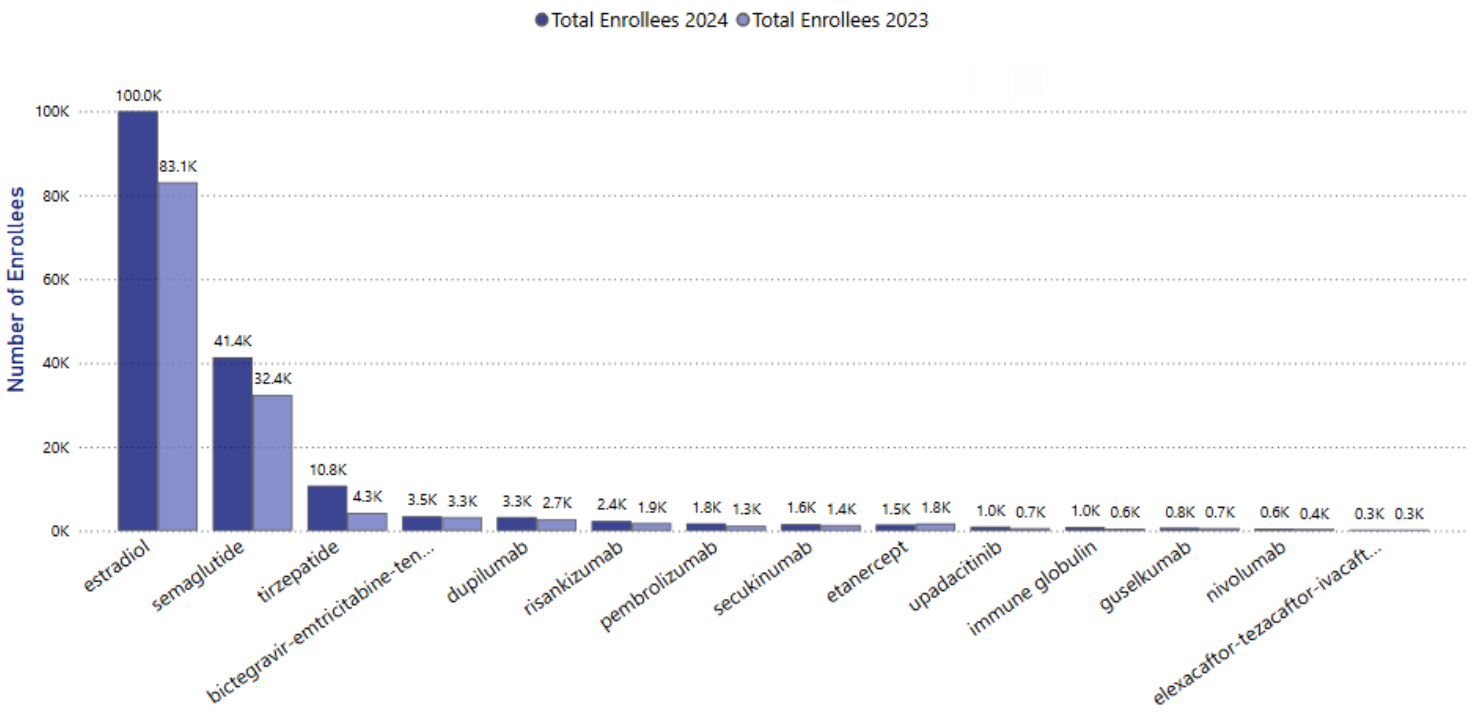


Figure 3: APAC enrollee counts by drug for 2023 and 2024, ordered by 2024 enrollees.

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.

DRAFT

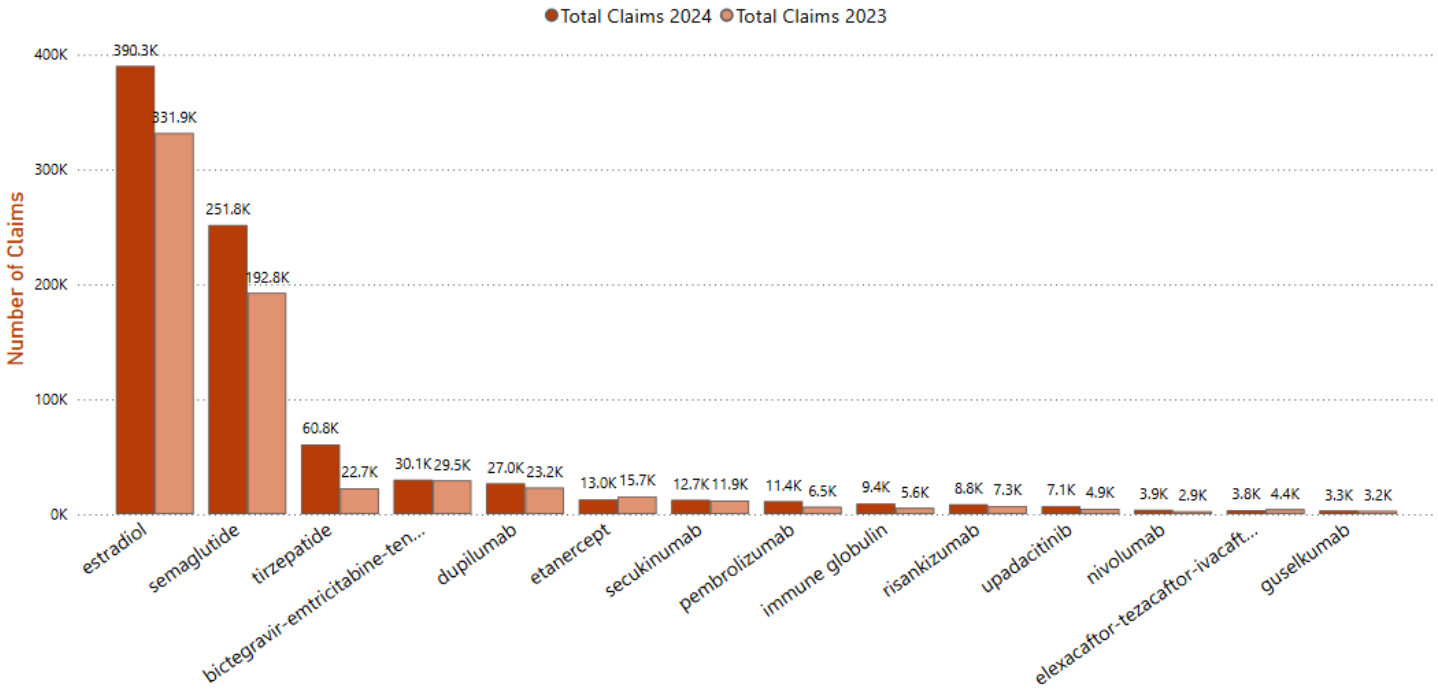


Figure 4: APAC claim counts by drug for 2023 and 2024, ordered by 2024 claims.

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,

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.

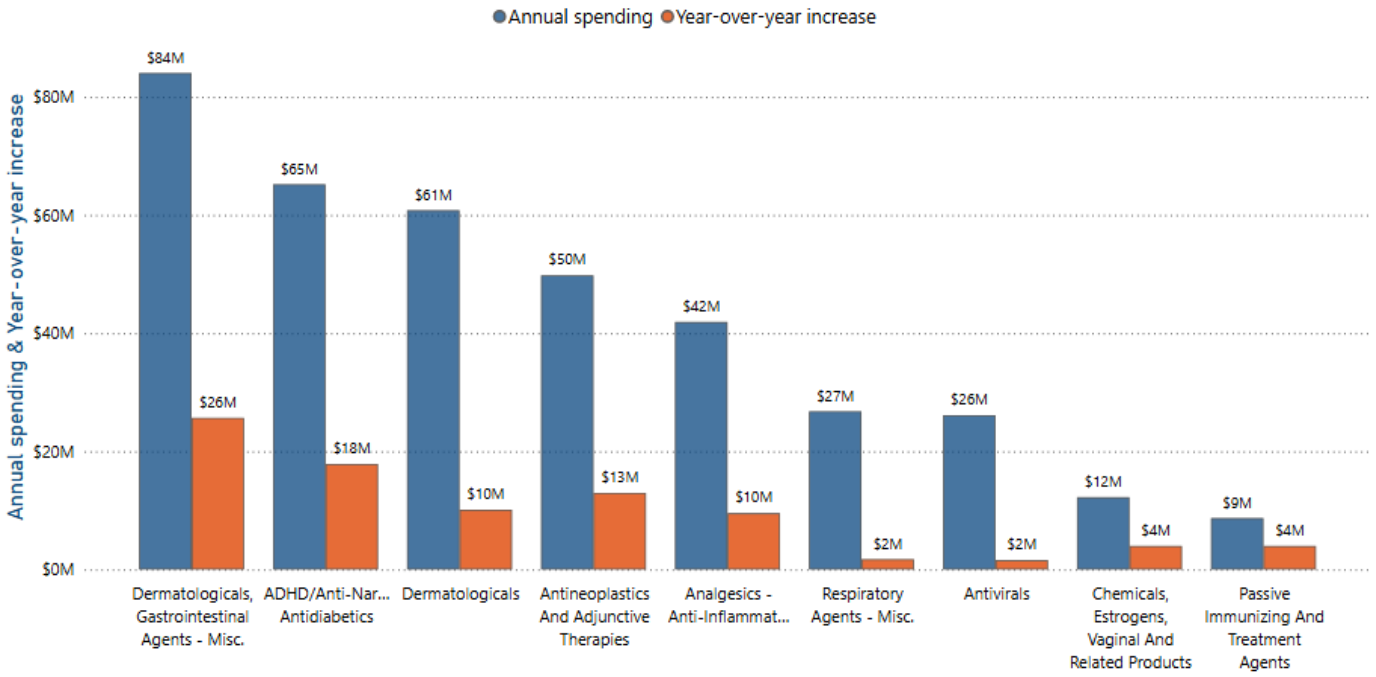


Figure 5 DPT reported net spending by therapeutic class for 2025

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.

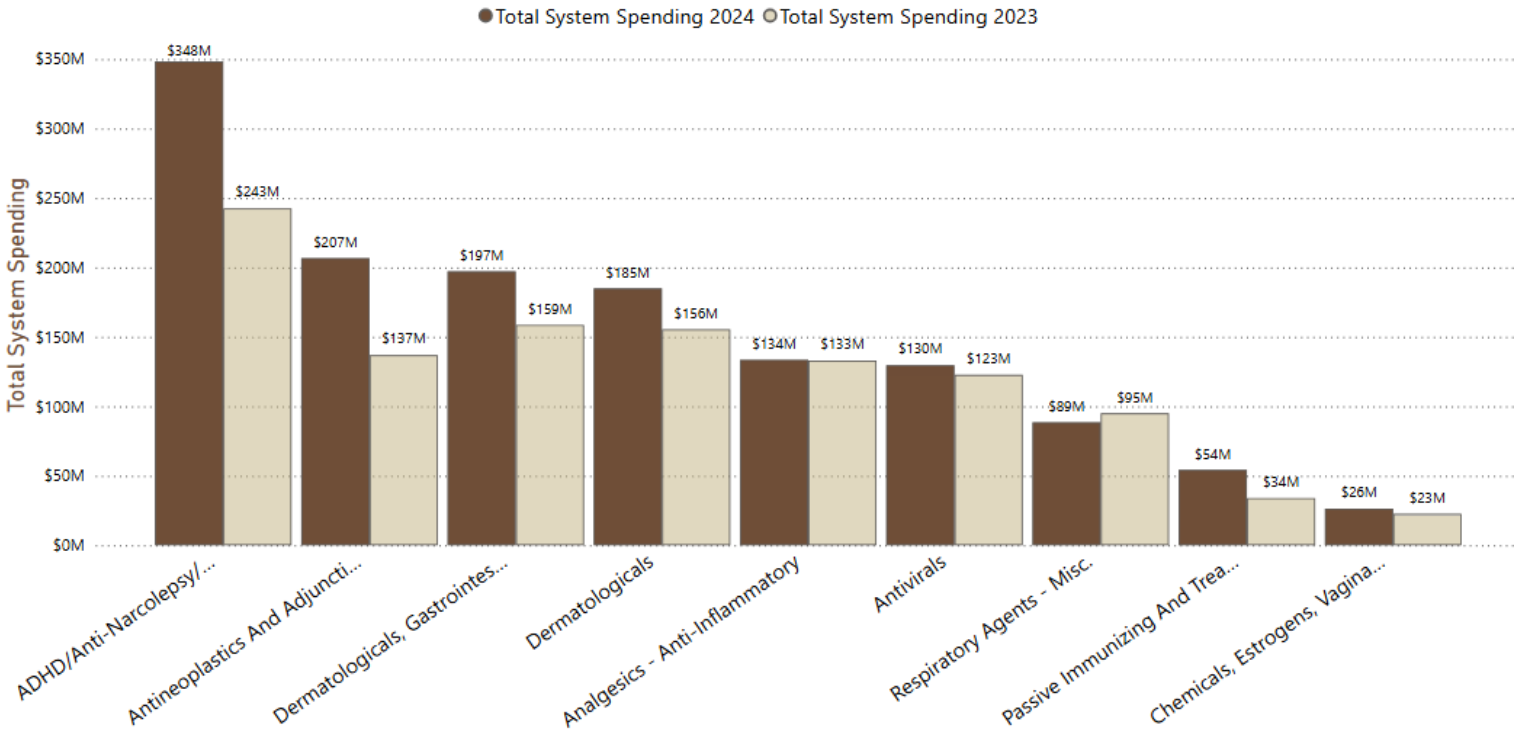


Figure 6: APAC total system by therapeutic class for 2023 and 2024, ordered by 2024 spending

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.

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

[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 overage 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.

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.

[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.

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.

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

---

[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*.

DRAFT

[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.

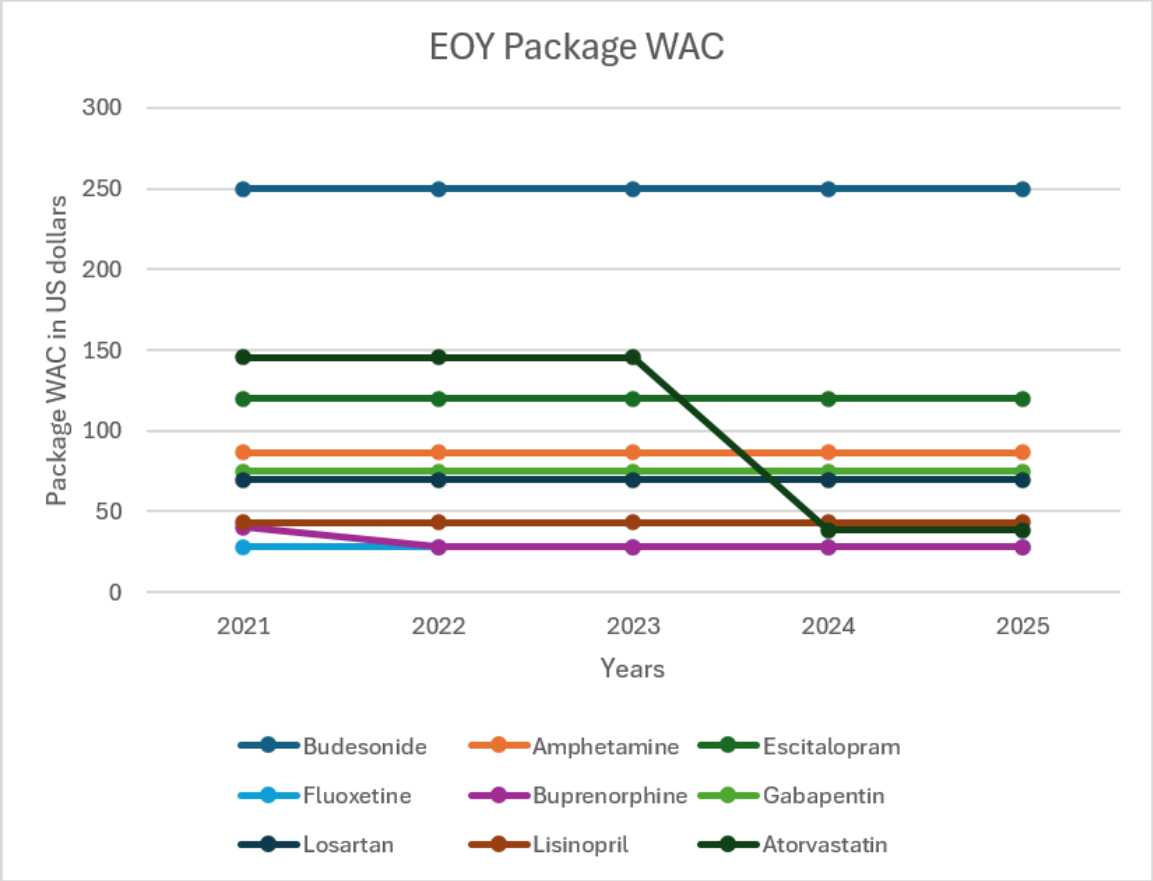


Figure 7: End-of-year generic drugs packaged WAC from 2021-2025

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

[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.

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,

---

[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.

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

[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]

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.