

**To:** Oregon Prescription Drug Affordability Board

**From:** Gail Lovelace Menasco

**Re:** Testimony given during the PDAB online community forum on May 11, 2026 and sent by email

**Date:** May 11, 2026

Dear PDAB,

Thank you for providing this forum to share experiences. I shared in the call the following information:

I have an individual ACA plan through a private health insurance company and am an Oregon resident. I want to raise a patient transparency issue. Last week, I tried to pick up mefenamic acid after my physician prescribed it because we had exhausted other options. I had met my out-of-pocket maximum (\$7500) and expected the medication to be covered at \$0. Instead, I was told at the pharmacy that insurance denied it because the “formulary wasn’t covered,” and that it would be \$60 per month.

The problem is that no one told me the next actionable step. The denial did not clearly say that this could be addressed through prior authorization or a formulary exception. I had to call my insurance company, speak to multiple people, and keep pushing before I learned my doctor could submit a prior authorization form and that it could potentially be approved within a few days.

This is a transparency failure. Patients should not have to know the magic words or make multiple calls just to find out whether a denial is final, whether a prior authorization is available, what form is needed, who must submit it, etc.

I would encourage Oregon to consider stronger denial-notice transparency requirements for prescription drugs. A denial should clearly state: the specific reason for denial; whether prior authorization, step therapy, or a formulary exception is available; what the prescriber must submit; the expected timeline; covered alternatives, if any; and appeal or external review rights.

Other states have moved in this direction. California requires denial notices to include clear reasons, criteria used, clinical reasons, grievance rights, and external exception information. Colorado requires prescription drug denials to identify covered drugs and dosages in the same class. New York requires specific denial reasons tied to the prescriber’s request and information on how to seek review.

This is a fixable policy issue. A patient should not leave the pharmacy thinking a medication is simply “not covered” when there is actually a defined pathway to request coverage.

Please let me know if my story is helpful to other policy makers. Thank you,