2025
Drug Review Report for the Oregon Legislature

March 18, 2026

Oregon Prescription Drug
Affordability Board

Acknowledgments

This report is a work product of the Oregon Prescription Drug Affordability Board.

Board members

Shelley Bailey, chairperson

Daniel Hartung, vice chairperson

Lauri Hoagland

Michele Koder

Dan Kennedy

Christopher Laman

John Murray

Prescription Drug Affordability Board staff:

Sarah Young, executive director, Prescription Drug Affordability Board and Drug Price Transparency Program

Cortnee Whitlock, program and senior policy analyst

Stephen Kooyman, project manager

Melissa Stiles, administrative specialist

Heather Doyle, data analyst

Pei Choo, data researcher

Other contributors of this report:

Jason Horton, public information officer, DCBS

Michael Plett, communications officer/editor, DCBS

Jessica Knecht, lead designer, DCBS

For more information:

Prescription Drug Affordability Board
350 Winter St. NE
Salem, OR 97309-0405
971-374-3724
pdab@dcbs.oregon.gov
dfr.oregon.gov/pdab

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Statutory authority and scope of the review

The Oregon Prescription Drug Affordability Board (PDAB) conducts annual affordability reviews under the authority granted by Senate Bill (SB) 844 (2021) and codified in Oregon Revised Statute (ORS) 646A.693 to ORS 646A.697.[1] The board was established to protect Oregon residents, state and local governments, commercial health plans, health care providers, and pharmacies from the high cost of prescription drugs by analyzing cost trends, conducting evidence-based drug reviews, and making recommendations to the Oregon Legislature.

Since the board's establishment, the Oregon Legislature has enacted legislation to refine the board's governance structure and review responsibilities. SB 192 (2023) expanded the board's membership from five members to eight, strengthening the board's capacity to conduct affordability reviews.[2] SB 289 (2025) further clarified the board's annual review obligations by specifying that, for each calendar year, the board will identify up to nine prescription drugs for affordability review, providing flexibility and meaningful evaluation of high-impact products.[3]

The board conducted reviews using criteria established in Oregon Administrative Rules (OAR) 925-200-0010 and OAR 925-200-0020.[4] These rules guide the identification of prescription drugs and insulin products that may pose affordability challenges, and they direct the board to consider utilization, total and per-patient costs, patient out-of-pocket costs, availability and costs of therapeutic alternatives, and the effects on equity and access when determining cost and affordability concerns.

1 SB 844 (2021) https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/SB844/Enrolled.

2 SB 192 (2023) https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureDocument/SB192/Enrolled

3 SB 289 (2025) https://olis.oregonlegislature.gov/liz/2025R1/Downloads/MeasureDocument/SB289/Enrolled

4 Oregon Prescription Drug Affordability Board, "PDAB Annual Report 2025," Oregon Department of Consumer and Business Services, January 2026. https://dfr.oregon.gov/pdab/Documents/reports/PDAB-Annual-Report-2025.pdf.

Overview of the 2025 review process

The 2025 drug review cycle began with the board's examination of 2023 prescription drug cost and utilization data submitted through the Drug Price Transparency (DPT) Program and the Oregon Health Authority All Payer All Claims (APAC) database. These datasets provided the foundation for understanding cost and utilization patterns and payer segments, including commercial, Medicaid, and Medicare markets. These data from plan year 2023, submitted to DPT in 2024, were the most recent data available at the beginning of calendar year 2025.[5]

Using these data, board staff developed a preliminary list of 158 high-impact prescription drugs and 71 insulin products. During public board meetings in early 2025, board members reviewed utilization trends, cost metrics, and other indicators and applied the criteria in OAR 925-200-0010 to prioritize products warranting further evaluation.[6]

The board then refined the preliminary list into a subset of prescription drugs and insulin products for deeper review. They focused on products with higher total spending, greater use, and indications of significant patient cost exposure. The board considered public comment alongside quantitative analysis during this phase of the review.

Following selection of the subset list, DCBS issued a data call to commercial health care insurers to obtain detailed information on net drug costs, rebates and discounts, utilization management practices, and patient out-of-pocket costs. The board compared insurer-reported data with APAC data to evaluate both gross and net cost perspectives.[7]

The board conducted structured affordability reviews for products on the subset list. A scoring rubric was developed as a tool to support consistency in evaluating concerns such as cost trends, patient burden, access restrictions, and utilization. While the rubric was used as a support tool, board members retained full discretion in their review determination.

Based on this comprehensive review, the board identified three prescription drugs and one insulin product that may create affordability challenges for the Oregon health care system or high patient out-of-pocket costs. These products demonstrated higher spending, significant utilization, and meaningful patient cost exposure relative to other products reviewed.

5 Oregon Prescription Drug Affordability Board, "PDAB Annual Report 2025," Oregon Department of Consumer and Business Services, January 2026. https://dfr.oregon.gov/pdab/Documents/reports/PDAB-Annual-Report-2025.pdf.

6 Oregon Prescription Drug Affordability Board, "PDAB Annual Report 2025," Oregon Department of Consumer and Business Services, January 2026. https://dfr.oregon.gov/pdab/Documents/reports/PDAB-Annual-Report-2025.pdf.

7 Ibid.

Subset list of drug and insulin products reviewed in 2025

As part of the 2025 drug review process, PDAB reviewed a subset of prescription drugs and insulin products identified through its data-driven selection process. The subset list reflected products that met initial criteria for further evaluation based on cost, utilization, and other affordability-related indications established in statute and rule.

Table 1 lists the drugs and insulin products included in the subset review and the board's determination of whether each product may create affordability challenges. Products marked "Yes" were identified by the board to meet the criteria. Products marked "No" were reviewed but were not identified as creating a significant affordability challenge at this time.

Table 1 – Final prescription drug list for Oregon PDAB 2025 review: voted on by the board Jan. 21, 2026.

Review grouping number	Therapeutic class	Proprietary name	Nonproprietary name	Identified
1	**Antipsychotics and antimanic agents**	**Vraylar**	**Cariprazine/cariprazine HCl**	**Yes**
1	Cardiovascular agents – misc.	Entresto	*Sacubitril; valsartan*	No
1	Migraine product	Ajovy	*Fremanezumab-vfrm*	No
1	Migraine product	Emgality	*Galcanezumab-gnlm*	No
1	Migraine product	Nurtec	*Rimegepant/rimegepant sulfate*	No
1	Migraine product	Ubrelvy	*Ubrogepant*	No
2	Antiasthmatic and bronchodilator	Trelegy	*Fluticasone furoate; umeclidinum bromide; vilanterol trifenatate*	No
2	Anticoagulants	Eliquis	*Apixaban*	No
2	Anticoagulants	Xarelto	*Rivaroxaban*	No
2	**Dermatological**	**Cosentyx**	**Secukinumab**	**Yes**
2	Digestive Aids	Creon	*Pancrelipase (amylase; lipase; protease)*	No
3	Antidiabetics	Jardiance	*Empagliflozin*	No
3	Antidiabetics	Mounjaro	*Tirzepatide*	No
3	Antidiabetics	Ozempic	*Semaglutide*	No
3	Antidiabetics	Rybelsus	*Semaglutide*	No
3	**Antidiabetics**	**Trulicity**	**Dulaglutide**	**Yes**
4	Insulin product	Basaglar KwikPen	*Insulin glargine*	No
4	Insulin product	Insulin Glargine-yfgn	*Insulin glargine*	No
4	Insulin product	Lantus	*Insulin glargine*	No
4	**Insulin product**	**Lantus SoloStar**	**Insulin gargine**	**Yes**
4	Insulin product	Semglee	*Insulin glargine*	No
4	Insulin product	Toujeo Max SoloStar	*Insulin glargine*	No
4	Insulin product	Toujeo SoloStar	*Insulin glargine*	No

Product-specific cost and affordability determination

This section presents the board's product-specific cost and affordability determinations for the prescription drugs and insulin products identified through the 2025 review process. For each product, the board evaluated utilization, system-level spending, pricing trends, and patient out-of-pocket costs, consistent with the statutory and rule-based criteria.

The following analyses summarize the factors supporting the board's determinations that each selected product may create affordability challenges for the Oregon health care system or high patient out-of-pocket costs.

Cosentyx

The board identified Cosentyx (*secukinumab*) as meeting the criteria for cost and affordability effects based on high utilization, substantial system-level spending, and sustained wholesale acquisition cost (WAC) increases over multiple years.

Cosentyx is a biologic immunomodulator approved for the treatment of several chronic inflammatory conditions, including plaque psoriasis, psoriatic arthritis, ankylosing spondylitis, and non-radiographic axial spondylarthritis. These conditions typically require long-term or maintenance therapy, resulting in continued use over time. Cosentyx is administered through injection and is classified as a specialty drug.

As a biologic therapy, Cosentyx is associated with high per-patient costs and limited availability of lower-cost therapeutic alternatives. While other biologic agents exist within the same therapeutic class, price competition has not substantially reduced overall system spending for the product.

Affordability effect on the Oregon health care system

Based on 2023 APAC data, Cosentyx accounted for more than $74 million in gross prescription drug spending in Oregon, and 1,382 Oregonians filled a prescription for the drug, reflecting broad utilization across payer types.[8] While utilization alone does not indicate affordability concerns, the extent of use across Oregon's insured population materially influences aggregate system-level spending and patient cost exposure. The combination of high utilization and high per-patient cost contributes to substantial aggregated spending pressure for both public and private purchasers.

The board also reviewed historical WAC pricing trends and found sustained increases averaging 6.7 percent annually from 2018 through 2024, exceeding general inflation benchmarks in several years reviewed.[9]

In addition to gross system costs, the board reviewed net cost information reported by commercial carriers. While the data indicates that rebates and discounts reduced net expenditures relative to gross spending, the net cost for Cosentyx remained substantial, and the effect of system-level spending raised affordability concerns. The board considered the differences in data scope between APAC and insurer-reported information when evaluating total system effect. Taken together, the board found that Cosentyx's high total spending, broad utilization, and sustained price growth makes it a meaningful driver of prescription drug spending in Oregon.

8 Oregon Prescription Drug Affordability Board, "Cosentyx (secukinumab) Drug Review Packet," Oregon Department of Consumer and Business Services, January 2026. https://dfr.oregon.gov/pdab/Documents/Cosentyx.pdf.

9 Ibid.

Affordability effect on patient out-of-pocket costs

Based on 2023 APAC data, the average annual out-of-pocket cost for a patient using Cosentyx was about $2,422 across Medicare and commercial payers.[10] These costs reflect deductibles, coinsurance, and cost-sharing associated with specialty tier placement and may pose an ongoing financial burden for patients requiring long-term therapy.

The board also considered that reliance on manufacturer patient assistance programs does not eliminate affordability concerns for all patients. Eligibility restrictions, changes in coverage, or gaps in assistance may leave some patients exposed to significant cost-sharing obligations, potentially affecting access to, or continuity of, care.

The board considered these system-level and patient-level effects together and determined that Cosentyx may create affordability challenges for the Oregon health care system or high patient out-of-pocket costs.

This determination was based on:

- ✓ More than $74 million in gross prescription drug spending in Oregon
- ✓ 1,382 Oregonians using Cosentyx
- ✓ WAC increases averaging about 6.7 percent annually over multiple years
- ✓ Substantial net cost to commercial payers after manufacturer rebates and discounts
- ✓ Annual patient out-of-pocket cost was about $2,422

Trulicity

The board identified Trulicity (*dulaglutide*) as meeting the criteria for cost and affordability effects based on substantial system-level spending, high utilization, and sustained price increases.

Trulicity is a glucagon-like peptide-1 (GLP-1) receptor agonist used for the ongoing management of Type 2 diabetes and is commonly used as chronic maintenance therapy. Because diabetes is a long-term condition, utilization and spending associated with Trulicity may persist over time.[11]

Affordability effect on the Oregon health care system

Based on Oregon's 2023 APAC data, Trulicity accounted for more than $152 million in total gross prescription drug spending in Oregon, and 18,659 Oregonians filled a prescription for the drug.[12] Utilization and spending were observed across all payer types, with Medicare representing the largest share of gross expenditures, followed by commercial and Medicaid payers.

The average annual percent change in WAC was 5 percent, exceeding the general consumer price index inflation rate from 2018 to 2024.[13]

The board also reviewed commercial insurer data reflecting net costs after all price concessions and other applied price reductions. This information was considered alongside APAC gross spending to evaluate overall system effect.

Affordability effect on patient out-of-pocket costs

Based on APAC data, patient out-of-pocket costs associated with Trulicity averaged about $528

10 Oregon Prescription Drug Affordability Board, "Cosentyx (secukinumab) Drug Review Packet," Oregon Department of Consumer and Business Services, January 2026. https://dfr.oregon.gov/pdab/Documents/Cosentyx.pdf.

11 Oregon Prescription Drug Affordability Board, "Trulicity (dulaglutide) Drug Review Packet," Oregon Department of Consumer and Business Services, January 2026. https://dfr.oregon.gov/pdab/Documents/Trulicity.pdf.

12 Ibid.

13 Ibid.

annually across Medicare and commercial payers.[14] The board also considered access-related factors, including utilization management requirements such as prior authorization, reported by a majority of commercial plans.

After reviewing these factors, the board determined that Trulicity may create affordability challenges for the Oregon health care system or high patient out-of-pocket costs.

This determination was based on:

- ✓ Total gross spending of more than $152 million
- ✓ 18,659 Oregonians using Trulicity
- ✓ WAC increases averaging 5 percent annually and exceeding inflation in multiple years
- ✓ Annual out-of-pocket patient cost was about $528
- ✓ A majority of commercial plans included access-related factors

Vraylar

The board identified Vraylar (*capriprazine/capriprazine HCl*) as meeting the criteria for cost and affordability effects based on high utilization, significant system-level spending, and elevated enrollee out-of-pocket costs.

Vraylar is an atypical antipsychotic used in the treatment of serious mental health conditions, including schizophrenia and bipolar disorder. These conditions often require ongoing pharmacotherapy and may involve sustained use over time.

The board's review identified several marketed alternatives for Vraylar and included pricing and utilization context for those alternatives as part of the affordability review.

Affordability effect on the Oregon health care system

Based on 2023 APAC data, Vraylar accounted for about $37 million in total gross prescription drug spending in Oregon, and 3,897 Oregonians filled a prescription for the drug.[15] This level of utilization, combined with high per-enrollee cost, contributes to a meaningful system-level financial effect across payer types.

The board also reviewed commercial insurance data, which reflect net cost after manufacturer rebates and other price concessions. Commercial data indicate rebates provided for Vraylar were relatively modest (about 10 percent) and net prices per claim remain high.

Affordability effect on patient out-of-pocket costs

The board identified enrollee cost burden as a key affordability concern for Vraylar. Commercial enrollees paid an average of $1,659 annually, while Medicare enrollees paid an average of $458 annually.[16] When weighted across populations, the mean annual out-of-pocket cost exceeded $1,000 per enrollee.

While the median out-of-pocket costs were lower, the mean enrollee burden reflects that a subset of patients experienced substantial cost-sharing exposure. The board considered these out-of-pocket costs in the context of utilization patterns and system-level spending and found that the enrollee cost burden associated with Vraylar may pose access and affordability challenges for some patients.

The board considered these utilization, spending, and patient cost factors together and determined that Vraylar may create affordability challenges for

14 Oregon Prescription Drug Affordability Board, "Trulicity (dulaglutide) Drug Review Packet," Oregon Department of Consumer and Business Services, January 2026. https://dfr.oregon.gov/pdab/Documents/Trulicity.pdf.

15 Oregon Prescription Drug Affordability Board, "Vraylar (capriprazine/capriprazine HCl) Drug Review Packet," Oregon Department of Consumer and Business Services, January 2026. https://dfr.oregon.gov/pdab/Documents/Vraylar.pdf.

16 Ibid.

the Oregon health care system or high patient out-of-pocket costs.

This determination was based on:

- ✓ Total gross prescription drug spending of about $37 million
- ✓ 3,897 Oregonians using Vraylar with 29,623 total claims reported in Oregon in 2023, indicating sustained use across payer types
- ✓ Annual out-of-pocket patient cost was about $1,046

Lantus SoloStar

Consistent with statutory requirements under ORS 646A.694, the board identified Lantus SoloStar (*insulin glargine*) as one insulin product for inclusion based on high utilization, substantial system-level spending, and patient cost-sharing exposure.

Insulin glargine is a long-acting recombinant insulin analog indicated to improve glycemic control in Type-1 and Type-2 diabetes. It is administered through subcutaneous injection and is typically used as basal (long-acting) insulin as part of ongoing diabetes management. The insulin glargine market includes multiple proprietary products with some insulin glargine products approved as interchangeable biosimilars to Lantus.

Affordability effect on the Oregon health care system

Based on 2023 APAC data, 17,503 Oregonians were prescribed Lantus SoloStar, resulting in 77,732 claims and more than $44 million in total gross prescription drug spending.[17] While utilization alone does not indicate affordability concerns, the breadth of use across payer types amplifies the total system-level spending effect, contributing to a higher aggregate gross expenditure. Insurer reporting indicated total commercial payer net spending was about $2.9 million, reflecting costs after price concession and other applied price reductions.[18] The board found that this level of utilization and spending across payer types contributes to affordability pressure for the Oregon health care system.

Affordability effect on patient out-of-pocket costs

Based on 2023 APAC data, the average annual out-of-pocket costs for a patient using Lantus SoloStar was about $208 across Medicare and commercial payers. Patient out-of-pocket costs averaged about $44 per claim, with total gross enrollee cost-sharing exceeding $3.4 million across all payer types.[19] Commercial insurer data further indicated $417,965 in enrollee out-of-pocket costs, the highest among insulin glargine products reviewed.[20]

The board considered the out-of-pocket measures alongside insulin's clinical necessity and recurring use, recognizing that ongoing cost-sharing for an essential medication can contribute to patient affordability challenges.

Given insulin's essential and recurring use, the board determined that Lantus SoloStar's utilization, system-level spending, and patient cost exposure may create affordability challenges for the Oregon health care system or high patient out-of-pocket costs.

This determination was based on:

- ✓ Total gross spending of more than $44 million
- ✓ 17,503 Oregonians using Lantus SoloStar
- ✓ Annual out-of-pocket patient cost was about $208

17 Oregon Prescription Drug Affordability Board, "Insulin Glargine Drug Review Packet," Oregon Department of Consumer and Business Services, January 2026. https://dfr.oregon.gov/pdab/Documents/insulin-glargine.pdf.

18 Ibid.

19 Ibid.

20 Ibid.

Recommendations

The board evaluated two policy options designed to address prescription drug affordability identified through PDAB affordability review process. Both are options aimed to limit out-of-pocket costs for Oregonians as presented to the Legislature for consideration. Additional detail on each option is provided in Appendix A.

Policy Option 1: Patient out-of-pocket cost cap
Policy option one is designed to limit patient cost exposure by establishing maximum cost sharing thresholds for identified prescription drugs. Under this approach, patients would not pay more than a defined cap per prescription or per month, regardless of underlying list price, benefit design, or deductible status. The intent is to provide predictable, stable cost sharing for drugs identified through PDAB affordability reviews.

Policy Option 2: Point-of-sale rebate pass-through
Policy option two is designed to directly reduce patient out of pocket costs for drugs identified through PDAB affordability reviews by applying manufacturer rebates at the point-of-sale. Instead of rebates being retained within the system and reflected only in net costs to insurers, the rebate would be passed through to the patient at the pharmacy counter. This approach may lower the patient's immediate cost burden and align the price paid at the point of sale more closely with the drug's net cost.

Conclusion

PDAB's 2025 drug review applied a structured, evidence-based methodology grounded in statutory criteria, rule guidance, and multiple data sources, including APAC gross spending and commercial health insurer reporting net cost information. Through this process, the board identified Cosentyx, Trulicity, Vraylar, and Lantus SoloStar as products that may create affordability challenges due to a combination of utilization, system-level spending, continued price growth, and patient cost exposure. While rebates and other price concessions reduce net expenditures for some payers, the reviews indicated that these deductions do not fully offset the aggregate financial burden experienced across the health care system or certain patient populations requiring ongoing therapy.

Taken together, the findings highlight that affordability concerns are not driven by a single metric, but by the intersection of high per-patient costs, continuing use patterns, and cumulative spending across public and private payers. For essential and maintenance therapies in particular, even moderate cost-sharing can create recurring financial strain that may affect patient adherence and access over time. The board's determination therefore reflects both the system-level fiscal effect and the lived cost burden experienced by Oregonians who rely on these medications for long term disease management.

These results support a targeted policy approach that prioritizes products associated with affordability challenges while preserving flexibility for future reviews as market conditions evolve. Continued monitoring of utilization, price trends, net cost dynamics, and patient out-of-pocket costs will ensure that policy reviews remain evidence-based and responsive to emerging cost pressures.

Oregon Prescription Drug Affordability Board

Appendix A

Policy Memorandum

To: Members of the Oregon Prescription Drug Affordability Board

From: Cortnee Whitlock, program and senior policy analyst

Date: March 17, 2026

Re: Two policy options to reduce patient out-of-pocket costs for drugs identified through the drug review criteria

Purpose

This memorandum presents two policy options for the board's consideration in the 2025 Drug Review Report for the Oregon Legislature. Both police approaches aim to reduce patient out-of-pocket costs at the pharmacy counters for prescription drugs identified through the boards' review process.

The policy options focus on drugs that may create affordability challenges for patients, including medication reviewed by the board such as Cosentyx, Trulicity, Vraylar, and insulin product Lantus SoloStar. High cost-sharing for these therapies can lead to prescription abandonment, reduced medication adherence, and poorer clinical outcomes.[1,2]

The two policy approaches differ in how affordability protections are achieved:

1. Targeted patient out-of-pocket caps
2. Targeted point-of-sale rebate pass-through

[1] Doshi JA, Li P, Huo H, Pettit AR, Armstrong KA. Association of Patient Out-of-Pocket Costs With Prescription Abandonment and Delay in Fills of Novel Oral Anticancer Agents. J Clin Oncol. 2018 Feb 10;36(5):476-482. doi: 10.1200/JCO.2017.74.5091. Epub 2017 Dec 20. PMID: 29261440.

[2] Doshi JA, Li P, Ladage VP, Pettit AR, Taylor EA. Impact of cost sharing on specialty drug utilization and outcomes: a review of the evidence and future directions. Am J Manag Care. 2016 Mar;22(3):188-97. PMID: 27023024.

Both approaches are designed to improve affordability for patients while preserving access to clinically appropriate therapies and maintaining stability within the prescription drug supply chain.

Policy context

The board's statutory role is to conduct affordability reviews of prescription drugs reported to the Drug Price Transparency Program to evaluate drug pricing and recommend strategies to enhance affordability.[3] In this capacity, the board weighs options to lower costs for patients, safeguard access to necessary treatments, and support the long-term sustainability of the health care system. Key stakeholders include patients affected by high out-of-pocket expenses, state health plans, pharmacy benefit managers (PBMs), and drug manufacturers. The board has indicated interest in adopting a targeted approach to reduce patient out-of-pocket expenditures for the drugs identified through the affordability review process. During the drug review process, the board evaluated drug pricing, utilization trends, and patient access concerns.

Patients frequently face significant cost-sharing obligations tied to the allowed amount of a drug under their health plan, particularly when cost-sharing is structured as coinsurance based on a drug's list price. These costs can remain high even when health plans receive rebates or other price concessions that reduce the net price of the drug.

Evidence consistently shows that higher patient cost-sharing is associated with[1]:

- Increased prescription abandonment
- Delayed treatment initiation
- Reduced medication adherence
- Worse clinical outcomes for chronic and specialty conditions.

Recent state and federal policies—such as insulin cost-sharing caps—demonstrate a growing policy trend toward targeted protections for medications that are both high-cost and clinically essential.[4,5]

Within this context, the board may consider policy approaches that reduce patient cost-sharing at the pharmacy counter for drugs identified through the affordability review process. Unlike price regulation policies, these approaches do not regulate manufacturer pricing or pharmacy reimbursement. Instead, they limit the patient's financial liability at the pharmacy counter.

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[3] Oregon Revised Statute 646A.693–.697 (2025), available at Oregon Legislature, https://www.oregonlegislature.gov/bills_laws/ors/ors646a.html.

[4] Kaiser Family Foundation. The Facts About the $35 Insulin Copay Cap in Medicare. June 2024. The Facts About the $35 Insulin Copay Cap in Medicare | KFF.

[5] Congressional Research Service, Insulin Coverage Under Private Health Insurance and Medicare Part D: In Brief, R47409 (February 6, 2023), https://www.congress.gov/crs-product/R47409.

Policy option 1: Patient out-of-pocket cost caps

Overview

This policy option would establish caps on patient out-of-pocket costs for prescription drugs identified through the board's affordability review process.

The policy would function as a benefit design protection, limiting the share of costs paid by patients when filling prescriptions for identified drugs.

Policy direction

The board may recommend that the Legislature:

1. Establish caps on enrollee out-of-pocket costs for prescription drugs identified through the board's affordability review process.
2. Apply caps to copayments, coinsurance, and deductible-related cost-sharing.
3. Require reporting and oversight provisions to monitor patient affordability, plan spending, and potential premium impacts.

Trigger and scope

The policy would be triggered when the board identifies a prescription drug as creating affordability challenges through its affordability review process.

The requirement would apply to:

- State-regulated commercial health benefit plans
- Plan-contracted pharmacy benefit managers (PBMs)

Self-funded ERISA plans would not be directly subject to the policy due to federal preemption but may be indirectly influenced by market changes.

Policy implications

Out-of-pocket caps provide immediate financial relief for patients, but they do not change the underlying price of the drug. Instead, they redistribute cost-sharing across the insurance risk pool.

As a result, health plans may adjust benefit designs or premiums over time to offset increased plan liability.

Policy option 2: Point-of-sale rebate pass-through

Overview

This policy option would require that manufacturer rebates and other price concessions be reflected in patient cost-sharing at the point of sale for prescription drugs identified through the board's affordability review process.

Currently, many patients pay coinsurance based on a drug's list price[6], even though health plans receive rebates that significantly reduce the net cost of the drug.[7]

This policy would align patient cost-sharing with the net price of the drug after rebates, ensuring that negotiated discounts benefit patients directly at the pharmacy counter.

Policy direction

The board may recommend that the Legislature establish:

1. A targeted point-of-sale rebate pass-through requirement for drugs identified through the board's affordability review process.
2. A net-price cost-sharing requirement, ensuring that rebates and price concessions reduce the price used to calculate patient cost-sharing.
3. Reporting and oversight requirements to monitor rebate pass-through levels, affordability outcomes, plan spending, and potential premium impacts.

Trigger and scope

The policy would be triggered when the board identifies a prescription drug as creating affordability challenges through its affordability review process.

The requirement would apply to:

- State-regulated commercial health benefit plans
- Plan-contracted PBMs

Self-funded ERISA plans would not be directly subject to the policy due to federal preemption but may be indirectly influenced by market changes.

Policy implications

Applying rebates at the point-of-sale would allow patients to benefit directly from negotiated manufacturer discounts.

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[6] Manufacturer List Price: The price a drug manufacturer publicly sets as the baseline price before any rebates or discounts, often aligned with the Wholesale Acquisition Cost (WAC) or another published list price.

[7] Net Cost of a Drug: The actual amount paid for a drug after subtracting all rebates, discounts, and other price concessions.

However, because rebates currently offset plan drug spending, redirecting these savings to patients could increase net plan spending and may lead to some premium adjustments or changes to benefit design across the broader insurance risk pool.

Guardrails to protect access and prevent unintended consequences

Both policy options could include guardrails to ensure that affordability improvements do not lead to new barriers to patient access.

Potential safeguards include:

- Anti-circumvention protections preventing plans or PBMs from offsetting savings through increased cost-sharing elsewhere.
- Access protections limiting the use of new utilization management restrictions such as prior authorization or step therapy.
- Transparency and reporting requirements to monitor policy impacts.

These guardrails help ensure that affordability improvements do not unintentionally reduce access to necessary therapies.

Reporting and evaluation framework

To evaluate the impact of either policy approach, the Legislature could require annual reporting on:

- Patient out-of-pocket spending for identified drugs
- Utilization and adherence trends
- Plan liability and premium impacts
- Changes in formulary placement or utilization management
- Disparities in cost burden across populations

Collecting these metrics would allow for analysis to assess if the policies improve affordability while monitoring for unintended consequences.

Supply chain considerations

Both policy options aim to improve patient affordability without disrupting existing prescription drug supply chain relationships.

Neither approach would directly regulate:

- Manufacturer list prices
- Rebate negotiations
- Pharmacy reimbursement arrangements

Instead, the policies would affect how patient cost-sharing is calculated at the pharmacy counter.

Conclusion

The board may consider recommending that the Legislature pursue targeted policy approaches to reduce patient out-of-pocket costs for prescription drugs identified through the board's affordability review process.

Two policy pathways for consideration:

1. **Patient out-of-pocket caps**, which provide immediate financial protection by limiting cost-sharing.
2. **Point-of-sale rebate pass-through**, which aligns patient cost-sharing with the net price of the drug after rebates and price concessions.

Both approaches seek to improve patient affordability while maintaining access to clinically appropriate medications and preserving stability in the prescription drug supply chain.