Recommendations

Potential Senate Bill (SB) 844 cleanup

1. **Propose a language change from "nine drugs a year" for affordability reviews to "up to nine" drugs a year.**
   The recommendation is to revise language in SB 844 to remove the requirement to review nine drugs and change the language to "review up to nine prescriptions drugs." This change will ensure the board focuses on reviewing drugs that are known to cause affordability challenges, based solely on cost or criteria, rather than trying to identify drugs that may or may not cause challenges to the health system or out-of-pocket costs to meet legislative thresholds. The initial review process revealed challenges in identifying specific drugs, as some may not actually cause affordability issues.

2. **Remove the requirement that DCBS provide PDAB with a list of prescription drugs each calendar quarter.**
   The information is provided to PDAB by DCBS under ORS 646A.689 (2) and (6) and ORS 743.025, including insulin products that are submitted annually by prescription drug manufacturers and health insurance companies. Manufacturers are required to report 60 days before a price increase for brand-name and generic prescription drugs according to ORS 646A.683 (2), but the information is based on the current year and may not apply to the reporting requirement in ORS 646A.694 to review drugs from the previous calendar year. Removing the quarterly reporting language will ensure a more accurate review of prescription drugs by the board.

3. **Replace the generic drug report annual requirement with a new provision that relevant content would be incorporated into the affordability review report. This information could include generics or biosimilar availability, pricing, and marketplace commentary when relevant to the drugs under review.**
   The generic drug market does not have significant year-over-year changes, and the current report does not provide significant market identifiers that effect prescription medication prices and costs. Any significant effect on the market system will be captured in the annual report requirements under OAR 646A.696.

Additional recommendations

4. **Expand patient assistance program (PAP) reporting to the DPT Program**
   It is recommended to expand PAP reporting requirements to include manufacturer coupons and any other payment that reduces a patient's out-of-pocket cost to fill a prescription. The board also recommends manufacturers be required to report on

all PAPs they maintain or fund to the DPT Program.

5. **Require pharmacy benefit managers and insurers to report on copay accumulators and maximizers to the DPT Program**
   Implement mandatory reporting on copay accumulator and maximizer programs to ensure equitable access to essential medications and prioritize transparency. With enhanced reporting, the board will aim to monitor the effect of copay accumulators on patient costs and access to medications.

6. **Require brokers to make Consolidated Appropriations Act disclosures about reimbursements and fees to the relevant purchasing entities**

   - Any broker or entity facilitating the purchase of health insurance or prescription drug benefits for purchasing entities must provide an annual disclosure of all direct and indirect compensation received, as required by the Consolidated Appropriations Act (CAA). This disclosure must include any commissions, fees, or other forms of compensation related to the transaction.
   - Brokers must proactively offer these CAA-compliant disclosure schedules in writing to the relevant purchasing entities (Oregon Educators Benefit Board, Public Employees' Benefit Board, fee-for-service (FFS) provider, Medicaid, ArrayRx, etc.) during contract negotiations or renewals, and no later than 30 days before the renewal of any contract or service agreement.

7. **Require reimbursement of the dispensing fee**
   It is recommended that all payors, including coordinated care organizations, commercial health plans, and pharmacy benefit managers operating within the state shall reimburse the dispensing fee equal to or greater than the dispensing fee used in Oregon's medical assistance programs. The dispensing fee may be updated periodically based on updated surveys or economic conditions. The model shall not alter patient copayment amounts.

8. **Require Oregon Health Plan FFS and coordinated care organizations to purchase through a statewide purchasing group**
   Statewide purchasing groups shall use programs that leverage the collective buying power of state agencies to secure better prices and terms for goods and services. These programs are designed to make procurement more efficient and cost effective for state and local government entities.

9. **Extend Oregon Health Plan's preferred drug list for all classes of prescription drugs**
   Oregon Health Plan FFS has a uniform preferred drug list for some classes; however, to use the most cost-effective medications and to reduce administrative burdens for providers, it is recommended to extend the current preferred drug list for all classes to CCOs for coverage of prescription drugs.