2024 Oregon Public Hearing on Prescription Drug Prices
Dec. 4, 2024
Link to the video: https://youtu.be/9ZHy9lHXRjY

Transcript:

Andrew Stolfi: Good morning, everyone, and welcome to our annual prescription drug price transparency hearing.

On behalf of the Oregon Department of Consumer and Business Services and the Division of Financial Regulation, I would like to welcome you to our *sixth* annual public hearing on prescription drug prices.

My name is Andrew Stolfi. I use he/him pronouns. I am the Oregon state insurance commissioner and the director, excuse me, of the Oregon Department of Consumer and Business Services.

We're glad to have you join us in person and online for today's public hearing. We have a couple presentations today, a presentation on this year's drug price transparency report, it will be followed by two topics with invited speakers, and we have two public comment sessions to hear directly from you. We encourage you to sign up to provide testimony using the chat if you're joining us online or on the signup sheet near the door in the back of the room here. You are also welcome to email us written testimony after the hearing. I should note that this public hearing will follow public meeting laws and regulations.

I'm here to serve again as facilitator for this public hearing and we are fortunate to also have ***three*** legislators with us to help moderate our discussion and discuss the information presented and ask questions of the presenters. I will let each of our guests introduce themselves.

Sen. Deb Patterson: Thank you so much Director Stolfi and it's a pleasure to be here. I'm Senator Deb Patterson, use she/her pronouns, and I'm chair of the Senate Health Committee. I'm real honored to be here. I'm very grateful to those who have been working on this since the bill was passed in 2018.

I'd like to, if you don't mind, say a word of thanks to Lily Sobolik (I'm not sure pronouncing Lily's last name right), Sally Sylvester, Sofia Parra, and Taran Heins, respectively, senior policy advisor of the Department of Financial Regulation, compliance specialist, program coordinator, and research analyst. Thank you to all other contributors from DCBS who made this incredible report possible.

I hope you have a chance to look at it. You will find recommendations in the report. You will also find startling numbers, such as the fact that we spent, just on the Oregon Health Plan alone, $1.46 billion in the last year on prescription drug price cost. And 31 percent of patients aren't able to afford the medicines that they need or they use them every other day or in a half. Thank you. Thank you for the work done on this and we look forward to the full report and hearing from the experts who will be speaking as well. Thank you.

Rep. Emerson Levy: Thank you, Senator Patterson. Representative Emerson Levy from Bend, Redmond, and Sisters. I'm really happy to be invited here today. I've been working on some access to pharmaceutical bills, and will continue to do so in the future, as well as bringing some transparency to pricing.

Rep. Rob Nosse: My name is Rob Nosse. I'm the state representative for House District 42, which is inner southeast Portland, and a little sliver of inner northeast Portland. I've been serving in the legislature now for a decade. In 2017 and 2018, I worked on the bills that have led to this report that we have before us here today, and honestly, I always look forward to the information.

We made a policy decision back in 2017/2018, that having more information about what's going on with pricing would help guide us down the road in future legislative sessions about what we might try to do to reduce the expense of medications in our state. I look forward to seeing what some of the trends are, and what recommendations and what things we might try here in the State of Oregon to bring the cost of prescriptions down. Thanks for having me and I look forward to hearing what we're going to learn today.

Stolfi: Thank you very much to the three of you for joining us. We appreciate your leadership in drug price issues over the years as well.

Our agency's Division of Financial Regulation protects consumers and regulates insurance, depository institutions such as banks and credit unions, trust companies, securities, and consumer financial products and services. It also administers the Drug Price Transparency program, and provides staff support for the Prescription Drug Affordability Board. The division is part of the Department of Consumer and Business Services, which is Oregon's largest consumer protection agency.

During today's hearing we will be sharing information about the Drug Price Transparency program, which was created by the 2018 Prescription Drug Price Transparency Act. We will also discuss details from the program's 2024 annual report, which is available on our website.

You are going to hear today from invited panelists on two important topics. The first topic is **drug advertising**. The second topic is **drug rebates**. We will have presenters from academia, patient advocates, and industry representatives.

Most importantly, however, before this hearing we reached out to Oregonians and asked them to send us their stories about prescription drug pricing. Many of these were included in our annual report and I encourage you to read all of those.

As I do each year, I'd like to share a few of the stories that we received from consumers.

To begin, one Oregonian said, "Thank you for focusing on prescription drug prices. We need action today. Too many Oregonians cannot afford to buy groceries and fill the prescriptions they need. This situation cannot continue. We all deserve access to affordable health care, and that includes medications. Please do everything in your

power to address unreasonably excessive costs."

Someone else shared, "As a patient coordinator for a rheumatology group, one of my primary job duties is to help patients while we unravel the complexity of each insurance in an effort to get the medication their provider wants them to take. We navigate the obstacle course of step therapy requirements set by insurance companies in an effort to control the medications and treatments instead of allowing providers to practice medicine. Often our team will spend weeks or months trying to fight with insurance, while the patient remains in flared disease state of autoimmune diseases such as rheumatoid arthritis, gout, psoriasis, lupus, and many more.

Just this week, *an insurer* denied the only medication proven to be safe for pregnant or nursing mothers to a nursing mother because they want proof she hasn't tried and failed medications that impact her liver health and are directly transferable to the baby. If we are able to prescribe the 'first choice' medication, I then help the patient with the next hurdle, affordability.

Most drug manufacturers have copay assistance for biologic meds because of the cost, however insurance companies are adopting policies that exclude the use of copay card to meet out-of-pocket max. This means that *my patient* will fill their Humira with the pharmacy at a copay of $4,500 using their copay card provided by Humira, only to find out after two months of billing cycle that the pharmacy has reversed payment from Humira and is now charging them $9,000 because the insurance has told them to, saying the copay card isn't allowed to pay toward out-of-pocket limits. Now *that patient* has a bill from the pharmacy for $9,000 and has not made a dent in their $10,000 out-of-pocket maximum.

Patients should be able to get the medication their doctor thinks is best for them, use any assistance available to pay for it, and live a pain-free, disease-controlled life."

And finally, there's a lot of stories. Again, I'd encourage you to read them all. But finally, someone said, "In 2022, I paid $20 per prescription. In 2023, that went up to $30 for no reason other than it was 2023. Now in 2024, the same prescription is $40, so it has doubled in just over a year just because the calendar changed. Same medication. Same amount. Same person. Pure profit for someone other than me."

These, as I said, are just a few of the real life stories that show the difficult choices facing many Oregonians, and why this program is trying to determine what can be done to make life-saving and life-improving, medications more affordable.

Before inviting Ralph Magrish, who's the executive director of our Prescription Drug Affordability Board to share a few words, *I want to mention again, as I have each year, that the lawsuit filed by the Pharmaceutical Research and Manufacturers of America (PhRMA) in federal court in 2019 seeking to invalidate the laws that authorize this program is still ongoing.*

As announced earlier this year, the U.S. District Court in Oregon issued a decision in February that part of the Prescription Drug Price Transparency Act violates the First Amendment to the U.S. Constitution and is, therefore, unenforceable. DCBS has appealed the decision and the case is pending before the Ninth Circuit Court of Appeals.

Following the decision, the program suspended annual price increase data reporting. Currently, the program permits manufacturers to voluntarily report price increase data.

We cannot comment further about the ongoing lawsuit, but remain disappointed that PhRMA decided to challenge these laws designed to provide transparency and to help Oregonians better understand why drug prices are rising.

With that, I'd like to introduce Ralph Magrish to talk about Oregon's Prescription Drug Affordability Board.

Ralph Magrish: Thank you, Director Stolfi. Hello, everyone. I'm Ralph Magrish, and I use he/him pronouns. I am the manager of the Drug Price Transparency program here at DCBS and executive director of the Oregon Prescription Drug Affordability Board, also known as the PDAB.

Just a little bit about Oregon's PDAB; it's an eight member board appointed by the governor and confirmed by the senate. It is comprised of people with backgrounds in clinical medicine and healthcare economics.

PDAB's legislative charge is to protect residents in the state, state and local governments, commercial health plans, healthcare providers, pharmacies licensed in the state, and other stakeholders within the healthcare system from the high cost of prescription drugs.

I want to give you an update on the activities of the PDAB. I have three for you this morning.

The Prescription Drug Affordability Board approved its legislatively mandated report on an upper payment limit implementation plan, at its November 20th meeting, for prescription drugs sold in the State of Oregon that are subject to affordability reviews. The board currently does not have authority to set upper payment limits in Oregon at this time. The plan will be submitted to the legislature later this week for their consideration and posted to the PDAB website.

Second, the board will meet two weeks from this morning on December 18th to finalize its policy recommendations to the legislature on legislative changes necessary to make prescription drugs more affordable in our state.

And finally, also on the 18th, the board will get its first look at our preliminary list of drugs and data provided by the Drug Price Transparency program here, as required by statute for its review, and begin to identify what drugs and insulin products will undergo affordability reviews in 2025.

To identify those drugs, the board will evaluate in detail the data collected from insurance carriers and some manufacturer information, which you will hear about shortly at a high level from Taran Heins, our research analyst. This information and more, including consumer input, will be used to conduct affordability reviews during the second half of 2025 to identify drugs that may create affordability challenges for healthcare

systems or high out-of-pocket costs for Oregonians. The affordability review is a qualitative and quantitative data assessment that includes consumer, patient, and provider engagement. The board is statutorily required to identify nine drugs and at least one insulin product each year that may create these hardships and challenges for Oregonians.

For context about the breadth and depth of this work, the board will begin reviewing its data in January for 158 individually branded drugs, each one which may come with different strengths, dosages, package sizes, and formulations. It will also begin to look at 30 different proprietary branded insulin products that come in 85 different strengths, dosages, package sizes, and formulations. It will also begin to look at 30 different branded insulin products that come in 85 different strengths, dosage, and vile sizes.

All information about past and future board meetings and our work and endeavors in this area are available on the board's website. Lastly, I want to thank our collective with, I want to express our collective appreciation and gratitude for all those participating today, to those who have shared their stories, to those who will shortly, and to those who are serving as our presenters, panelists, and moderators today. Thank you.

Stolfi: Thank you, Ralph. First up on our agenda will be the department's presentation. It's going to be followed by the first public comment period. Then we're going to have invited panels on our two topics, which again, are drug advertising and drug rebates.

After the presentations for each segment, there'll be time for the moderators to discuss the issues and ask questions of those presenting, and at the end of the hearing, we'll have our second public comment period. Again, I please encourage you, if you'd like to give public comment, to sign up in the back of the room or on the chat.

With that, I'm very happy to turn things over to three stars of our program. We've got Sofie, Taran, and Lily. They're going to provide information about the Drug Price Transparency program and our 2024 legislative report. Over to you.

(slide 3)
Sofia Parra: Thank you, Andrew. Hello, everyone, and thank you for joining us today at this hearing. I am Sofia Parra. I use she/her pronouns and I am the program coordinator for Oregon's Drug Price Transparency Program.

I'll give you a little information about the program, and then Taran will take you through the data, and Lily will cover our policy recommendations, which are all from our 2024 annual report that we posted last week. We also post the slides that you are seeing today, and written comments, and the recording of this hearing on our website for everyone. Next slide, please.

The Prescription Drug Price Transparency Act created the Drug Price Transparency program. Oregon laws give the program authority to require reports from manufacturers, insurers, and PBMs (pharmacy benefit managers). Prescription drug manufacturers who meet the definition of a reporting manufacturer as shown on our slides are the ones who will be required to register and pay fees to cover our program staff. Next slide, please.

I like to show this supply chain diagram, we have it in our report because it shows just how complex the system can be, and this is all just to get a drug from a manufacturer to a consumer. And there's even others that probably aren't included on this chart that are involved. This creates a lot of confusion. You can just see how crazy it looks. Next slide, please.

We have three reports that are required by prescription drug manufacturers. They have a new drug report. Currently, the amount set is $670 or more for a one-month supply. This was the 2019 amount for Medicare Part D back then in 2019, and so we are updating our rules. The current amount is $950 a month to be considered a specialty drug, so we're going to be updating our amounts to match that. Still sounds like a lot of money for the drugs that are underneath that amount that don't report, won't be reported to us.

We also have reporting for annual price increases. As mentioned, there were some changes to that and so it only applies when there is a patient assistance program currently, and the drug was increased by 10 percent or more. We also have a 60-day notice, which they have to, they're supposed to report when they have a planned price increase at least 60 days prior, and it's with those thresholds, depending on whether it's brand or generic.

Then we also receive information from insurers, the top 25 most costly and most prescribed and the most impact on premiums. And then of course, this year we started receiving reports from PBMs. We do expect some additional amounts and information to be required next year, and so we expect that information to improve.

And then finally, consumers. We really need to get information from consumers. We have tried to make it easier to report. We're still not getting a large response, and so we would like to encourage consumers. We've provided each of our legislators with a few of our cards that show how to access the consumer reporting that they can share and hand out. And we just encourage consumers to provide that information to us, so we can see the actual impact at the consumer level because we have manufacturer, insurer and PBM information, and we really need that consumer information. And we also encourage consumers to send us stories like Andrew shared at this hearing, and we will post those as an exhibit to our report. They are currently posted and we will update them with additional stories if we get some more stories. Next slide, please.

I just wanted to share a little bit about compliance efforts. We review the reports that we get from the manufacturers. We try to educate them when they're lacking. Most respond and have the information in there. Our goal is compliance. For those that don't come into compliance, they go to our enforcement unit and our enforcement unit has issued its first civil penalties of $75,000 in 2024.

Trade secret claims are another issue that we deal with, so that we can publish as much information as possible. We need to review these claims before we can post the information that is considered not a trade secret. So, that's another part of our process. We have gotten almost 600 reports in the last year with 1,200 data elements claimed as trade secret that all have to be reviewed to see if they're legitimate claims. So, that's quite a bit of our work. Next slide, please.

And this is just a reminder that we have the data on our website. You can see PBM data, insurer data, stories, report price increases, you know, see what other consumers have reported, see what manufacturers have reported. So, we have that data that's part of, a big part of, our program. And then, next slide, please.

Taran's going to take you into some of the details. I just wanted to share a few highlights real quick. We have the highest new drug reports are between $2.2 and $3.5 million. They're for a hemophilia B treatment and some sickle cell disease treatments. I think there's one-time treatments, but still pretty spendy stuff. PBMs reported receiving $287 million from manufacturers in 2023 for the medications given to Oregonians. So that's just our state and almost all of it was deemed to be passed to insurers per their reporting. And then health insurers reported to us that 10 to 27 percent of their pharmaceutical spending was covered by rebates. And then once again, Humira made by AbbVie continues to be our most costly drug reported by insurers. Next, Taran will cover our data.

Taran Heins: Great. Thank you, Sofie. Again, my name is Taran Heins using he/him pronouns and I'm the research analyst for the Drug Price Transparency Program in Oregon. Here's a quick synopsis of the main points of the report we've prepared for you guys, but I encourage you all to read the analysis in more detail.

The left figure sheet here shows the tracking of inflationary increases of three quantities, the first being medical care in light blue there, the second being prescription drugs in green, and the final being the overall average inflation rate shown in orange. This information is based on the consumer price index for all urban consumers, known as the CPI-U, and we took the time period beginning 1980 to the end of 2023. During this period, prices for prescription drugs in medical care are coupled and inflated 100 percent more than the rate for consumer price index for all items, that average rate. This shows that the increase in medical expenses and prescription drugs are having a large effect on inflation. What this means is that, for example, if in 1980 you paid $10 for a prescription medication and, for example, a hamburger maybe also cost $10 during that time period, by the end of 2023, all else being equal, that prescription medication now be twice the cost of that hamburger.

The right figure here is comparing the total prescription expenditures to out-of-pocket costs from 1994 to 2022. We see a quickly growing gap between these two quantities. During this time period, out-of-pocket costs have risen from $23.75 billion to $56.72 billion. This is an increase of almost $33 billion or 138 percent increase. Meanwhile, total prescription drug expenditures increased from $53 billion in 1994 to over $405 billion in 2022. This is an increase of almost $353 billion or 665 percent increase. Yes, sir.

Rep. Nosse: Those statistics that you're quoting are those for the State of Oregon or those for the United States?

Heins: These are for, let's see.

Parra: I think these are all the United States.

Heins: Yeah, these are United States. Yeah, these are definitely United States charts.

Heins: Good question. Thank you. Finally, an estimated 72.2 million people did not seek medical care due to the cost, and around 31 percent were also concerned about affording their prescription medications. Next slide, please.

Moving on to our new specialty drug reporting section. The figure on the left here shows the count of reports year to year that we received, with the red being the generic type reports, and the blue being brand type reports. This is for both images here. The image on the right shows the type of drugs associated with the reports we received this year. We received 529 such reports, a slight decrease from last year's amount and about half were for generics and half were for brands, brand-name designated drugs. Meanwhile, anti-neoplastics and adjunctive therapies were the therapy class that took up the most amount of these reports, representing about 20 percent of that 529 reports received this year. Yes, ma'am.

Sen. Patterson: Could I ask a question also? On these new prescription drug manufacturer things that are manufactured, are they actually new drugs or are they old drugs that have been kind of changed a little bit?

Heins: Yes.

Parra: They're supposed to be new drugs.

Heins: Yes, excellent.

Parra: They could be new versions of old drugs.

Sen. Patterson: Oh, I see.

Rep. Levy: But it’s a point of clarification. So, they're supposed to be new drugs, but it also could be a similar drug that has just changed their patent somewhat. That's what was included in there.

Parra: Yeah, I think they would meet the reporting requirements if they had to get new approvals, correct.

Heins: Great. Next slide, please.

The program received new prescription drug reports for drugs with wholesale acquisition costs ranging from $5.61 to $3.5 million. The highest wholesale acquisition cost reported to us this year was for Beqvez at $3.5 million. This is a one-time gene therapy used for the treatment of adults with moderate to severe hemophilia B and a history of threatening bleeds. The second and third highest wholesale acquisition cost reported to us was for Lyfgenia at $3.1 million and Casgevy at $2.2 million. Lyfgenia and Casgevy are both sickle cell therapies. Next slide, please.

Similarly, this figure shows the 10 highest wholesale acquisition costs for new generic drugs according to the program this year. Again, these prices are not necessarily the

same as a price billed to patients or insurance. While the entries are the top 10 highest gross wholesale acquisition costs reported this year, we have ordered this table by their unit wholesale acquisition cost due to differences in package size and package differences. What I mean by that is the cost per pill, the cost per tablet, etcetera. Here we see that generic pricing tends to be lower than that of brand name drugs. Next slide, please.

Manufacturers of brand name drugs reported more than $3.7 billion in total marketing spend in reports received this year, September 2023 to August 2024. The amounts for marketing are generally representative of spending during the first year a drug is on the market. Manufacturers did not classify over two-thirds or $2.5 billion of their total marketing spend amounts. The one-third that was classified was split almost evenly between direct-to-consumer marketing and healthcare provider marketing. I mean. Yes, sir.

Rep. Nosse: These are big numbers.

Heins: Yes.

Rep. Nosse: This is their advertising in our state?

Heins: State for one year.

Parra: Well, no. This is marketing nationwide. We don't expect them to be able to divvy up their marketing costs for the state. This is nationwide marketing.

Heins: Thank you, Sofie. Yes. Oh, was there another? Yeah, yeah, of course.

Rep. Levy: I just wanted to know. I just looked it up because I thought it was, I believe less than 50. I think maybe 55 new drugs were approved by the FDA that were truly new drugs. We have 500.

Heins: Yes.

Rep. Levy: Wow.

Heins: The remaining, meanwhile, over one quarter or 26.7 percent of the marketing total was taken up by anti-neoplastics and junctive therapies. These are cancer treatments. Meanwhile, the second highest drug class associated with these marketing descriptions were analgesics and anti-inflammatories. These are pain relievers and inflammation relief drugs that took up about 8.6 percent of the reported marketing spend.

Finally, other sources report that in 2023, drug companies spent an estimated $2.87 billion on direct to consumer marketing advertisements for the top 10 pharmaceutical drugs on the market. Next slide, please.

Here's a graph showing the number of annual price increase reports received this year, with this year's reflecting those who submit voluntary data. As a result of the court's decision, we received very few reports this year, a 94 percent reduction in reports of

those kind. Next slide, please.

Moving on to our 60-day increase reports. Studying within these reports, we see that the effective date of these price increases shows that 449 out of 691 reports occurred at the beginning of the year. This is when that price jumps. Smaller spikes occurred in June and in March. Next slide, please.

Continuing to our section on pharmacy benefit managers, per ORS 735.537, the Drug Price Transparency program has published the aggregated sum of four data points for all 17 PBMs not considered exempt from our reporting requirements. Those four data points are shown in the headers of this table here. Across our reporting PBMs, $287.5 million was received in the form of rebates and payments from manufacturers. Of this amount, $283.6 million or 98.7 percent was reported to be passed to the insurers, leaving less than one percent to be passed enrollees in the pharmacy program or to be retained as revenue by that PBM. Next slide, please.

Additionally, the program found that the largest six PBMs ranked by rebate volume received the vast majority of total rebates reported to us at $286.7 million. The six middle sized PBMs received almost $735,000 and the five smallest PBMs received under $20,000 in manufacturer payments last year. Next. Yes?

Rep. Levy: Question - on the note on slide 17, it says that this doesn't include federal military plans, PEBB, OEBB, self-insurance, and anything covered by ERISA or Medicaid. So, it's just strictly OHP? What would be left, ACA, some ACA plans and then OHP?

Parra: As far as what is being reported to us on the previous slide?

Rep. Levy: Yeah, the note at the bottom where it says that what it doesn't include.

Parra: Yeah, because the PBM reporting, we just wanted to clarify that it doesn't include a lot of state government plans and things like that. It's going to be the insurance, private insurance, and stuff.

Rep. Levy: Okay, including OHP.

Parra: I don't. (Medicaid.) I don't think it would. I wouldn't think it would.

Rep. Levy: Okay, got it. Back one slide. Just, yeah. Thank you. That's it.

Parra: Yeah. I'm sorry, the audience can't hear the legislators very well because we're not always switching the microphones. There was a question about the note on the bottom. And so we're just trying to clarify that the Oregon Health Plan (Medicaid) would not be included in this either because it's not part of the reporting.

Rep. Nosse: Is that how we passed the bill? Like when we did this back in 2018, we excluded all those plans?

Parra: I think they're naturally excluded from the definition because it would have to be. I

don't know that we can require reporting based on some of those other structures. We'd have to look into that. We can look into that and do some more analysis.

Rep. Nosse: I mean because those are big, big chunks of the healthcare system that are not reporting and letting us know.

Parra: Or not using PBMs. Any insurer who doesn't use a PBM is not going to be part of this reporting, too. Some insurers do their own PBM work. They do not all use an external. (comment about vertical integration is not audible) No, they just do their own. They're not vertically integrated. They do it themselves.

Stolfi: I think the original bill just used our standard definition of an insurer, which would not include, for example, PEBB, OEBB, or Medicaid.

Rep. Nosse: Interesting.

Stolfi: But policy makers would, you would have the ability, as those are just other state programs, to ask them to report.

Parra: I'm not sure the audience can hear Andrew. He was talking about the original law using our standard definition of insurer. And so we will look into whether there's any way to expand some of that.

Rep. Levy: Thanks for the clarification.

Heins: Next two slides please to the 19. Thank you.

Moving on to our insurer reporting section, the following graphs represent the spending per prescription and spending per enrollee by insurance companies for all entries within their top 25 most prescribed generic, brand name, and specialty drugs. We're going to be using the Center for Medicare and Medicaid Services definition of specialty drug here, which is defined as more than $670 for a 30-day supply and may include both brand and generic designated drugs. The average spending per prescription for generic drugs within these tables was $15, and the average spending per prescription for specialty drugs was $2,316. Meanwhile, the average spending per enrollee for generic drugs with $42, and the average spending per enrollee for specialty drugs was $7,296. Next slide, please.

Additionally, we aggregated spending by these companies across drug types, i.e. the generic, the brand name, and specialty. We also aggregated across market types, i.e. the large group, small group, and individual shown here in this slide. The spending totaled nearly $1.2 billion and about 68.4 percent of that was spending on specialty pharmaceuticals. Next slide, please.

Rep. Nosse: Wait, can you go back to that.

Parra: Back a slide, please.

Rep. Nosse: Thank you. Okay, explain it again, just maybe differently or slower.

Because I think this is, I want to see if I remember something correctly. So what you're showing me is the bulk of our spend is on specialty drugs.

Heins: Correct.

Rep. Nosse: And those are often new, new therapies. They're very expensive. They're not generic yet.

Parra: It could be biosimilars, or other expensive generics would be included as well.

Rep. Nosse: There might be some expensive generics. Okay. But my understanding is, if we were to compare that with the bulk of what's prescribed, the vast majority of plans are prescribed generics by large numbers are the main drug that's prescribed.

Heins: Yes, sir. Generics tend to dominate the number of prescriptions, but specialties tend to dominate the spending amounts.

Rep. Nosse: So the conclusion I'm trying to make in my brain is, if we could find some way to get the cost of specialty drugs to come down and be more reasonable, that would be a significant achievement in light of what prescribers are actually utilizing.

Heins: Yes, the impact on specialty would probably be more than the impact on generic and brand. Next slide, please.

The figure on the left here shows that planned spending on prescription drugs varies widely as a percentage of total premiums collected. BridgeSpan had the highest share of spending with 47 percent of its total premium collected spent on pharmaceuticals. Cigna had the second highest share of spending at 31 percent. Kaiser and Health Net had the smallest amount of spending on pharmaceuticals with respect to total premium collected at 17 percent and 16 percent respectively. Referencing the figure on the right there, information about total premiums in amount of member months covered was collected for those same companies. The above figure shows the company's average premium collected per member per month. Next slide, please.

The right figure shows spending on each drug category, i.e. generic, brand name, and specialty, as a percentage of total spending on prescription drugs. Across the board, all plans spent the most on specialty drugs and the least on generic drugs. However, this is opposite to the actual volume of prescriptions. As I mentioned, generic drugs constitute the vast majority of these prescriptions. So, did we have a question? Excellent. Okay.

While specialty drugs represent the fraction of prescriptions despite driving the majority of the spending. BridgeSpan was a company with the highest percentage of this pharmaceutical spending on specialty drugs at 87 percent. PacificSource and Samaritan were the companies with the lowest percentage of spending on specialty pharmaceuticals with 56 percent and 58 percent, respectively. United reported the highest percentage of spending on generics at 31 percent and PacificSource had the highest spending on brand name drugs also at 31 percent. Referencing the figure on the left though, in total spending terms, Kaiser had the most total spending for generic, brand, and specialty drugs at $368.2 million. Providence had the second most total

spending at $285.9 million. BridgeSpan had the least total spending at $1.5 million. Next slide, please.

Overall, individual market plans spent the most per member, averaging $168.58 in total spending per member per month. Of that amount, $23.38 or 13.9 percent was shouldered by the plan member and the rest was covered by the plan. Several factors may be contributing to the difference in spending between plan types. In general, employer sponsored plans in the small and large group markets tend to have larger numbers of young, healthy enrollees and as a result, claims cost for prescription drugs are likely to be lower in those plans due to lower incidence of chronic conditions. Individual plans may also have less market power and thus have less ability to negotiate lower prices or higher rebates from their manufacturers and wholesalers. Next slide, please.

The price of a drug is influenced by many factors, but manufacturer rebates are one of the most significant that we track. Typically, a manufacturer will pay a rebate for a portfolio of drugs known as a formulary, rather than on a drug by drug basis. Rebates are generally paid to the insurers and negotiated by intermediary companies known as pharmacy benefit managers, also known as PBMs. Insurance companies typically use these rebates to lower their premiums. As a program, we gather cost information from insurers; net of rebates to the maximum extent possible. In the figure shown here, the blue bars represent the amount of costs that were covered by the rebates, and the red bars represent the remaining cost to be paid by the insurance company. Amounts for individual, large group, and small group spending were added together by carriers shown here. This year, Providence reported the highest percentage of rebates compared to total spend at 27.3 percent. United and PacificSource came in second and third, both with 25.8 percent of total spending being covered by these rebates. Kaiser again reported the lowest amount of rebates at 0.3 percent of spending covered by such rebates. Next slide, please.

Finally, data from all carriers was aggregated to generate a list of 10 drugs with (A) the most prescriptions, (B) most total annual spend, and (C) the most year-to-year increase from last year's annual spend. Atorvastatin calcium, levothyroxine sodium, and lisinopril are the most, second most, and third most prescribed drugs among carrier reported data. These drugs and many others were on last year's most prescribed prescription table as well. Next slide, please.

Here we see the 10 drugs that had the highest spending for the year. Again, Humira for the sixth year in a row remains the most costly drug reported to us, totaling $53.3 million in spending this year. Biosimilars for Humira became available early 2024. Keytruda, a cancer therapy, reported $37.82 million in plan spending, which is a 33.9 percent increase from last year's increase, sorry, last year's total spending. Meanwhile, Stelara, a dermatological, reported $31.16 million in spending for 2023, which represents a 7.6 percent increase from last year's spending. The drugs on this year's most costly table that were also on last year's most costly table are Humira, Keytruda, Stelara, Biktarvy, Skyrizi, Entyvio, Enbrel, and Cosentyx. Next slide, please.

Here we see the drugs, the 10 drugs that have the highest increase in plan spending year-to-year. Keytruda was the drug with the highest gross increase in plan spending at

$13.6 million. This is an increase that is 14.6 percent higher than Keytruda's increase from last year. Skyrizi was the drug with the second highest gross increase in plan spending at $10.5 million, representing a 24.7 percent higher utilization than last year's cost increase. The drugs that were on this year's greatest increase in plan spending table that were also on last year's are Keytruda, Skyrizi, Ozempic, Dupixent and Stelara. Finally, the drugs that appeared in the top 10 most costly table this year and also top 10 greatest increase table this year are Keytruda, Stelara, Skyrizi, Entyvio, Ozempic, and Dupixent. We will continue to monitor the pricing practices of these drugs and, of course, many others. I will now hand it over to Lily.

Lily Sobolik: Thanks, Taran. I'm Lily Sobolik, a senior policy advisor with the division, and as we previously talked about, part of the legislature's charge to the Drug Price Transparency program is that we provide policy recommendations about containing costs of prescription drugs and reducing the effects of price increases. So this year, the program has five policy recommendations and I'll provide a brief overview of each. You can go to the next slide, please.

For our first recommendation, which may look familiar from previous reports, we continue to recommend the legislature consider requiring all reporting manufacturers to report annually on all patient assistance programs they maintain, support or fund. This would greatly improve the transparency for consumers and collecting more complete patient assistance program information would allow for more robust analysis by the program.

Recommendation number two, is a companion to the first recommendation and again, the program continues to recommend the legislature require insurers and PBMs to annually report data regarding their copay accumulator programs in Oregon. This would improve transparency and newly-reported data would provide information to support more evidence-informed policymaking. For example, perhaps analysis of the effects of the 2024 House Bill 4113 regarding copay accumulators themselves.

Recommendation number three, again might look familiar from previous reports, the program continues to recommend the legislature establish a multi-state purchasing authority to leverage Oregon substantial pharmacy purchasing power across public entities. The program also recommends that the legislature require state entities purchasing prescription drugs to do so through the existing Oregon Prescription Drug Plan, excuse me, program, also known as ArrayRx, unless greater discounts and aggregate savings are available elsewhere, and that that program be required to annually report to the legislature. Next slide, please.

Recommendation number four, the program recommends that the legislature centralize Medicaid drug purchasing, a shift from having each of the 16 coordinated care organizations separately purchase and manage pharmacy benefits. This would streamline administrative efforts and lower state spending without reducing benefits for consumers.

Recommendation number five, the program recommends that the legislature create a centralized pharmacy purchasing and analytics resource for state government, which has numerous programs separately purchasing drugs. This would streamline services,

consolidate expertise, eliminate duplicate resources, and expedite analysis, ultimately strengthening the state's purchasing power and producing statewide savings. Go ahead.

Rep Levy: Thank you, this is really helpful. So, on the number three to recommend establishing a multi-state purchasing authority, what would that look like? What states would be involved, and is there any other examples in the country that do that? And what is their economy of scale that they get from doing that?

Sobolik: That's a great question. One thing that I'll start with is that the policy recommendations take a little bit of a different character in the report. In the appendix, there is a kind of enhanced version of the report that do, we did not answer all of those questions in advance of this report, but we did pose a number of the questions of things for policymakers to consider, just like you mentioned already, when thinking about implementation. In terms of states that already do this, California with their Cal, I believe it's Cal Rx program, they, I believe it started in 2021 or 2022, they now have the authority to manufacture their own drugs or partner with other manufacturers, and they have already started manufacturing insulin and I believe, it is in the report, but I believe it's at a 40 percent discount. Did I say, there's also, sorry, I believe that's naloxone.

There are, this is a new area, but I think there are some partnerships that the state could look at. I will also say that ArrayRx or the Oregon Prescription Drug Program, does already partner with about five different states, but they do not have the bulk purchasing authority in statute, but they do have collaborative partnerships across the country already that could be leveraged.

Rep Levy: And the bulk purchasing would save money.

Sobolik: The other thing about the ArrayRx program is that state entities are not required to purchase through them right now.

Rep Levy: Thank you.

Sobolik: You're welcome. Yes, go ahead.

Rep Nosse: Easy question. These five recommendations, are any of them likely to be turned into bills by the Department of Consumer Business Services? Or is it sort of like lifting this up as sort of looking at us as legislators to say you ought to consider this?

Sobolik: The latter.

Rep Nosse: Okay. All right, good. I have two kind of technical questions. I thought we did centralize some of the pharmacy purchasing that we do.

Sobolik: You're thinking about recommendation number five.

Rep Nosse: I am. I could swear I've been in conversations where we're like, let's make sure that our prison system and some of the other systems that purchase a lot of medications, we're doing it all together.

Sobolik: I know that this has been discussed over a number of years, not necessarily in this forum, but in other forums. I can't speak to individual agencies that might be doing that themselves, but I do know that there is still more opportunity for centralizing and having that kind of resource that would really maximize the power that the state has. And again, how we are envisioning this is not necessarily just in purchasing, but also in analytics. So perhaps there's a nuance there, but I can certainly look into that more for specifics agencies or programs that are coordinating already.

Rep Nosse: So then, are there other states that centralized their purchasing of Medicaid drugs?

Sobolik: Yes.

Rep Nosse: Do you know them off the top of your head?

Sobolik: I think it's in the report. So my, my previous self did. Yes. Yes, as of July 2023, eight other states do this. California, Missouri, New York, North Dakota, Ohio, Tennessee, Wisconsin, and West Virginia.

Rep Nosse: That's a real mix of states. All of them have different kinds of Medicaid programs. I'll just say, I'll put this out into the universe. Any CCO types that are listening to this. It would be good to get some time with me explaining, reminding me why we're not a fan of this, because this idea keeps coming up to the point where I feel like I need to be reminded again as to why some of you don't think it's a good idea or why we shouldn't pursue this because it keeps coming up. And I might be interested and I don't have a bill on this.

Maybe somebody else does. Having some conversation, if we don't do it during the part of the session where we're considering bills, maybe after to get some of these states to come and talk to us about their centralized purchasing, because I'm sure this would be a hot topic.

Sobolik: One thing that I'll add to what you said Representative Nosse, is in this appendix version that has some additional detail, at a very high level, not to the level that a CCO would be sharing directly with you, but I do include some potential stakeholder perspectives that policymakers might want to consider as you're thinking about moving forward. It would be a reduction in funding to CCOs.

Rep Levy: Understood. Thank you.

Sobolik: There any other questions?

Stolfi: All right. Well, Lily, Taran, Sofie, thank you so much for your presentation. We've had some good questions and discussion as we went, but I'll see if any of our legislators have any other questions or thoughts.

Parra: On the next slide is, are there any other questions?

Rep Nosse: Director Stolfi, is this a place where we can talk a little bit about the lawsuit

and its impact on the program or is that not a good idea? Well, because it was brought up, I'm not sure if that's awkward. And if it is, you could just say moving on, representative. But if now reporting is voluntary, it really, at least for the moment, it really sort of wounds the program pretty significantly, I would argue.

Parra: We have a section in our report that talks about some of the data we're missing now. That's the voluntary reporting.

Rep Nosse: Any other? No. Mic drop. Okay, got it.

Stolfi: As I said, we're going to be disappointed by the lawsuit and can't comment on the lawsuit itself. But the impacts of the district court's opinion, that there were impacts from district court's opinion, the report does outline what those are, and how we've had to cease requiring certain data.

Heins: The graph on page, on slide 15, also illustrates as well.

Sen. Patterson: I have one, kind of small, question that is, why is Kaiser such an outlier on these graphs? I'm not trying to throw them out to the bus or anything, but there must be a simple answer.

Parra: Number of members.

Heins: Yeah. I think basically, it's dominating because it is a humongous company that mostly deals with generics, I think it was. But basically, yeah. So they already, yeah. I think there's a lot of variables that go into these calculations.

Sen. Patterson: So the amount that they spend on specialty drugs, because I do know that they lean towards generic, but the amount that they spend on specialty drugs that reflects a larger enrollment.

Parra: Specialty is generic and brand name drugs that exceed that pricing threshold that we have of $670. Next year, it'll move to $950.

Rep Levy: And $950 is the Medicaid, Medicaid or Medicare? Medicare, sorry.

Stolfi: Any other questions or reactions? Thank you again.

We're now going to go to our first public comment period, for those who've signed up in advance. I know we have one individual who we will introduce in a second. Just wanted to note for the record, we did receive regrets from Andrea Meyer at AARP. She was unfortunately unable to join us this year and personally share the perspective of AARP's more than 500,000 Oregon members. But we did receive written comments from AARP that are part of the record and encourage everyone to read those.

So with that, our first public comment is from Tara Stafford from St. Charles Rheumatology. I'll see if Tara, here we are. Please, Tara. I can't hear you. She looks like she's talking. Yeah, I could see you talking, but unfortunately, we can't hear you. Look to the back of the room for any help we can get there.

Zoom host: We have changed your settings, Tara, so you should be able to use your mic now.

Tara Stafford: Okay. Can you hear me now if I have my headset on?

Stolfi: Yes, we can. Thank you.

Stafford: Perfect. Okay. I apologize for that, technical difficulties. Always so fun. Much of what I'm going to say you already read, but I appreciate the opportunity to present my testimony. My testimony is gained through experience in patient care and contact over the last four years in my job role. I'm a patient access coordinator at St. Charles Rheumatology.

I assist our patients in navigating the affordability for specialty medications prescribed by providers. I say navigate as if the path is clear, but it's more like a labyrinth. Rheumatologists prescribe specialty medications to combat autoimmune and inflammatory disorders that manifest in joint pain, arthritic problems, vascular problems, and dermatologic symptoms. Many of the medications they prescribe are on the charts that you referenced earlier. I'd like to briefly highlight the complexity we encounter in hopes that there could be continued legislation and guidelines for insurance companies to act as advocates for patients, instead of detriments. It is important to note, however that they're part of a larger problem. The inflated prices from specialty medications and manufacturers are astounding, as already spoke to earlier.

The fact that they offer copay assistance and free drug program is only a small band-aid to the injury the drug marketplace inflicts on our patients. Albeit, the programs are how most of our patients are affording the medication prescribed. If I had to estimate, I would say probably three percent of our patients actually pay for their medication in whole without the help of manufacturer copay, a card, or free drug program. This means that the manufacturers are both creating and carrying the bulk of the expenses in my opinion. So, when you ask if a manufacturer rebate program is needed, I would say yes, in the current process it is. I did want to acknowledge and thank you for the efforts put forward by this committee. House Bill 4113 has been long anticipated by myself and my patients. The bill changes the access and affordability to the patients doing away with hopefully the accumulator model insurance plans. I represent a variety of patients that are all caught between the medication, what the insurance allows, and what their provider thinks is best. I'm not using their real names for obvious reasons, but I did want to give you some stories.

Chris has rheumatoid arthritis so bad that he can't hold the tools that he uses for his chosen profession. Our doctor prescribed Humira, shelf price $7,000 a month, to help Chris and it worked great. He didn't miss a day of work for months. And then Chris got a bill from the specialty pharmacy for close to $8,000, the out-of-pocket amount he thought that his manufacturer copay card was going to assist him with. We know that this is because his insurance is an accumulator model plan. So, unfortunately, in addition to the bill from the pharmacy, Chris learned that he had accumulated only less than $200 toward his copay/co insurance, which meant that he would have to pay $8,000 for the Humira in addition to the $8,000 owed to the pharmacy. Because of an exclusive

contract between the specialty pharmacy and his medication, Chris had no choice when it came to specialty pharmacy, and really no options left in accessing Humira, other than to pay out-of-pocket. So, we appealed his case to the manufacturer of Humira, AbbVie, and got him enrolled in the free drug programs for the rest of the year. So, Chris has been able to take Humira for the remainder of the year, missing only the three months that he battled his insurance and pharmacy.

I also want to tell you about Emma. Emma has been on Cimzia for two years, shelf price $6,000 monthly. Emma got a new job, which means that she has new insurance. Her new insurance won't authorize her to continue on Cimzia because of the step therapy policy that they have. They want her to try other medications that are their first line treatment. Emma's been trying to have a family with her new husband, but may have to choose between changing her family planning and pain because Cimzia is the only medication FDA approved for RA (*rheumatoid arthritis*) when nursing or pregnant. To advocate for the patient, we are in the process of applying to the manufacturer, UCB, to enroll Emma in their free drug program and bypass her insurance.

Joan is one of my favorite patients. At 93, she's got so much spirit and spunk. I really enjoy every interaction with her. Joan is on Enbrel and Medicare. A few years ago, I was helping her apply for the manufacturer free drug program and it became a very long and arduous process and Joan began to get despaired. She was on the verge of selling her car to be able to afford the next few months' worth of medication when the Amgen Safety Net approved her for their free drug program.

The cost of specialty medication and the control the insurance companies have are forcing our patients, my patients, to choose between livelihood and pain, family or pain, and freedom or pain. We can do better than we currently do in Oregon. We have to set a new standard requiring insurance companies to allow providers to decide what's best for their patients, limiting the price manufacturers can charge for the medication, and educating patients on taking advantage of cost programs from the manufacturers and nonprofits. There are better solutions and we're currently accepting. Again, I thank the committee for their willingness to address these issues and start the process for change.

Stolfi: Thank you, Tara, very much for joining us and sharing those stories. As a reminder, anyone else would like to give testimony during our second public comment period at the end of the hearing can sign up at the back of the room here, or in the chat online. Next slide, please.

We're going to move on now to our first invited panel discussion. The topic for this is drug advertising. Who really pays for drug advertising, and is what you see, what you get? We know from multiple sources that billions of dollars a year are spent on advertising drugs to both consumers and the healthcare industry. As consumers, we see the TV and social media ads. There are also marketing dollars spent to promote drugs to doctors, hospitals, PBMs, and other healthcare decision-makers. We have invited speakers from varied perspectives to talk about drug advertising and the costs, particularly their impact on consumers. For example, how do these expenses affect the cost of drugs in the U.S., especially considering that most other countries don't allow direct to consumer advertising? And how do ads affect what drugs are available to patients? Presenters, please keep your presentations to six to eight minutes. If you

provided slides, please just ask our staff when you're ready to proceed to the next slide, and please stick around after your presentation for Q&A with our moderators. With that, we're going to turn to our first presenter and that is Michael DiStefano.

Michael DiStefano: Hello.

Stolfi: Yep, we can hear you, Michael. Go right ahead.

DiStefano: Yeah. Thanks for inviting me. Good morning, everyone. Could you just advance to the first slide, please? Thank you. So I'll be talking this morning briefly about consumer advertising and drug benefit. Next slide, please.

So, as some of you may already know, the U.S. and New Zealand are the only two countries in the world that allow direct to consumer advertising or DTCA for prescription drugs, and from 1997 to 2016, spending on DTCA in the U.S. grew from $1.3 to about $6 billion annually. And consumer advertising was the component of medical marketing that increased most rapidly over this time period, and the number of ads over this time period increased from 79,000 to nearly five million with about 700,000 of those ads being TV commercials. Next slide, please.

And so we know from the literature that DTCA is associated with increased patient requests for and increased clinician prescribing for advertised products. And this phenomenon would be concerning, if this increases the use of cost in effective drugs. So, for example, if consumer advertising increased use of a branded product at the expense of a cheaper generic or biosimilar that was available instead, or if advertising increased use of a branded reformulation rather than a cheaper generic. Sometimes this is referred to as product hopping, where a manufacturer releases branded reformulation with a small change to the originator branded product ahead of the entry of a generic and then they move patients to that reformulation, perhaps through advertisements, and then it's more difficult to substitute the generic after that. It could also increase the use of a branded product versus another branded competitor that might have just worked better for that individual patient, thus leading to like overall less or fewer healthcare costs for that patient. Or advertising can just increase use of branded products that are not priced in accordance with value. If the price of that drug even after rebates is above what we would consider a value based price, then arguably any use of it is inefficient and there might have been some alternative use of resources that would have been more efficient. Next slide please.

What do we know about the relationship between drug advertising and drug innovativeness or added benefit? Some previous research examined the relationship between clinician targeted promotion and drug innovativeness. From 2013 to 2014, top promoted drugs were found to be significantly less likely to be innovative than top selling drugs, and here innovativeness was defined as either a first-in-class drug or a drug that had received a priority review designation from the FDA. Over the same period, in another study, nearly all of promotional spending on top promoted drugs was for drugs with little to no therapeutic gain, and here therapeutic gain is defined and determined by some agencies internationally that assess the benefit of a drug relative to its existing therapeutic alternatives. In some more recent research from 2015 to 2021, fewer than one-third of the most common drugs featured in television ads were rated as having

moderate or greater added benefit. Next slide, please.

My co-authors and I, we wanted to build on this, this body of research trying to address some of the minor limitations with these existing papers. Small samples of drugs. Not always controlling for potential confounders between the relationship – the relationship between advertising and drug innovativeness. And more research, we thought, was needed into DTCA, including beyond just TV ads, covering things like radio and print ads, and research that's not just focused on clinician-targeted ads. Next slide, please.

So this is what we set out to do, and I'm just very briefly covering this this paper today. But we asked the question, what drug characteristics are associated with larger proportions of promotional spending allocated to DTCA versus clinician targeted ads? We looked at the top 150 drugs with the highest U.S. sales in 2020. We drew our promotional spending data from IQVIA Channel Dynamics. This includes data on promotional spending across categories of product sampling, clinician contacts, meetings, events all the way to DTCA - and DTCA here includes TV ads, print ads, outdoor billboard ads, radio. We collected data on several co-variates, including added benefit. And as I mentioned previously, this measure of added benefit comes from international organizations that assess the benefit of a drug relative to its existing therapeutic alternatives. Next slide.

This was the primary finding. We found that, on average, drugs with low added benefit have 14.3 percent more promotional spending allocated to DTCA versus drugs with high added benefit, and that's an absolute increase in percent. We did find that this result was robust in terms of both its direction and its magnitude across four sensitivity analyses that were all based on different model specifications. Next slide, please.

Just briefly, one limitation of this type of research is, although these added benefit ratings are widely used in published research, these international agencies may incorporate value judgments that aren't aligned with the U.S. public or they might not always incorporate the most recent clinical evidence. Although, we did in our research, use the best added benefit rating for any of these drugs regardless of time of assessment. Next slide, please.

What's the main significance of our finding? I think it raises this question around whether allocating a greater share of promotional spending to DTCA versus clinician-targeted ads might or could reflect a strategy to drive patient demand for drugs clinicians would be less likely to prescribe. Maybe because there are similarly or more effective treatments available possibly at a lower cost or because the physicians face burdensome utilization controls like prior authorization, which are intended to direct utilization toward maybe more cost effective, cheaper and more effective treatments. And if this is happening, the overall effect could be to raise costs through inefficient utilization. Next slide, please.

Looking ahead and hopefully setting up the next presentation, this DTCA landscape is rapidly evolving and there's an increasing reliance, I believe, on digital ads, potentially targeted social media advertising. I really think it will be important for future research to focus on this unique element of DTCA. And that's all I have for now. Thank you for listening.

Stolfi: Thank you. Thank you very much, Michael, and please stick around. We're going to go through the presenters and then do questions at the end. So, next we have Sneha Dave. Over to you.

Sneha Dave: Yes, thank you so much, and I apologize, I will be off camera as I'm in India and I'm trying to protect the bandwidth to be able to stay the whole time for this presentation. Next slide, please. Next slide.

I'm so thrilled to be here. My name is Sneha and I'm the executive director at Generation Patient. We're a nonprofit representing young adults with chronic and rare conditions. We're led entirely by young adult patients as well, which really makes our organization community-led. We don't take any private healthcare industry funding, which is really, really important to the integrity of our work. Our work spans everything from peer support to research and policy. We do a lot of roundtables, bringing together patients and a variety of different clinicians, as well as our leadership programming. You could skip 2 slides, please.

Today I'm going to talk a lot more about direct to consumer advertising on social media and particularly on emerging platforms like TikTok and Meta. And when we think about direct to consumer advertising, we rightfully think about the cost that industry spends on marketing versus research and development, versus areas that truly matter to patients. But I also think there is this bigger picture issue of the real public health implications of advertising on social media where the regulations have not kept up with the evolving landscape of platforms like TikTok and Meta. Just to set the stage here, we saw a recent workshop in 2021 labeling adolescents and those with chronic health conditions as vulnerable populations on social media to direct to consumer advertising. Next slide, please.

I just wanted to talk a little bit about the impact of social media and direct to consumer ads. We saw during the COVID-19 pandemic that the misinformation, the majority of misinformation, just came from 12 people who had a combined 59 million followers across multiple social media platforms. So we know that we don't need a large number of people to actually extend the reach to millions and millions of people. Unique features of social media include virality and viewership, especially on TikTok and Instagram Reels, where again, one person is able to reach millions of people. And especially when we're thinking about the lack of regulations and what it means to really be able to oversee influencers and other people who are advertising prescription medications, it becomes scary for the widespread reach.

I think another huge challenge that we're seeing is the use of influencers and micro influencers to reach patients more broadly. We've seen quite a few advertisements, which I'll share very brief examples of, of influencers talking about prescription medications without having adequate safety information displayed. It is a requirement for pharmaceutical advertisements to have a fair balance of both safety and efficacy information. But we've seen in several ads where the safety information is not displayed as adequately or is missing, or is not in a place where followers would actually be able to find where that is. Next slide, please.

Rep Nosse: Sneha. I hope I said your name right. While you were talking, I did a quick anecdotal survey of my Instagram, which I use, and for every three posts of something that I actually wanted to follow, I had five different digestive advertisements, like some sort of fiber supplement. I'm 57 years old, so I think I'm being profiled. Something that would help me lose weight, control my gut, blah, blah, blah. Like every 3rd slide.

Dave: Yeah, absolutely. And this, I think, really talks about a huge, larger issue with the algorithms and how patients and people online are being targeted without them even knowing or wanting to be. So, yeah. I'm going to probably speed this up just a bit because I only have a minute or two left. We've seen the advertising regulations really stuck in the Stone Age. And not only, did FDA release a guidance 10 years after, recently, 10 years after they'd first done so, which was in 2014, which is two years before TikTok was actually even launched, they also had not held a workshop since 2009, which really highlights the fact that there is so much opportunity for FDA and other regulatory agencies to play a more proactive role on some of these platforms that they have not addressed nearly as much as they need to. Next slide, please.

So this is just an example of a challenge that we've seen with the increase of pharmaceutical ads. For example, this is an influencer, who we've blocked out the name for, but these micro interactions are particularly concerning, and again, are an example of why we need increased regulation when we're thinking about direct messages, comment sections that don't have necessarily clear guidance or guidelines on behalf of the FDA. And really can create this opportunity for influencers to have a unique interaction with followers and convince them of things that may not necessarily be the best for them. And this is a sponsored advertisement from Nurtec ODT. Next slide, please.

This is another example of an influencer in a migraine medication, again Nurtec ODT, in this case partnering with New York Fashion Week. When we looked at the Instagram stories and the posts on Instagram, we found no safety information, but just a talk or conversation about how important and effective this medication is, which is really valid, but also again, an example of the fact that these regulations are very much behind and again have the potential to reach a large number of number of young adult patients in a way that really can create undue influence in an increased parasocial relationship. Next slide, please. And I think we might actually skip ahead a couple of slides just because I want to be respectful of time.

But yes, this is an example actually of an advertisement that now has nearly, I think, a million likes and probably 200 million views and had no safety information displayed anywhere on the advertisement. Next slide, please. Next slide.

Essentially, I will just go ahead and continue, because I don't want to wait for the slide to share more, but we have been really focused on taking action for closing some of the loopholes that exist for oversight on social media. We … next slide, please.

We released legislation earlier this year, which we drove with Senators Durbin and Braun, which is bipartisan legislation. We drafted an opinion editorial in STAT news, which led to a letter to Commissioner Califf. And this piece of legislation addresses some opportunities that exist for interagency collaboration, such as with the Federal Trade

Commission and the Food and Drug Administration. It authorizes the FDA to have $15 million per extra per year to increase oversight capacity for social media specifically, but it also really calls out the use of influencers and telehealth companies in particular and their role of spreading false and misleading information regarding prescription medications, which is very much long overdue. Next slide, please.

And I believe everybody has access to these slides, so feel free to look at them more in depth that way. Next slide, please. And actually, I think we can go to the second to last slide just for the sake of time.

Just a couple of takeaways, especially for the purposes of this hearing. Can you go back a slide, please? It's very important to expand regulations to address emerging social media platforms as it pertains to direct to consumer advertising. Very important to involve young patients, who are the most impacted by these advertisements.

A lot of this legislation and the recommendations that were created were really developed by our young adult patient community who are living with conditions like hemophilia, lupus, hemiplegic migraines, and who have had direct experience with these advertisements, and have seen the harm that they have caused or can cause. And then I know that as far as a state level, there are certain restrictions versus federally, but I think there's opportunity with state consumer protection laws, and other state specific restrictions, for pharmaceutical advertisements that curb the false and misleading nature of advertisements that have not presented adequate safety information, in particular, in addition to efficacy. That's all for today, but I really appreciate your time, and certainly I'm available to answer any questions either after the rest of the panel or at a later time.

Stolfi: Thank you very much. Yeah, please do stick around if you can, to see if we have questions at the end. And we're going to turn next to Dharia McGrew.

Dharia McGrew: Confirming you can hear me?

Stolfi: Yes, we can. Go right ahead.

McGrew: Great. Thank you. Director Stolfi, esteemed members of the Legislature, thanks again for inviting PhRMA to speak at this year's annual hearing. Next slide, please. I apologize that I couldn't be there in person, but thank you for inviting us. Next slide. Oh, that one's good. Sorry.

Who is PhRMA? I am, for the record, Dharia McGrew, Director of State Policy on behalf of the Pharmaceutical and Research Manufacturers of America. PhRMA is a trade association representing 30 of the country's leading innovative biopharmaceutical research companies who together have invested more than a trillion dollars in research over the last 25 years on new treatments and cures. Next slide, please.

Before getting into numbers on advertising, I want to remind and set the stage on the pathway a drug takes coming to market. It takes $2.5 billion dollars on average in 10 to 15 years to bring a new drug to market. It is very risky and an expensive endeavor. And I bring this up before advertising because I think it is important to set the numbers that you're talking about in the context of the industry. Next slide, please.

The industry is responsible for a huge segment of the R&D in the United States. One out of every $6 on R&D is spent by the biopharmaceutical industry. So again, the scale is quite large when you're talking about advertising as one of the business factors. Next slide, please.

Now every year there are regular reports that come out about the advertising spend of specific companies versus their R&D, and I can't speak to any specific company, but generally what we see in those articles is a misrepresentation of SEC filings. Every public company does file with the SEC numbers for reported sales, general, and administrative expenses, and those SGA numbers are often reported as marketing, which is not an appropriate analysis of that, of those numbers. Those SGA numbers do include many types of activities that we would consider marketing promotion, like DTC advertising that we're talking about, healthcare provider advertising, and business aspects associated with that marketing. But SG and A also includes many activities that most people would agree are unrelated activities, like shipping and distribution of drugs and office furniture. So, we find that comparisons of spending on R&D versus marketing are often misleading and grossly overstate marketing and promotion. Next slide, please.

The biopharmaceutical industry does spend significantly more on R&D than on marketing and promotion. So when you appropriately account for the marketing promotion out of the SGA numbers, we find that, the industry we are now spending over $120 billion per year on R&D bringing new drugs to market and $30 billion on marketing promotion. Of that $30 billion, $6.6 (billion) goes to DTC advertising. So it is a much smaller proportion compared to what we are spending on R&D, and sometimes there is a misinformed or unfortunate statement I've heard people make, claiming that if companies didn't spend money on the ads that people are seeing or the jingles that get stuck in their head, people will say, that money could be reinvested in research or spending on drugs. And it's a misrepresentation of business practices, really. Next slide, please.

It's not, R&D and marketing are not a zero sum game in any industry, and in particular our industry. You wouldn't just remove one bucket and assume that all the money would go into another bucket. And I think to illustrate that point, it's important, it's useful to see that since direct to consumer advertising began in 1997, the amount of money spent on DTC advertising has remained fairly stable in that timeframe, while the amount of money spent on R&D has quadrupled. I think that this is illustrative that spending on R&D is not, can't be just substituted for DTC advertising. Next slide, please.

I want to make sure that we have time to answer questions on this panel. Thank you.

Stolfi: Thank you very much, Dharia. And please, yes, please do stick around for questions. We're going to go to our last presenter as part of this panel, Gray Brokaw.

Gray Brokaw: Thank you so much. First off, I want to thank our panelists for having me here. This is a wonderful opportunity. I think I can share a little bit of what some of the other presenters have already spoken to, and give our campaign perspective at OSPIRG. My name is Gray Brokaw, they/them. I'm a campaign associate at OSPIRG working on our healthcare campaigns. We are a public interest group advocating for

lower healthcare costs across Oregon. At OSPIRG, we believe that the cost of healthcare should provide a reasonable value proposition to consumers. Direct to consumer advertising, however, undermines that goal and therefore it is our position at OSPIRG that direct to consumer drug advertising should not exist.

In fact, as you all know, the U.S. is one of only two countries where direct to consumer advertising for pharmaceuticals is legal. The other is New Zealand. In America, we know the names of pharmaceutical drugs like we know car and clothing brand names. Direct to consumer advertising promotes drugs that are best for the revenue of the pharmaceutical companies and not necessarily what is best for the health of Oregonians. These advertisements jack up costs and likely prove detrimental to health outcomes. These advertisements are costing patients their hard-earned dollars and their health, while social media is opening up new avenues for advertisement expansion. This is just downright wasteful. In America, we are spending far too much and receiving far too little for our healthcare dollar. Manufacturers have spent more than $1 billion a month on ads in recent years. Last year, three of the top five spenders on TV advertising were drug companies. Drug companies are raking in this revenue while patients are largely unaware of cheaper alternatives that can work just as well.

This is because new brand name drugs are not, are much more expensive than generic drugs because they remain under patent protection. Producing strong profits for pharmaceutical companies even though they can function effectively the same. Under the influence of these ads, customers are paying extra for no added value. This is not only bad for our wallets, but it's also bad for public health.

When we go to the doctor, we receive one-on-one, individualized care from a knowledgeable medical professional who is knowledgeable of our health background and best positioned to suggest what interventions are most likely to create valuable health benefits.

The purpose of ads in general, on the other hand, from clothing to cars, is to sell product. To convince viewers that they lack something in their lives that this product can fulfill. And drug advertising functions effectively the same. Sometimes the cheapest option is, in fact, the best option. But that's not what we're seeing on TV. The most common drugs advertised are often found to be least likely effective. A study from Johns Hopkins Bloomberg School of Public Health found that the share of promotional spending allocated to consumer advertising was on average 14.3 percentage points higher for drugs with low added benefit compared to drugs they found to have higher added benefit.

As I'm sure you're aware, this means we are spending more in pharmaceuticals that don't give us the most impactful outcomes. What's worse is that these advertisements spur patients to seek out medications that they may not need. They convince patients who are healthy, that they are not. They are highly biased and broad in scope, designed to get between patient and doctor. The average television viewer in the United States watches as many as nine drug advertisements per day, which adds up to about 16 hours per year, which actually far exceeds the amount of time that the average individual spends with their primary care physician.

A Mayo Clinic study from 2013 found that nearly 70 percent of Americans regularly took at least one prescription drug, and researchers identified prescription drug abuse as the fastest growing drug problem in the United States. This whole system is backwards. Patients shouldn't be going to their doctor with a solution asking for a specific drug like Xanax, because this can cause conflicts between doctor and patient when the doctor doesn't recommend the drug that the patient wants. Knowledgeable medical professionals are the best qualified to provide solutions and drug advertising interferes with this process. Especially when a doctor's holistic approach might lead to a recommendation of a lifestyle change for long-term health of the patient rather than the quick fix of pharmaceutical.

Direct to consumer drug advertising can mislead consumers in a big way. Most ads use appeals to emotion. They depict characters who have lost control of their social, emotional and physical lives without a medication. They offer ambiguous claims to promote their drugs. Some ads claim to provide a quote “leading treatment” for a condition, but they fail to mention that there may only be a couple of treatments available. Other claims, other ads claim that quote “no other treatment has been proven better.” Yet, that's not really saying very much. If there is no better treatment, but there may be older, less expensive, perhaps over-the-counter alternatives. Perhaps worst of all, some ads use anecdotes to sell these drugs. They appeal to the masses using language like, quote “I don't care about studies, it works for me” or this one's really common quote “this drug gave me my life back.” The use of anecdotes to sell drugs is particularly harmful because studies and facts do in fact matter. When it comes to our health, the advice of a medical professional should be front and center. We shouldn't make health decisions just because someone said it worked for them, especially when that person is a paid actor or spokesperson.

This is particularly insidious with the rise of social media, where the line between paid spokesperson and influencer is particularly fuzzy … and regulation is particularly lax. The urgency of social media is increasing the urgency for action. Technological innovation requires legislative innovation. The FDA regulates drug ads, but control of social media is limited and lagging behind. The FDA can only regulate what manufacturers say and not what influencers say in their ads.

So influencers skirt around the traditional guidelines. If there's no established financial relationship between an influencer and a manufacturer, the content falls outside of current FDA regulation. This means that influencers don't have to disclose when they're being paid at all, and they don't have to list side effects and risks. We're seeing these ads pop up more and more on Facebook, Instagram and TikTok. And social media allows for more targeted advertising reaching specific demographic groups, such as on TikTok, increasingly to younger audiences. These influencers are muddying the waters and seeming more like real people or peers than a spokesperson.

And consumers and young people are more likely to believe and trust what influencers say than paid spokespeople that they see on TV and other advertisements. Those long disclaimers that we're so used to seeing on TV, where they list every possible side effect in a really calm and very quick voice, are largely absent on social media. This allows for drug advertisers to pass off their drugs as cure-alls. Influencers should be required to include this information. We deserve public reporting and transparency when influencers

receive payments to promote drugs on their social media accounts. In conclusion, direct to consumer drug advertising convinces patients to seek expensive and in some cases unnecessary care, interfering with the relationship between patient and medical provider and contributing to the growing issue of over medication. These ads use misleading language to convince the public that if only they tried a new drug, if only they tried this new product, all of their problems would magically disappear. And in the process, this lines the pockets of pharmaceutical companies.

The lack of regulation on social media is only accelerating the issue, which is why it is high time that we join the rest of the world and put a stop to direct to consumer drug advertising. Thank you.

Stolfi: Thank you very much, Gray. Please stick around there. And if we could add the other panelists to our video, for those that are on video. We have a couple minutes for questions now. Reminder for our legislators up here to turn your mic on if you have a question. We'll see if you have any.

Rep Nosse: Thank you, director. So I don't really dispute anything that any of you shared, including Dharia. If you're still here, the information that you shared about the R&D that the pharmaceutical industry does in this country, really for the rest of the world. Here's sort of my generic question though, which is: In the United States under the First Amendment, as I sort of understand, as it gets interpreted and has occasionally been reinterpreted, are we allowed to regulate drug advertising?

McGrew: Yes, thank you. Drug advertising. Well, first let me back up a little bit and say, as a parent, I think digital advertising to youth is very important conversation. I appreciate the speakers that are bringing light to this. It is a rapidly evolving environment. So I think this is an important conversation. At the same time, prescription drug advertising brings important knowledge of treatments, and potential benefits, and risks to the public's attention. And what is said in the ads is very tightly regulated by the FDA.

Rep Nosse: Okay. That rings true for all the advertising I see on television. Like there's definitely usually a 30 second, like if you have this issue, or this issue, you should check it out or whatever. But my question is sort of generally fundamental to any of the researchers or a lawyer, which is, are we allowed to regulate pharmacy? I understand the FDA is a lot, is regulating the manufacturer, but, in general, are we allowed to regulate this? Go ahead. You first.

Dave: Yeah. I'm certainly not a lawyer, but I think there is something called the Central Hudson test created by the Supreme Court, which essentially allows the government to regulate commercial speech where it's necessary to advance something, like protecting public health.

Rep Nosse: Okay. What was that? What is that called again? Central Hudson?

Dave: Yes, it's a Central Hudson test.

Stolfi: I'll add representative, that’s very helpful. I think Michael wanted to come off mute

for a second. The U.S. did prohibit direct to consumer advertising for drugs until the ‘80s. So, we could look at why that changed at that time and currently.

Rep Nosse: Everything looks better in the 80's, the music, the haircuts, ...

Stolfi: Yes, but then and currently direct to consumer tobacco advertising is prohibited. But Michael, if I was right, I, I think I saw you come off mute if you wanted to add something.

DiStefano: Yeah, I wasn't going to add much, but I do think the First Amendment, especially with the current Supreme Court constitution, poses a barrier to outlawing direct to consumer advertising. But it is the case as others have mentioned that consumers are protected in theory from false and misleading advertisements by both the FTC and the FDA, which has primary jurisdiction for prescription drugs. I do think, while the FDA does focus on this to some degree, like as mentioned, there may be some resource limitations for them, especially with the proliferation of social media advertising. It's very hard to be on top of any claim that is being made right at any given time. The laws also typically extend, I believe, the regulations just to manufacturers, packers, and distributors. Those are the ones that the FDA is really focusing on, but there is a whole bunch of new entities that are making claims about prescription drugs.

You see this with clinics that offer ketamine infusions. They're not really manufacturers, packers, or distributors in the legal sense of those words, but they're offering prescription drugs. And so who has, who's putting the time and resources into regulating those claims that, through some other research I've done, there are some false and misleading claims. So just some additional context on that question.

Rep Nosse: What about our phones and social media and youth is a big conversation that's kind of certainly happening in this state and across the United States in a lot of ways. So we'll see. Stay tuned.

Sen. Patterson: Thank you so much. Thanks to all the presenters. This is extremely informative. Relating back to the report and some of the reports that were submitted by pharmaceutical companies on the pricing of their products. How, and I'm looking back at your slide, Dr. DiStefano, that's on the DC, direct to consumer advertising and spending, the bottom point: Branded product not priced in accordance with value. How is value determined on the pricing of a drug?

DiStefano: It's a great question. I don't really want to open a huge can of worms, but the short answer is, and Dharia you may want to follow up, but we don't really price drugs in accordance with value in this country for the most part, right? They're priced according to what companies think the market will bear. There are other countries that do this.

The UK has the National Institute for Health and Care Excellence (NICE). They statutorily primarily use cost effectiveness analysis to determine if a drug is going to be covered by the NHS (UK National Health Service) and they make a recommendation. And if they say it should be covered because the price they determined, the price submitted by the manufacturer, they've determined is a cost effective one, then the NHS covers it. And if NICE doesn't recommend that drug, then the manufacturer doesn't sell

the drug in the NHS, which is the whole country's public health insurance program. Not all countries use cost effectiveness analysis.

In the U.S., there have been efforts to prohibit and ban the use of cost effectiveness analysis, specifically cost effectiveness analyses that use the quality adjusted life year component. But there is legislation out there that would ban similar measures to the quality adjusted life year. So, there are real debates to be had about the impacts of using cost effectiveness analysis. There are concerns around discrimination, etcetera, but I do think efforts to ban these things, which probably are supported in some part by manufacturers and patient advocacy organizations, aren't helpful if we do want to have some approach to defining what a value based price would be. I'll stop there.

Sen. Patterson: Thank you very much.

Stolfi: Dharia? Yeah, you're welcome to.

McGrew: Yes, thank you, Director Stolfi. Yeah, I agree largely with what Dr. DiStefano said. Conversations of value and added value of one medicine compared to another are very difficult to analyze. There are lots of different metrics. We would say that there are methods of assessing value that do provide useful information. However, there are concerns with others. There are many, many different metrics out there and some of the metrics do incorporate discriminatory analysis into them against people with, populations with disabilities. So, there are some methods of value analysis that are better than others. But largely speaking, I think when people here look to other countries and say, well, this country has decided it has value or doesn't have value, you're comparing vastly different healthcare systems. And apples to oranges comparison of two different healthcare systems are not always helpful for us.

Stolfi: Yeah. Thank you, Dharia.

DiStefano: I can also just quickly add that the Medicare drug price negotiation program is an opportunity for the U.S. to be thinking about how they want to define the value of a drug and whether prices should be aligned with value. Now, Medicare statutorily, well maybe it's in the regulations, Medicare has explicitly stated they will not use QALYs (quality adjusted life years), because it raises such strong objections. But it remains to be seen whether there's some alternative that they have used to arrive at the most recent first round of negotiated prices. But in March, I think we should get fuller explanations from them about how they've arrived at those prices.

Rep. Levy: I have one, one comment and then one question. I mean, I just think we should say the quiet part out loud about quality, that many of the models use a healthy white male as the standard and that creates some disparity on how a life is valued and just has a lot of objection to that model. Second, I would say a concern that is popping up for me, and I would love to hear your feedback Dr. McGrew and Dr. DiStefano, is that when I look on social media, I looked on all three of my accounts last night, I, like Chair Nosse, was bombarded with not branded drugs, but alternatives.

Rep. Nosse: Yeah, supplements.

Rep. Levy: Yeah, I got seven ads yesterday for an alternative to Ozempic. It says, you don't qualify for Ozempic, here's how you get it. Seven ads yesterday.

Rep. Nosse: I'm not on the right social media.

Rep. Levy: I know you got to get online, but my concern and what I'm seeing is that probably because of the cost of entry, social media being much lower, that what we're seeing is branded products on TV and probably and more in compliance than some of these off model products. And as a mom, just the creation of a parasocial relationship with these off branded products. I'll be honest, I didn't really see it until last night. So, I went digging and now I see it everywhere and I would love to hear your feedback. Do you see it's more alternative products non-regulated or you think it's all? On specifically creating that parasocial relationship with children?

Rep. Nosse: Sponsored by a supplement.

Rep. Levy: He needs to disclose that. Yeah, I would just, I would love your feedback of where you see the trend going. Is it, are we talking big pharma is having a parasocial relationship with our kids or is, as legislators when we go to regulate this, it's kind of hard when there's a lot of different kind of noodles in the soup. I just made that up.

DiStefano: Was there an example specifically of supplements you're seeing? Supplements that aren't, if they're not considered prescription drugs, then the consumer advertising around those should be overseen by the FTC.

Rep. Levy: Yeah, sorry. The chair got a lot of supplements, what I got was a direct to consumer: You can take this pill because you don't qualify for Ozempic.

DiStefano: Oh, yeah. What you're seeing there is probably, it's the compounded versions of semaglutide, tirzepatide. That's a huge market, which I have some other research on and I'd be happy to follow up with you offline. But yeah, those are prescription drugs. So, going back to my comment earlier, the regulations cover false and misleading advertising by manufacturers, packers, and distributors, but you have these entities that fall, it's not clear they meet any of those, those designations.

When you have the FDA, which is already probably not resourced sufficiently to regulate advertisements by manufacturers, are they really going to be able to spend a lot of time regulating all the advertising on websites by like brick and mortar weight loss clinics, med spas that are purchasing the compounded GLP-1s from compounding pharmacies and having it prescribed and selling it to consumers? I think probably not, right? The FDA is not going to be able to cover all of those businesses. Maybe a few big ones, like Hims or whatever.

Rep. Levy: Yeah, I get a lot of those. I would say this is really illuminating for me and I think for people watching at home, I think seeing that parasocial relationship created is really informative. So, I appreciate you guys bringing that to our attention.

Stolfi: Yes, thank you very much. We're unfortunately a bit behind, so we're going to have to jump to the next panel. But Michael, Sneha, Dharia, and Gray, thank you very

much for the information. All the slides are available. And apologies we couldn't get to some of the questions in the chat, but we will do our best for the next panel.

Let's move on to panel number two. The topic here is drug rebates. Why are rebates necessary and how do they help or harm the consumer and how do they affect what drugs are available? Manufacturers sometimes provide rebates to wholesalers, PBMs, insurers, plan sponsors, governments or patients to reduce the cost of certain drugs. This raises several questions, such as what effects do rebates have on the price of drugs paid by everyone else? We also know that rebates are used for formulary development, which can impact patient copays and out-of-pocket costs. How do rebates help some consumers and harm other consumers? Is that process transparent and equitable? To learn more about all of this, we've invited speakers from varied perspectives to talk about drug rebates and how they impact consumers. Presenters, please keep your presentations to six to eight minutes, shorter if you can. And if you provided slides, just indicate when to move to the next one. And we're going to start. Our first panelist is Mahir Patel.

Mahir Patel: Great. Thanks, Commissioner Stolfi and legislators. I'm Mahir Patel, chief pharmacy officer at Regence Blue Cross of Oregon. You can go to the next slide.

Just a little bit of background on Regence Blue Cross Blue Shield of Oregon. You know, we're a local not-for-profit health insurer that started over 80 years ago. We cover about a million people and have a broad provider and pharmacy network across the state. And as with most health plans, we partner with the pharmacy benefit manager or PBM to administer our pharmacy benefit. Like several Blue Cross Blue Shield plans nationwide, Regence has chosen to partner with Prime Therapeutics as our PBM. Next slide.

It's no secret that prescription drug spend is the fastest growing driver of healthcare costs in the nation. While Regence works to be a good steward of member premiums and invests 88 percent of every member dollar back into the healthcare cost, Regence is no exception. We feel the acute impact of year over year increase in drug spend. In 2023, 25 percent of the premiums we collected in the individual/small group market were spent on prescription drugs. 2023 to 2024, our drug spend for a fully insured line of business increased by $43 million, and similarly, we saw per member, per month spend increase across our lines of business by $15 PMPM over the past year. Next slide.

The growth in drug spend and the importance of cost stewardship of the member premium is why pharmacy rebates, specifically preservation of the past due model of pharmacy rebates, are vital to health plans. So, how do rebates relate to these costs? Well, in general, I'd remind the group that the majority of drugs still today are for generic drugs, which aren't eligible for rebates. In fact, 90 percent of prescriptions filled by our members are generic drugs. So, of the remaining 10 percent that are brand name drugs, only a subset of those are actually eligible for rebates. And when we think about the history of rebates, they've been around since the early 1990s. Instead of drug manufacturers providing volume of market share discounts upfront, they decide to offer rebates to pharmacy benefit managers after the volume of market share had been achieved, usually due to preferred formula replacement.

These rebates are negotiated off of the drug’s list price and the health plans work with

PBMs to negotiate rebates on their behalf to obtain the best possible pricing for their members. As we'll discuss in a moment, most PBMs have an arrangement with their health plan partners where a portion of or all of the rebates are actually passed on through the health plan or into the health plan and utilized to lower member premiums across the member pool. In Regence's fully insured market, we have 100 percent pass through arrangement with Prime. In our ASO, or administrative services only, self-funded market, we do offer point of sale rebates where rebates are used to reduce member cost share at the point of sale. However, few employers select this option because cost savings for all their employees are higher in a pass through arrangement. Go to the next slide.

We won't spend too much time on this slide, but just want to offer an illustration of the overall flow of funds in pharmaceuticals and the retail drugs supply chain, highlighting how the past due rebate is utilized to lower member premiums. Where the yellow stars are on the chart indicates the track of rebates, which flows from the manufacturer to the PBM and then from the PBM to the health plan, and then to the member in the form of reduced insurance premiums.

As mentioned earlier, we do see a small number of our ASO groups choose a benefit plan that is designed to apply the rebate at point of sale to the member cost share, though the majority choose a benefit design to apply the rebate across the member pool in a pass through model, highlighted by the gold stars. You can also see where members who are on a high cost drug can sometimes access manufacturer coupons, copay coupons represented by the green dotted line across the middle of the graphic. These can be used to lower member cost sharing at the pharmacy counter for drugs where costs remain high despite PBM negotiating. Next slide.

As reviewed earlier, I want to reiterate some of the points from the Drug Price Transparency report. Seventeen PBMs reported to the Drug Price Transparency Board and out of the 17, eight reported zero retained rebates or payments from manufacturers, meaning that 100 percent of rebates and payments were passed through to their respective health plan partners or enrollees. This includes Regence. Prime Therapeutics passes on 100 percent of rebates to us and we use them to lower cost for our members. Like Regence, the vast majority of insurers in the Oregon market have found that utilizing a pass to rebate model ensures the highest cost savings for all our members. Next slide.

And as indicated previously, there is low adoption of point of sale rebates currently. So, let's take a look at some of the issues related to point of sale rebates. As I mentioned earlier, rebates are only available for a select group of brand name drugs, so only members utilizing a brand name drug that's eligible for rebates would benefit from point of sale rebates as opposed to all members who currently benefit from rebates being used to reduce premiums. Also, cost savings via point of sale rebates would only apply until a member hits their out-of-pocket maximum, again limiting the benefit of rebates. In addition, many of the rebate eligible drugs already have coupons or copay assistance programs to help reduce member cost share. So, many of those members are already experiencing decreased cost share. Therefore, point of sale rebates have limited benefit and would impact all members by increasing their premiums. And now … go to the next slide. Just open it up for questions or pass it on to the next speaker.

Stolfi: Thanks, we'll wait till the end. Thank you, Mahir. Please stick around. We're going to do questions at the end and we're going to move now back to Dharia McGrew.

Dharia McGrew: Thank you. Again, for the record, Dharia McGrew, director of state policy on behalf of PhRMA. Next slide, please. As this is an annual hearing, annual topic showing the same slide that I have shown a few years in a row now, and this is a very, very simplified version of the supply chain, you've seen a couple different versions of this today, but it is used to illustrate that the flow of physical actual medicine and the flow of money are completely different. And then outside of that, or sort of around that, you have rebates. And what is a rebate? Well, after a patient has picked up their medicine at the pharmacy and the pharmacy seeks reimbursement for that medicine from a PBM, the PBM will go back to the manufacturer and ask for the rebate. And that is a pre-negotiated amount of money back that is paid after the drug is dispensed. And I have heard it implied or directly stated that this is somehow some sort of shady aspect of this supply chain, and so I just want to state that it is not unique to this supply chain. These types of rebates do exist in a lot of different supply chains. They are most often not seen by the consumer side. They're done on the back end. That being said, the rebate system in this industry is broken and drastically in need of reform. Next slide, please.

So, the rebates that have been paid back by manufacturers to PBMs and plans in the last decade or so have increased, and increased, and increased and are now over $300 billion per year. So, you're seeing a huge growth in the bubble. The gross price or the list price of a drug compared to the net price or what the payer is actually paying for that drug, and in this time frame that we're showing you here, the net price or actual payer price of drugs has remained flat or risen with inflation in the last five to seven years. And yet, this bubble of rebates keeps getting bigger, and bigger, and bigger. And why is that? Next slide, please.

There are several factors going into this. One is consolidation of PBMs into massive corporations and vertical integration with payers and specialty pharmacies and providers. So, if you think back to the cartoon supply chain, you now would have three to four of the different entities on that supply chain who are ultimately the same company, and you know serving the same bottom line, and that is pushing this growth in rebates. There is also massive growth increase in formulary tiers, more tiers in a design and utilization management. So, this is driving increased negotiation of rebates because manufacturers want their drug to be as accessible as possible to patients and on a better tier. And also, a little bit of success of the industry is causing this. I will say that there is a lot of competition because we've had growth and success in bringing new drugs to market in competitive therapeutic classes. In the first talk from the Drug Price Transparency program, it showed a huge number of new drugs that are in the cancer space. And so, that indicates a lot of competition in that space. With companies competing against each other, there's more incentive to negotiate higher rebates to get best formulary placement so that their drug is accessible to patients. Next slide, please.

Now as I mentioned, massive consolidation of the PBMs. While there are hundreds of manufacturers, there are three companies that have an 80 percent market share. I think if you include the fourth, the next largest company, it is about 90 percent market share of these mega corporations. So, they have increased very, very concentrated power and

say over what's happening in this, and that is driving higher and higher negotiation of rebates. Next slide, please.

Now there has been an increased scrutiny in the last several years over the opaque practices of middle men. Experts have been showing that PBMs have incentives to prefer medicines with a higher list price and large rebates. For example, you could have two versions of one drug where one is a, where they have the same net price, one has no rebate, and a low just the price is the price, and another has a high rebate, high list price and a high rebate. And ultimately, the net price is the same. And we have seen, manufacturers have seen that those low starting cost drugs are having a hard time getting traction. The formulary, they're not getting on formulary because the PBMs are choosing the drug, even if it's the same net price, they're choosing the drug with the higher rebate.

Why would they do that? One of the reasons is they provide a service to their plan, their plan clients, and they need to be able to say, look at how much money we saved you. We negotiated this much money and look at how much, how many millions of dollars we got for you, and to then be able to pass it back to the plans. Next slide, please.

Now, as I said, this system is in drastic need of reform, and unfortunately, we can't just snap our fingers and make the rebates go away. They are baked into our system in a lot of different ways. There are some rebates that are statutorily required. There are also rebates that are built into, expectations of rebates are built into your insurance premiums, and into many of our government sponsored plans are counting on getting those rebates. So, if rebates suddenly went away, that would be a massive shift, an upset into our healthcare system.

While we do support reforms of the system at the federal level, there are things that states can do. State policy makers do have some options, and appreciate that the previous speaker did mention sharing rebate savings directly with patients at the pharmacy counter. We believe that policy is much more possible than they think it is, and we believe that it directly helps patients who are suffering the most. It's a very targeted policy, or scalpel policy, that helps patients that need it the most.

We don't think that it's fair for patients to be paying massively more than their PBM paid for a negotiated savings. And then you know a bigger question is addressing these incentives to cover high cost medicines and high list prices with large rebates. As I mentioned, one incentive is the PBMs need to show their clients the work that they're doing for them. Second is how the PBMs make their money, how that company makes revenues, and that is often based on price-based compensation. So, as if they were a salesperson on commission, they are more and more and more getting, deriving revenue from fees, more fees with percentage based off the list price of a drug. So, instead of just one fee or keeping a portion of the rebate, now there are administrative fees, data fees, portal service fees, refill reminder fee, network fee.

These fees are adding up and becoming a bigger portion of the revenue for PBMs, which is part of why the trend the first year of transparency data in Oregon looks like it does. Oregon is ahead of other states in PBM transparency, and looking forward to what we see next year when there is more robust reporting on those fees. But what we

believe that state policy makers can do, as well as federal policy makers, is delink that connection where their fee is based on the list price and it should be a flat fee based on the function that is performed rather than the list price of the drug. And that would disrupt the incentive to choose a higher list price drug for the formulary. And with that, I wrap up my talk. Thank you.

Stolfi: Thank you, Dharia, and please stick around for questions at the end. And we're going to turn now to Tony Grillo.

Tony Grillo: Okay. Can you hear me okay?

Stolfi: We can. Please go ahead.

Grillo: Thank you. My name is Tony Grillo. I'm a pharmacist with Express Scripts, one of the big three PBMs that have been referenced a couple times. I lead our financial analysis and forecasting teams here at Express Scripts, but have quite a bit of experience on the clinical and formulary side. I'd like to add a few things. Rebates is a big topic. Would like to add a couple things specific to how rebates work within drug choice. So, I'll speak to Express Scripts as our standard formularies, which cover tens of millions of members. We have a very diverse set of clients, payers that include employers, health plans, health systems, labor groups, public sector including local, state, and federal governments. So first and foremost, these formularies are governed by clinical first, regardless of any cost or rebates or anything.

At Express Scripts, we have a pharmacy and therapeutics committee that is made up of independent practicing physicians that create guidelines for drugs and dosage forms that we follow. And there is a firewall between that pharmacy and therapeutics committee and the people that are making the decisions. The committee makes the decisions on formulary placement. Really three, I think the important things, are three buckets that the pharmacy and therapeutics committee put drugs into. One is they must be on the formulary; must add they're clinically differentiated, there's no competition, you have to be preferred. Another is must not be on a formulary; meaning that they have safety or efficacy issues and the opinions of those clinicians that they should not be on the formulary.

And then really this is where the rebates come into the play, and this is where they say a drug may be on the formulary, it's optional. And in that kind of bucket, you have drugs that are optional, meaning that they must be one of a certain number of products in a category or just they may or may not be on the formulary. Those guidelines are passed down to the committee that makes those formulary decisions. They are not questioned, they are followed and that committee then makes formulary determinations based on those guard rails. Now this is where pharmaceutical manufacturers can compete on formulary positioning and this is where you had three things that drive these rebates. Really it's scale, competition, and control. And these rebates are used to offset costs to the consumer, whether it be by premiums or point of sale rebates.

These rebates are in these categories with competition. It's kind of a bidding situation where manufacturers bid for formulary placement and those rebates then are provided after the drug is filled and then provided back to the payer. And we've seen on several

slides, and this is true where the overwhelming vast majority of those rebates are passed on to the payer. And the other thing I want to mention, because I heard the admin fees, that's another situation where the overwhelming vast majority, in the similar way as rebates, those admin fees are passed on to the payers. So, the delinking is a situation where it delinks the admin fees or those fees from the cost of the drug. But as it stands today, those fees are actually typically used again to decrease the cost of the drug.

What we would advocate is, allowing the health plans, the payers, to decide how they offset the cost of their benefits, whether that is point of sale rebates, which we have available to our clients, or whether that is by using those dollars to offset the overall cost and premiums associated with that. The other thing I want to reiterate, because I want to make sure that we leave time, is that again, these rebates are typically available in categories with competition. And so when you're looking at some of those high cost drugs, some of those high cost drugs, like Humira, in that category does have rebates, some of them don't. Oncology and gene therapy especially, those are the highest growing and highest cost drugs. Rebates are not really a thing in those categories because there's not real competition there. In those situations, that it's kind of a misnomer that there are rebates to be had today. It's only that competition that drives the rebates in those categories. I'll stop there.

Stolfi: All right. Well, thank you, Tony. And please do stick around for questions. And we're going to move to our final panelist, Benjamin Rome.

Benjamin Rome: Hi, everyone. Can you hear me? Okay?

Stolfi: We can. Please go right ahead.

Rome: Great. Thanks so much for the invitation and having me here today. My name is Ben Rome. I am an assistant professor of medicine at Harvard Medical School and a health policy researcher focused on prescription drugs, access, affordability at Brigham and Women's Hospital and Harvard Medical School. If you go on to the next slide, you'll just see my disclosures. That's just my research funding.

And then going to the next slide, we've now, you've seen a few versions of this sort of supply chain. So I don't want to belabor this again, but just to point out that the flow of drugs obviously requires multiple steps, right?

Manufacturers sell drugs to wholesalers, or intermediaries to pharmacies or hospitals or clinics, who then dispense the drugs to patients. And that whole flow relies on a price that's set by the manufacturer, right? The list price set by the manufacturer to the wholesaler determines the price down that supply chain. Health plans ultimately are the ones, and PBMs that they hire, are the ones paying most of the cost of the drugs. Now they can share some of the cost with the patient in the form of out-of-pocket costs, but they're the ones who really want to negotiate lower prices. Wholesalers, pharmacies don't care. They're in the middle. As long as they make a markup, as long as they make a small amount more than what they pay for the drug to the upstream part of the supply chain, they don't really care what the price is, but health plans do. And so they negotiate directly with manufacturers. And that's why rebates occur sort of after and outside of the

traditional supply chain, because if you had to pass all those rebates through, it would get complex, right? So how much pharmacies would make and wholesalers and manufacturers, etcetera. And in the meantime, manufacturers also want to lower patient out-of-pocket cost to make their drugs more available to consumers. So they offer coupons and copay assistance, which you've also heard about. When we talk about net price, we're really talking about the price of the drug, the sort of list price that's set by the manufacturer that flows through the supply chain, minus those rebates and also minus the coupons and patient assistance programs, which are a smaller share of the costs. On the next slide.

If you think about this holistically in terms of where the money goes when you spend a dollar on a prescription drug, most of that money goes to the drug manufacturer and then the rest is split between the different intermediaries in the supply chain, which includes the wholesalers, pharmacies, PBMs, and insurers. Overall, 58 percent is kept by the manufacturers. This is data from a study by folks at USC from a few years ago. It's not perfect data, but it gives, I think, a right, a good gestalt of the right ballpark of where these numbers are. But I will note that for brand name drugs, manufacturers keep a larger share of the dollar spent, 76 percent, and for generic drugs, a much smaller percent. And the reason for that is simple. Generic drugs are less expensive to manufacture and produce, and the prices are lower. So, if you have $1,000 drug, a small $20 markup on that represents a very small share. If you have a $5 drug, a $20 markup is a much larger percentage of the total cost. Next slide.

Pharmacy benefit managers sit in the middle of this sort of complex network, of complex supply chain. They really are middle men in the most direct sense of the word. And most public and private insurers contract with PBMs to manage their prescription drug benefits and negotiate with manufacturers and pharmacies. There are hundreds of health insurers in the United States. There are dozens of drug manufacturers. There are thousands of pharmacies. And so the contracting between all these entities is really streamlined by PBMs. That's the value added to the system. And that's why health insurers pay PBMs, is to manage this work of negotiating with manufacturers and setting contracts with pharmacies. So, what do PBMs do? They set formularies as you just heard about, they negotiate with manufacturers via rebates, and they set contracts with pharmacies and determine how much pharmacies will get paid for the prescription drugs when patients go and fill them.

On the next slide, you've also seen this already, that rebates have grown, which means that the list prices of drugs in the United States are rising faster than the net prices after accounting for rebates. That widening gap has raised eyebrows over the last few years. This is data from 2007 to 2018. In the last few years, as mentioned, the net prices have been a little slower, but in the last one or two years, they started to climb again. Fundamentally, I think this just gives a good flavor of where things are.

On the next slide, you'll see that, also has already been mentioned, rebates vary between different types of drugs, predominantly based on whether or not PBMs have the ability to negotiate based on alternatives available. For drugs like diabetes treatments or anticoagulants or asthma or COPD medicines, rebates can exceed 40 percent of the amount that is spent on the prescription drugs at the list price. This is data from Medicare, from MedPAC, but there are other classes of drugs like cancer drugs or

antiretrovirals where rebates make up less than 10 percent of the spending. And part of the reason in Medicare is that there are several classes, which have asterisks here, that are protected classes, meaning there's required coverage statutorily, Medicare must cover them. And you can see that many of those have very small rebates. So, this really is a negotiation game. There's evidence that when there's ability of the PBMs to negotiate and pit one manufacturer against the other, they're able to negotiate higher rebates. On the next slide.

I think the fundamental problem that, as we talk about this issue of rebates, is the effect on patients. And we've heard multiple iterations of this today. But I just want to go through an example of why rebates can lead to higher costs for patients. And the simple answer is that rebates offset health plan spending, assuming that the rebates are passed to the health plan, which usually they are. And they do translate to lower premiums, but they don't often lead to lower out-of-pocket costs. So you could imagine a patient who's enrolled in an insurance plan that charges 25 percent co-insurance. So they, the patient pays 25 percent, and the rest is paid by the payer. If you have two drugs, drug A and drug B, drug A might have a price of $100 with no rebate, and drug B has a price of $200 with $100 rebate. And in this case, the patient would pay 25 percent. That amounts to $25 in the first case, and $50 in the second case. So really, with the rebated drug, the patient is paying more than 25 percent of the cost of the drug, even though the net price overall is $100 in both cases. On the next slide.

There's been a lot of talk about how to reign in this problem, regulate PBMs, and make sure that patients are protected. I just want to pose for you all, overarching goals that you might want to think about when tackling this problem. First is improved transparency. This isn't just for me as a researcher, although I would love more data, but I really think that improved transparency could shine some more light on how money is moving in the supply chain, and give a better sense of the policy options. Now, that said, transparency may by itself not make any dramatic changes in terms of costs. The second is you do want to maintain the ability of PBMs to aggressively negotiate with drug manufacturers. You do not want a situation where regulating the PBMs kind of ties their hands behind their back and they sort of no longer have the ability to negotiate. As I showed you, the data from Medicare shows that when you require PBMs, for example, to cover a full class of drugs, they lose the ability to negotiate rebates in that class of drugs.

Third is you want to remove perverse incentives to favor high-priced, high rebate drugs over lower priced drugs. I think everyone agrees here. How you do this? There's many different policy proposals, but clearly you don't want situations where the PBMs or any other intermediary is making more money off a more expensive drug. That just leads to perverse incentives. And finally, you want to protect patients from paying out-of-pocket costs based on the artificially inflated list prices. Patients pay out-of-pocket costs in all parts of healthcare. Many of you may have received a bill, say from a hospital or an emergency room, and you'll see the charge that the hospital sent to the insurance company, and then the allowed amount by the insurance company, that's the negotiated rate.

And if you pay out-of-pocket costs based on the negotiated rate, I don't think anyone has a problem with that. But drugs is the one situation where patients are essentially paying

on a sort of pre-negotiation price. And that is a problem, particularly for these very highly rebated drugs. Now I'll just point back again, the number two here that you just want to make sure that if you're going to regulate, and push, and require, for example payers or PBMs to pass those rebates on to consumers, that might have an effect on the ability to negotiate for certain classes of drugs. You have to be very careful to think about all of these policy goals together, not just focus on one goal specifically. With that, I'll stop. Thanks so much for having me and I'm looking forward to questions and discussion.

Stolfi: Thank you, Ben. All right, let's add all of our panelists back. I know we still have the second public comment period coming up. And we started a couple minutes late, so we'll end a couple minutes past when we were scheduled. But Lorren, get ready, you're going to be after our questions. Let's open it up. See if our legislators have any questions, I just remind you to turn the mic on if you do.

Rep. Levy: Thank you, Director Stolfi. I have a really quick question for Dr. Rome. When I look at your explanation, someone who's kind of new to healthcare policy, but in my career as a financial attorney, I see a lot of things, a lot of processes that are similar to hedge funds and derivatives. And maybe that's why some of it makes sense and some of it doesn't. The thing that I keep coming back to, again as someone who's kind of a novice to PBMs, when we look at the price and who's able to negotiate a better price because plans don't want to negotiate a price, that's the part that doesn't completely click for me. What gives someone more power over the next? Are they a better attorney or they have more buying power? That part just doesn't make any sense to me and quite honestly feels a little bit superfluous and I would say like financial leakage right there.

Rome: Yeah, it's a good question. I actually agree with Dharia's point here, which is that the consolidation of PBMs, the fact that there's only three large PBMs, is part of the reason that there's been this increase in rebates. I just want to point out that increasing rebates means increasing savings on premium. So, it's like there's a double edged sword here. I think the scale of the rebates now is a little bit off the charts in terms of the ratio of price of list or net price. But in every other sector of healthcare, we wouldn't care that much about that, right?

You wouldn't care that the hospital charges three times as much as was actually paid as long as the patient is not adversely affected by that transaction. I think when all is said and done and sort of settled up at the end of the day, I think that this is why the primary focus of where there's anger about rebates is around patient costs at the pharmacy counter. Because if that one issue was not there, then it's really, fundamentally a negotiation between PBMs and drug manufacturers.

And I don't think anyone cares if they just duke it out to try to get the best prices on drugs that are available, at the best net prices, right? That's really, fundamentally, as long as the PBMs are negotiating the best net prices, I don't think people would have so much of a problem with the rebate system.

Rep. Levy: Yeah, I agree. What does the patient see at the end of the day? I would, my gentle push back is, I think that the consumer is becoming more informed and they do care that the hospital charged them more. Maybe five years ago they didn't, but people are becoming increasingly aware of their increased costs and want to know where all the

funny money system is going. And I completely appreciate the complexity. I think that the consumer is more engaged now than ever.

Rome: Yeah, I think that's totally fair. And again, I mean, the lowest net price, meaning that it's fundamentally after negotiation is what drives premiums. So I agree, patients care about their premiums and they care about their out-of-pocket cost. There's obviously some tension. If you require plans to lower out-of-pocket costs, it's the same amount and there's no way to lower the prices of the drugs, then premiums will go up. Those things are in balance.

So again, the way Medicare, the way the Congress handled this in Medicare, in Medicare Part D for next year, out-of-pocket costs are going down dramatically. There's a $2,000 per year limit on out-of-pocket costs in Medicare Part D starting in January. That's going to cost the government a lot of money. And the way that was paid for is negotiating prices with a select number of drugs. So you have to keep in balance the policy priorities.

We may want, it may be worthwhile, to impose consumer protections for payers and PBMs to basically say, look, insurance companies left to their own devices are charging patients too much, too much out-of-pocket. We should lower that.

But if you do that alone and don't address the prices of the drugs, you're sort of hanging them out to dry. They're going to lose out in the negotiation process with drug manufacturers.

Rep. Levy: Absolutely. I really appreciate the complexity. You're welcome to Oregon anytime if you'd like to help us out.

Stolfi: And time for one more question, if there is one.

Rep. Nosse: I keep going back. Never mind, end up being more of a soliloquy.

Stolfi: You'll still have time for that in a moment then. Mahir, Dharia, Tony, Ben, thank you very much for joining us. Really appreciate it. Remind everyone that the slides and presentation are available online for anyone who'd like to see those.

Rep. Nosse: I do agree with the director. It was good information. Thank you to all the panelists that have been before us.

All right, so we're going to go to Lorren Sandt, who's online and has requested to give a public comment. If you could try to keep your comment to about three minutes or less.

Lorren Sandt: Good afternoon, Director Stolfi. Thank you so much. Esteemed panel, really appreciate all the conversation today. I did try to make it down there in person, but the fog and the ice was a bit much. I thought I'd just go back home. One, I really want to remind everybody, we did pass a QALY ban in Oregon and it does discriminate and it has discriminated in Oregon and I don't need to go into that. We've had lots of hearings on it and it did pass. So, please respect that we have a QALY ban in our state.

The advertising. Very interesting, but it's a national issue. I don't know that any reform in Oregon on advertising is going to change the price of drugs in Oregon. That's a national issue as far as I'm concerned and there's so many other things that we have to talk about in Oregon, like specialty drugs. We've been told numerous times that we can't define, change the definition of what specialty drugs are, but specialty drugs cost a lot of money for patients and we should revisit what the definition of a specialty drug is. PBMs should not be able to decide what is a specialty drug. I would like to see the State of Oregon decide what's a specialty drug and then apply that to everyone.

The call, again, for need for consumer engagement from DCBS. We as advocacy organizations have offered numerous times to help with that. Please reach out to us. Let us help you. Let us get the right surveys with the right data that you need to make the right decisions. And don't depend on patients who are sick and working to be able to come to meetings in the middle of the day, in the middle of the work week, and talk to you about this. We really need a better system. Let us help you with that, so that you can get the answers you need.

We do need better consumer protection. I heard a story in a RAC meeting last week that just boiled my blood. Basically, a pharmacist was told to go back to a patient and get another $10, because the PBM changed the copay rather than honoring a contract. We need more protection and I wish that you guys would spend more time talking about PBM reform, true PBM reform and not about things that we have no control over. I appreciate the conversation about advertising. I agree with all of it. It is dangerous. I think social media is evil for everything, but I also want Oregon to focus on where we have opportunities to make real changes for Oregonians at the prescription drug counter.

Thank you for all your hard work. I know how difficult this is. I really do appreciate everything you guys are doing, but we need to make real reforms here. PBMs are making way too much money and just take a look at what the FTC has looked at on a federal level. I think we need to do that same sort of deep dive in Oregon. We're getting the transparency, but that's not enough. As you saw from your report, very few are reporting in and Representative Nosse, as you noted, many, many plans are excluded in that information. So, I think we need more information. Thank you very much. I appreciate your time.

Stolfi: Thank you very much as well. Before we close, glad to give our moderators time for short soliloquies.

Sen. Patterson: I'll be real short. I just wanted to say thank you to everyone and all of our panelists. Thank you to everyone who participated online. Thank you to those who worked so hard to put together this report and this presentation today. I took a ton of notes. I know others did too. We will be taking this seriously and working on these issues. We really appreciate the deep dive and we'll do our due diligence. I look forward to continuing the conversation.

Rep. Levy: Thank you all for being here. That's incredible amount of work. Thank you for inviting me.

Rep. Nosse: The legislative session is about to start in the middle of January. And if people that are listening have ideas about what could bring down the cost of prescription drugs or bring down the cost of insurance, given the way the American healthcare system works, please bring those ideas forward and we'll vet them and see if any of them can pass.

Stolfi: Well, thank you to our moderators. Thank you again to all of our presenters. A huge thank you to the staff, without which this would not be possible. You're all amazing. Thank you. Thank you everyone whose joined us. Please, if you have any ideas or suggestions for next year's hearing, the email is at the end of the slide. Please send us your information. With that, this 2024 annual hearing is adjourned. Thank you.