October 10, 2025

Oregon Prescription Drug Affordability Board
350 Winter Street NE
Salem, OR 97309-0405
pdab@dcbs.oregon.gov

Dear Chair Bailey, Vice Chair Burns, and PDAB Members,

Thank you to the Board for your work on behalf of Oregon patients and the health care system. I also want to welcome Michele Koder and Sarah Young to the Board.

My name is Auden Friedman, and I am a campaign associate with the Oregon State Public Interest Research Group, or OSPIRG. OSPIRG is an advocate for consumers, for their safety, health, and fair treatment. In health care, OSPIRG is an advocate for high value care. Too often consumers pay high prices but don't receive higher quality of care. OSPIRG, through grassroots campaigns and with the help of over 30,000 supporters in Oregon, seeks to cut health care costs which do not pay dividends in quality. OSPIRG is also a member of the Oregon Coalition for Affordable Prescriptions or OCAP, and we share their sentiments today. We support the PDABs continued efforts to fulfill its mission: ***to protect Oregonians and our state's health care system from the high costs of prescription drugs.***[1]

We need the PDAB now more than ever. As the Oregon health care budget shrinks due to federal policy changes and large premium increases are predicted, we must face the problem of cost.[2] [3] The health care that we all need to live happy and fulfilling lives is increasingly being priced out of our reach. Prescriptions are a glaring example of this. According to the RAND corporation, we pay 2-3 times as much as other OECD countries for the exact same drugs.[4] This affects everyone: individuals who pay out-of-pocket for high priced drugs, patients who see their insurance premiums rise, and all taxpayers.

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[1] Deb Patterson et al., "Relating to the Price of Prescription Drugs," Pub. L. No. 844 (2022), https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/SB844/Enrolled.
[2] https://www.oregon.gov/das/Financial/Documents/Federal-Impact-HR1-Initial-Analysis.pdf
[3] https://www.kff.org/affordable-care-act/aca-marketplace-premium-payments-would-more-than-double-on-average-next-year-if-enhanced-premium-tax-credits-expire/
[4] https://aspe.hhs.gov/sites/default/files/documents/bc582e25376d714694524a492fb15f36/international-prescription-drug-price-comparisons.pdf
p.vii. "In brief, when analyzing data for all prescription drugs available in the United States and comparison countries, we found that U.S. prices for drugs in 2018 were 256 percent of those in the 32 OECD comparison countries combined. U.S. prices were even higher than those in comparison countries for brand-name originator drugs (with U.S. prices at 344 percent of those in comparison countries) but were lower, on average, than those in comparison countries for unbranded generic drugs (with U.S. prices at 84 percent of those in comparison countries).

That is why the work of the PDAB is so important. The affordability reviews that the PDAB conducts are important first steps in understanding where there are harmful excess costs in the market. That is valuable information. But even better than information is informed action, like Colorado's PDAB took in setting the first-in-the-nation upper payment limit on Enbrel. The Colorado Consumer Health Initiative estimates that this UPL will save Coloradans $32 million a year. In Maryland, the PDAB approaches a UPL decision on diabetes drugs Jardiance and Farxiga.[5] To echo county officials who urged the Maryland board to move forward with UPLs, "Drugs don't work if people can't afford them."[6]

Today, the board will make legislative recommendations. We strongly encourage PDAB to empower itself with a tool to fulfill its founding charter: UPL authority. Oregonians are still burdened by the cost of prescription drugs. The PDAB, and particularly its potential UPL authority, is still one of our best hopes for cutting into the glut of unnecessary cost in health care. We ask the board to follow the example set by Colorado in making bold and necessary strides to lower the cost of unjustifiably priced prescriptions.

Thank you for the opportunity to comment on this important issue.

Auden Friedman - OSPIRG

[5]https://marylandmatters.org/2025/09/30/county-leaders-urge-prescription-drug-board-to-set-upper-payment-limits/

[6]https://marylandmatters.org/2025/09/30/county-leaders-urge-prescription-drug-board-to-set-upper-payment-limits/

To: Oregon Prescription Drug Affordability Board

From: Warren Westmoreland

Date: 10/29/2025

Topic: I need a list

I am 73 years old.

I just received notification that my insulin, Basaglar, will increase from $420 per year to $9399.16 per year. My Medicare Advantage Plan carrier is Pacific Source.

Are all insulins in Oregon still price-regulated?

If not, please send me a list of those insulins that are still price-regulated? I will be trying to find a substitute for Basaglar, though my doctor is not happy about this situation.

Please let me know as soon as possible.

Thank you

Warren Westmoreland

Bend, OR

October 30, 2025

Oregon Prescription Drug Affordability Board
C/O Division of Financial Regulation
350 Winder St. NE, Room 410
Salem, OR 97301

Re: Letter of Concern – PDAB Affordability Review Process and Board Operations

Dear Chair Bailey and Members of the Board:

The Caring Ambassadors Program is a national, nonprofit advocacy organization based in Oregon City, Oregon. Caring Ambassadors has been empowering patients to be advocates for their health since 1997. Following discussions during last month's PDAB meeting, we are writing as stakeholders who are concerned that, as currently constituted, the Board's review process is at risk of producing recommendations that are incomplete, inconsistent, and potentially harmful to patient access. Given the genuine divergence among Board members on the affordability review process, the alignment of Upper Payment Limit (UPL) recommendations, and the lack of consideration for the complex system drivers associated with the healthcare system, we respectfully request that the Board reconsider its approach to making healthcare more affordable for Oregonians.

The Board continues to rely on flawed and outdated data:

Johnson & Johnson's public comment letter, dated April 14, 2025, raised that the Board "created [the subset list] using flawed, outdated data and inconsistently applied eligibility criteria," and urged the Board to pause and fix data errors before proceeding. The letter notes explicitly incorrect WAC calculations and the use of 2023 data that omits important market changes, such as therapeutic equivalents and newly available biosimilars.

At the July 16th meeting, Board members echoed concerns about the data, noting specific calculation errors and citing, "In some places in the report, net cost was higher than the gross cost." Reviewers described specific tables as "overwhelming" and recommended front-loading "critical information," with other details moved to appendices. Board members again pointed out errors in the insulin data at the October 15th meeting.

Instead of delaying, the Board has chosen to continue its drug review process and developed a scoring rubric, which may or may not be used by Board members. However, it's crucial to understand that this data is pivotal in creating a more accurate and fair process. We strongly urge the Board to reassess its approach before moving forward. These are not minor editorial issues — they directly impact on the Board's ability to reach sound, evidence-based findings.

The review scope neglects important system drivers (PBMs, insurance design, 340B), thus risking misattribution of responsibility:

As highlighted during the most recent Board Meeting and throughout the years, several cost drivers are significant factors in the health care system and the cost of a drug for a patient. A patient's affordability challenges often stem from high out-of-pocket expenses determined not only by drug manufacturers but also by health plans, PBMs, and even the 340B federal drug discount program. The EACH/PIC Survey revealed that the type of benefit plan was the primary determinant of affordability.[1] As suggested by some Board members, understanding, clarifying, and exposing how each of these cost drivers interacts within the system can yield significant benefits in reducing patients' drug costs. This understanding can pave the way for substantial positive changes in the healthcare system.

PBMs manage prescription drug benefits on behalf of insurers, employers, and government programs. They negotiate prices and rebates with manufacturers, determine formulary placement, and set pharmacy reimbursement rates. They operate on rebate-driven formularies, spread pricing, non-transparent rebate retention, formulary steering, and preferred networks, among other practices.

Health plans and insurance design pool risk and negotiate with PBMs and providers to manage total healthcare costs, aiming to protect patients from catastrophic spending while still affecting patient costs. High-deductible plans still leave patients paying inflated upfront costs, even if the insurer or PBM receives rebates later. Coinsurance based on list price can still result in a patient paying the full list price rather than the net price. Additionally, accumulators and maximizers block copay assistance from counting towards a patient's deductible.

Finally, the 340B federal drug pricing program enables certain hospitals and clinics to purchase outpatient drugs at steep discounts — up to 90% below the list price — with no obligation to pass those discounts on to patients. Give more attention to profit retention rather than patient savings, to the incentives to use high-priced drugs, to the proliferation of contract pharmacies and duplicate discounts, and to the opaque impact on payer mix, which leads to hospital consolidation and higher overall system costs.

Governance, consensus building, and clarity of mission:

Records show, particularly from the last Board meeting, genuine disagreement among Board members on key priority issues such as upper payment limit setting, systems costs versus patient out-of-pocket expenses, the scope of comparisons, data sources, and the general effectiveness of the Prescription Drug Affordability Board. Members recommend both that the Board's focus be on cost to the healthcare system rather than cost to patients, and that it 'remember, payer expenses also impact patient costs,' which demonstrates a lack of a unified operational framework for review. A standard decision framework is crucial for avoiding contradictory or non-actionable Board output and ensuring alignment and consensus among Board members.

Before advancing the process, the Board should publish a binding decision framework that defines primary and secondary outcomes, establishes standard comparators, and sets rules for balancing confidential versus public data. This framework will provide the Board with the necessary guidance for its future actions.

Patient and Provider engagement:

No conversation about the value of a treatment can be complete without robust input from patients and providers. Asking patients and providers to put something in writing on a public website or attend a 4-hour meeting in the middle of the week to testify for 3 minutes, where the Board cannot ask questions or respond, is not patient engagement. The survey responses we have seen to date in the packets have not been 'robust' as described by staff. Numerous groups have called for the establishment of a stakeholder advisory council, but this has been disregarded. You will only have the public's trust in your work through transparency and engagement.

Consider the current environment and threats to our healthcare system:

The PDAB began with great intentions; however, time has shown that it cannot be effective in making prescriptions more affordable with its current focus on only a single part of the supply chain. New Hampshire has dissolved their efforts, and we encourage the Board to recommend the same. Suppose you move forward and request UPL authority amid the crisis our state budget is facing in the next few years due to the loss of federal support. Will the State have funding to implement a new cost structure for a select few drugs throughout the healthcare system? We will be making severe cuts, not adding programs.

Additionally, the State has already invested in ArrayRX, where patients save up to 80% on FDA-approved medications. Will setting a UPL on a few drugs really help patients afford their medications more than the program already established? Since the PDAB formed, numerous studies have cited that a UPL will not result in a decrease in patient costs and may potentially harm access to care.[2-4] In the next few months, as you contemplate your recommendations to the legislature, please consider whether your time and expertise could be used elsewhere in our State to help save Oregonians from the draconian policies and budget cuts pushed upon the State from the Federal government.

Caring Ambassadors respectfully requests that the Board respond publicly with an action plan that addresses the recommendations above, including a timeline for fixing the identified errors. We appreciate the Board's efforts and the complexity of the task before you. We hope that you find these comments constructive in ensuring the PDAB's work products are accurate, transparent, and targeted at the actual drivers of affordability challenges for Oregonians.

Sincerely,

Lorren Sandt, Executive Director

1. Patient Experience Survey: Prescription Drug Affordability and Unaffordability
2. Specialist Physicians' Perspectives on State PDABs: Access, Affordability, and Administrative Burden
3. Research Explores Health Plan Perceptions of PDABs and UPLs
4. Update: Health Plans' Perceptions of PDABs and UPLs

724 Columbia St. NW, Ste. 310 • Olympia, WA 98501 • PHRMA.ORG

November 5, 2025

Oregon Prescription Drug Affordability Board
350 Winter Street NE
Salem, OR 97309-0405
pdab@dcbs.oregon.gov

Re: Oregon Prescription Drug Affordability Board: October 15, 2025 Meeting Materials

Dear Members of the Oregon Prescription Drug Affordability Board:

The Pharmaceutical Research and Manufacturers of America ("PhRMA") is writing in response to the Oregon Prescription Drug Affordability Board's (the "PDAB's" or "Board's") meeting materials for its October 15, 2025, meeting, including the draft "2025 policy recommendations," scoring framework, and affordability review reports (collectively, the "Meeting Materials").[1] PhRMA represents the country's leading innovative biopharmaceutical research companies, which are focused on developing innovative medicines that transform lives and create a healthier world. Together, we are fighting for solutions to ensure patients can access and afford medicines that prevent, treat, and cure disease. PhRMA member companies have invested more than $850 billion in the search for new treatments and cures over the last decade, supporting nearly five million jobs in the United States.

We provide below select comments and concerns with respect to the Meeting Materials.

I. Confidentiality Concerns

In its draft "2025 policy recommendations," the Board suggests providing an "[e]xemption under the Public Meetings Law (ORS 192.660(4)) from having media present at executive sessions so the board can review trade secret information in private."[2] PhRMA supports this recommendation, which would be an important step toward safeguarding trade secret information. Additional measures are needed, however, to protect against unlawful and unconstitutional disclosures of trade secrets and other forms of confidential and proprietary information.[3]

As PhRMA has explained previously, state and federal law protect trade secret information from disclosure; it cannot be disclosed publicly without violating state and federal prohibitions against the misappropriation of trade secrets.[4] The PDAB Statute independently requires the Board to safeguard from public disclosure confidential information it receives—including not just trade secrets but other "[c]onfidential [or]

[1] October Meeting Materials (Oct. 15, 2025), *available at* https://dfr.oregon.gov/pdab/Documents/20251015-PDAB-document-package.pdf. In filing this comment letter, PhRMA reserves all rights to legal arguments with respect to Oregon Senate Bill 844 (2021), as amended by Oregon Senate Bill 192 (2023) and Oregon Senate Bill 289 (2025) (codified at Or. Rev. Stat. § 646A.693 *et seq*.) (collectively, the "PDAB Statute"), and the Board's implementation of the PDAB Statute. PhRMA also incorporates by reference all prior comment letters to the extent applicable.

[2] Meeting Materials at 18.

[3] *See, e.g.*, Letter from PhRMA to Board (Oct. 3, 2025) at 1-2; Letter from PhRMA to Board (Mar. 6, 2025) at 1-2; Letter from PhRMA to Board (June 28, 2024) at 4; Letter from PhRMA to Board (Feb. 11, 2023) at 7-8.

[4] *See* 18 U.S.C. § 1839(5)(B)(ii)(II) (defining "misappropriation" under the federal Defend Trade Secrets Act); Oregon Uniform Trade Secrets Act, Or. Rev. Stat. § 646.461-.475.

proprietary" information as well.[5] The PDAB Statute's prohibition on the disclosure of confidential, proprietary, and trade secret information would be illusory—and would raise serious due process, takings, and other constitutional concerns—if the Board unilaterally disclosed the information without a pre-release opportunity for administrative and judicial review.[6]

For these reasons, any exemption to the Public Meetings Law should make clear that it applies to the review not just of trade secret information, but also other confidential and proprietary information covered by the PDAB Statute. In addition, PhRMA continues to urge the Board to establish a clear process for the receipt, handling, and processing of manufacturers' confidential, proprietary, and trade secret information that is consistent with state and federal law.[7] Finally, in circumstances where the Board thinks that particular information *might be* confidential, proprietary, or trade secret information—but the Board ultimately concludes that it is not—the Board should alert the entity that generated the information and give that entity an advance opportunity to challenge the Board's decision before the information is publicly disclosed.

II. Concerns with Affordability Review Process

a. Lack of Clear, Consistent, and Meaningful Standards in the Draft Scoring Framework

PhRMA reaffirms its unaddressed concerns regarding the lack of clear, consistent, and meaningful standards in the "Methodology for Drug Reviews and Scoring Rubric and Worksheet" (the "Draft Scoring Framework").[8] PhRMA continues to believe that additional work is needed to provide consistent and transparent assessment in the Board's affordability review process.[9] For example, the Draft Scoring Framework relies on vague and arbitrary cutoffs, and the Board has not explained how it determined the scoring metrics used in each domain.[10] The Draft Scoring Framework also includes consideration of metrics and questions for which the Board does not appear to have sufficient information to provide a meaningful answer.[11] Additionally, PhRMA remains concerned that the Draft Scoring Framework does not clearly articulate how each metric in the framework relates to patient affordability and will be used in the affordability review process.[12]

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[5] PDAB Statute § 646A.694(7)(b) (The Board "*shall* keep strictly confidential any information collected, used or relied upon for the review ... if the information is: ... (b) [c]onfidential, proprietary or a trade secret []."(emphasis added)). In addition, the Fifth Amendment's prohibition against taking private property without just compensation similarly prohibits the uncompensated disclosure of trade secrets. Courts have made clear that "when disclosure [of pricing information] is compelled by the government," even the "failure to provide adequate protection to assure its confidentiality ... can amount to an unconstitutional 'taking' of property." *St. Michael's Convalescent Hosp. v. California*, 643 F.3d 1369, 1374 (9th Cir. 1981) (brackets and quotation marks omitted). For further discussion, see Letter from PhRMA to Board (June 28, 2024) at 4 and Letter from PhRMA to Board (Aug. 1, 2023) at 1-2.

[6] *See* Letter from PhRMA to Board (Oct. 3, 2025) at 2; Letter from PhRMA to Board (Feb. 11, 2023) at 8.

[7] *See, e.g.*, Letter from PhRMA to Board (Oct. 3, 2025) at 1-2.

[8] Meeting Materials at 21-27; Letter from PhRMA to Board (Oct. 3, 2025) at 2-4; Letter from PhRMA to Board (Aug. 18, 2025) at 1-4.

[9] *See* Letter from PhRMA to Board (Oct. 3, 2025) at 2-4; Letter from PhRMA to Board (Aug. 18, 2025) at 1-4.

[10] *See* Letter from PhRMA to Board (Aug. 18, 2025) at 3. For example, in the "Price concessions" domain, the Board provided no rationale for why "50-75% of [claims] discounted" is categorized as "moderate impact" and was assigned a score of 1, while "25-50% claims discounted" is categorized as "high impact" and assigned a score of 2. *Id.*; Meeting Materials at 21.

[11] *See* Letter from PhRMA to Board (Oct. 3, 2025) at 3. For example, one of the "Key questions" for the "Therapeutic alternatives" domain asks, "[d]o those alternatives have fewer access restrictions?" Since the carrier data call does not request plan-reported information regarding therapeutic alternatives, it is unclear how the Board could answer this question. *See* Meeting Materials 25. Similarly, a "Key question" for the "System & payer costs" domain asks, "[w]hat is the annual cost burden on Medicaid, Medicare, and commercial insurers?" *Id.*

[12] *See* Letter from PhRMA to Board (Aug. 18, 2025) at 3-4; Or. Rev. Stat. § 646A.694(1); *see also, e.g.*, *Lane Cnty. v. Land Conservation & Dev. Comm'n*, 138 Or. App. 635, 641 (1996) (explaining the "fundamental principle of administrative law" that agencies may not

PhRMA reiterates its request that the Board revise the Draft Scoring Framework to address vague and inconsistent terminology, explain the differences between the scores in each domain, clarify how each metric is connected to patient affordability, and address other issues identified in our prior comments.[13]

b. Inconsistency of Information Considered by the Board in Affordability Reviews

As PhRMA has noted in previous letters, inconsistencies, errors, and the lack of clarity surrounding the data in the affordability review reports raise serious questions about the reports' reliability—and ultimately whether the Board can satisfy its obligation to conduct affordability reviews in a manner required by the PDAB Statute.[14] The Board should address these discrepancies and verify that each report contains consistent information to guard against inconsistent and arbitrary decision-making. The Board should also adopt procedures for reviewing and evaluating the accuracy and completeness of the information it will consider, and for permitting manufacturers and other stakeholders to provide input where information may be inaccurate or incomplete.

* * *

On behalf of PhRMA and our member companies, thank you for consideration of our comments. Although PhRMA has concerns about the Meeting Materials, we stand ready to be a constructive partner in this dialogue. Please contact dmcgrew@phrma.org with any questions.

Sincerely,

Dharia McGrew, PhD
Senior Director, State Policy
Sacramento, CA

Alexandra Hussey
Senior Director, Law
Washington, DC

act in a manner contrary to their statutory authority); *Humane Soc. of U.S. v. Bryson*, 924 F. Supp. 2d 1228, 1236 (D. Or. 2013) (noting that an "agency's decision would be arbitrary or capricious, for example, if the agency 'relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, [or] offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise'") (quoting *Motor Vehicle Mfrs. Ass'n of the U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983)).

[13] Letter from PhRMA to Board (Aug. 18, 2025) at 1-4; Letter from PhRMA to Board (Oct. 3, 2025) at 2-4.

[14] *See* Or. Rev. Stat. § 646A.694(1) (listing affordability review factors); *see also, e.g.*, Letter from PhRMA to Board (Oct. 3, 2025) at 2-5; Letter from PhRMA to Board (Aug. 18, 2025) at 1-4; Letter from PhRMA to Board (Jan. 11, 2025) at 3-5. *See generally, e.g.*, *Lane Cnty.*, 138 Or. App. at 641. PhRMA specifically reiterates its prior comments that the Board is required under the PDAB Statute to consider all information outlined in the PDAB Statute. *See* Or. Rev. Stat. § 646A.694(1).

November 6th, 2025

Dear Members of the Oregon Prescription Drug Affordability Board,

My name is Anika Miller, and I am a second year pharmacy student at Oregon State University/Oregon Health & Science University. Prior to entering pharmacy, I worked as a Career and Technical Education (CTE) Health Science educator. My passions are community, health, and education - values that guide my commitment to improving access to essential medications for all Oregonians.

I want to express my deep gratitude for the Board's ongoing work to evaluate the affordability of high-impact prescription drugs. Your deliberations are critical to ensuring that life-saving therapies are not out of reach for the people who need them most. As an intern at a local community health clinic, I witness firsthand the devastating consequences of medication inaccessibility - patients rationing insulin, skipping doses of anticoagulants, or being unable to start GLP-1 therapy due to cost. These are not isolated cases; they reflect systemic barriers that disproportionately affect vulnerable populations.

I've reviewed the public comments submitted so far and am concerned by the volume of letters from pharmaceutical manufacturers requesting removal of their drugs from consideration. While industry perspectives are part of the process, I urge the Board to prioritize the voices of everyday Oregonians whose health and lives are directly impacted by unaffordable medications. Your commitment to transparency and public engagement is commendable, and I thank you for valuing these voices.

I strongly support the inclusion of the following three drug categories in the final list for the 2025 legislative report:

1. Direct Oral Anticoagulants (Eliquis, Xarelto)
These drugs are guideline-recommended for stroke prevention in atrial fibrillation and treatment of venous thromboembolism. They are among the most prescribed and highest-spend medications in Medicare. Reducing their cost would prevent hospitalizations and save lives.

2. Insulins (e.g., Basaglar, Lantus, Glargine, Semglee, Toujeo)
Insulin is a life-sustaining medication for individuals with type 1 and advanced type 2 diabetes. Cost barriers have led to rationing and preventable complications. Federal efforts to cap insulin costs at $35/month have demonstrated the public health benefits of affordability. Oregon should continue to lead by ensuring access to both brand-name and biosimilar insulins.

3. GLP-1 Agonists (Ozempic, Mounjaro, Trulicity, Rybelsus)
These medications are transforming diabetes care and showing promise in obesity and cardiovascular disease management. Their high cost has placed them out of reach for many, despite their potential to reduce long-term healthcare expenditures and improve quality of life. Making these therapies affordable is a public health imperative.
These three categories represent the greatest opportunity for population-level health improvement through affordability reform. They are widely used, clinically essential, and associated with high morbidity and mortality when access is limited.

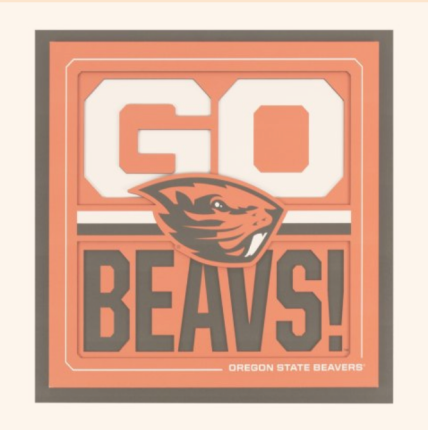
While other drugs under review - such as migraine therapies, COPD treatments, and specialty medications - are valuable, they do not carry the same urgency in terms of public health impact, prevalence, or lack of alternatives. Many have generics, biosimilars, or insurance prioritization that mitigate access barriers for most patients.

In summary, I urge the Board to prioritize affordability reviews for insulin products, GLP-1 agonists, and direct oral anticoagulants in your final recommendations. These drugs are essential, widely used, and represent the greatest opportunity to reduce preventable harm and improve health equity across Oregon.

Thank you for your dedication to this important work and for considering the voices of students, clinicians, and community members who see the real-world impact of drug pricing every day.

Sincerely,

Anika R. Miller
PharmD Candidate, OSU/OHSU
Former CTE Health Science Educator
Corvallis, Oregon



National
Multiple Sclerosis
Society

Oregon Division of Financial Regulation
Oregon Prescription Drug Affordability Board
350 Winter St. SE
Salem, OR 97309

November 11, 2025

RE: National Multiple Sclerosis Society, 2025 policy recommendation comments

Members of the Oregon Prescription Drug Affordability Board:

Thank you for your continued engagement with all stakeholders and for focusing on the patient's perspective. The National Multiple Sclerosis Society (Society) appreciates the Prescription Drug Affordability Board's (Board) leadership and investigation into the high cost of prescription medications. We encourage the Board to continue its review of all practices that limit access to needed life-changing therapies and increase the price that patients pay for those therapies.

Multiple sclerosis (MS) is an unpredictable, often disabling, disease of the central nervous system, which interrupts the flow of information within the brain and between the brain and the body. Symptoms range from numbness and tingling to blindness and paralysis. The progression, severity, and specific symptoms of MS in any one person cannot yet be predicted, but advances in research and treatment are moving us closer to a world free of MS. The Society works to cure MS while empowering people affected by MS to live their best lives. To fulfill this mission, we fund cutting-edge research, drive change through advocacy, facilitate professional education, collaborate with MS organizations around the world, and provide services designed to help people affected by MS move their lives forward.

Costs of living with MS

People with MS have a variety of healthcare needs including, but not limited to, addressing neurological symptoms, emotional and psychological issues, rehabilitation therapies to improve and maintain function and independence, and long-term care. These needs vary dramatically from person to person and can change year-to-year as the disease progresses.

MS is a highly expensive disease, with the average total cost of living with MS calculated at $88,487 per year[1]. MS may impact one's ability to work and can generate steep out-of-pocket costs related to medical care, rehabilitation, home & auto modifications, and more. For individuals with MS, medical costs are an average of $65,612 more than for individuals who do not live with this disease. Disease-modifying treatments (DMTs) are the single largest component of these medical costs. As of February 2024, the median annual brand price of MS DMTs was more than $107,000. Five out of seven of the DMTs that have been on the market for at least 13 years are priced at over $100,000 annually and continue to see regular price increases.

Upper Payment Limits authority

The Society views upper payment limit (UPL) authority as having the potential to lower out-of-pocket costs for patients by directly addressing the dollar cost of prescription medications. High out-of-pocket costs are typically due to co-insurance, which is when the patient must pay a

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9109149/

National
Multiple Sclerosis
Society

percentage of the wholesale acquisition cost (WAC), or list price, as opposed to a flat copay amount. This is especially true for MS DMTs. A lower UPL would in turn create lower out-of-pocket costs for those who must pay co-insurance.

The Society continues to support the establishment of UPLs and recommends the Board put such authority forward in your legislative recommendations. We look forward to commenting on the Board recommendations for any MS-related medications identified as cost burdensome. We applaud the multiprong approach in identifying these medications by referencing data as well as continuing to engage with stakeholders who are impacted by these costs

Pharmacy Benefit Managers 'spread pricing'
When a Pharmacy Benefit Manager (PBM) charges a health plan more for a medication that what the PBM reimburses the issuing pharmacy, keeping this difference as PBM revenue, this is called 'spread pricing'. The Society advocates prohibiting unfair and deceptive pricing models including spread pricing and would recommend any financing use 'pass through' pricing models.

Expanded PDAB scope
The Society understands the price of the medication is but one aspect of what makes access to these high-cost prescriptions out of reach for many people with MS and other conditions. The Society will continue to look at the entire healthcare system and encourages legislatures and boards like this to continue their work in addressing all aspects of the prescription drug supply chain that get between patients and their medications. The Society would support efforts to increase the scope and authority of the current PDAB to encompass more of the prescription drug system and its actors.

Medicaid prescription drug 'carve outs'
Most states, including Oregon, which contract with Medicaid managed care organizations (MCOs) for their state Medicaid services include their Medicaid pharmacy benefits and health benefits into a single contract. However, some states "carve out" or de-link their prescription drug coverage from healthcare managed care, meaning the health benefit and drug benefit are separate contracts with the state. The Society encourages the state to explore all options which could lower the cost of prescription drugs but cautions that any system should be analyzed and monitored for instances of excessive utilization management and/or limited formularies to ensure such reforms do not create new barriers to accessing needed medications.

The Society thanks the Board for its ongoing focus and engagement on this key issue for all Oregonians. Please continue to consider the Society and myself as references as the board continues its work.

Respectfully,

Seth M. Greiner
Assistant Director, Government Affairs
Seth.Greiner@NMSS.org

HIV+HEP
POLICY INSTITUTE

November 14, 2025

Oregon Prescription Drug Affordability Board
350 Winter Street NE
Salem, OR 97309-0405
pdab@dcbs.oregon.gov

Re: Public Comment for November 19, 2025 Board Meeting

Dear Members of the Oregon Prescription Drug Affordability Board:

The **HIV+Hepatitis Policy Institute** appreciates the opportunity to comment on the Board's updated legislative recommendations. As a national patient advocacy organization that works to promote quality and affordable healthcare for individuals living with or at risk of HIV, hepatitis, and other chronic conditions, we see firsthand how PBM practices, pharmacy access, and insurance design determine whether patients can remain on lifesaving treatment. We appreciate the Board's continued focus on practical, patient-centered reforms that Oregon can move forward with.

We submitted comments on October 9th on the proposed recommendations however, below, we now offer comments aligned to the numbering of the final recommendation options, along with some additional thoughts.

Recommendation 1: PBM Reform and Pricing Transparency
We strongly support Recommendation 1, which provides Oregon with a clear and practical path to improving transparency and accountability within the pharmacy benefit system. PBMs play a major role in determining what patients pay for their medications, yet their pricing, rebate, and contracting practices often remain hidden from policymakers and consumers. Requiring full transparency across commercial plans, including disclosure of spread pricing, rebate retention, and administrative fees, will help the state understand how dollars move through the system and where inefficiencies may be driving higher costs.

We also support efforts to delink PBM compensation from drug prices. Replacing percentage-based or rebate-driven payment models with transparent service fees will realign incentives and reduce the preference for higher-cost drugs. This change would help ensure that clinical value, rather than profit potential, shapes coverage and formulary decisions.

Finally, eliminating spread pricing in Medicaid and managed care is an essential step toward protecting both patients and taxpayers. Spread pricing allows PBMs to keep the difference

between what they charge the state and what they reimburse pharmacies. Removing this practice will reduce waste and ensure that public funds are used for patient care rather than middleman markups. Sixteen states have already enacted laws banning or restricting PBM spread pricing, demonstrating bipartisan recognition that this practice drives unnecessary costs.[i]

Recommendation 2: Pharmacy Network Access (Any-Willing-Provider)
Allowing any qualified pharmacy to participate in plan networks is a straightforward and highly impactful tool for improving patient choice and continuity of care. For people living with and at risk of HIV, relationships with trusted pharmacies are essential to maintaining adherence and avoiding treatment interruptions that can lead to resistance, poorer outcomes and in the case of prevention, HIV aquisition. This reform will improve geographic access, prevent pharmacy deserts, and reduce plan-driven disruptions that harm patients.

Recommendation 4(b): Point-of-Sale Rebate Models
Requiring that negotiated manufacturer rebates be passed directly to patients at the pharmacy counter would immediately reduce out-of-pocket costs for Oregonians. Today, most rebates are retained by PBMs and insurers rather than lowering what patients pay at the pharmacy, meaning those with high deductibles or coinsurance rarely see the benefit of these negotiated discounts. Ensuring rebates are applied at the point of sale would deliver real savings to patients, improve medication adherence, and reduce long-term healthcare costs by preventing lapses in treatment. This reform ensures that negotiated savings flow to the people who need them most rather than remaining within the system.

Recommendation 6: 340B Program Transparency
We support the recommendation for a transparent review of how the federal 340B Drug Pricing Program operates within the state, including how program savings are used to support patient care and safety-net providers. The 340B program was created to help low-income and uninsured patients access affordable medications and to enable safety-net providers to expand services that support them. It plays a vital role in sustaining care for patients living with HIV through Ryan White clinics and community health centers, and in HIV prevention. A clearer understanding of how program savings are generated and reinvested would help policymakers assess the program's economic and public health impact and ensure that benefits reach the intended populations.

Recommendation 8: Future of Oregon's PDAB
The Board's openness to reconsidering its structure, whether by dissolving the PDAB or redefining its purpose, reflects a thoughtful and responsible assessment of what will best serve Oregonians. We also want to acknowledge the time and care the Board has put into this work. It was encouraging to hear members at the last meeting speak honestly about the limits of the current list price review approach and the need to think differently about what will truly help patients.

We agree that Oregon may be able to make faster and more meaningful progress through direct legislative action. Many of the most impactful ideas the Board has identified, such as PBM reforms, stronger pharmacy access protections, and efforts that lower patient out-of-pocket costs, can move forward without PDAB price review authority. If the Legislature decides to dissolve the PDAB, Oregon could redirect its energy and resources toward reforms that deliver clearer and more immediate benefits to patients.

If the Board continues in some form, we encourage a more focused mission that zeroes in on the areas where the PDAB can add the most value. A reimagined Board could help improve transparency across the system, support the stability of Oregon's pharmacy network, and highlight practical strategies that make medications more affordable for patients. This direction would allow the PDAB to contribute meaningfully without taking on a model that has been difficult for other states to implement.

Thank you for the opportunity to comment. If you have any questions or need additional information, please feel free to contact our Government Affairs Manager, Zach Lynkiewicz, at zlynkiewicz@hivhep.org.

Sincerely,

Carl E. Schmid II
Executive Director

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[i] MultiState, *State PBM Reform: How States Are Trying to Control Pharmaceutical Spending* (Jan. 6, 2025)

Regence | 200 SW Market Street, 11th Floor
Portland, OR 97201

November 14, 2025

Prescription Drug Affordability Board
350 Winter St. NE
Room 410
Salem, OR

SUBMITTED VIA EMAIL

RE: Policy Proposals and Board Composition

Dear Members of the Oregon Prescription Drug Affordability Board,

We thank the Prescription Drug Affordability Board (PDAB) for the opportunity to comment on both the board's composition and its proposed policy recommendations. As one of Oregon's largest health insurers serving nearly 1 million Oregonians, we write to express serious concerns about two interconnected issues that threaten the board's effectiveness and credibility.

Board Composition: The Critical Gap in Health Plan Expertise
The departure of Robert Judge represents the loss of the Board's only insurer representative with experience in the complexities of financing prescription drugs. The Board has made the decision to replace this vacancy with another clinical perspective. For a Board specifically chartered with prescription drug affordability, proceeding without health plan expertise creates an unnecessary blind spot that fundamentally undermines the board's core mission.

At the October 15 meeting, Board member John Murray stated that anyone can apply to be on this Board but are choosing not to and went on to say that the Board has the right people who want to be here. This perspective fails to acknowledge that the board is not open to all who apply, rather candidates must be selected to apply. Highly qualified candidates representing critical parts of the supply chain, including payers, were not selected, leaving the board with an abundance of clinical and retail pharmacy perspectives and lacking expertise in alternate aspects of the supply chain that greatly impacts affordability.

The PDAB's effectiveness does not depend on the enthusiasm of its members, rather on whether the Board possesses the diverse and required expertise necessary to make informed decisions about prescription drug affordability. A Board can be composed entirely of dedicated, well-intentioned individuals and still lack the critical

perspectives needed to develop sound policy. The question isn't whether current members want to be here—it's whether the Board has the right mix of expertise to understand the full complexity of prescription drug financing and its impact on Oregon consumers.

Health plans occupy a unique position in the prescription drug ecosystem with comprehensive visibility into both medication utilization and overall health care patterns across entire member populations. With prescription drugs now consuming approximately 30% of health care spending, payers' data-driven insights are irreplaceable, revealing which high-cost medications truly reduce total expenses and which simply increase premiums without offsetting benefits. Without payer representation, the board loses access to critical real-world evidence that connects drug-pricing decisions to their actual impact on health care costs and consumers.

Additionally, health plans provide practical insight, identifying potential administrative barriers or misaligned incentives before policies are finalized. This forward-looking ability ensures that well-intentioned affordability measures don't inadvertently create new access barriers for vulnerable patients or introduce new loopholes that other stakeholders might exploit to increase prices. The position health plans have in the market requires them to be pragmatic due to their direct responsibility for health care access and affordability. Insurers navigate the complex intersection of regulatory requirements, market dynamics, and economic realities that are paramount when crafting viable solutions.

True progress in prescription drug affordability requires insights from those who must ultimately translate policy concepts into coverage decisions directly affecting patient lives and health care costs. Insurer expertise on the PDAB isn't just beneficial, it's fundamental to developing prescription drug policies that deliver meaningful affordability improvements for Oregonians.

Policy Recommendations: A Concerning Departure from Statutory Authority
Beyond the Board’s composition, we are troubled by the board's proposed policy recommendations that exceed its statutory mandate. The PDAB was created with a clear and specific purpose to protect Oregonians, and health care stakeholders from the high costs of prescription drugs.

The board's statutory responsibilities are well-defined and include:

- Collecting and evaluating information concerning prescription drug costs in Oregon
- Performing affordability reviews of prescription drugs

- Studying the prescription drug distribution and payment system
- Making recommendations to the Legislature to make prescription drugs more affordable

Of all the policy proposals put forward this year, 85% fall outside the board's statutory authority**.** Many of these proposals impact provider reimbursement rather than consumer affordability, which represents a significant departure from the board's core mission of addressing prescription drug costs.

The proposals expanding into PBM regulation shift the board's focus from drug pricing and affordability to provider reimbursement structures, which is critical because the prescription drug system is already extraordinarily complex. Understanding pharmaceutical pricing strategies and their impact on consumers requires deep, specialized expertise. Adding PBM oversight introduces an entirely separate complex system with its own intricate stakeholder dynamics, reimbursement mechanisms, and market forces. By attempting to simultaneously address both drug manufacturers and PBMs, the board risks diluting its effectiveness across two distinct, complex systems rather than excelling at its core mission. If the legislature has been grappling with PBM issues over multiple sessions and through dedicated stakeholder workgroups for the past 18 months, this alone demonstrates the complexity and specialized attention these issues demand. The PDAB, with its current composition and resources, is not equipped to comprehensively tackle both systems simultaneously.

Recommendations

We respectfully urge the board to:

- **Maintain a balanced composition** that includes health plan expertise essential to understanding prescription drug financing and affordability—not based on who wants to serve, but on what expertise is needed
- **Refocus on its statutory mandate** of prescription drug affordability for Oregon’s health care stakeholders
- **Withdraw the proposed expansion** into drug delivery system regulation and PBM oversight
- **Concentrate resources** on the core responsibilities outlined in the board's establishing statute

Oregonians need the PDAB to remain focused on its essential mission of making prescription drugs more affordable. Without appropriate expertise on the board and with an inappropriately broadened scope, the PDAB risks undermining the important work it was established to perform. Poorly informed policy proposals developed

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without comprehensive market perspective risk increasing the consumer burden of cost and impeding drug access.

As a tax-paying nonprofit where 90% of every premium dollar pays for our members' medical claims and expenses, we remain committed to working with the board within its proper scope to achieve meaningful prescription drug affordability for all Oregonians.

Thank you for your consideration of these concerns. We look forward to the board's continued focus on prescription drug affordability within the scope of its statutory authority and with the expertise necessary to fulfill that mission effectively.

Sincerely,

Mary Anne Cooper
Director of Government Relations
Regence BlueCross BlueShield of Oregon

November 19, 2025

Via Electronic Mail
Oregon Prescription Drug Affordability Board
PO Box 14480
Salem, OR 97309
pdab@dcbs.oregon.gov

Re: November 19 continued Board review of insulin products

Dear Members of the Oregon Prescription Drug Affordability Board:

Sanofi appreciates the opportunity to submit comments to the Oregon Prescription Drug Affordability Board ("OR PDAB") regarding the Board's potential selection of certain insulin products for affordability reviews, pursuant to OAR 925-200-0010. We understand that the OR PDAB is considering whether to include one or more of Sanofi's insulin glargine products, including Lantus®, Toujeo®, and unbranded products, Insulin Glargine U-100 and Insulin Glargine U-300, in the subset list of prescription drug and insulin products for review. For the reasons described below, OR PDAB's consideration of Sanofi's insulin products is inappropriate and inconsistent with the goal of ORS 646A.694, which is to identify products that currently create affordability challenges for the health care system or high out-of-pocket costs for patients.

1. **The 2023 data is outdated and does not reflect the significant reductions in list prices and other market trends, which reduce Oregon's cost and spending metrics for Sanofi's insulins.**

To further our commitment to support patients directly at the pharmacy counter and accelerate the transformation of the U.S. insulin market, in January 2024, Sanofi reduced the list price of Lantus®, our most widely prescribed insulin in the United States, by 78%.[1] Additionally, beginning January 1, 2024, all commercially-insured patients who fill their Lantus® prescriptions at participating pharmacies have their out-of-pocket responsibility capped at $35 for a monthly supply. At the same time, Sanofi launched Insulin Glargine Injection U-300, an unbranded version of Toujeo®, at a list price that was 60% less than Toujeo's® list price. For additional information regarding the steps

[1] In conjunction with this pricing action, Sanofi withdrew the lower priced, unbranded version of Lantus, Insulin Glargine U-100, from the market because the new list price for Lantus was below the list price of Insulin Glargine U-100. At that time, Sanofi also reduced the list price of our short-acting Apidra® (insulin glulisine injection) 100 Units/mL by 70%.

Sanofi took in 2024 to drive insulin affordability, please see our 2025 Pricing Principles Report.[2]

Although payers, including PBMs and government and private insurers, ultimately decide which medicines to cover, how much to reimburse dispensing pharmacies, and patients' out-of-pocket responsibility, Sanofi's pricing actions have reduced pharmacy reimbursement and out-of-pocket costs for these products. Unfortunately, although Sanofi continues to provide lower cost options to payers and PBMs, patients often do not realize the full cost savings because incentives within the health system drive health plans and middlemen to favor high list prices and larger rebates over lower priced options.

Taken together, the scope of these changes mean that the OR PDAB's 2023 data simply do not accurately reflect current costs, utilization, and spending. At a minimum, the OR PDAB should not consider including Sanofi's insulin products in an affordability review unless and until it can review current data that reflects these changes.

2. **Sanofi's insulin glargine products are highly utilized and affordable life-saving treatments for Oregon residents with diabetes.**

The inclusion of Sanofi's insulin products, like Lantus®, among the top gross spending products is presumably a result of the number of patients who rely on these insulin products – not their prices. As demonstrated by Oregon's own 2023 data,[3] Sanofi's insulin glargine products are not among the highest cost insulin products on a per prescription or per patient basis across multiple metrics, including overall costs, payer payments, and patient out-of-pocket costs. Indeed, healthcare providers and patients choose Sanofi's insulin glargine products because of their well-established clinical benefits and their affordability.

We are proud of the meaningful ways in which our products have transformed the standard of care for patients, from the introduction of Lantus®, which provided significant improvements in basal insulin levels, to the introduction of Toujeo®, a next generation basal insulin that more closely mimics the body's endogenous insulin secretions, among others. In addition to delivering meaningful innovation in the types of insulin available to patients, we are proud of the role we have played in transforming the patient experience through the

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[2] Sanofi 2025 Pricing Principles Report: Action Driving Insulin Affordability, *available at* https://www.sanofi.us/assets/dot-us/pages/images/our-company/Social-impact/responsible-business-values/pricing-principles/Sanofi-2025-Pricing-Principles-Report_Action-Driving-Insulin-Affordability.pdf.

[3] *See* Insulin Preliminary Data, Oregon PDAB Data Dashboard, *available at* https://app.powerbigov.us/view?r=eyJrIjoiOGM2YjhlMWUtNzE2OC00MmU1LTk2MjktYWUzZGMyNTNmZmQ1IiwidCI6ImFhM2Y2OTMyLWZhN2MtNDdiNC1hMGNlLWE1OThjYWQxNjFjZiJ9.

development of devices to ease the daily burden of insulin administration, allowing for fewer injections and, in some cases, fewer refills and related patient copays.

We have coupled these clinical innovations with our progressive and industry-leading pricing principles, which reflect our commitment to sustainable pricing and transparency,[4] and a suite of innovative affordability programs to help people reduce their prescription medicine costs, regardless of their insurance status or income level. As a result, no Oregon patient has to pay more than $35 per month for their Sanofi insulin product.[5] Please also see the attached document from our 2025 Pricing Principles on Sanofi's actions to drive insulin affordability.[6]

Given these utilization and cost trends – even using 2023 data, Sanofi's insulin glargine products are not an appropriate target for the OR PDAB.

3. **The data the OR PDAB is relying on does not appear to take into account the significant rebates and other price concessions that Sanofi provides to payers.**

The "list price" of a medicine often receives the most attention in public discussions, but it does not reflect the price patients pay at the pharmacy counter, nor does it reflect the amount health insurance companies pay (or that Sanofi receives).

Sanofi provides significant discounts, rebates, and fees to different stakeholders across the healthcare value chain, including to payers and their pharmacy benefit managers ("PBMs"), to ensure our medicines are accessible to patients. Sanofi pays these price concessions to insurers (or their PBMs) after a medicine is dispensed to a patient so it is not captured in the "payer paid" amount. As a result, the "payer paid" and "overall spend" data have no relation to the net amount payers actually pay for Sanofi's insulin products.

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[4] *See* Sanofi 2025 Pricing Principles Report, *available at* https://www.sanofi.us/assets/dot-us/pages/images/our-company/Social-impact/responsible-business-values/pricing-principles/Sanofi-2025-Pricing-Principles-Report.pdf.

[5] Additional details regarding our programs are available at https://www.teamingupfordiabetes.com/sanofidiabetes-savings-program.

[6] Sanofi 2025 Pricing Principles Report – Action Driving Insulin Affordability, *available at* https://www.sanofi.us/assets/dot-us/pages/images/our-company/Social-impact/responsible-business-values/pricing-principles/Sanofi-2025-Pricing-Principles-Report_Action-Driving-Insulin-Affordability.pdf.

OR PDAB clearly recognizes the importance of understanding net spend to its analysis as it has collected this data for non-insulin products.[7] OR PDAB should consider payer spend net of rebates for insulin products as well.

For these reasons, Sanofi respectfully requests that the Board remove Lantus®, Toujeo®, Insulin Glargine U100, and Insulin Glargine U300 from consideration for the subset list of insulin products. Further, any consideration of these products should and at a minimum take into account updated data on insulin products before proceeding with any insulin product review.

Please feel free to contact me at with any questions at carissa.kemp@sanofi.com or (208) 954-6330.

Sincerely,

Carissa Kemp
Lead, State Government Relations, Sanofi

Enclosure:

Sanofi 2025 Pricing Principles Report – Action Driving Insulin Affordability

[7] *See* Carrier Preliminary Data, including Carrier Spend Net of Rebate and Carrier Spend Net of Rebate per Enrollee, Oregon PDAB Data Dashboard, *available at* https://app.powerbigov.us/view?r=eyJrIjoiOGM2YjhlMWUtNzE2OC00MmU1LTk2MjktYWUzZGMyNTNmZmQ1IiwidCI6ImFhM2Y2OTMyLWZhN2MtNDdiNC1hMGNlLWE1OThjYWQxNjFjZiJ9. The 2023 insulin data from the Oregon All Payer All Claims Database (APAC) is gross and not net of rebates. *See* Insulin Data Process, Oregon Prescription Drug Affordability Board (Jan 2025), *available at* https://dfr.oregon.gov/pdab/Documents/Insulin-Data-Process-Documentation.pdf.

Action Driving *Insulin Affordability*

Insulin affordability has been a longstanding challenge for people with diabetes. Manufacturer discounts provided to payors – intended to make insulin more affordable – have sadly not translated into reduced costs for patients at the pharmacy counter due to misaligned market dynamics.

More than 11% of the U.S. population lives with diabetes

Our industry must remain focused on identifying and implementing solutions that continue to widen patient access and increase system-wide affordability.

Given this mandate, **Sanofi has taken action to improve access and affordability for millions** by actively reshaping our approach to insulin pricing and patient support.

Sanofi put into place significant pricing changes in 2024.

- The price of Lantus® (insulin glargine injection) 100 Units/mL, our most widely prescribed insulin in the U.S., was reduced by 78%, and the list price of our short-acting Apidra® (insulin glulisine injection) 100 Units/mL was cut by 70%.
- Sanofi placed a $35 cap on out-of-pocket costs for a 30-day supply of Lantus for patients with commercial insurance or without insurance – paying the difference on what insurance companies charge patients at the pharmacy. This is an evolution of a program that began in 2018, when Sanofi became the first company to voluntarily introduce a program where uninsured patients could access one or more of our medicines at a set price.
- We launched an unbranded biologic for Toujeo® U-300 (insulin glargine) injection 300 Units/mL at 60% less than the list price to continue to provide lower cost options to payors and pharmacy benefit managers pharmacy benefit managers (PBMs). However, **patients have yet to realize the full cost savings because incentives within the health system drive health plans and middlemen to favor high list prices and larger rebates over this lower priced option.**

Our mission is to ensure that no patient falls through the cracks; therefore, our suite of patient support programs are designed to help most people reduce the cost of their insulin, including Toujeo U-300 (insulin glargine) injection 300Units/mL, Lantus (insulin glargine injection) 100 Units/mL, Apidra (insulin glulisine injection) 100 Units/mL and Admelog (insulin lispro injection) 100 Units/mL.

- 100% of commercially insured people are eligible for Sanofi's copay assistance programs, regardless of income or insurance plan design, ensuring patients pay no more than $35 for a 30-day supply.
- 100% of uninsured people are eligible for the Insulins Valyou Savings Program - regardless of income level - enabling them to buy one or multiple Sanofi insulins at $35 for a 30-day supply.
- Free medications are provided to qualified low- and middle-income patients through the Sanofi Patient Connection program. Some people facing unexpected financial hardship may be eligible for a one-time, immediate month's supply of certain Sanofi medicines while waiting for their application to be processed.

Sanofi also offers a commercial copay assistance program for patients taking SOLIQUA 100/33 (insulin glargine and lixisenatide) injection 100 Units/mL and 33 mcg/mL, an injectable prescription medicine that contains two diabetes medicines, insulin glargine and lixisenatide, where patients pay as little as $35 for a 30-day supply, with a maximum savings of $365 per pack, up to 2 packs, for each 30-day supply.

Sanofi Insulins in 2024: By the Numbers

Significant Price Reductions for Insulins in the U.S.

Lantus price reduced by
▼78%

Apidra price reduced by
▼70%

These reductions bring the aggregate list price of Sanofi insulins back to 2012 levels, decreasing rebates to industry middlemen and aiming to improve patient affordability.

Commitment to Affordable Insulin

$35 cap

Out-of-pocket costs for Lantus are capped at $35 for all patients with commercial insurance.

Bridging the Affordability Gap with Patient Support

102,988

# of times Insulins *Valyou* Savings Program was used

$25.7 million+

patient savings from use of Insulins *Valyou* Savings Program

$6.7 million+

patient savings stemming from our partnerships with GoodRx, Amazon Pharmacy, and other third-party partnerships to cap the cost of some Sanofi insulins at $35 a month for commercially insured patients.

724 Columbia St. NW, Ste. 310 • Olympia, WA 98501 • PHRMA.ORG

November 16, 2025

Oregon Prescription Drug Affordability Board
350 Winter Street NE
Salem, OR 97309-0405
pdab@dcbs.oregon.gov

Re: Oregon Prescription Drug Affordability Board: November 19, 2025, Meeting Materials

Dear Members of the Oregon Prescription Drug Affordability Board:

The Pharmaceutical Research and Manufacturers of America ("PhRMA") is writing in response to the Oregon Prescription Drug Affordability Board's (the "PDAB's" or "Board's") meeting materials for its November 19, 2025, meeting, including the draft "2025 Annual Report" ("Draft Annual Report") and draft "2025 policy recommendations" ("Draft Policy Recommendations") (collectively, the "Meeting Materials").[1] PhRMA represents the country's leading innovative biopharmaceutical research companies, which are focused on developing innovative medicines that transform lives and create a healthier world. Together, we are fighting for solutions to ensure patients can access and afford medicines that prevent, treat, and cure disease. PhRMA member companies have invested more than $850 billion in the search for new treatments and cures over the last decade, supporting nearly five million jobs in the United States.

We provide below select comments and questions with respect to the Meeting Materials.

I. Draft 2025 Annual Report

PhRMA recognizes the Board's efforts to draft a thoughtful analysis of cost and utilization trends found in the data reported by carriers to the state's Drug Price Transparency ("DPT") Program. PhRMA appreciates that the Board recognizes the "clear and consistent trend" in the data showing that "increased utilization is the primary driver of rising prescription drug spend."[2] PhRMA also emphasizes the Board's finding that, where spending increases outpace utilization, non-price factors, like formulary design and rebate structures, "contribute to observed trends."[3]

However, PhRMA continues to have concerns about the integrity of the data on which the Board relied for its price trend analysis.[4] The Board identifies some limitations of and inconsistencies in the data, factors which inhibit stakeholders' ability to understand and evaluate the data and conclusions in the report. While PhRMA appreciates the Board's efforts to discuss data limitations and explain differences in data figures across the lists and tables in the Draft Annual Report, the report contains a number of discrepancies that would benefit from further explanation. While the Board's recognition of data limitations is a positive step, PhRMA requests that the

[1] November Meeting Materials (Nov. 19, 2025), *available at* https://dfr.oregon.gov/pdab/Documents/20251119-PDAB-document-package.pdf. In filing this comment letter, PhRMA reserves all rights to legal arguments with respect to Oregon Senate Bill 844 (2021), as amended by Oregon Senate Bill 192 (2023) and Oregon Senate Bill 289 (2025) (codified at Or. Rev. Stat. § 646A.693 *et seq*.) (collectively, the "PDAB Statute"), and the Board's implementation of the PDAB Statute. PhRMA also incorporates by reference all prior comment letters to the extent applicable, including its unaddressed concerns regarding the lack of clear, consistent, and meaningful standards in the "Methodology for Drug Reviews and Scoring Rubric and Worksheet" (the "Draft Scoring Framework"). Meeting Materials at 52-54; *see* Letter from PhRMA to Board (Oct. 3, 2025) at 2. PhRMA continues to believe that additional work is needed to provide consistent and transparent application of the Draft Scoring Framework in the Board's affordability review process.

[2] Meeting Materials at 11 (Oregon's commercial health insurance market); *see id.* at 23, 31 (Oregon's prescription drug market).

[3] *Id.* at 32.

[4] *See* Letter from PhRMA to Board (Sept. 16, 2023) at 1-3; Meeting Materials at 5-41.

Board elaborate on how the carrier-reported data were analyzed in this report, as well as in previous Board analyses, to enable stakeholders to better understand the data.

PhRMA offers the following, non-exhaustive examples of concerns the Board should address to help stakeholders understand the data discussed in the Draft Annual Report:

- ***Data inconsistency.*** PhRMA has questions regarding discrepancies observed in data within tables, across tables, and with the data published in the DPT Program's Annual Report.[5] While the Board acknowledges that the difference in total spending between 2023 and 2024 does not equal the year-over-year change in spending reported in the tables 3 and 4 due to variation in insurer submissions,[6] it is still unclear how the Board arrived at the year-over-year spending change shown in these tables.[7] Similarly, in some places 2023 total spending values in this report do not match the values reported in the Oregon Drug Price Transparency (DPT) Program annual report.[8] Further, although the report recognizes inconsistency across tables within the report, stakeholders request that the Board describe in more detail why there would be such wide variation in data for the same drug across the tables.[9] In addition, and of particular concern, data points presented in this analysis as 2023 annual spending totals do not match the data set that was used by the Board to determine which drugs to review in 2025.[10] Reliance on conflicting data undermines the Board's ability to conduct its work in a manner that is "rational, principled, and fair" and creates a risk of irrational or ad hoc comparisons that are inconsistent with the requirements of the Oregon Administrative Procedure Act ("APA").[11]

  Given the variation in data across tables in the report, PhRMA requests that the Board provide a comprehensive and transparent explanation of the methodology it used, including how specific calculations were performed and results were analyzed. Without more clarity, it is difficult to verify data accuracy, which could result in misleading conclusions.

- ***Data set limitations.*** The Draft Annual Report acknowledges that "[d]ata limitations shape interpretation" but nevertheless draws conclusions based on that data.[12] The report also notes that "[t]rends are based on required insurer reporting, representing about one-quarter of the Oregon insured population" and thus "does not represent the full payer landscape."[13] While PhRMA appreciates that the report contains a section discussing data limitations, this discussion is relatively limited. Without more

[5] *See, e.g.*, Dep't of Consumer & Bus. Servs., DPT Program Results and Recommendations – 2024 (Nov. 27, 2024) at 56-57, *available at* https://dfr.oregon.gov/drugtransparency/Documents/20241121-dpt-hearing/Prescription-Drug-Price-Transparency-Annual-Report-2024.pdf.

[6] Meeting Materials at 14.

[7] For example, across all drugs in Table 3, the difference between 2024 and 2023 reported spending is nearly $27 million lower than the year-over-year change reported in the table. Further, the 2023 and 2024 reported spending values indicate that five drugs had spending decreases, not increases, year-over-year. For these five drugs, year-over-year spend appears to decrease $30 million, not increase $12 million as indicated by the year-over-year column.

[8] For example, the 2023 spending values reported in Table 3 also do not match the values reported in Figure 41 of the Oregon DPT Program Annual Report. Oregon Prescription Drug Price Transparency Program results and recommendations – 2024. Nov 27, 2024 https://dfr.oregon.gov/drugtransparency/Documents/20241121-dpt-hearing/Prescription-Drug-Price-Transparency-Annual-Report-2024.pdf

[9] Footnotes 9 and 10 recognize that "the total annual spend in 2023 and 2024 reported in the MC ["Most Costly"] submission does not equal the total annual spend reported in the GI ["Greatest Increase"] submission" *See* Meeting Materials at 20, 23.

[10] *See* Board, *Data for Drug Reviews*, *available at* https://dfr.oregon.gov/pdab/Pages/data.aspx (last visited Nov. 13, 2025).

[11] *See* Ore. Rev. Stat., ch. 183; *Gordon v. Bd. of Parole & Post Prison Supervision*, 343 Or. 618, 633 (2007); Letter from PhRMA to Board (Sept. 16, 2023) at 2.

[12] Meeting Materials at 32.

[13] *Id.*

extensive explanation, the Board's reliance on DPT data—without accounting for significant differences in plan design and excluded patient populations—could mislead and result in incorrect conclusions based on observed trends.[14] The Board should expand on its explanations throughout the report to better contextualize its observations and conclusions.[15]

- ***Stakeholder validation.*** The Draft Annual Report presents new data from 2024 that were not previously disclosed to the public. Stakeholders should have the opportunity to review the Board's findings and the methodology by which the data were derived, particularly given the variation in the tables throughout the report. PhRMA continues to recommend that the Board adopt procedures for reviewing and evaluating the accuracy and completeness of the information it will consider, and for permitting manufacturers and other stakeholders to provide input and meet with the Board to provide feedback where information may be inaccurate or incomplete.[16] It is particularly critical that such opportunities be afforded *before* the Board relies on any data or findings.[17] The Board should share its data and methodology with stakeholders, including manufacturers, to promote accuracy and better contextualize findings.[18]

- ***Defining affordability.*** PhRMA recognizes that the focus of this analysis is on cost and utilization trends but urges caution in reaching conclusions about what the trends could reveal about *affordability*, especially when the Board has not defined "affordability" despite the manifest importance of such standard.[19] We continue to urge the Board to fully consider and define "affordability" before reaching any conclusions or decisions regarding it.[20]

II. Draft 2025 Policy Recommendations

PhRMA appreciates the Board's ongoing work to explore and develop many of the policy recommendations suggested by Board members that seek to address factors that may affect affordability.[21] PhRMA reiterates its support for policy recommendations that address the many factors throughout the supply chain that impact patient affordability, including recommendations that would require health insurance companies and pharmacy benefit managers ("PBMs") to pass rebates to patients at the pharmacy counter, delink PBM fees from the price of a drug, and increase PBM transparency.[22] PhRMA reiterates our prior comments on the Board's policy recommendations and highlights the following:

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[14] Use of inconsistent and incomplete data inhibits the Board's ability to satisfy its obligations under the APA. *See supra* n.[11; *see also* Letter from PhRMA to Board (Aug. 1, 2023) at 2.

[15] *See id.* at 29-31.

[16] *See, e.g.*, Letter from PhRMA to Board (Sept. 16, 2023) at 2-3.

[17] *See* Letter from PhRMA to Board (Oct. 3, 2025) at 4; Letter from PhRMA to Board (Sept. 16, 2023) at 2-3.

[18] *See* Letter from PhRMA to Board (Sept. 16, 2023) at 2-3.

[19] *See* Letter from PhRMA to Board (Jan. 7, 2025) at 3 ("The absence of clear and consistent standards, for example in the definition of affordability, was an important part of the decision to pause affordability reviews in June 2024."); Meeting Recording (June 26, 2024), *available at* https://youtu.be/9z2VkDiR_XA?si=pu2JpLRrtj9nZloe&t=1860 (statement of Board member John Murray: "What does 'affordability' mean to this Board? . . . That's the kind of discussion I need to hear and have to end up with a concept that I can work off of to make decisions . . . ."); Meeting Recording (June 26, 2024), *available at* https://youtu.be/9z2VkDiR_XA?si=PLikEaOvFpuZPSRS&t=1380 (statement of Board member Daniel Hartung: "I also support this pause and reset . . . I think we can get maybe back to first principles . . . really thinking about what affordability means as others have indicated . . . .").

[20] *See* Letter from PhRMA to Board (Oct. 3, 2025) at 2; Letter from PhRMA to Board (Aug. 18, 2025) at 1-2.

[21] Meeting Materials at 42-51.

[22] *See* Letter from PhRMA to Board (Oct. 3, 2025) at 4; Letter from PhRMA to Board (Oct. 6, 2023) at 1-2; Meeting Materials at 48-51.

- ***Pass through rebates at the point of sale.***[23] Manufacturers often provide significant discounts, rebates, and other price concessions directly to PBMs and health insurers, but many patients do not benefit from these discounts because health insurance companies and their PBMs do not pass the savings to patients at the point of sale.[24] PhRMA supports requiring PBMs to pass rebates directly to patients at the pharmacy counter, which would improve access and affordability by reducing patients' out-of-pocket costs for their medications.

- ***Delinking PBM fees from the price of a drug.***[25] PhRMA emphasizes that delinking PBM fees from drug prices is critical to reduce perverse incentives that experts have found may cause PBMs to prefer prescription drugs with higher list prices over ones with lower list prices.[26] Instead of the current system, which compensates PBMs based on the price of a medicine, PhRMA supports PBMs and other supply chain entities receiving a fixed fee based on the value of the services they provide.

- ***PBM transparency.***[27] PhRMA supports policy recommendations that improve transparency into PBM operations, including mandatory reporting on accumulator adjustment and copay maximizer programs implemented by health insurers and PBMs.[28] The lack of transparency in these programs raises concerns, especially considering these programs contribute to increased costs for patients by not counting assistance towards patients' cost sharing requirements, which impacts a patients' ability to get the full benefit of cost-sharing assistance to help them access their medicines. Additionally, PBMs and insurers should provide patients with real-time, comprehensive information in an easily accessible and understood format. The information should include anticipated out-of-pocket costs, utilization management requirements, and exceptions and appeals processes, enabling patients to make better choices based on their individual needs. Further, prohibiting mid-year formulary changes would enhance transparency and predictability for patients.

- ***Public meeting law changes regarding media attendance at executive sessions.***[29] PhRMA supports the Board's proposal to seek an "[e]xemption under the Public Meetings Law (ORS 192.660(4)) from having media present at executive sessions so the board can review trade secret information in private."[30] As discussed in prior comments, state and federal law protect trade secret information from disclosure; it cannot be disclosed publicly without violating state and federal prohibitions against the misappropriation of trade secrets.[31] Additionally, the PDAB Statute instructs that the Board "shall keep strictly confidential"

[23] Meeting Materials at 46.
[24] *See* Letter from PhRMA to Board (Nov. 1, 2024) at 5.
[25] Meeting Materials at 43, 48.
[26] U.S. House Committee on Oversight and Accountability. The Role of Pharmacy Benefit Managers in Prescription Drug Markets. Published July 23, 2024, hfps://oversight.house.gov/report/pbm-report; Press Release, Federal Trade Commission, FTC Launches Inquiry into Prescription Drug Middlemen Industry (June 7, 2022), https://www.ftc.gov/news-events/news/press-releases/2022/06/ftc-launches-inquiry-prescription-drug-middlemen-industry; Press Release, Federal Trade Commission, FTC Deepens Inquiry into Prescription Drug Middlemen (May 17, 2023), https://www.ftc.gov/news-events/news/press-releases/2023/05/ftc-deepens-inquiry-prescription-drug-middlemen. *See* Letter from PhRMA to Board (Oct. 3, 2025) at 4; Letter from PhRMA to Board (Oct. 6, 2023) at 2.
[27] Meeting Materials at 44, 48.
[28] *See* Letter from PhRMA to Board (Jan. 7, 2025) at 5.
[29] Meeting Materials at 47, 51.
[30] *Id.*; *see* Letter from PhRMA to Board (Nov. 5, 2025) at 1-2.
[31] *See* 18 U.S.C. § 1839(5)(B)(ii)(II) (defining "misappropriation" under the federal Defend Trade Secrets Act); Oregon Uniform Trade Secrets Act, Or. Rev. Stat. § 646.461-.475; *see also* Letter from PhRMA to Board (Nov. 5, 2025) at 1-2; Letter from PhRMA to Board (Oct. 3, 2025) at 1-2. In addition, the Fifth Amendment's prohibition against taking private property without just compensation similarly prohibits the uncompensated disclosure of trade secrets. Courts have made clear that "when disclosure [of pricing information] is compelled by the government," even the "failure to provide adequate protection to assure its confidentiality . . . can amount to an

a broader range of information that includes "*[c]onfidential, proprietary or a trade secret*" information.[32] PhRMA appreciates the Board's efforts to protect trade secret information. However, PhRMA urges it to, among other things, clarify that this exemption would apply to other confidential and proprietary information, as required under the PDAB Statute.[33]

- ***340B program transparency***. Congress created the 340B Drug Pricing Program to help vulnerable and uninsured patients access needed medicines. Unfortunately, the program has strayed from its original purpose, instead becoming a massive profit generator for large hospital systems, for-profit pharmacies, PBMs, and other middlemen. Consequently, patients are not benefiting from the billions of dollars in price concessions manufacturers provide annually to support the 340B program. According to recent research from IQVIA, Oregon employers and workers face an annual cost of $131 million due to the 340B program.[34] Additionally, the cost of the 340B program per beneficiary for state and local government employers is approximately 6% higher than for commercial employers, underscoring the broader impact of the program's cost shifting in healthcare expenses. Transparency into the impact of the 340B program in Oregon will provide crucial information to evaluate whether vulnerable Oregonians are receiving the benefits intended for them under the federal 340B program and help the State better understand how the program has become a hidden cost to Oregon's employers, taxpayers, and patients. This data will provide meaningful information about achieving the shared goal of bettering the lives of patients in need throughout Oregon and help Congress as it evaluates reforms to redirect the 340B program to its original intent of serving patients in need.[35]

* * *

On behalf of PhRMA and our member companies, thank you for consideration of our comments. While PhRMA has questions about the Meeting Materials, we continue to stand ready to be a constructive partner in this dialogue. Please contact dmcgrew@phrma.org with any questions.

Sincerely,

Dharia McGrew, PhD
Senior Director, State Policy
Sacramento, CA

Alexandra Hussey
Senior Director, Law
Washington, DC

unconstitutional 'taking' of property." *St. Michael's Convalescent Hosp. v. California,* 643 F.3d 1369, 1374 (9th Cir. 1981) (brackets and quotation marks omitted). For further discussion, see Letter from PhRMA to Board (June 28, 2024) at 4; Letter from PhRMA to Board (Aug. 1, 2023) at 1-2.

[32] PDAB Statute § 646A.694(7)(b) (emphasis added).

[33] Before accepting confidential, proprietary, or trade secret information, the Board should establish a clear process for handling such information in compliance with state and federal law. The Board should also provide pre-disclosure notice and opportunity to challenge determinations that information is not confidential, proprietary, or trade secret information. *See* Letter from PhRMA to Board (Nov. 5, 2025) at 1-2; Letter from PhRMA to Board (Oct. 3, 2025) at 2; Letter from PhRMA to Board (Feb. 11, 2023) at 8.

[34] IQVIA. (2025). The cost of 340B to Oregon: Fact sheet. IQVIA. Retrieved from https://www.iqvia.com/-/media/iqvia/pdfs/us/fact-sheet/340b-fact-sheets/oregon--cost-of-340b-fact-sheet.pdf

[35] States do not have the authority to regulate the federal 340B program, but we offer these comments based on Oregon's assertion of alleged authority to regulate aspects of the federal program when it enacted House Bill 2385. *See* Complaint, *PhRMA v. Rayfield*, No. 25-1754 (D. Or. Sept. 26, 2025), Dkt. 1 (challenging the constitutionality of H.B. 2385).

OCAP OREGON COALITION FOR AFFORDABLE PRESCRIPTIONS

November 16, 2025

Oregon Prescription Drug Affordability Board
350 Winter Street NE
Salem, OR 97309-0405
pdab@dcbs.oregon.gov

Dear Chair Bailey, Vice Chair Burns, and PDAB Members,

Thank you for the time and care you have devoted to the important work of the Oregon PDAB. As the Oregon Coalition for Affordable Prescriptions, we represent everyday Oregonians struggling with the rising of prescription drugs. Since 2017, our mission has been to increase transparency and affordability of prescription medications for Oregon patients.

We advocated for the establishment of this board in 2021, because your mandate to protect Oregonians and our healthcare system from the high cost of prescription drugs[1], fills a long-standing gap in consumer protections. **Your work today is an important step toward lowering prescription drug costs and increasing price transparency for Oregon patients, small businesses, and communities.**

As you know, the data available to you tells only part of the story. The same billion-dollar industry that engineered the opaque system limiting your access to information now criticizes your methodology. Meanwhile they continue to bring in record profits from struggling Americans.

Earlier this month, three of the largest pharmaceutical manufacturers reported third quarter earnings that surpassed Wall Street analyst expectations, following numerous price hikes on drugs with high utilization throughout the year.[2] One CEO even said: *"We've beaten and raised in every quarter in 2025."*[3]

At the same time, nearly one third of Oregonians have reported rationing their medication or not filling prescriptions because of cost.[4] This is what those high earnings cost our communities.

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[1] Deb Patterson et al., "Relating to the Price of Prescription Drugs," Pub. L. No. 844 (2022), https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/SB844/Enrolled.
[2] The Campaign for Sustainable RX Pricing, "Big Pharma Earnings Watch: Abbvie, Amgen, & Pfizer," CSRxP, November 6, 2025, https://www.csrxp.org/big-pharma-earnings-watch-abbvie-amgen-pfizer/.
[3] Kevin Dunleavy, "AbbVie Boosts Revenue Forecast by $400M Thanks to Booming Sales of Skyrizi, Rinvoq," Fierce Pharma, October 31, 2025, https://www.fiercepharma.com/pharma/abbvie-boosts-revenue-forecast-again-thanks-booming-sales-skyrizi-rinvoq.
[4] Altarum, "Oregon Survey Respondents Worry about High Drug Costs; Support a Range of Government Solutions – Healthcare Value Hub," Healthcarevaluehub.org, August 18, 2024, https://healthcarevaluehub.org/chess-state-survey/oregon/2024/oregon-survey-respondents-worry-about-high-drug-costs-support-a-range-of-government-solutions/.

As you finalize your end-of-year report and recommendations to the Legislature, we urge you to be clear about the tools this board needs to fully meet its statutory mission. Your affordability review work is essential. It has the potential to improve health outcomes, strengthen small businesses, and keep money in our local economy. But to be effective, the PDAB must have the authority and resources to act.

As we shared last month, other states are showing what this can look like. Colorado's PDAB set the first in the nation Upper Payment Limit (UPL) on a specific drug[5] and Maryland is poised to follow.[6]

We know some stakeholders are working to sow doubt by predicting reduced access if reforms such as UPLs are implemented. These claims come from the same actors who benefit from the status quo, often amplified through patient groups they fund. So, we must ask, who benefits when drug companies are allowed to raise list prices faster than the rate of inflation? *Not regular Oregonians.*

Medication is not accessible if people cannot afford it. Access to lifesaving medication shouldn't be behind an ever-growing paywall.

As Oregon faces federal threats and rising drug costs, we urge you to meet the moment and remain focused on your core charge by completing robust affordability reviews and meaningful policy recommendations. **Every Oregonian deserves to be able to afford the medications they need to live healthy and productive lives.**

Thank you for the opportunity to submit these comments. Our board is available to support your work in any way we can. You can reach us at info@affordablerxnow.org or through BethAnne Darby at Strategies 360 Oregon.

Sincerely,
The Oregon Coalition for Affordable Prescriptions Board
John Mullin, Board Chair (Seanduine; Health and Human Service Advocate)
Christi Marcotte, (Oregon Health Care Professional)
Charlie Fisher (OSPRIG)

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[5] Celine Castronuovo, "Colorado Adopts First State Payment Cap for Amgen's Enbrel," Bloomberg Law, October 3, 2025, https://news.bloomberglaw.com/health-law-and-business/colorado-finalizes-first-state-payment-cap-for-amgens-enbrel.

[6] Danielle J Brown, "County Leaders Urge Prescription Drug Board to Set 'Upper Payment Limits' - Maryland Matters," Maryland Matters, September 30, 2025, https://marylandmatters.org/2025/09/30/county-leaders-urge-prescription-drug-board-to-set-upper-payment-limits/.

COMMUNITY ACCESS NATIONAL NETWORK

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November 15, 2025

Oregon Prescription Drug Affordability Board
Department of Consumer and Business Services
350 Winter Street NE
Salem, OR 97309-0405

RE: Policy Recommendations and Drug Reviews

Dear Honorable Members of the Oregon Prescription Drug Affordability Board,

The **Community Access National Network** (CANN) is a 501(c)(3) national nonprofit organization focusing on public policy issues relating to HIV/AIDS and viral hepatitis. CANN's mission is to define, promote, and improve access to healthcare services and support for people living with HIV/AIDS and/or viral hepatitis through advocacy, education, and networking.

UPL Recommendation is Not Logical

Near the end of the October 2025 meeting, a board member suggested recommending that the legislature authorize the Board to set Upper Payment Limits. While the Board's deliberations make it clear there is a desire to effect positive change, it is also evident that there is frustration about how to bring that to fruition. Reconsidering UPLs as a potential recommendation is illogical and contradicts previous Board discussions. Several Board members have already opposed UPLs based on findings that UPLs do **not** achieve the intended policy outcomes, as detailed below.

Regarding logic, early on in the Board's work, the independent Stauffer-Meyer report commissioned by the Board, through evidence-based modeling, indicated that any meager potential savings from a UPL would not be worth the expenditure required for implementation. Most importantly, while the findings did not reveal any actual savings for patients, they *did* reveal potential adverse fiscal outcomes for the system, such as the Medicaid program.

We urge the Board to focus on what is best for Oregonians, regardless of the deeply problematic federal Most Favored Nation (MFN) proposals or Colorado's recent decision to set a UPL for Enbrel. Moreover, Colorado's recent UPL setting is not only a year away from going into effect, but it was not developed in good faith.

The Colorado Board and Staff neglected meaningful debate and expertise, dismissed patient concerns, and is now struggling to meaningfully discuss implementation, all while forging a path toward predictable litigation. Despite intensive discussion and the evidence-based need for scientific methods, no monitoring baseline or metrics have been established, and the manner in which the figure was set, without proper interaction with the manufacturer, is questionable and will inevitably result in challenges.

Challenges lead to more delays and legal expenses. The Oregon PDAB already discussed the length of time this process has taken. It would be more effective to focus on recommendations with less potential for delay and for which the Oregon Board already has significant support.

The Board desires to do what is best for Oregonians. Thus, it is unwise to waste resources and political capital to recommend UPL authority to the legislature for something that is grossly unproven and potentially damaging to patients and the system. UPLs only address one part of a complex system without regard for ripple effects and ignore plan-design issues, especially in commercial markets. Recommending the patient-centered options the Board has already discussed would better achieve beneficial outcomes for Oregonians.

Furthermore, because UPLs are the ideation of particular non-governmental actors, the Board would be wise to investigate why this issue has again risen, despite a lack of support in terms of debate or research as to efficacy in achieving greater “affordability” for Oregon or its residents.

Other Recommendations Being Considered

We support the recommendation to delink PBM compensation from drug prices and to discourage other fee/rebate mechanisms that enhance PBM profits but increase costs for the system and patients. Removing incentives that favor higher-priced drugs would be a systematic way to work against inflated drug list prices. Additionally, we support the suggestion of recommending legislative action that eliminates PBM pharmacy steering, which would increase patient access and even the playing field for independent pharmacies, as well as rebate pass-through.

We also support the recommendation to enable the use of NADAC cost basis for affordability evaluations. This information is voluntarily submitted and is already used by state Medicaid programs to determine drug reimbursement. This would increase data quality by adding transparency into the real-world, evidence-based acquisition costs from independent and chain pharmacies.

You also make a strong case for the policy recommendation on 340B funds reporting. Examining the flow of funds would clarify how some hospitals receive significantly more 340B revenue than safety-net providers and other covered entities that align with the program's original intent. That is a directly patient-focused endeavor that would positively impact patient affordability. Additionally, reporting would examine the state-specific interaction between 340B and Medicaid rebates.

Clarity in Ongoing Drug Reviews

As the Board continues the drug review process, we encourage the development of clear explanations of how the scoring rubric and domains are used in final determinations. Without a transparent methodology of how determinations are decided, public trust is at risk and would weaken the legislature's ability to confidently support actions based on your findings.

While CANN is primarily focused on policy matters affecting access to care for people living with and affected by HIV, we stand in firm support of all people living with chronic and rare diseases and recognize the very reality of those living with multiple health conditions and the necessity of timely, personalized care for every one of those health conditions. State Prescription Drug Affordability Boards are of profound importance to our community.

We thank you for all of your ongoing efforts. Your candid, transparent approach to difficult discussions is acknowledged and appreciated.

Respectfully submitted,

Ranier Simons
Director of State Policy, PDABs
Community Access National Network (CANN)

On behalf of
Jen Laws
President & CEO
Community Access National Network

Johnson & Johnson

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Via Electronic Submission

November 17, 2025

Shelley Bailey, Board Chair
Oregon Prescription Drug Affordability Board
Division of Financial Regulation
Oregon Department of Consumer and Business Services
350 Winter St. NE, Room 311
Salem, OR 97301
pdab@dcbs.oregon.gov

Dear Board Chair Bailey:

Johnson & Johnson Innovative Medicine ("J&J") offers comments to the Oregon Prescription Drug Affordability Board ("PDAB" or "Board") in advance of the November 19, 2025 Board meeting. We support policy solutions that improve patient access and affordability to treatment while avoiding unintended consequences for pharmacists and other healthcare stakeholders. Accordingly, J&J urges the PDAB to include the following Board member recommendations in its 2025 Annual Legislative Report ("Report"):

- Pharmacy Benefit Manager ("PBM") reforms to safeguard patient access and promote sustainable affordability; and
- Modification of the PDAB's scope to enable more patient-centered reforms across the healthcare ecosystem.

A. PBM Reform

J&J supports Board member recommendations on PBM reform that would demonstrably improve patient access, reduce out-of-pocket burdens, and support the sustainability of local pharmacies. In particular, we support:[1]

- Delinking PBM fees from the price of a drug or other fees/rebates and instead instituting service fees for PBMs;
- Requiring that PBM rebates and discounts be directly shared with patients at the pharmacy counter at point of sale; and
- Preventing PBMs from requiring pharmacies to dispense medications below their cost.

As noted in the PDAB's 2024 UPL Report to the Legislature, these reforms would protect patients from additional financial burden and preserve the viability of pharmacies, which in turn, enhances access to services, especially in underserved areas.[2]

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[1] *Agenda*, OREGON PDAB, (Oct. 13, 2025), https://dfr.oregon.gov/pdab/Documents/20251015-PDAB-document-package.pdf (last visited Nov. 13, 2025).

[2] *Prescription Drug Affordability Board (PDAB) Upper Payment Limit (UPL) Report to the Legislature*, OREGON PDAB https://dfr.oregon.gov/pdab/Documents/reports/PDAB-upper-payment-limit-report-2024.pdf#page-26 (last visited Nov. 13, 2025) [HEREINAFTER ["OR PDAB 2024 UPL REPORT")].

B. Amend the PDAB's Scope

J&J supports amending the PDAB's scope to allow the Board to focus on the healthcare ecosystem in its entirety. Limiting the Board's scope to conducting reviews of manufacturer drug pricing is unsound policy and impedes patient-centered solutions, especially since stakeholders have repeatedly identified formularies, plan design, and utilization management as the primary drivers of patient access and affordability barriers. This flawed policy has resulted in persistent challenges, including:

- Lack of standardized definition or consensus on "affordability to whom," creating risk of unintended consequences for patients;
- Policy that overlooks the role of PBMs and payers in patient affordability and access challenges;
- Inability to build consensus on evidence-based processes while also addressing stakeholders' concerns;
- A mandated annual deadline that prevents thorough, consistent drug reviews;
- Flawed datasets and erroneous calculations acknowledged by multiple Board members and stakeholders;
- Rapidly evolving Federal health policy, rendering two-year-old data outdated, and ignoring the impact of recent changes, such as loss of exclusivity, generics coming to market, and CMS establishing "Maximum Fair Prices"; and
- Last-minute introduction of a scoring rubric without adequate review or public comment.

Moreover, granting the PDAB UPL authority is unlikely to solve these problems and may produce unintended consequences for patients, as multiple stakeholders and the Board's own reports have indicated. For example, the Board's 2024 "Constituent Group Engagement Report" indicated that many respondents feared a UPL would result in reduced patient access and increased patient costs, among other issues.[3] The Board's 2024 UPL Report to the Legislature also noted patients' concerns that they would face treatment access challenges because payers and PBMs are likely to exclude UPL drugs from coverage or place them on higher formulary tiers.[4] Likewise, pharmacists report that they may avoid acquiring drugs subject to UPL due to inadequate reimbursement, creating shortages that compel patients to travel farther for their medicines and incur additional costs.[5] Therefore, if the Board's scope is expanded, it should be done in a manner that allows for patient-centered solutions and stakeholder feedback.

We respectfully submit our recommendations above for the Board's consideration. As one of the nation's leading healthcare companies, J&J has a responsibility to engage with stakeholders in constructive dialogue to address gaps in affordability and access as well as protect our nation's

[3] *Constituent Group Engagement Report: Draft*, MYERS AND STAUFFER, (August 14, 2024), https://dfr.oregon.gov/pdab/Documents/OR-PDAB-UPL-Report-Draft-20240821.pdf (last visited Nov. 13, 2025).
[4] OR PDAB 2024 UPL REPORT, *supra* note 2.
[5] Beulah Brent, *Prescription Drug Affordability Boards: A Flawed Approach to Equity and Access*, HEALTH AFFAIRS, (Sept. 21, 2025), https://www.healthaffairs.org/sponsored-content/national-minority-quality-forum/prescription-drug-affordability-boards-a-flawed-approach-to-equity-and-access (last visited Nov. 13, 2025).

leading role in the global innovation ecosystem. We know that patients are counting on us to develop and bring medicines to market. We live this mission every day and are humbled by the patients who trust us to help them fight their diseases and live healthier lives.

Sincerely,

Michael Valenta

Vice President, Value, Access & Pricing, Strategic Customer Group
Johnson & Johnson Healthcare Systems, Inc.