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

Testimony on PDAB Policy Recommendations

February 13, 2026

Chair Bailey and Members of the Board,

My name is Mary Anne Cooper, and I am the Director of Government Affairs of Regence BlueCross BlueShield of Oregon. On behalf of Regence and our members, we thank the PDAB for the opportunity to comment to the Board today. As one of the state's largest health plans, Regence is committed to addressing persistent and emerging needs for the nearly 1 million Oregonians we serve.

We understand the Board will no longer pursue upper payment limits to promote affordability for the drugs selected. Regence shares the Board's commitment to improving prescription drug affordability for Oregonians. However, we have significant concerns that the policy recommendations discussed at the January meeting will not achieve meaningful affordability improvements for patients using Trulicity, Cosentyx, Vraylar, and Lantus SoloStar. Our concern is that these broad, system-wide policies lack the targeted focus necessary to reduce out-of-pocket (OOP) costs for Oregonians struggling to afford these specific drugs. Many of the proposals hold potential for unintended, negative consequences on affordability and some are duplicative of current federal-level efforts. Ultimately, they may result in higher premiums for members while failing to deliver the intended and timely relief for these four medications.

The Fundamental Problem: Mission Drift

While the Board is mandated to protect affordability for all health care stakeholders in the State, the current review process identified specific drugs requiring immediate action. The policy recommendations extend far beyond the affordability of the four products selected, dilute the Board's impact, and could delay relief for the Oregonians who need help with these specific medications. Broad, system-wide reforms may serve other policy goals, but they do not constitute a focused response to the affordability crisis identified through this review process nor do they protect health care stakeholders from the high costs of prescription drugs.

Lack of Evidence Connecting Policies to Outcomes

None of the proposed policies include analysis demonstrating how they will specifically reduce OOP costs for patients taking these identified drugs. Without this evidence, the Board is essentially recommending policy experiments on Oregon's health care system while patients continue to struggle with unaffordable

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medications. Before advocating for any of these proposals, the Board should require clear impact analyses demonstrating the projected reduction in patient costs for each of the four drugs under review.

Several Board members have acknowledged concerns about unintended consequences. These policies could create access disruptions when formulary restrictions prevent plans from adopting newly approved, more affordable alternatives. They will shift costs when rebate pass-through requirements eliminate savings that keep premiums affordable for members and they will impose administrative burdens that ultimately raise premiums. The Board must conduct thorough actuarial and operational assessments before advocating for policies with such overarching impact.

Critical Concern: Delinking PBM Payments

The delinking proposal added in the January meeting deserves particular scrutiny. This policy is based largely on a theoretical information with limited real-world implementation data, making affordability impacts very unpredictable. Delinking would fundamentally restructure how pharmacy benefit managers (PBMs) are compensated, removing their financial incentive to negotiate aggressively for lower drug prices. The theory suggests this might curb rising drug costs and reduce conflicts of interest, but the impact could be the opposite with higher costs for the four identified drugs because PBMs no longer benefit from securing deeper discounts and rebates. As a result, plans would lose an effective negotiating tool precisely when aggressive negotiation is most critical to ensure best pricing is achieved for members.

In contrast to the theory that delinking would lower drug spending, another analysis indicates that, non-rebated drugs contribute to the largest price increases. Researcher's state, "*Consistent with other research, we find that rebates are not associated with list price increases. In fact, among the drugs with the largest price increases, 9 out of 10 were non-rebated. If Congress wants to lower drug prices, the data show that targeting rebates will not be effective.*" As such, rebated drugs as negotiated by PBMs are not the primary cause for high drug spend. If delinking results in the removal of rebates from the system, we collectively have an overall diminished ability to mitigate the rising cost of drugs.

Additionally, the complexity of implementing this policy could create market disruption and uncertainty, delaying any potential affordability relief for months or years. Patients struggling with the cost of these medications cannot afford to wait while Oregon experiments with a complete reimbursement model overhaul. If delinking fails to deliver the promised savings, the damage to Oregon's pharmaceutical market may be difficult to reverse. Additionally, if Oregon acts

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independent of or inadvertently counter to recent federal action on this and other PBM reform policies, it risks duplication of labor and further destabilization of drug supply channels and access.

Critical Concern: Prohibiting Specialty Tiers
The Bucket A proposal to eliminate specialty tiers for high-cost chronic drugs would directly undermine patient affordability. Specialty tiering serves a critical function: it creates cost-sharing structures that guide patients and providers toward clinically equivalent medications that offer better value. Removing these tiers eliminates price competition among manufacturers and reduces incentives for pharmaceutical companies to offer rebates or discounts. Without this market pressure, patients may inadvertently use high-cost drugs that provide limited additional therapeutic benefit compared to lower-cost alternatives. The result is a cascade effect: higher drug expenditures that lead to increased premiums for all Oregonians, including those who don't use specialty medications.

Critical Concern: Formulary Stability – No Mid Year Negative Changes
While we rarely implement mid-year negative changes, on occasion this tool can be a significant cost-saving opportunities, such as when a high-cost brand drug loses patent protection and a generic equivalent or biosimilar becomes available. Other use cases include updating coverage when new clinical evidence reveals safety or efficacy concerns for covered drugs.

Prohibiting these changes entirely would force health plans to wait up to a year to respond to market shifts, potentially locking members into higher-cost or low-value medications when more affordable, clinically appropriate alternatives exist. This inflexibility could drive unnecessary spending and ultimately increase premiums for all members. We support formulary stability as a general principle, but maintaining the ability to make reasonable mid-year changes when they can demonstrably improve affordability or clinical outcomes is essential for responsible benefit management.

Critical Concern: Targeted OOP Caps
Lastly, caps on cost-sharing may ease an individual patient’s financial burden at the pharmacy, these policies merely shift costs throughout the health care system without reducing what medications actually cost. Pharmacy expenses already account for nearly 25% of all employer health care spending in 2025, which is expected to rise by 11-12% in 2026. Cost caps remove accountability from drug manufacturers while requiring health plans and employers to absorb escalating prices.

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The core issue is not patient cost-sharing, it's unsustainable pharmaceutical pricing without accountability or transparency. Cost caps treat a symptom while exacerbating the disease.

A More Focused Path Forward
The Board should refocus on drug-specific interventions that directly target cost drivers for each of the identified medications. It is evident from the Board's discussions that there are significant gaps in understanding how health care is financed. These gaps create substantial risk of creating policies that destabilize established drug channels and inadvertently increase overall health care costs.

The Board should work collaboratively with plans, PBMs, manufacturers, and providers to develop tailored solutions rather than imposing one-size-fits-all market reforms based on incomplete understanding of market dynamics. The complexity of health care financing demands collaboration, not sweeping reforms built on theoretical models and incomplete information.

We urge the Board to step back from these broad, untested policies and instead develop focused interventions for the specific drugs identified as affordability challenges. Oregon consumers deserve to realize the direct cost-savings they were promised when this Board was established. Before moving forward, invest time in understanding how current payment mechanisms work, why they exist, and what the full consequences of changing them might be. Conduct thorough impact assessments with input from actuaries and operational experts who understand the intricate relationships between formulary design, rebate structures, premium calculations, and patient cost-sharing.

Thank you for considering these concerns. I welcome the opportunity to work collaboratively toward solutions that genuinely improve affordability for Oregonians who need these medications.

Thank you for your time and consideration.

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