June 17, 2025

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

TO: Members of Oregon Prescription Drug Affordability Board

I am writing to share my concerns regarding the Oregon Prescription Drug Affordability Board's process for selecting medications and conducting affordability reviews. As a physician, the well-being of my patients is my primary focus, and I am deeply troubled that the current approach to affordability reviews may jeopardize access to essential medications.

I am a board-certified pediatric rheumatologist and spent my career caring for young people with chronic or disabling conditions. Many of my patients, including those with juvenile idiopathic arthritis and lupus, rely on specialized, innovative, yet often expensive therapies.

The criteria used to identify therapeutic alternatives often fail to account for the complexities of individual patient care, such as cases where substitution is not clinically appropriate due to unique medical conditions or treatment needs. Unilaterally designating certain medications as "therapeutic alternatives" fundamentally disrupts the physician's ability to exercise their medical expertise in concert with their patient. Healthcare providers like myself consider therapeutic equivalents when considering medication substitutions as a matter of standard practice, but "therapeutic alternatives" do not constitute therapeutic equivalents. Patients who suffer from complex chronic conditions, such as rheumatoid arthritis and other rheumatologic diseases, require continuity of care to successfully manage their conditions. Policymakers have no business overriding their doctor's prescribing recommendations.

Additionally, the lack of clarity in how collected data is evaluated undermines confidence in the affordability review process. Without detailed methodologies or standards for assessing therapeutic alternatives and other critical factors, the Board risks decisions that do not adequately reflect real-world patient experiences or clinical realities. Establishing clear, consistent processes and ensuring transparency in decision-making are essential steps toward improving access to affordable medications for those who depend on them.

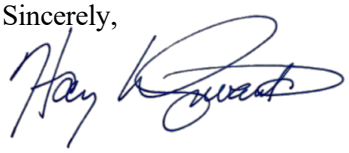
The proposed list of potential therapies for affordability review is extensive and could significantly impact Oregon patients across a wide range of disease states. I am deeply concerned about the potential unintended consequences of such evaluations, especially when conducted under tight timelines and without sufficient public input.

I share your goal to lower prescription drug costs, but the current process risks limiting access to essential medications. Physicians and patients are eager to collaborate with the Board to ensure affordability decisions reflect real-world patient needs on a more thoughtful, patient-centered approach. As it stands

now, the Board's actions could inadvertently restrict access to medications for those who need them most in Oregon.

Thank you for your attention to this critical issue.

Sincerely,



Harry L. Gewanter, MD, FAAP, MACR
President, Virginia Society of Rheumatology
Board Member, Let My Doctors Decide Action Network

TO: Oregon Prescription Drug Affordability Board
FROM: Robert Popovian, Pharm.D., MS
RE: PDAB public comment
DATE: 6/16/2025

It is important for the Oregon PDAB to consider the real-world results from the announced suppression of prices through the Inflation Reduction Act (IRA) on patient out-of-pocket (OOP) costs.
Please visit the Pioneer site: https://pioneerinstitute.org/the-inflation-reduction-act-ira-overview/

The information regarding the impact of the announced IRA price reductions on patient OOP costs is based on **actual** OOP data secured through IQVIA. This is **not** a modeling project.

Summary of Results:
All data compares OOP prices between 1Q2024 and 1Q2025.

- The average OOP cost increased overall for all MFP medicines included in the analysis.
- The average OOP cost across all nine MFP drugs rose by $23.91, from $74.51 to $98.42.
- This represents a 32% increase in average OOP cost across all nine MFP medicines.
- OOP costs increased specifically for seven of the nine medicines with a negotiated MFP.
- Cost increases ranged from $10.56 to $316.81.
- Of the two medicines that did not have OOP increases, one faced new biosimilar competition that only became available in 2025.
- All four of the largest PBMs increased OOP costs for six of the seven medicines with cost increases. One medication had OOP increases from three of the four PBMs.

Due to rebate contracting, higher-priced drugs offer more generous rebates. Thus, suppressing retail prices may reduce PBM revenue and profit margins. While this reduction in PBM profit may appear beneficial, an **unintended outcome** is that PBMs can recoup lost profits by increasing patient OOP costs. The Pioneer data clearly demonstrates this scenario for the medicines subjected to IRA price setting.

For example, despite a ~40% list price reduction for **Januvia**, patient OOP costs actually increased year-over-year.

It is also important to note that in the case of **Stelara**, multiple biosimilars are now on the market. Stelara biosimilars were priced at approximately ~80% or more discount. However, patient OOP costs dropped by only 27%. As such, patients did not recoup the full value of price reductions through biosimilar competition.

The consequences of price suppression may extend beyond higher OOP costs. PBMs may implement additional policies in response to lost profitability. For example, PBMs and their vertically integrated insurance companies may:

- Increase administrative barriers such as prior authorization and step therapy, limiting access to PDAB or non-PDAB medicines.
- Raise premiums.
- Increase OOP costs for drugs not evaluated by PDAB.
- Exclude certain drugs from formularies, restricting patient access.

The reason I am sharing this information with the PDAB Board is fivefold:

1. Any price suppression by Oregon PDAB may result in higher patient OOP costs.
2. Oregon PDAB must implement mechanisms to monitor and penalize PBMs that increase OOP costs for medicines under PDAB evaluation.
3. Oregon PDAB must implement mechanisms to monitor and penalize PBMs that increase OOP costs for medicines not under PDAB evaluation.
4. Oregon PDAB should develop a strategy to prevent PBMs from adopting policies that harm patients and Oregon taxpayers beyond higher OOP costs, such as formulary exclusions.
5. Unless the State of Oregon, in collaboration with PDAB, eliminates rebate contracting for any drug benefit program where patients incur OOP costs, suppressing retail prices will become another failed attempt to improve patient affordability.

June 17, 2025

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

Re: June 18, 2025 Board review and possible vote for updated data subset list of prescription drugs and insulin products pursuant to OAR 925-200-0010

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

[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%.

regarding the steps 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 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.

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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.

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]

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.

OR PDAB clearly recognizes the importance of understanding net spend to its analysis as it has collected this data for non-insulin products.[6] 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.

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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] *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.

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:

2025 Sanofi Pricing Principles Report

sanofi

2025 Pricing Principles Report

Advancing Responsible Leadership

At Sanofi, we work passionately to help prevent, treat, and cure illness and disease, understand and solve healthcare needs of people across the world, and transform the practice of medicine.

We have a longstanding commitment to promoting healthcare systems that make our treatments accessible and affordable to those in need. In May 2017, Sanofi reinforced this commitment with the introduction of our Pricing Principles, which details how we price our medicines and advocates for policy solutions to make the system work better for patients.

Our goal—then and now—is to foster a culture of transparency that helps our stakeholders better understand our pricing decisions and facilitates a more informed discussion related to the pricing of medicines across the U.S. healthcare system.

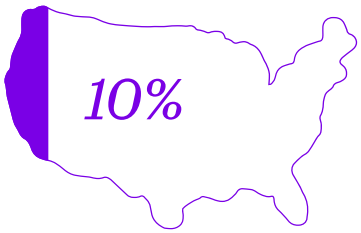
This report outlines our principles, 2024 pricing decisions, and our perspectives on advancing solutions to improve patient outcomes and affordability in the United States.

Our Pricing Principles *& Perspectives*

We share concerns about patients' affordability of medicines while recognizing that we are only one of many stakeholders involved in healthcare delivery.

At Sanofi, we price our medicines according to their value while advancing broader solutions that improve patient outcomes and support affordability within the U.S. healthcare system. Our pricing strategy underscores our commitment to patient access while minimizing our contribution to overall healthcare system spending. We remain transparent in how we price our prescription medicines and limit price increases in the United States.

As of September 2024, prescription medicines accounted for only



of U.S. healthcare spending, marking a reduction of approximately 4% compared to the previous year.[1]

The pricing principles we put forth focus on three pillars:

- **Clear Rationale for Pricing** at the time of launch of a new medicine
- **Reporting of U.S. Pricing Actions** on our medicines over time
- **Continued Transparency in the U.S.** around our pricing decisions

[1] Altarum. Health Sector Economic Indicators. November 2024.

Clear Rationale for Pricing

When we set the price of a new medicine, we follow a rigorous process that includes consultation with external stakeholders and consideration of the following factors:

A holistic value assessment using various internal and external methodologies to define or quantify value, incorporating patient perspectives and priorities. This includes:

- Clinical value and outcomes: the benefit the medicine delivers to patients and its effectiveness compared to the standard of care
- Economic value: how the medicine reduces the need for – and costs of – other healthcare interventions
- Social value: how the medicine contributes to quality of life and productivity

Similar current or future treatment options at launch to understand the landscape within the disease areas where our medicines or vaccines may be used.

System-wide affordability, including steps we must take to promote patient access and contribute to a more sustainable system for payors and healthcare systems.

Unique launch factors specific to a medicine or vaccine at its launch. For example, we may need to support ongoing clinical trials, implement regulatory commitments, or develop sophisticated patient support tools.

Reporting of U.S. Pricing Actions

We acknowledge our role in preserving the sustainability of our healthcare system and limiting our contribution to U.S. healthcare spending growth.

Our approach to pricing actions for existing medicines balances our ambition to chase the miracles of science, patients' access to the medicines they need, government policies, and evolving marketplace trends.

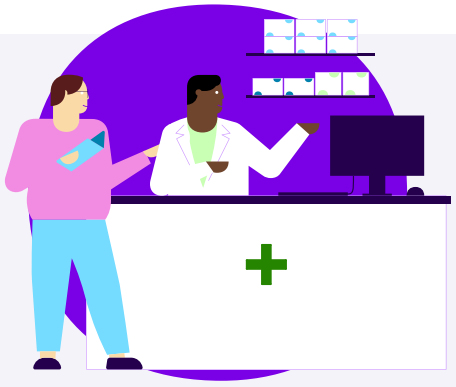
The guiding principle for any list price actions taken during the fiscal year 2024 was to adhere to a level consistent with our approach to responsible pricing.

Sanofi will annually disclose additional background if price actions trigger a prescription drug mandatory supplemental rebate under the Inflation Reduction Act (IRA) of 2022.

Continued Transparency in the U.S.

To maintain an open dialogue and recognize calls for continued transparency in our pricing actions, **we annually disclose our average aggregate U.S. list and net price changes from the prior calendar year**. We believe this information contributes to better-informed discussions to improve patient access and affordability.

It is important to note that patient cost-sharing and coverage decisions are made by public and private payors and employers, not manufacturers. It is most often the case that patients' out-of-pocket costs ultimately depend on how their health plan structures insurance coverage and to what extent it passes through negotiated discounts.



Although list prices often garner the most attention, they often do not represent the price patients pay.

Learn more about misaligned incentives in the drug supply chain impacting patient affordability.

Learn more →

A Look Back
2024 Pricing Actions

Our Pricing Principles reflect our unwavering dedication to providing patients with innovative and life-changing treatments while limiting costs and minimizing our contribution to healthcare spending growth.

Clear Rationale for Pricing

In 2024, Sanofi ushered in scientific breakthroughs by expanding the indications for five of our existing medicines, widening their FDA-authorized labels to treat additional conditions. This achievement was based on extensive and continued research and data, offering new treatment options to different patient populations with unmet needs.

Although post-approval research is less heralded than the investigation and launch of new medicines, continuing research into a medicine's potential to treat multiple different diseases can help unlock its full economic and societal value, allowing more people to benefit from treatments that may improve their conditions.

Specifically, post-approval research is critical for medicines targeting immune system disorders, an area with significant unmet need and severe symptoms, in which the body's immune system mistakenly attacks healthy cells or fails to respond to harmful invaders, causing inflammation and pain.

Our R&D approach, rooted in immunoscience, investigates the underlying causes of inflammation in the body and leverages our deep understanding of biological pathways, often linking seemingly unrelated conditions and broadening the populations of patients that can benefit from our medicines.

These "unsung heroes" of science highlight how fostering an innovative ecosystem that values post-approval research expands these medicines' value to patients and society – an ecosystem at risk due to new government price-setting policies.

Sanofi supports policy solutions that preserve drug discovery while ensuring affordable patient access to life-changing medicines.

Learn more about health care reforms we support.

Learn more →

Unlocking New Potential for Existing Medicines

Our 2024 Milestones in Pediatric, COPD, and Multiple Myeloma Treatments

January 2024

Dupixent® (dupilumab) was approved for pediatric patients aged 1 year and older weighing at least 15 kg with eosinophilic esophagitis, the first and only U.S.-approved medicine indicated for as young as 1 year old. The label was also updated to include efficacy and safety data for patients aged 12 and older with uncontrolled moderate to severe atopic dermatitis affecting the hands and/or feet.

May 2024

Altuviiio's® [Antihemophilic Factor (Recombinant), Fc-VWF-XTEN Fusion Protein-ehtl] label was updated with Phase 3 pediatric study results, showing effective bleed protection in children with hemophilia A with once-weekly dosing.

June 2024

Kevzara® (sarilumab) was approved for treating active polyarticular juvenile idiopathic arthritis in patients weighing 63 kg or more.

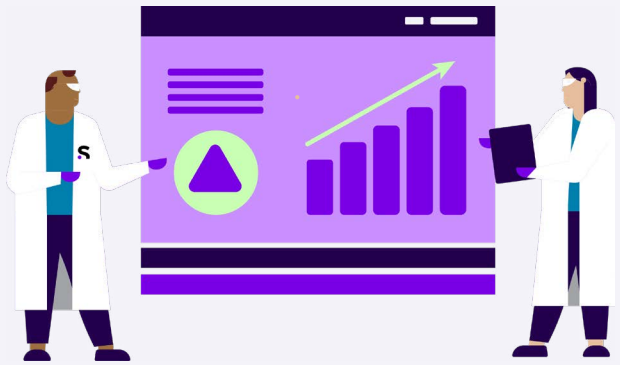
September 2024

Sarclisa® (isatuximab-irfc) was approved in combination with standard-of-care treatment for adults with newly diagnosed multiple myeloma who are not eligible for autologous stem cell transplant.

Dupixent was approved as an add-on maintenance treatment for adults with inadequately controlled COPD and an eosinophilic phenotype, making it the first-ever biologic for these patients in the U.S. Dupixent is not indicated for the relief of acute bronchospasm in this COPD population. It is also approved as the first and only add-on maintenance treatment for patients as young as 12 years of age with inadequately controlled chronic rhinosinusitis with nasal polyps, expanding on the 2019 approval for adults.

October 2024

The label of Flublok® (Influenza Vaccine) was updated with data from a safety study involving over 48,000 pregnant individuals aged 18 and older.



We keep delivering for patients with the continued momentum of Dupixent, our leading biologic medicine

Approved in

7

indications, driven in part by type 2 inflammation

Treating more than

1 million

patients worldwide[2]

[2]This worldwide number is largely comprised from 10 countries (Canada, China, France, Germany, Italy, Japan, the Netherlands, Spain, the UK, and the US), with the rest of the world comprising ≈10% of this number. This number is comprised of the following US approved indications: AD, asthma, CRSwNP, PN, and EoE. Data through August 2024.

Reporting of U.S. Pricing Actions

In 2024, Sanofi increased the price of *40* of its *80* prescription medicines in line with our Pricing Principles.

Effective January 1, 2024, Sanofi significantly reduced the list price for two insulin products in the U.S.

- The list price of Lantus® (insulin glargine injection) 100 Units/mL, our most prescribed insulin, was reduced by ▼*78%*
- Similarly, the list price of our short-acting insulin, Apidra® (insulin glulisine injection) 100 Units/mL, was lowered by ▼*70%*

Continued Transparency in the U.S.

U.S. Portfolio Annual Aggregate Price Change from Prior Year[3]

Year	Average Aggregate List Price	Average Aggregate Net Price
2016	4.0% Increase	2.1% Decrease
2017	1.6% Increase	8.4% Decrease
2018	4.6% Increase	8.0% Decrease
2019	2.9% Increase	11.1% Decrease
2020	0.2% Increase	7.8% Decrease
2021	1.5% Increase	1.3% Decrease
2022	2.6% Increase	0.4% Decrease
2023	4.3% Increase	15.7% Decrease
2024[4]	1.1% Increase	7.4% Increase

[4]Excluding the unique dynamics of the insulin market, Sanofi saw a 4.5% increase in aggregated gross price and a 3% decrease in net price. This demonstrates the increased demand for rebates and its overwhelming impact on the flow of revenue through the drug supply chain without directly impacting patients' out-of-pocket costs.

[3]As of December 31, 2024

Gross Sales Sanofi Paid as Rebates in 2024

36%
of our gross sales to payors as rebates

$4.3 billion
in mandatory rebates to government payors as required by federal law

$7.4 billion
in rebates negotiated with health plans and pharmacy benefit managers (PBMs) and their related fees

Sanofi's annual net price change is influenced by a number of factors, including the level of discounts, rebates, and fees paid to ensure access to our medicines; the makeup of our product portfolio; the type of health plan or program through which the medicine is dispensed (especially those with both negotiated and government-mandated rebates and discounts); and the extent of patient assistance we provide to improve the affordability of our medications.

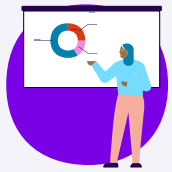
We experienced a 7.4% increase in 2024 in our average aggregated net price across our portfolio, the first increase reported since we began disclosing aggregate data. This increase was influenced by several factors, including dynamics within our insulin portfolio and the broader U.S. insulin market.

In 2024, Sanofi took a significant price reduction for Lantus, our most-prescribed insulin product. As a result of this price reduction within existing regulatory contracts, we saw an increase in net prices due to lower rebates across several channels. The portfolio impact of this net price increase was amplified by an increase in Sanofi market share for Lantus in 2024, which was due in part to a competitor product exiting the insulin market.

It is worth noting that the vast majority of Sanofi medicines still face heightened demand for rebates and fees from health plans and PBMs – which continue to assert control over drug pricing and patient out-of-pocket costs.

Living Out *Our Commitments*

Learn about our perspectives on significant policy issues impacting patient access and affordability and see how we are actively working to lower the out-of-pocket costs of prescription medications for all patients.



The Disconnect Between List Prices & Patient Costs

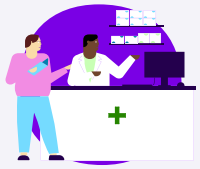
Learn more →

Prioritizing Patient Affordability: Our Patient Support Programs

Learn more →

A Closer Look at 340B

Learn more →



Action Driving Insulin Affordability

Learn more →

Navigating the Complexities of Accessing Specialty Medicine

Learn more →

Health Policy Solutions Protecting Innovation

Learn more →

June 18, 2025

My name is Melissa Horn and I am the State Legislative Affairs Director for the Arthritis Foundation. Thank you for the opportunity to comment on the list of drugs included in the affordability review process. While we have a broader set of principles on patient-centered value assessment that could be applicable to all drugs on the list, I'd like to focus my comments today on Humira's inclusion in the affordability review process.

The Arthritis Foundation supports efforts to improve drug affordability for patients, however, we are concerned that reviewing Humira may not be the best use of the Board's capacity. While Humira has historically been a high-cost drug, the market landscape is rapidly evolving. There are now over 10 FDA-approved Humira biosimilars.

Access to biosimilars has increased greatly over the past year, with major PBMs like CVS and Optum Rx preferring biosimilars over Humira on their formularies. CVS and Optum Rx removed Humira from their lowest net cost formularies in 2024 and 2025. These actions are beginning to lower prices and change market dynamics.

We think the state of OR would be better served by focusing on how to incentivize and ensure access to biosimilars to more people, rather than conducting an affordability review on their reference product. Thank you for your consideration and we look forward to opportunities to engage with the Board in the future.

Melissa Horn, MPA (she/her)
Arthritis Foundation
Director of State Legislative Affairs | Department of Advocacy and Access
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mhorn@arthritis.org
24/7 Helpline: 1.844.571.4357

PCMA

June 30, 2025

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

Dear Chair Bailey and members of the Oregon Prescription Drug Affordability Board:

I am writing to share our disappointment with the Oregon State Pharmacy Association's (OSPA) June 14th comment letter to the Oregon Prescription Drug Affordability Board (Board) calling for a ban on PBMs from operating in the state. Such hyperbole is a disservice to OSPA's members as well as all Oregonians. Ignoring the incongruity of calling for a ban while also asking the Board to adopt its legislative agenda, OPSA makes several inaccurate statements about PBMs and their role in the drug supply chain.

PBMs help manage the drug benefit for more than 3.5 million Oregonians and are projected to save them more than $13.6B over the next 10 years. Every single state employee plan in U.S. contracts with a PBM, including the Oregon Public Employees' Benefit Board (PEBB). Virtually every single state Medicaid program, including the Oregon Health Plan, contracts with a PBM. They do so because PBMs help lower the cost to the payer and patient. PBMs role is to exert downward pressure on drug prices set by drug manufacturers.

As you know, the statutory mission of the Board is to "protect Oregon residents and stakeholders from the financial burdens associated with exorbitant drug prices." OSPA's request to force the closure of certain pharmacies to protect their own interests contradicts this purpose. Further, eliminating PBMs in Oregon would remove a key mechanism in controlling prescription drug prices, leading to higher costs for consumers at the pharmacy counter. The Board is tasked with studying the entire prescription drug distribution and payment system to identify affordability challenges and recommend reforms. Banning PBMs would remove a critical component, limiting the Board's ability to assess and improve how drug costs are managed across the entire supply chain.

The recommendations made by OSPA fall far short of doing anything to help expand access or lower costs for patients, who should be at the center of any policy considerations, particularly from the PDAB. In light of the above, it is important to consider each of OSPA's recommendations.

Prohibiting vertical integration
OSPA states there has been a decrease in the number of pharmacies in the state. However, upon a deeper examination of these closures, there is little evidence that most closures are related to PBM business practices. Bi-Mart closed 13 pharmacies in Oregon attributing the closures to "rising medical costs and Oregon's corporate activity tax." Rite Aid is closing hundreds of pharmacies across the country due to a high debt load and continued lawsuits related to its role in the opioid

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crisis. Seeking legislation that would force the closure of additional pharmacies that offer greater access to Oregon health care consumers is counter to patient access and OSPA's stated concern.

Eliminating opaque reimbursement models
Spread pricing is not a reimbursement model. It is a contract between a health plan and a PBM, unrelated to pharmacy reimbursement. During stakeholder meetings leading up to the 2025 legislative session, it was made clear spread pricing is not a reimbursement model for pharmacies.

Of the handful of states that have enacted a ban on spread pricing, none have seen a reduction in prices for patients nor an increase in pharmacy reimbursement. They have, however, seen the elimination of a choice for payers and employers in how they manage their prescription drug benefit expenditures. Data from DCBS showed nearly all pharmacy reimbursements were above their acquisition costs. Of the 8.3% of claims that were reimbursed below acquisition cost, the high net profit reimbursement claims made up for these losses and resulted in a net pharmacy profit when looking at the totality of all prescription claims paid.

Requiring 100% rebate pass-through to payers and patients
PBMs already do this at a client's request. It is always up to the client how they choose to compensate PBMs, including if a PBM is contractually allowed to keep an agreed-upon percentage of rebates. Please refer to the DCBS Drug Price Transparency Program report which shows how all rebates are handled by Oregon-licensed PBMs. Dictating how health plans compensate PBMs will not lower costs for patients or increase reimbursement for pharmacies.

Restricting formulary practices that prioritize PBM profit over patient care
Nationally, 90% of all drugs dispensed are generic. If PBMs favored higher rebated brand drugs, the percentage of generic drugs dispensed would be significantly lower. Additionally, simply pursuing higher rebates for the sake of higher profits fails to make economic sense. Example:

- There are two therapeutically equivalent competing brand drugs that are safe and effective in treating a specific medical condition.
- A PBM negotiates a $100 rebate on a $1,000 drug and is contractually permitted to retain 5% or $5 as compensation for its services.
- The PBM negotiates a $200 rebate on a $2,000 competitor drug and is contractually permitted to retain 5% or $10 as compensation for their services.
- With the second drug, the PBM retains a higher rebate ($10 instead of $5)
- However, the cost to the health plan increases significantly from $905 to $1810

No one would hire a PBM if they pursued higher rebates instead of working to ensure payers get the lowest net cost possible.

In conclusion, not a single one of these recommendations passed in other states has resulted in lower costs for payers or consumers. Pharmacists are seeking increased reimbursements and dispensing fees which will result in higher overall costs. We encourage the OSPA to engage in constructive dialogue on this matter rather than advocating for extreme measures that may lead to higher costs and reduced access for payers and patients.

While we continue to stand ready to work with pharmacists, we reject the call for actions that would dramatically and unnecessarily disrupt Oregonians' ability to access safe and affordable

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medications. We hope the Board will reject OSPA's effort to turn the PDAB into a weapon in its legislative advocacy campaign.

Sincerely,

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