COMMUNITY ACCESS NATIONAL NETWORK

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

RE: Ongoing Deliberations

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.

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.

Orphan Drug Review Deliberations Remain A Concern

We remain concerned about Board discourse around including drugs with orphan designations in drug reviews. Previous deliberations made it clear that the board and staff believe there is legal standing to review orphan-designated drugs with indications for non-orphan conditions. This is further evidenced by the inclusion of 11 orphan drugs on the subset list for consideration in the 2026 drug review.

Oregon statute (ORS 646A.694) explicitly states that a drug **designated** as an orphan drug by the FDA for a rare disease or condition is not subject to the state's prescription drug affordability review, **full-stop**.

"(2) A drug that is designated by the Secretary of the United States Food and Drug Administration, under 21 U.S.C. 360bb, as a drug for a rare disease or condition is not subject to review under subsection (1) of this section."

Furthermore, Article IV, section 21 of the Oregon Constitution dictates, "Every act, and joint resolution shall be plainly worded, avoiding as far as practicable the use of technical terms." Good faith interpretations require the reader ***not*** to insert a meaning where none exists on a "technicality". Even still, no such technicality exists in the operative language of ORS 646A.694(2).

Staff's position amounts to "Weellllllll….technically…" demonstrating this interpretation as a naked attempt to shoehorn a predetermined conclusion that is necessarily bad faith and contrary to the plain language of the statute.

Most importantly, rare disease medications are expensive by nature of the small populations they serve and the lack of therapeutic alternatives, biosimilars, or generics. We urge extreme caution in the affordability assessment of these treatments, as making affordability determinations based on orphan or non-orphan indications affects all indications, not just those identified as non-orphan.

Continued Support of Policy Recommendations

We continue to support the selection of patient out-of-pocket caps and point-of-sale rebate pass-through as concepts to include in the 2025 drug review report. Regarding rebate pass-through, we'd like to highlight West Virginia as real-world evidence that it is effective and improves affordability for both patients and the system. We have attached and linked an insurance bulletin from the West Virginia Offices of the Insurance Commissioner detailing this data.

The update to the Pharmacy Audit Integrity Act mandates that "a covered individual's defined cost sharing for each prescription drug shall be calculated at the point of sale based on a price that is reduced by an amount equal to at least 100 percent of all rebates received, or to be received, in connection with the dispensing or administration of the prescription drug. Any rebate over and above the defined cost sharing would then be passed on to the health plan to reduce premiums." Any rebates in excess of a patient's defined cost-sharing cannot be retained by a PBM as profit but must be passed on by the health plan to lower premiums.

The data shows the effective difference between premium rate changes with and without the pass-through rebate. For the plan year filings of 2023, 2024, and 2025, the pass-through rebates resulted in notable reductions in final premium rate changes. Thus, patient cost share being determined by net cost, coupled with lower premium rate changes, indicates a benefit for patients and the system.

This real-world evidence disproves any communications from PBMs servicing state employee benefit plans that could push back, claiming that rebate pass-through would increase premiums and charges to the state. Moreover, it will be important to ensure that future contracting prevents PBMs from increasing fees to make up for lost rebate revenue as more PBMs move to fee-based structures, as indicated in a recent March 2026 analysis reported in Modern Healthcare.

Community Engagement Efforts Are Promising

We applaud your efforts to engage the community, as evidenced by your fliers promoting local public and virtual forums for Oregonians to discuss their challenges with drug costs. Holding public forums at libraries later in the day, when people are typically done with their workday, is a good-faith effort to improve access to participation. Additionally, the posted virtual options at later times bolster opportunities for public input.

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

WEST VIRGINIA INSURANCE BULLETIN
No. 26-01

Insurance Bulletins are issued when the Commissioner renders formal opinions, guidance or expectations on matters or issues, explains how new statutes or rules will be implemented or applied, or advises of interpretation or application of existing statutes or rules.

► Prescription Drug Rebate Impact to Commercial Health Insurance Plans◄

In 2021, the Legislature passed House Bill 2263 amending West Virginia's Pharmacy Audit Integrity Act (PAIA) located in Chapter 33, Article 51 of the West Virginia Code. The 2021 updates to the PAIA generally went into effect on January 1, 2022. One of the more substantive updates to the law was regarding prescription drug rebates. The West Virginia Offices of the Insurance Commissioner (OIC) is issuing this Insurance Bulletin to publicly provide frequently requested information regarding the effects of the prescription drug rebate law on health insurance rates as reported by commercial health insurers to the OIC.

W.Va. Code §33-51-9(k) provides "a covered individual's defined cost sharing for each prescription drug shall be calculated at the point of sale based on a price that is reduced by an amount equal to at least 100 percent of all rebates received, or to be received, in connection with the dispensing or administration of the prescription drug. Any rebate over and above the defined cost sharing would then be passed on to the health plan to reduce premiums."[1] This provision of the PAIA is oftentimes referred to as the "point-of-sale" or "pass-through rebate" provision. Any rebate calculated by a pharmacy benefit manager (PBM) to be over and above a covered individual's defined cost sharing may not be retained by the PBM but must be passed on to the health benefit plan and must be used by the health benefit plan to reduce the cost of premiums. *See* W.Va. Code St. R. §114-99-5.14.3.

Beginning in 2023, the OIC asked health insurers who file rates with the OIC to calculate the total amount of rebates received on prescription drugs and to assess the impact thereof on health insurance rates. Health insurers have been asked to separate the rate effect due to West Virginia's prescription drug rebate law from the health insurer's otherwise filed rate request without the effect of the prescription drug rebate law. Health insurers have complied and provided the OIC with the percentage that their annual rate request was reduced due to receipt of prescription drug rebates. Data submitted to the OIC by the health insurers is subsequently reviewed by OIC contracted actuaries.[2] Health insurers who have submitted this information in their annual filings are Aetna Health Insurance Company, CareSource West Virginia Company, Highmark Blue Cross Blue Shield, The Health Plan of West Virginia, THP Insurance Company, UnitedHealthcare Insurance Company, and Optimum Choice, Inc.

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[1] W.Va. Code §33-51-3 defines "defined cost sharing" as "a deductible payment or coinsurance amount imposed on an enrollee for a covered prescription drug under the enrollee's health plan." [2] The OIC does not currently possess specific data on how rebates affected the rate filings of specific insurers prior to 2022. Prior to the implementation of the point-of-sale or pass-through rebate law, PBMs and health insurers were able to negotiate rebate contract terms. Some insurers may have required 100% of rebates to be passed through to the insurer, while other insurers may have allowed their PBM to retain rebates, or portions thereof, as part of the PBM's compensation.

2023 Filings (2024 Plan Year):

Insurer	Plan Type	Rate Change Without Pass-Through Rebate	Pass-Through Rebate Effect on Rate	Final Rate Change
Company A	Any Size	17.10%	-5.50%	11.60%
Company A	Large Group	16.20%	-5.50%	10.70%
Company B	Individual	6.10%	-3.10%	3.00%
Company C	Individual	10.40%	-8.30%	2.10%
Company C	Small Group	13.50%	-7.10%	6.40%
Company C	Large Group	9.60%	-1.80%	7.80%
Company D	Individual	6.57%	-6.72%	-0.15%
Company D	Small Group	16.18%	-6.28%	9.90%
Company E	Small Group	6.41%	-5.55%	0.86%
Company F	Small Group	29.60%	-14.00%	15.60%
Company G	Small Group	29.40%	-14.00%	15.40%

2024 Filings (2025 Plan Year):

Insurer	Plan Type	Rate Change Without Pass-Through Rebate	Pass-Through Rebate Effect on Rate	Final Rate Change
Company A	Any Size	18.80%	-6.20%	12.60%
Company A	Large Group	18.70%	-6.20%	12.50%
Company B	Individual	15.097%	-2.75%	12.347%
Company C	Individual	12.30%	-9.60%	2.70%
Company C	Small Group	17.60%	-9.67%	7.93%
Company C	Large Group	17.30%	-0.70%	16.60%
Company C	Transitional	18.90%	-10.30%	8.60%
Company D	Individual	7.72%	-7.45%	0.27%
Company D	Small Group	17.80%	-7.07%	10.73%
Company E	Small Group	11.89%	-7.60%	4.29%
Company F	Small Group	21.80%	-11.70%	10.10%
Company F	Large Group	5.21%	0.00%	5.21%
Company G	Small Group	21.900%	-11.70%	10.200%

2025 Filings (2026 Plan Year)

Company	Plan Type	Rate Change Without Pass-Through Rebate	Pass-Through Rebate Effect on Rate	Final Rate Change
Company A	Any Size	24.70%	-8.00%	16.70%
Company A	Large Group	26.00%	-8.00%	18.00%
Company B	Individual	9.300%	-2.20%	7.100%
Company C	Large Group	21.10%	-7.70%	13.40%
Company C	Individual	20.20%	-6.30%	13.90%
Company C	Small Group	25.11%	-8.91%	16.20%
Company D	Individual	15.81%	-7.93%	7.88%
Company D	Small Group	24.38%	-7.56%	16.82%
Company D	Large Group	15.82%	-8.42%	7.40%
Company E	Small Group	28.67%	-7.50%	21.17%
Company E	Large Group	5.09%	-8.00%	-2.91%
Company F	Small Group	12.57%	-2.62%	9.95%
Company F	Large Group	22.60%	-13.00%	9.60%
Company G	Large Group	22.60%	-13.00%	9.60%
Company G	Small Group	10.10%	-1.30%	8.80%

Please e-mail any questions concerning this Insurance Bulletin to OICBulletins@wv.gov.

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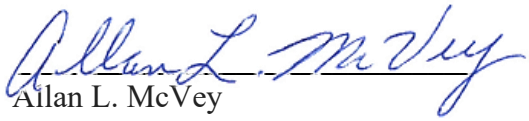

Allan L. McVey
CPCU, ARM, AAI, AAM, AIS
Insurance Commissioner