

September 14, 2026

VIA ELECTRONIC SUBMISSION

Oregon Prescription Drug Affordability Board
350 Winter Street NE
Salem, OR 97309-0405
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RE: Oregon Prescription Drug Affordability Board (PDAB): September 16, 2026 Meeting Materials — Updated Draft Drug Review Reports for Mounjaro® and Humulin® R U-500 and 2026 Policy Concept Memorandums

Dear Members of the Board:

Eli Lilly and Company (“Lilly”) appreciates the opportunity to provide comments on the Oregon PDAB (“the Board”) materials for the September 16, 2026, meeting, which include the updated Draft Drug Review Reports (“the Reports”) for our products Mounjaro® (tirzepatide) and Humulin® R U-500 (insulin human), as well as the policy concepts the Board is considering for its 2026 annual report.¹ Lilly is one of the world’s leading innovation-driven, research-based pharmaceutical and biotechnology corporations, committed to equitable and affordable access to our medicines so that our innovations can transform more people’s lives.

Lilly shares the Board’s goal of improving patient outcomes by making effective treatments accessible. However, price controls do nothing to make medicines more affordable for patients and any actions to meaningfully address affordability will require targeting underlying incentives in the pharmaceutical supply chain in need of reform, rather than misguided policies like UPLs. We reiterate our comments in our prior letter affirming that both Mounjaro® and Humulin® R U-500 are affordable in Oregon. We also reiterate our prior comments regarding ongoing methodological concerns with how the Board defines affordability.²

Lilly Is Committed to Patient Affordability

Throughout our 150-year history, Lilly has worked to address some of the most pressing health challenges facing humanity, including diabetes, depression, cancer, and obesity. Today, more than 71 million people are estimated to use a Lilly medicine.³ Our commitment to patients and society goes beyond the medicines we make; we are committed to equitable and affordable access to our medicines so that our breakthroughs can transform more people’s lives.

The Board Should Adopt Policies in its Annual Report that Address Patient Affordability

Lilly appreciates the opportunity to comment on the policy concepts the Board is considering for its 2026 annual report. Consistent with our longstanding view that affordability to patients is the most important goal, we support policies that would make meaningful changes to what

¹Oregon Prescription Drug Affordability Board. Mounjaro® (tirzepatide), Version 4.0, Sept. 8, 2026; and Humulin® R U-500 (insulin regular), Version 4.0, Sept. 8, 2026.

² Letter from Lilly to Board (June 15, 2026)

³ Lilly Sustainability Highlights, 2025. <https://sustainability.lilly.com/>

patients actually pay and improve access to medicines. We oppose price controls, like UPLs, that would harm patient access to medicines without providing out-of-pocket relief to patients.

Lilly opposes setting reference prices or upper payment limits using Medicare “Maximum Fair Prices.”

Lilly respectfully opposes the proposal to adopt model legislation setting reference prices, or upper payment limits (UPLs), for Oregon’s state-regulated commercial market based on the Inflation Reduction Act’s (IRA) Medicare Drug Price Negotiation Program Maximum Fair Prices (MFPs). A UPL is a unilateral price-setting mechanism, and, as we have noted in prior comments, price controls do little to make medicines more affordable for patients while creating serious risks for access and innovation.

First, UPLs do not address the actual drivers of patients’ out-of-pocket costs. What a patient pays at the pharmacy counter is determined by the patient’s plan and its Pharmacy Benefit Manager (PBM) through cost-sharing that varies with formulary tier and deductible, not by a drug’s list or net price. The experience of the federal program that produces MFPs is instructive: even for selected drugs, plans have shifted toward coinsurance. One analysis found that seniors paid higher out-of-pocket costs for 14 of the 24 selected drugs, and only an estimated 11 percent of Part D enrollees are projected to pay less per prescription for the ten selected drugs in 2026.⁴ The proposal’s own “use of savings” provision directs plan-level savings to reduce health care costs for members but does not ensure any reduction in patient cost-sharing at the point of sale — effectively undermining its patient-affordability rationale.

Second, importing Medicare-negotiated prices into a commercial market imports a federal program’s objectives and valuation into a setting they were not designed for. An MFP is the product of a statutory ceiling-price formula and a price-setting mechanism conducted for the Medicare population; it does not reflect the value or the market dynamics of Oregon’s commercial market.

Third, UPLs are likely unlawful. Colorado’s UPL, which was benchmarked to a Medicare MFP, was recently preliminarily enjoined on federal preemption grounds.⁵

Fourth, price-setting erodes the incentives for the research that produces new and improved medicines:

- Independent modeling projects that price-setting under the IRA could reduce small-molecule research and development by approximately \$232 billion over twenty years, resulting in an estimated 188 fewer small-molecule treatments;
- A historical analysis found that a meaningful share of new treatment uses occur well after initial approval, including 15 percent of biologics’ lifetime approvals more than 13

⁴Pioneer Institute, analysis of real-world prescription and out-of-pocket cost data; DLA Piper, Keeping watch on Medicare: 2026 maximum fair prices for ten selected drugs (Jan. 2026).

⁵ See *Amgen Inc. v. Mizner*, No. 1:25-cv-03452, 2026 U.S. Dist. LEXIS 148973 (D. Colo. July 1, 2026) (granting preliminary injunction against Colorado UPL).

years out and 15 percent of small molecules' more than 9 years out, precisely the windows the IRA's price-setting timelines put at risk; and

- Industry-sponsored clinical trials on already-approved medicines declined by approximately 36.6 percent following the IRA.⁶

Extending MFP-based price-setting into a state's commercial market would compound these effects without delivering meaningful benefit to patients. For these reasons, we urge the Board not to advance the MFP-based reference-pricing concept, and instead to prioritize supply-chain and patient-focused reforms that address the drivers of patient cost without the unintended consequences of price-setting.

Lilly supports policies that examine and address supply-chain dynamics to ultimately improve patient affordability.

The Board's review focuses on describing an individual product's utilization, price, spending, rebates, value, and cost-sharing, rather than examining how manufacturers, PBMs, health plans, plan sponsors, prescribers, pharmacists, purchasers, and other stakeholders shape what Oregonians ultimately pay.⁷ We have consistently urged the Board to examine these dynamics, because the affordability challenges Oregon patients experience most often arise from plan benefit design choices and supply-chain incentives — high deductibles, adverse formulary placement, and patient cost-sharing tied to undiscounted list prices (i.e., for medicines on coinsurance tiers) — rather than from the medicines themselves.

Robust negotiation between manufacturers and PBMs yields significant price concessions off the list price of medicines.⁸ Despite this, many patients, whether through their deductibles or coinsurance designs, struggle to afford their prescribed medicines because their plan sets their cost-sharing amount as a percentage of the undiscounted list price.⁹

This dynamic is largely unique to the pharmacy benefit. For most other covered health care services, a patient's cost-sharing obligations are calculated based on the rate the plan has negotiated with the provider.¹⁰ Patients' exposure to undiscounted list prices in the pharmacy

⁶Philipson TJ, Ling Y, Chang R, The impact of price setting at 9 years on small molecule innovation under the Inflation Reduction Act, University of Chicago (Oct. 2023); IQVIA Institute for Human Data Science, Proliferation of Innovation Over Time (Feb. 2025); National Pharmaceutical Council, *Do Early Signals Persist? Updated Evidence on the IRA's Potential Impact on Clinical Developments in Approved Drugs* (2026), <https://www.npcnow.org/resources/earlysignals-npcbrief-626>.

⁷Oregon Prescription Drug Affordability Board, Policy Memorandum: Expanding Oregon PDAB scope (Sept. 8, 2026).

⁸Berkeley Research Group. The pharmaceutical supply chain, 2013–2023. January 2025. https://cdn.aglty.io/phrma/global/blog/import/pdfs/PhRMA_Supply-Chain-2013-2023_White-Paper_V484.pdf.

⁹Trish E, et al. Drug cost-sharing based on net price benefits Medicare Part D patients. USC Schaeffer Center; March 17, 2020. <https://schaeffer.usc.edu/research/net-price-drug-rebates-would-benefit-medicare-part-d-patients/>. Trish E, Blaylock B, Van Nuys K. Cost-sharing for preferred branded drugs in Medicare Part D. *JAMA*. 2025;333(13):1170-1172. <https://doi.org/10.1001/jama.2024.28092>.

¹⁰Lieberman SM, et al. Sharing drug rebates with Medicare Part D patients: why and how. Brookings Institution; March 9, 2022. <https://www.brookings.edu/articles/sharing-drug-rebates-with-medicare-part-d-patients-why-and-how/>.

benefit has resulted in a system of “reverse insurance,” where drug utilization from sicker patients effectively subsidizes lower premiums for everyone else through higher rebates.

These patient-borne costs often result in nonadherence, which contributes to negative health outcomes and avoidable downstream medical spending, including hospitalizations.^{11,12} Policies that lower patient out-of-pocket cost exposure at the pharmacy counter therefore have the potential to improve adherence and reduce total health care spending for plans and public programs over the long run.

We have long believed that rebates and other price concessions for all medicines should be passed through to the patient at the point of sale (i.e., rebate pass-through). Doing so would reduce patient cost exposure, improve adherence, and improve health outcomes, while better aligning PBM formulary design incentives.¹³ Copay caps that limit patient out-of-pocket costs would similarly reduce cost exposure and improve adherence. The Board should continue to recommend reforms that address the warped supply-chain incentives that expose patients to higher cost-sharing obligations, which would enable lower costs at the point of sale and create the conditions for list and net price parity.

Lilly supports a commercial continuity-of-care requirement for prescription drugs.

We support the continuity-of-care concept, which would require a receiving commercial plan to honor, for a defined transition period, a prescription-drug prior authorization or step-therapy exception issued under a patient’s immediately preceding coverage while the new plan completes its own review. Patients who change plans mid-treatment can face a reset of prior authorizations that delays dispensing, forces resubmission of clinical information, and can lead to treatment interruption — a form of nonmedical switching. The risks of nonmedical switching are well documented and include an increased likelihood of adverse events, reduced adherence, and long-term complications.¹⁴ A transition protection keeps patients on stabilized therapy during a coverage change while preserving the receiving plan’s formulary, benefit, safety, and utilization-review authority.

Lilly Appreciates that Several Data-Quality Issues Have Been Corrected

We appreciate that the Board has revised both Reports, each now Version 4.0, dated September 8, 2026, to address several of the data-quality concerns we raised in our June 15, 2026, comment letter. We are pleased to acknowledge corrections in the price concession

¹¹ Nekui F, et al. Cost-related medication nonadherence and its risk factors among Medicare beneficiaries. *Med Care*. 2021;59(1):13-21. <https://doi.org/10.1097/mlr.0000000000001458>.

¹² De Avila JL, et al. Prevalence and persistence of cost-related medication nonadherence among Medicare beneficiaries at high risk of hospitalization. *JAMA Netw Open*. 2021;4(3). <https://doi.org/10.1001/jamanetworkopen.2021.0498>.

¹³ Medicare Payment Advisory Commission. Assessing post-sale rebates for prescription drugs in Medicare Part D. In: *Report to the Congress: Medicare and the Health Care Delivery System*. Ch. 2. MedPAC; June 2023. https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch2_MedPAC_Report_To_Congress_SEC.pdf.

¹⁴ Ellingson L. Position on non-medical switching for diabetes patients. *J Diabetes Metab Disord Control*. 2017;4(5):138-139.

rubric labeling, updated price concession totals, and the addition of more complete insulin affordability context. We thank the Board and its staff for the attention given to these items.

Certain Data-Quality Issues Remain Outstanding

Notwithstanding these improvements, several issues we identified in the Humulin® R U-500 Report remain uncorrected. Two in particular remain: an inaccurate source citation in the Report's drug-information table and the continued treatment of an unmarketed presentation as a separate product. The "Drug information" table (Table 5) still cites the prescribing information for Eliquis® (apixaban), a Bristol-Myers Squibb anticoagulant, as its source, rather than the Humulin® R U-500 label.¹⁵ In addition, while the Report now acknowledges that the Humulin® R U-500 vial is not marketed, it continues to score the concentrated vial as a separate product. Affordability findings for a presentation no longer available to patients have little practical bearing on the Report's conclusions and should be removed.

We note one additional internal inconsistency that appears in the Mounjaro® Report. The "Estimated average monetary price concession" section based on carrier-submitted data states that "92.3 percent of claims benefited from some form of price concession, leaving 47.6 percent at full gross cost." The 47.6 percent figure is the percentage of gross cost remaining after concessions, not the share of claims paying full gross cost. Because 92.3 percent of claims received a concession, only approximately 7.7 percent, not 47.6 percent, would be at full gross cost.¹⁶

Lilly appreciates the opportunity to respond to the Board's materials. We value the Board's shared commitment to improving prescription drug access and patient affordability, we are grateful for the corrections made to the Reports, and we believe that Lilly medicines like Mounjaro® and Humulin® R U-500 positively contribute to the health and well-being of patients in Oregon.

Sincerely,



Rachel Dolan
Senior Director, US Public Policy
Eli Lilly and Company

¹⁵Humulin® R U-500 Report, Table 5 (Drug information) source note (citing Eliquis (apixaban) Prescribing Information, Bristol-Myers Squibb Company).

¹⁶Mounjaro® Report, "Estimated average monetary price concession" section; Table 15 ("Percentage of gross cost remaining after concessions 47.6%"; "Percentage of discount 52.4%").