



September 15, 2026

Oregon Prescription Drug Affordability Board
Attn: Sarah Young, Executive Director
350 Winter Street NE
Salem, OR 97304

Re: 2026 Prescription Drug Affordability Board recommendations

Members of the Board:

On behalf of the Pharmaceutical Care Management Association ("PCMA"), the trade association representing America's pharmacy benefit managers ("PBMs"), thank you for the opportunity to submit our comments to the Oregon Prescription Drug Affordability Board (PDAB) regarding policy concepts the Board is considering for inclusion in its 2026 PDAB Annual Report to the Oregon state legislature.

About PCMA

PBMs are electively hired by employers, unions, government programs and others to drive down prescription drug costs and manage prescription drug benefits for more than 289 million Americans. PBMs are the only part of the drug supply chain whose primary function is to lower prescription drug costs, saving Oregon patients or those paying for their benefits \$22.5 billion over the next decade, or roughly \$1,154 per person.

We share the Board's goal of lowering prescription drug costs for Oregonians. It is our understanding that the Board will consider a variety of drug benefit recommendations for the legislature to consider as a strategy to protect Oregonians from the high cost of prescription drugs. Several of the proposals under consideration, however, could limit the negotiating and cost-management tools used to achieve this goal. While perhaps well-meaning, these policies fail to address the root cause of high drug prices. Moreover, they would largely shift expenses to patient premiums, deductibles, and other cost-sharing.

The Board should therefore evaluate each proposal against a clear standard: whether it reduces total net drug spending and delivers measurable value to patients and plan sponsors.

That net-cost standard is especially important when evaluating proposals to eliminate spread pricing, delink PBM compensation from drug prices, or restructure rebate and contracting arrangements. Although often described as transparency reforms, each could materially change how prescription drug benefits are financed and administered—and recommendations for these policies should advance only if the evidence shows lower overall costs. Several of the proposals under discussion have already been considered through federal and state legislative and regulatory processes. The Board should evaluate whether additional recommendations would create duplicative requirements.

Manufacturer Rebates

Manufacturer rebates, discounts, and other negotiated concessions reduce the cost of coverage and can support lower premiums and costs for plan sponsors and consumers. Prescription drug

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affordability should be measured by net cost, not rebates in isolation. Before disrupting these tools, the Board should require evidence that an alternative model will deliver equal or greater savings. Without that evidence and a mechanism requiring manufacturers to lower prices, such changes could increase costs for Oregon families and employers.

The Board is also considering a recommendation to apply manufacturer rebates at the point of sale (POS). In practice, rebates are available only for a small subset of drugs—generally high-cost brand-name medicines—so this approach would benefit only a limited number of insured Oregonians. For most enrollees, applying rebates at the POS would increase premium costs. Plan sponsors today can apply estimated rebate amounts at POS, but most do not because patients are highly sensitive to premium increases, and POS rebates are correlated with higher premiums. Most rebated drugs already have lower cost-sharing because they are preferred drugs under a patient's prescription drug benefit plan design.

Eliminating or restricting rebates does not require a manufacturer to reduce its list price by a corresponding amount. Without an enforceable mechanism ensuring that foregone rebates become lower prices, the likely result may be fewer negotiated savings rather than lower drug costs.

Spread Pricing

With regard to spread pricing, PBMs are compensated by employers, unions, and government programs through a mix of spread pricing, rebates, and a flat administrative fee. Banning spread pricing removes one of the ways entities pay for prescription drug benefits to help hold down prescription drug costs. Employers, labor unions, and government programs always choose how to pay their PBM when they shop for services.

In fact, many small and mid-sized employers choose spread pricing because it provides predictable, stable drug costs without large month-to-month swings. In a spread model, those paying for prescription drug benefits pay a PBM one set rate for each drug, regardless of which pharmacy fills it. Just like gas stations may charge different prices for a gallon of gas, pharmacies determine what they charge for their drugs, and the cost may differ.

The “spread” is simply the difference between what the PBM pays the pharmacy and what the employer pays the PBM. That difference can be either negative or positive, and as a result of this arrangement, the PBM assumes the risk for drug cost increases. Spread contracts incentivize PBMs to build networks of lower-cost pharmacies, and for those pharmacies to buy lower-cost versions of drugs.

PBM Compensation

Delinking proposals seek to limit how health plans and employers choose to manage and pay their PBMs. Prohibiting employers and health plan sponsors from electing to compensate PBMs based on the savings they provide will encourage drug manufacturers to raise their prices. PBM customers can already negotiate flat fee administrative fee compensation for PBM services if they so choose. The current pay-for-PBM-performance model works effectively in numerous industries and helps PBMs deliver prescription drug savings to patients and plan sponsors every year by forcing manufacturers to negotiate. If plan sponsors are unable to incentivize their PBM to find ways to lower costs - and are prohibited from encouraging PBMs to negotiate against drug manufacturers - ultimately, costs will increase.

According to the National Bureau of Economic Research, this policy would significantly alter drug pricing and utilization, shifting billions of dollars annually from patients to drug

manufacturers. Patients will pay higher drug prices, and Big Pharma will have a financial windfall.

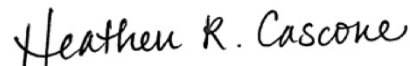
The key policy question should be whether the PBM reimbursement arrangement is transparent to the plan sponsor and aligned with the plan's goals. Plan sponsors have different needs: a large employer, a union trust, a small business, and a fully insured plan may prefer different compensation arrangements. Mandating flat fees does not guarantee lower patient costs. In fact, it may result in higher premiums or less aggressive rebate/discount negotiations.

Conclusion

As the Board considers potential reforms, the central question is whether each approach will lower total net costs and improve affordability for Oregonians. Effective policy is that which is supported by evidence identifying the practice at issue, its financial impact, who bears the cost, and the expected affordability benefit. Insurance markets, pharmacy environments, benefit designs, demographics, and existing regulatory frameworks vary significantly from state to state.

PCMA and its members welcome the opportunity to continue working with the Board and other stakeholders on evidence-based solutions that make prescription drugs more affordable for Oregonians.

Sincerely,

A handwritten signature in black ink that reads "Heather R. Cascone". The signature is written in a cursive, flowing style.

Heather R. Cascone
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