

October 6, 2026

Oregon Prescription Drug Affordability Board
350 Winter Street NE
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pdab@dcbs.oregon.gov

Re: Oregon Prescription Drug Affordability Board: September 16, 2026, Meeting Materials

Dear Members of the Oregon Prescription Drug Affordability Board:

The Pharmaceutical Research and Manufacturers of America (“PhRMA”) is writing in response to the Oregon Prescription Drug Affordability Board’s (the “PDAB’s” or “Board’s”) meeting materials for its September 16, 2026, meeting (“September Board Meeting”), which include the Board’s scoring framework, drug review reports, and 2026 policy concept memoranda (collectively, the “Meeting Materials”).¹ PhRMA represents the country’s leading innovative biopharmaceutical research companies, which are focused on developing innovative medicines that transform lives and create a healthier world. Together, we are fighting for solutions to ensure patients can access and afford medicines that prevent, treat, and cure disease. PhRMA member companies have invested more than \$900 billion in the search for new treatments and cures over the last decade, supporting nearly five million jobs in the United States.

We provide below select comments and concerns with respect to the Meeting Materials for the September Board Meeting.

I. Affordability Review Process

PhRMA remains concerned about the lack of clear, consistent, and non-arbitrary standards governing the Board’s affordability review process.² For example, despite conducting affordability reviews, the Board has yet to establish a definition of affordability.³ Additionally, the Board’s scoring framework continues to rely on vague and arbitrary cutoffs and does not clearly articulate how each metric in the framework is to be used in the affordability review process.⁴ PhRMA reiterates that the Board must develop standards to facilitate consistent and transparent affordability reviews.⁵ Without clear standards to guide its determinations, the Board risks arbitrary decision-

¹ September Meeting Materials (Sept. 16, 2026), available at <https://dfr.oregon.gov/pdab/Documents/20260916-PDAB-document-package.pdf>. In filing this comment letter, PhRMA reserves all rights to legal arguments with respect to Oregon Senate Bill 844 (2021), as amended by Oregon Senate Bill 192 (2023) and Oregon Senate Bill 289 (2025) (codified at Or. Rev. Stat. § 646A.693 *et seq.*) (collectively, the “PDAB Statute”), and the Board’s implementation of the PDAB Statute. PhRMA also incorporates by reference all prior comment letters to the extent applicable. See, e.g., Letter from PhRMA to Board (May 4, 2026); Letter from PhRMA to Board (Mar. 5, 2026); Letter from PhRMA to Board (Feb. 9, 2026); Letter from PhRMA to Board (Jan. 9, 2026); Letter from PhRMA to Board (Nov. 16, 2025); Letter from PhRMA to Board (Nov. 5, 2025); Letter from PhRMA to Board (Oct. 3, 2025); Letter from PhRMA to Board (Aug. 18, 2025); Letter from PhRMA to Board (Jan. 11, 2025); Letter from PhRMA to Board (Jan. 7, 2025); Letter from PhRMA to Board (Sept. 15, 2024); Letter from PhRMA to Board (Apr. 13, 2024); Letter from PhRMA to Board (Nov. 11, 2023); Letter from PhRMA to Board (Oct. 15, 2023); Letter from PhRMA to Board (Oct. 6, 2023); Letter from PhRMA to Board (Sept. 16, 2023); Letter from PhRMA to Board (May 14, 2023); Letter from PhRMA to Board (Apr. 16, 2023).

² See, e.g., Letter from PhRMA to Board (Feb. 9, 2026) at 2-3; Letter from PhRMA to Board (Nov. 5, 2025) at 2-3; Letter from PhRMA to Board (Oct. 3, 2025) at 2.

³ See, e.g., Letter from PhRMA to Board (Feb. 9, 2026) at 2; Letter from PhRMA to Board (Nov. 16, 2025) at 3; Letter from PhRMA to Board (Jan. 7, 2025) at 3.

⁴ See, e.g., Letter from PhRMA to Board (Feb. 9, 2026) at 2; Letter from PhRMA to Board (Nov. 5, 2025) at 2-3; Letter from PhRMA to Board (Aug. 18, 2025) at 3.

⁵ See Letter from PhRMA to Board (Feb. 9, 2026) at 2-3; Letter from PhRMA to Board (Nov. 5, 2025) at 2-3; Letter from PhRMA to Board (Oct. 3, 2025) at 4-5; see also *Feitelson v. City of Salem*, 46 Or. App. 815, 822 (1980) (“If there is to be any meaningful judicial review, an agency must demonstrate that it has considered the factors prescribed by statute and its own regulations and has not acted in an arbitrary manner or on an ad hoc basis”).

making and inhibits the public's ability to validate and meaningfully engage with Board decisions.⁶

Further, PhRMA remains concerned that the lack of clarity surrounding the data that the Board relies upon to produce affordability review reports raises serious questions about their reliability and ultimately whether the Board can satisfy its obligation to conduct affordability reviews in a manner consistent with its obligations under the PDAB Statute.⁷ Accordingly, PhRMA reiterates its request that the Board adopt clear procedures, provide more information on how it reviews and evaluates the information it considers, and permit manufacturers to review, verify, and provide input on data reported by or accessed from third-party sources.

II. 2026 Policy Concept Memoranda

The Meeting Materials include links to five “policy concept memos” for consideration and possible advancement as recommendations to the Legislature.⁸ PhRMA provides below select comments and concerns with respect to these memoranda.

A. “Expand PDAB Scope Beyond Current Affordability Reviews for Individual Drugs”

The Board is considering a policy proposal to “expand its scope beyond its current affordability reviews for individual drugs” to “examine how market practices affect cost and access,” noting that the current reviews do not focus on how a broader array of supply chain actors contribute to patient cost and access to medications.⁹ Specifically, the Board proposes that it could annually select and review one or two subjects—such as pharmacy benefit manager (“PBM”) compensation, pharmacy reimbursement, or “cost sharing accumulators and maximizers”—and issue a report reflecting its findings.¹⁰ PhRMA appreciates the Board’s recognition that factors throughout the supply chain impact affordability and access for Oregon patients and reiterates the need to address the practices that drive patients’ out-of-pocket costs.¹¹ For example, PBM and health insurer practices directly impact patient costs through, among other things:

- Benefit design choices (e.g., complex prescription tiering mechanisms and utilization management policies, like prior authorization and step therapy; cost-sharing requirements like coinsurance and deductibles); alternative funding programs (“AFPs”), and copay accumulator adjustment and maximizer programs);¹² and
- Rebates, discounts, and other price concessions paid by drug manufacturers to PBMs and insurers that

⁶ See Letter from PhRMA to Board (Feb. 9, 2026) at 2; see also e.g., *Sun-Ray Drive-In Dairy, Inc. v. Or. Liquor Control. Comm’n*, 16 Or. App. 63, 72 (1973) (“The danger of inconsistent, subjective and ad hominem decision making is minimized by the deliberate adoption of written, published policy standards applicable alike to all[.]”).

⁷ See Letter from PhRMA to Board (Feb. 9, 2026) at 2-3; Letter from PhRMA to Board (Nov. 5, 2025) at 3; Letter from PhRMA to Board (Oct. 3, 2025) at 4–5.

⁸ September Meeting Materials (Sept. 16, 2026) at 75 (links to memoranda); 76-87 (accompanying presentation).

⁹ Policy Memorandum from Cortnee Whitlock to Oregon PDAB, Expanding Oregon PDAB Scope (Sept. 8, 2026) at 1, 6, <https://dfr.oregon.gov/pdab/Documents/PDAB-Scope-Expansion-Memo.pdf> (“Expanding Oregon PDAB Scope Memo”).

¹⁰ See Expanding Oregon PDAB Scope Memo at 5; see also Letter from PhRMA to Board (Jan. 7, 2025) at 5 (sharing “concerns with the lack of transparency for copay accumulator and maximizer programs.”).

¹¹ See, e.g. Letter from PhRMA to Board (Apr. 13, 2024) at 2; Letter from PhRMA to Board (Apr. 16, 2023) at 3.

¹² Accumulator adjustment programs (“AAPs”) block manufacturer cost-sharing assistance from counting towards cost-sharing requirements, including deductibles and maximum out-of-pocket limits. Copay maximizer programs involve inflating patients’ cost-sharing to fully deplete available cost-sharing assistance before insurance coverage kicks in. AFPs utilize third-party vendors, sometimes in partnership with smaller PBMs, to convince employers to drop coverage of some or all specialty medicines, and assist patients in getting access to those medicines through patient assistance programs intended for uninsured or underinsured patients or other means instead. AFPs are a type of cherry-picking strategy to avoid individuals with higher health risks, such as individuals with pre-existing conditions.

are not being shared directly with patients at the point of sale.¹³

PhRMA encourages the Board to examine these factors and their impacts on Oregonian patients. To facilitate this expanded review, the Board should recommend that reviews of other supply chain entities be funded by fees assessed on those entities.¹⁴

B. “Orphan Drug Review Refinements”

PhRMA opposes the proposed policy concept recommending that the orphan drug exemption in O.R.S. § 646A.694(2) be amended to permit the Board to conduct affordability reviews of drugs with orphan designations that also have been approved for non-orphan indications.¹⁵ The Oregon Legislature was clear when it enacted an categorical exemption for all drugs designated by the Food and Drug Administration (“FDA”) for a rare disease or condition under 21 U.S.C. § 360bb. The statute unambiguously provides that “[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 [the PDAB Statute].”¹⁶ The statute exempts orphan designated drugs as a whole, not merely their specific orphan designated indications. The Board’s own policy memorandum acknowledges that “[t]he statute refers to a ‘drug’ with a designation,” yet the Board’s “rule treats the exemption as indication-specific.”¹⁷

The Orphan Drug Act (“ODA”) is a cornerstone of U.S. policy for addressing the needs of patients with rare diseases. Congress enacted the ODA in 1983 to incentivize the development of drugs for rare diseases, recognizing that the small patient populations affected by these conditions made drug development financially challenging without targeted support.¹⁸ The ODA provides critical incentives for orphan drug development, including tax credits for clinical testing costs, waiver of some FDA user fees, and seven years of market exclusivity. Since its enactment, the FDA has approved more than 800 orphan drugs for conditions that previously had few or no treatment options.¹⁹ Oregon’s categorical exemption likewise recognizes the significance of orphan designated drugs and the need to limit regulatory actions that could undermine the incentives that are critical to rare disease drug development.

C. “Address Key Issues in Pharmacy Benefit Manager (PBM) Practices”

PhRMA appreciates the Board’s continued attention to the role of PBM practices in driving prescription drug costs for Oregon patients and supports policy concepts that propose to address such practices, including policies to eliminate spread pricing, delink PBM compensation from drug prices, require PBMs to share rebates and other price concessions to reduce patient costs, and establish conduct standards for PBMs.²⁰

¹³ On average, rebates, discounts, and price concessions can lower the price that plans actually pay for medication by 50% or more. Adam J. Fein, Inflation-Adjusted U.S. Brand-Name Drug Prices Fell for the Seventh Consecutive Year as a New Era of Drug Pricing Dawns, DRUG CHANNELS (Jan. 7, 2025), <https://www.drugchannels.net/2025/01/inflation-adjusted-us-brand-name-drug.html>.

¹⁴ Cf. Or. Rev. Stat. § 646A.695; Or. Admin. R. 836-200-0553.

¹⁵ Policy Memorandum from Cortnee Whitlock to Oregon PDAB, Orphan Drug Review Refinements (Sept. 8, 2026) at 1, <https://dfr.oregon.gov/pdab/Documents/PDAB-Orphan-Drug-Review-Refinement-Memo.pdf> (“Orphan Drug Review Refinements Memo”).

¹⁶ Or. Rev. Stat. § 646A.694(2) (emphasis added); see, e.g., Letter from PhRMA to Board (May 4, 2026); Letter from PhRMA to Board (Feb. 9, 2026) at 3; Letter from PhRMA to Board (Jan. 7, 2025) at 4.

¹⁷ Orphan Drug Review Refinements Memo at 2.

¹⁸ See Pub. L. No. 97-414, 96 Stat. 2049 (1983).

¹⁹ PhRMA, *Progress in Fighting Rare Diseases*, available at <https://phrma.org/policy-issues/future-of-medicine/rare-diseases> (last visited Sept. 22, 2026).

²⁰ Policy Memorandum from Cortnee Whitlock to Oregon PDAB, PBM Practices (Sept. 8, 2026), <https://dfr.oregon.gov/pdab/Documents/PDAB-PBMpractices-Memo.pdf> (“PBM Practices Memo”); see, e.g., Letter from PhRMA to Board (Jan. 9, 2026) at 1–2; Letter from PhRMA to Board (Nov. 16, 2025) at 3–4; Letter from PhRMA to Board (June 28, 2024) at 5–6.

- **Eliminating spread pricing.**²¹ PhRMA supports the proposal to eliminate spread pricing. Through the practice of spread pricing, PBMs profit from the difference between the amount reimbursed to pharmacies for a medicine and the amount charged to a PBM’s health plan clients. For example, the state of Ohio was overcharged nearly \$225 million in a single year due to PBM spread pricing.²² More than 20 states have taken action to rein in spread pricing, and the Congressional Budget Office found that prohibiting the use of spread pricing in Medicaid would save taxpayers an estimated \$900 million over 10 years.²³ Spread pricing adds opacity to a supply chain that needs transparency to best serve the needs of patients.
- **Delinking PBM compensation from drug prices.**²⁴ PhRMA supports the proposal to delink PBM compensation from drug prices. Delinking PBM fees from drug prices and improving transparency within PBM operations are critical steps toward addressing perverse incentives that experts have found may cause PBMs to prefer prescription drugs with higher list prices over ones with lower list prices.²⁵
- **PBM conduct and rebate dynamics.**²⁶ PhRMA supports policy reforms that would address PBM conduct, including “a duty to disclose material conflicts and avoid self-dealing” and a requirement to share “manufacturer rebates and other price concessions [with] the plan sponsor” to reduce “point-of-sale cost sharing.”²⁷ The evolution and growing scope of PBMs’ influence on plan sponsors’ choices in the market and patients’ ability to afford and access their prescriptions requires a regulatory structure that protects patients. In short, PBMs should be required to put patients’ and their clients’ best interests ahead of their own bottom line when executing their contractual duties. Establishing an explicit duty of good faith and fair dealing is one of the first steps that should be taken to hold PBMs accountable to plan sponsors and patients.

PhRMA also continues to support policies that would allow patients to benefit directly from rebates, discounts, and other price concessions.²⁸ Patients often do not benefit from the significant rebates, discounts, and other price concessions that manufacturers provide because health insurers and their PBMs often fail to pass the savings to patients at the point of sale.²⁹ PBMs in Oregon received \$377.2 million in rebates, fees, and other payments from manufacturers but passed only \$432,204 (0.11 percent) to patients in 2025.³⁰ Requiring PBMs to share negotiated rebates, discounts, and other price concessions directly with patients at the pharmacy counter would reduce patients’ out-of-pocket costs, thereby improving affordability.

²¹ PBM Practices Memo at 1, 4-6, 22.

²² Press Release, Ohio Auditor of State, Auditor’s Report: Pharmacy Benefit Managers Take Fees of 31% on Generic Drugs Worth \$208M in One-Year Period (Aug. 16, 20218), <https://ohioauditor.gov/news/pressreleases/details/5042>; Ohio’s Medicaid Managed Care Pharmacy Services, Auditor of State Report, August 2018, https://audits.ohioauditor.gov/Reports/AuditReports/2018/Medicaid_Pharmacy_Services_2018_Franklin.pdf;

²³ Congressional Budget Office. “Analysis of Prescription Drug Pricing Reduction Act of 2019.” March 13, 2020. <https://www.cbo.gov/system/files/2020-03/PDPRA-SFC.pdf>.

²⁴ PBM Practices Memo at 1, 6–8, 22.

²⁵ See STAFF OF H.R. COMM. ON OVERSIGHT & ACCOUNTABILITY, THE ROLE OF PHARMACY BENEFIT MANAGERS IN PRESCRIPTION DRUG MARKETS (July 23, 2024), <https://oversight.house.gov/report/pbm-report>; Press Release, Federal Trade Commission, FTC Launches Inquiry into Prescription Drug Middlemen Industry (June 7, 2022), <https://www.ftc.gov/news-events/news/press-releases/2022/06/ftc-launches-inquiry-prescription-drug-middlemen-industry>; Press Release, Federal Trade Commission, FTC Deepens Inquiry into Prescription Drug Middlemen (May 17, 2023), <https://www.ftc.gov/news-events/news/press-releases/2023/05/ftc-deepens-inquiry-prescription-drug-middlemen>; see also Letter from PhRMA to Board (Nov. 16, 2025) at 4; Letter from PhRMA to Board (Oct. 3, 2025) at 4; Letter from PhRMA to Board (Oct. 6, 2023) at 2.

²⁶ PBM Practices Memo at 1, 8-11, 22.

²⁷ *Id.* at 10–11.

²⁸ See *id.* at 11 (proposing to require PBMs to, among other things, share “manufacturer rebates and other price concessions[with] the plan sponsor” to reduce “point-of-sale cost sharing.”).

²⁹ See, e.g., Letter from PhRMA to Board (Nov. 16, 2025) at 4; Letter from PhRMA to Board (Nov. 26, 2024) at 5.

³⁰ DEP’T OF CONSUMER & BUS. SERVS., OREGON DRUG PRICE TRANSPARENCY REPORT: PHARMACY BENEFIT MANAGER DATA – 2025 at 5, <https://dfr.oregon.gov/drugtransparency/Documents/DPT-pbm-data-2025.pdf> (last visited Sept. 24, 2026).

D. “Commercial Health Plan Continuity of Care Requirement for Prescription Drugs”

PhRMA supports the proposal to address the disruption patients face when transitioning between health insurance plans by requiring insurers to honor prior authorization approvals and step therapy determinations made by the patient’s previous health insurance plan for a defined transition period.³¹ PhRMA agrees with the proposal to require a 90-day transition period to prevent patients from experiencing interruptions in previously authorized therapies solely due to a change in their insurance coverage. During this transition period, insurers should be required to permit patients to continue their current therapy without being required to obtain a new prior authorization or switch to or step through an alternate medication.

Further, insurers should be required to provide advance notice before mandating a transition to an alternative drug, with a defined minimum notice period that gives patients and their providers sufficient time to respond. These protections should be reflected in denial and transition communications so that patients are aware of their rights during coverage changes.

E. “Set Reference Prices for State-Regulated Commercial Markets Using Medicare Drug Price Negotiation Program Maximum Fair Price (MFP)”

PhRMA supports the Board’s decision not to advance the proposal to use Medicare Maximum Fair Prices (“MFPs”) as reference prices for selected prescription drugs in Oregon’s commercial market and echoes many of the concerns raised by Board members.³² As PhRMA has previously stated, MFPs are specifically developed for the Medicare program and patient population under the statutory framework of the Inflation Reduction Act.³³ It would therefore be inappropriate to use these prices as reference prices for an entirely different market and patient population. In doing so, the Board would be disregarding the unique market dynamics and affordability challenges that patients in Oregon may be facing. MFP-based reference pricing would raise serious concerns for patient access.

The Centers for Medicare & Medicaid Services (“CMS”) sets its MFPs through the Medicare Drug Price Negotiation Program (“MDPNP”), but because the program is still at an early stage, many operational and legal issues remain unresolved. The MFPs for the initial set of drugs only recently went into effect. Although it will be years before the effects of MFPs on patient affordability and access are fully understood, two-thirds of beneficiaries are enrolled in Part D plans where their cost-sharing is expected to increase for many price-set drugs compared to before the IRA.³⁴ In addition, ninety-three percent of Part D beneficiaries are not expected to experience lower annual out-of-pocket spending from price setting in 2026, and even fewer are expected to benefit in

³¹ Policy Memorandum from Cortnee Whitlock to Oregon PDAB, Commercial health plan continuity-of-care policy concept (Sept. 8, 2026), <https://dfr.oregon.gov/pdab/Documents/PDAB-Commercial-Continuity-of-Care-Memo.pdf>.

³² Policy Memorandum from Daniel Hartung to Oregon PDAB, PDAB Policy Recommendation: Adopt National Academy for State Health Policy (NASHP) model legislation to reduce prescription drug expenditures by setting reference prices for state-regulated commercial markets using Medicare Drug Price Negotiation Program Maximum Fair Price (MFP) (Aug. 21, 2026), <https://dfr.oregon.gov/pdab/Documents/MFP-Policy-Proposal-Hartung-20260821.pdf>; Oregon PDAB Board Meeting (Sept. 16, 2026) at 2:51:59-2:58:52, <https://www.youtube.com/watch?v=Ka0ND0neLdU> (raising concerns about applicability and benefit of MFPs to Oregon, effects on affordability and access for patients (e.g., patient out-of-pocket costs, formulary changes), and effectuation challenges and deciding not to advance the proposal as a recommendation to the Legislature).

³³ Letter from PhRMA to Board (Oct. 3, 2025) at 3.

³⁴ Magnolia Market Access. (2026). When Lower Prices Don’t Mean Lower Costs: How Part D Benefit Changes Are Shifting Out-of-Pocket Spending in 2026 Under the Inflation Reduction Act. <https://www.magnoliamarketaccess.com/insight/medicare-part-d-cost-sharing-changes-2026/>.

later years.³⁵ Further, price controls have not solved for patient access issues – patients prescribed IPAY 2026 selected drugs for immunology and oncology faced initial rejection rates of 59% and 67% respectively.³⁶ The downstream effects of reference pricing on patient access are likely to be exacerbated by the use of MFPs in state populations.

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On behalf of PhRMA and our member companies, thank you for your consideration of our comments. Although PhRMA has concerns about the Meeting Materials, we stand ready to be a constructive partner in this dialogue. Please contact dmcgrew@phrma.org with any questions.

Sincerely,



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³⁵ Milliman. (August 2026). Assessing the annual beneficiary out-of-pocket impact of the Medicare Drug Price Negotiation Program. <https://www.milliman.com/en/insight/assessing-beneficiary-out-of-pocket-impact-mdpnp>

³⁶ IQVIA. (August 2026). Rejection Rates Unchanged by MFP Drug Coverage Requirement. <https://www.iqvia.com/locations/united-states/blogs/2026/07/rejection-rates-unchanged-by-mfp-drug-coverage-requirement>