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Testimony to the Oregon Prescription Drug Affordability Board

Jan.7, 2026

Chair Bailey and Members of the Board,

My name is Mary Anne Cooper, and I am the Director of Government Affairs of Regence BlueCross BlueShield of Oregon. On behalf of Regence and our members, we thank the PDAB for the opportunity to comment to the Board today. As one of the state's largest health plans, Regence is committed to addressing persistent and emerging needs for the nearly 1 million Oregonians we serve.

At the December meeting, Board members explored policy alternatives to upper payment limits such as out-of-pocket cost caps for drugs, like insulin cap mandates. While we recognize these proposals aim to alleviate patient burden from high prescription costs, out-of-pocket cost cap policies have many unintended consequences. They negatively impact health care affordability for Oregonians at large without addressing the fundamental issue of unsustainable pharmaceutical pricing. These prices don't disappear with cost caps; they are just distributed across all members of a health plan through higher premiums.

Co-Pay Caps Create Cost-Shifting, Not Savings

While caps on cost-sharing may ease an individual patient's financial burden at the pharmacy, these policies merely shift costs throughout the health care system without reducing what medications actually cost. Pharmacy expenses already account for nearly 25% of all employer health care spending in 2025, which is expected to rise by 11-12% in 2026. Cost caps remove accountability from drug manufacturers while requiring health plans and employers to absorb escalating prices.

Recent USC Schaeffer Center research shows that following the Inflation Reduction Act's $2,000 out-of-pocket cap, most Medicare beneficiaries are now paying more for drugs. [1] This is the "balloon squeeze" effect in action, when drug co-pay caps squeeze costs in one area, they pop up elsewhere through higher deductibles, premiums, and cost-sharing. As Part D plans absorbed higher drug costs, they nearly quadrupled average deductibles in Medicare Advantage plans (from $62 to $224) and shifted plans from fixed co-pays to coinsurance for

[1] USC Schaeffer Center for Health Policy & Economics. (2025, June 19). *Medicare Part D drug costs and the Inflation Reduction Act*. USC Sol Price School of Public Policy. https://schaeffer.usc.edu/research/medicare-part-d-drug-costs-ira/

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brand-name drugs. Most beneficiaries who didn't reach the $2,000 cap now face higher costs, demonstrating how caps provide relief to a few high-cost patients while making drugs more expensive for everyone else.

Cost caps also enable manufacturers to raise prices unchecked. When patients no longer see increases in their cost share, market pressure on pricing disappears. Over the last decade, insulin list prices have roughly doubled, even though the products remain unchanged.[2] Manufacturers retain full authority to set prices as they choose, knowing the financial impact is obscured from patients and absorbed by the broader insurance pool.

The core issue is not patient cost-sharing, it's unsustainable pharmaceutical pricing without accountability or transparency. Cost caps treat a symptom while exacerbating the disease.

A Better Path Forward

We urge the Board to reject out-of-pocket cap proposals and instead focus on solutions that address the root cause: excessive drug pricing by manufacturers. Only by tackling actual drug costs can we achieve sustainable affordability for all Oregonians without forcing cost-shifting that makes health care more expensive overall.

Without health plan expertise, the Board and its policies remain vulnerable to costly unintended consequences. The complexities of actuarial requirements, market dynamics, and cost-shifting mechanisms require deep understanding of how health insurance operates. As a tax-paying nonprofit, Regence dedicates 90% of every premium dollar to paying for medical claims and expenses. We have a vested interest in controlling costs while ensuring access to care. We encourage the Board to seek ongoing input from health plan experts as it considers policy solutions to ensure that well-intentioned proposals do not inadvertently harm the very Oregonians the Board seeks to help.

Thank you for your time and consideration.

Mary Anne Cooper
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Regence BlueCross BlueShield of Oregon

[2] USC Schaeffer Center for Health Policy & Economics. (2025, June 19). *Medicare Part D drug costs and the Inflation Reduction Act*. USC Sol Price School of Public Policy. https://schaeffer.usc.edu/research/medicare-part-d-drug-costs-ira/

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