



October 19, 2026

Oregon Prescription Drug Affordability Board
Division of Financial Regulation, Department of Consumer and Business Services
Salem, Oregon

**Re: Criterion (j) in the 2026 affordability reviews and the annual report
(Board meeting of October 21, 2026, agenda items 6 and 7)**

Dear Chair Bailey and Members of the Board:

Thank you for the opportunity to comment before the Board votes on the prescription drugs it reviewed in 2026. This letter concerns one criterion: the relative financial impacts of a drug on health, medical, or social services costs under ORS 646A.694(1)(j). [1] My principal recommendation is that the Board's 2026 findings and annual report record that this criterion was not assessed (rather than leave it silent), and that the Board commit to a documented, symmetric standard for weighing such evidence in future reviews.

I am a health economist and applied econometrician and the founder, President, and CEO of RxEconomics LLC. Before founding the firm in 2011, I spent approximately nine years at CVS Caremark and its predecessors, ultimately serving as Director of Strategic Research and Health Economist. I received my PhD in public policy (economics) from the University of Maryland, Baltimore County. My work spans pharmacy benefit design, medication adherence, and medical cost offsets from prescription drug use. In August 2026 I filed two comments with the Centers for Medicare & Medicaid Services (CMS) proposing a framework for this evidence in the Medicare Drug Price Negotiation Program, and in October 2026 I adapted it for the Maryland Prescription Drug Affordability Board. [5–7] Here, I tailor it to Oregon's statute, rule, and data.

My research clients include pharmaceutical and life-sciences companies. I prepared this submission independently; no client funded, requested, commissioned, or reviewed it.

I offer four recommendations:

1. Record criterion (j) as not assessed in each 2026 finding and in the annual report, and distinguish unavailable or inconclusive evidence, or data insufficient to quantify a downstream effect, from evidence of no material difference.
2. Adopt, for future reviews, a proportionate, symmetric two-stage standard for assessing this evidence.
3. Identify the comparator and economic perspective of every estimate, and count each dollar once.
4. Describe the evidence and its weight in each review report, and request proportionate methods documentation for unpublished or model-derived analyses.

I. The criterion and the 2026 record

ORS 646A.694(1)(j) lists among the Board's criteria "the relative financial impacts to health, medical or social services costs as can be quantified and compared to the costs of existing therapeutic alternatives." [1] OAR 925-200-0020 directs the Board to consider the statutory criteria "to the extent practicable" and specifies, to the extent the information can be quantified, both "the relative financial effects of the prescription drug on broader

health, medical, or social services costs, compared with therapeutic alternatives or no treatment” and “the total cost of the disease and the drug price offset.” [2]

In all eleven 2026 reviews, staff reported that “this analysis was not performed.” The Jardiance review, for example, explains that “there was no quantifiable data available to PDAB to assess these relative financial impacts in the Oregon population” and anticipates that “[f]uture reviews may incorporate findings from real-world evidence, health technology assessments, or economic modeling as such data become available.” [3] That is a candid description of an evidence gap. It does not establish that any reviewed drug leaves other health care spending unchanged, and the findings should not be read that way—whichever direction the unmeasured effect would run.

A comparison of drug costs alone can overstate the total financial burden of a drug that reduces hospital, emergency, or other service use, and it can understate the burden of a drug that requires more services (monitoring, administration, management of adverse events, or care during added survival time). Recognizing those possibilities creates no presumption of savings. The Congressional Budget Office’s 2012 estimate that a 1 percent increase in prescriptions filled would reduce Medicare spending on medical services by roughly 0.2 percent was an aggregate relationship for scoring policies that change prescription use—not a drug-level result—and it should not be applied to an individual drug. [4] The relevant question is whether credible evidence identifies a material downstream effect for the drug, comparator, Oregon population, and time horizon at issue. Where that question has not been answered, each 2026 finding (and the annual report) should say so.

II. A proportionate, symmetric standard for future reviews

I recommend a two-stage review, applied in proportion to the claim. [5, 7] In the first stage, staff would assess each study or analysis across eight domains: study design and causal identification (e.g., confounding by indication, healthy-adherer effects, informative censoring, and treatment switching); population and applicability to Oregon’s commercial, Medicaid, and Medicare enrollees; comparator and treatment contrast; outcome definition and measurement; time horizon and timing; economic perspective and cost measurement; statistical uncertainty and economic materiality; and transparency, sponsorship, and reproducibility. These are principles for judgment, not pass-fail tests, and no design label determines the result. A published comparative study may be evaluated from the article and its supplement, whereas an unpublished analysis, or a model converting an event effect into long-term costs, needs more documentation of its structure, parameter sources, and validation.

In the second stage, staff would synthesize the credible evidence (rather than count studies or average estimates that answer different questions) and report four descriptive judgments: comparative direction (favorable to the drug, adverse to the drug, negligible with sufficiently precise support, or indeterminate); economic materiality (whether the magnitude is consequential for the affected Oregon population, as distinct from statistically significant); certainty (identification, consistency, robustness, and reliance on extrapolation); and applicability to that population. A nonsignificant result alone does not establish a negligible effect. A permissible conclusion might be that hospitalization evidence is directionally favorable and material while the dollar magnitude remains uncertain, or, equally, that evidence on monitoring and administration indicates added costs the drug-cost comparison omits, again of unknown size.

Several guardrails keep the standard neutral. First, the same bar applies whether the evidence shows lower costs, no material difference, or higher costs, and whether it comes from a manufacturer, a carrier, a government agency, or an academic or public source. Second, nothing is counted twice. An avoided hospitalization can have both a clinical benefit and a financial consequence, and the Board should describe each separately rather than treat them as

independent corroboration of the same treatment effect. Third, observed, extrapolated, and modeled effects remain distinguishable; a well-supported model can be decision-relevant, but it should not borrow the certainty of an observed endpoint. Fourth, survival is treated explicitly. Longer survival can increase total spending while reducing disease-specific spending, and neither should be hidden in a net figure; outlays that arise because patients live longer are not evidence of inferior effectiveness. The report should also state whether costs during added years of life enter the estimate. Fifth, sponsorship triggers neutral scrutiny of who funded the work and who controlled its design, data, analysis, and publication, whatever the source. Finally, a bounded analysis of utilization and expenditures records payments linked to clinical events; it does not require valuing a health state or a year of life and is distinct from a cost-effectiveness ratio or quality-adjusted life year measure. Weighing this evidence in the Board's finding should remain qualitative (no formula, fixed weight, or dollar-for-dollar adjustment), and unavailable or inconclusive evidence should be reported as such rather than as a finding of no material difference.

III. Comparator, perspective, and Oregon data

The statute frames criterion (j) against “existing therapeutic alternatives,” while the rule adds “no treatment.” [1, 2] I recommend treating the statutory comparator as primary, using a no-treatment contrast where no therapeutic alternative exists or as supplementary information, and documenting any case in which the choice of comparator changes the conclusion. Similarly, a total-cost-of-disease estimate describes the size of the problem but does not, by itself, show the effect of a particular drug. The “drug price offset” in the rule is best read as a comparative quantity—one that may be favorable, adverse, negligible, or indeterminate.

The 2026 reviews already distinguish All Payer All Claims (APAC) gross payments (prior to price concessions), primarily net costs reported through the commercial carrier data call, and enrollee out-of-pocket costs. [3] Each downstream estimate should state which of these perspectives (or which payer's spending) it reflects, report patient cost sharing separately, and explain how overlapping views were reconciled so that the same avoided admission or the same rebate is not counted twice. Because the statute expressly names social services costs, those should be broken out, with the causal pathway to the drug comparison shown rather than assumed.

Moreover, Oregon's APAC database, which already underlies the reviews' spending analyses, could support criterion (j) work for some drugs, subject to data completeness and an appropriate comparative design. Any such analysis should state its coverage limits. As noted in the 2026 reports, APAC does not include data for many self-insured employer plans, and for these reviews its data on people with Medicare coverage are limited to Medicare Advantage and Part D (i.e., no Traditional Medicare Part A or Part B claims), so hospital and physician spending for many Oregonians may be missing. [3]

IV. Documentation in review reports

For each drug, the criterion (j) section of the review report should identify the therapeutic alternatives, affected population, time horizon, and economic perspective; summarize the evidence considered and its principal limitations; report the four Stage 2 judgments; and explain whether and how the evidence informed the Board's finding. A dated list of the studies and analyses considered would give each review a stable record and help show that similar evidence receives similar treatment across drugs, regardless of the finding.

Staff also need minimum methods information to evaluate a claimed downstream effect. Adapting my CMS proposal, I recommend a short methods form, triggered only when a submission presents or relies on a respondent-generated, sponsor-controlled, unpublished, or model-derived quantitative result whose core methods needed to evaluate the

claim are not available in a cited public source. [6, 7] Narrative comments and adequately documented published citations would be exempt, and confidential material would remain subject to the Board's applicable confidentiality protections.

V. Conclusion

Whatever policy concepts the Board adopts for its annual report, I recommend that the report state that criterion (j) was not assessed in 2026 and describe how the Board intends to consider such evidence in future reviews. A symmetric, qualitative standard can recognize credible evidence of lower or higher costs without presuming either, and it would give manufacturers, carriers, and the public a consistent target for the evidence they submit. I would be glad to discuss these recommendations with Board staff.

Respectfully submitted,

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References

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2. OAR 925-200-0020(1) and (2)(i)(A)–(B).
3. Oregon Prescription Drug Affordability Board. 2026 affordability review reports, section on relative financial impacts to health, medical, or social services costs. For example: Jardiance (empagliflozin), Version 4.0, September 8, 2026, pp. 9 and 29–30 (including p. 30, note 63). <https://dfr.oregon.gov/pdab/Documents/Jardiance-2026.pdf>
4. Congressional Budget Office. Offsetting Effects of Prescription Drug Use on Medicare's Spending for Medical Services. November 29, 2012. <https://www.cbo.gov/publication/43741>
5. RxEconomics LLC. Comment on CMS-4215-P, Medicare Drug Price Negotiation Program and Medicare Prescription Drug Benefit Program. Docket CMS-2026-2080; Comment ID CMS-2026-2080-0144 (received August 17, 2026). <https://www.regulations.gov/comment/CMS-2026-2080-0144>
6. RxEconomics LLC. Comments on the Drug Price Negotiation Revised Information Collection Request (CMS-10849). Docket CMS-2026-2080; Comment ID CMS-2026-2080-0146 (received August 17, 2026). <https://www.regulations.gov/comment/CMS-2026-2080-0146>
7. RxEconomics LLC. Comment on Proposed Action on Regulations, COMAR 14.01.04 Cost Review Study Process [26-133-P] and COMAR 14.01.01.05 Public Comment Procedures [26-132-P], 53:18 Md. R. 905 (September 4, 2026). Maryland Prescription Drug Affordability Board. October 5, 2026.