OREGON STATE PHARMACY ASSOCIATION
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July 9, 2025

Shelley Bailey, MBA
Chair, Oregon Prescription Drug Affordability Board
Department of Consumer and Business Services
350 Winter Street NE
Salem, OR 97309-0405

Subject: Rebuttal to Misleading PCMA Public Comments for July 2025 Meeting

Dear Chair Bailey and Members of the Oregon Prescription Drug Affordability Board,

I am writing to provide a direct rebuttal to the Pharmaceutical Care Management Association's (PCMA) public comments submitted for the July 2025 meeting. While PCMA attempts to defend the current Pharmacy Benefit Manager (PBM) model, their arguments consistently misrepresent the realities faced by Oregon patients and pharmacies, and fundamentally diverge from the PDAB's core mission to protect Oregonians from exorbitant drug prices.

The PDAB board consists of well-educated healthcare professionals who are knowledgeable about the abusive practices by PBMs. Unlike state legislators who are not industry professionals, you cannot be manipulated by the misleading narratives spread by PCMA and their insurance partner lobbyists. It's insulting that this organization attempts to undermine the discussion and doesn't even cite sources in their letter.

The Evidence Against PBM Claims
Recent testimony before the U.S. Senate Judiciary Committee by Dr. Neeraj Sood of USC's Schaeffer Institute provides damning evidence of PBM market manipulation that directly contradicts PCMA's assertions. Dr. Sood's research reveals that **more than 40% of prescription drug spending flows to intermediaries in the supply chain, including PBMs, rather than to manufacturers who actually develop medications**. Most significantly, vertically-integrated PBMs earn excess returns of 5.9% compared to 3.6% for the average S&P 500 company, demonstrating these are not competitive markets but oligopolies extracting economic rents from patients.

PCMA's letter asserts that PBMs save Oregonians billions and are essential to controlling drug costs. This narrative directly contradicts the lived experience of patients struggling with high out-of-pocket costs and pharmacies facing unsustainable operating conditions. My previous submission on June 14, 2025, on behalf of the Oregon State Pharmacy Association (OSPA), detailed how PBMs, through opaque, profit-driven models, restrict access, inflate costs, and undermine independent pharmacies.

Addressing PCMA's Misleading Claims

1. PCMA Claimed "$13.6 Billion in Savings" Costs Oregon Patients Real Money
PCMA suggests PBMs will save Oregonians $13.6 billion over the next 10 years. This figure is not only misleading, it's mathematically impossible to verify due to the very opacity PBMs create. Worse, this claimed

"savings" actually costs Oregon patients money at the pharmacy counter through a systematic scheme of list price inflation.

As Dr. Sood's research demonstrates, for every $1 increase in manufacturer rebates paid to PBMs, list prices rise by approximately $1.17. **This creates a perverse incentive system where PBMs profit from higher list prices while Oregon patients pay inflated costs when filling prescriptions**. Patients with high-deductible health plans or co-insurance pay based on these artificially inflated list prices, not the lower net price after rebates, meaning they're directly subsidizing PBM profits.

The insulin market provides a stark example of how PBMs extract money from patients: Between 2014 and 2018, while manufacturers' net prices decreased by 33%, **PBMs' share of insulin expenditures increased nearly three-fold, from $5.64 to $14.36 per $100 spent**. Oregon diabetes patients paid higher out-of-pocket costs while PBMs retained the savings negotiated on their behalf.

For Oregon's state budget, PBM opacity means taxpayers cannot verify whether they're receiving value for money. An audit by the Oregon Secretary of State found PBM transactions in Medicaid too complex and opaque to ensure accountability, making any claimed "savings" impossible to verify. True affordability means lower costs at the pharmacy counter for patients and verifiable savings for taxpayers, not hidden profits for PBMs.

2. PBMs Are Directly Responsible for Higher Patient Costs Through Pharmacy Closures
PCMA's attempt to dismiss PBM culpability in pharmacy closures by citing Bi-Mart and Rite Aid ignores how this crisis directly increases costs for Oregon patients. When pharmacies close due to PBM predatory pricing, patients must travel farther and pay higher prices at remaining chain pharmacies in "pharmacy deserts."

A 3-Axis Advisors analysis in Oregon found that **75% of Medicaid reimbursements to independent pharmacies don't even cover basic labor and drug costs**. These predatory reimbursement tactics force pharmacies to operate at a loss, creating a vicious cycle where Oregon patients lose access to affordable, convenient pharmacy services.

The data demonstrates how PBM practices directly harm Oregon patients:

- Over 200 pharmacy closures since 2008, forcing patients to travel farther for prescriptions
- A 56% increase in pharmacy deserts in just four years, reducing competition and increasing prices
- Oregon ranking last in pharmacy access among contiguous U.S. states, limiting patient choice

When pharmacies close, Oregon patients face higher costs through:

- Increased transportation costs and time off work to reach remaining pharmacies
- Loss of personalized pharmacy services that help patients manage medications effectively
- Reduced access to pharmacy-based healthcare services like immunizations and health screenings

When three PBMs control (at least) 80% of the prescription market, as documented by USC researchers, and systematically engage in below-cost reimbursements, the causal relationship to both pharmacy closures and higher patient costs becomes undeniable. Every pharmacy closure represents a direct cost increase for Oregon patients who lose convenient, competitive pharmacy access.

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3. Spread Pricing Directly Increases Patient Costs and Wastes Oregon Tax Dollars
PCMA's claim that "spread pricing is not a reimbursement model" is semantic misdirection that obscures how this practice directly increases costs for both patients and Oregon taxpayers. Spread pricing works as a hidden tax on every prescription: PBMs charge health plans (including Oregon's Medicaid program) one price while reimbursing pharmacies a lower amount, pocketing the difference as pure profit.

For Oregon patients, spread pricing means higher costs at the pharmacy counter in multiple ways:

- Higher insurance premiums: When PBMs overcharge health plans through spread pricing, these inflated costs are passed directly to patients through higher premiums and deductibles
- Increased co-pays: Many patients pay co-insurance based on the inflated amount PBMs charge health plans, not the actual pharmacy cost
- Pharmacy access fees: When pharmacies can't survive on below-cost reimbursements, patients must travel farther and pay higher prices at remaining chain pharmacies in "pharmacy deserts"

For Oregon taxpayers, spread pricing represents a direct waste of public funds. Every dollar of spread pricing profit extracted from Oregon's Medicaid program is a dollar that could have purchased additional healthcare services or reduced taxpayer burden. Even DCBS data, which PCMA selectively quotes, acknowledges that 8.3% of claims were reimbursed below acquisition cost, meaning taxpayers paid PBMs more than the actual drug cost while pharmacies lost money filling prescriptions.

PCMA's assertion that states banning spread pricing haven't seen cost reductions is demonstrably false. **Ohio's Medicaid program saved $140 million by removing large PBMs and eliminating spread pricing; savings that went directly back to taxpayers and the healthcare system.** Similarly, Dr. Sood's research shows Medicare could have saved $2.6 billion in 2018 on just 184 common generic drugs if purchased at transparent prices instead of through PBM-manipulated pricing schemes.

Eliminating spread pricing would deliver immediate savings to Oregon patients and taxpayers by:

- Reducing insurance premiums through lower administrative costs
- Decreasing co-pays by eliminating artificial price inflation
- Preserving pharmacy access by ensuring sustainable reimbursement rates
- Returning millions in taxpayer dollars to Oregon's Medicaid program for actual healthcare services

4. The 100% Rebate Pass-Through Would Put Money Back in Patients' Pockets
PCMA's suggestion that PBMs already pass through 100% of rebates "at a client's request" reveals the fundamental problem: the system is designed to obscure rather than deliver savings to Oregon patients. The issue isn't whether clients *can* request it; it's that the current system allows PBMs to profit from higher list prices and larger rebates while patients pay inflated costs.

Oregon patients are directly subsidizing PBM profits through higher out-of-pocket costs. Dr. Sood's research proves this point: PBMs have driven systematic increases in list prices to generate higher rebates for themselves. When Oregon patients with high-deductible plans or co-insurance fill prescriptions, they pay based on these artificially inflated list prices, not the lower net price after rebates that never reach the pharmacy counter.

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A mandatory 100% rebate pass-through would deliver immediate savings to Oregon patients by:

- Reducing out-of-pocket costs for patients with high-deductible plans who currently pay inflated list prices
- Lowering insurance premiums by eliminating PBM rebate retention as a profit center
- Reducing co-pays by basing patient costs on actual drug prices rather than inflated list prices
- Saving Oregon's Medicaid program millions in taxpayer dollars by ensuring all negotiated discounts benefit the state rather than PBM shareholders

OSPA's recommendation for *required* 100% rebate pass-through aims to eliminate the perverse incentive that drives up costs for Oregon patients while ensuring genuine savings reach those who need them most, patients at the pharmacy counter and taxpayers funding Oregon's healthcare programs!

5. Formulary Manipulation Favors PBM Profits Over Patients

PCMA's argument that high generic utilization proves PBMs don't favor higher-rebated drugs is a false equivalency. While generics are widely used where no alternatives exist, PBMs systematically restrict access to lower-cost alternatives within therapeutic classes in favor of drugs yielding higher rebates.

USC research found that **the share of drugs restricted in non-protected classes in Medicare Part D rose from 31.9% in 2011 to 44.4% in 2020**. By 2020, Medicare plan formularies excluded an average of 44.7% of brand-name-only drugs. These restrictions compromise patient care through non-medical switching, prior authorization delays, and step therapy requirements, all designed to maximize PBM rebate revenue rather than optimize patient outcomes.

The Broader Context of PBM Market Manipulation

Dr. Sood's testimony reveals the full scope of PBM market manipulation:

- **Market Concentration**: Just three PBMs control 80% of the prescription market, with the top five controlling 93.6% of Medicare Part D, far exceeding Department of Justice thresholds for "highly concentrated" markets.
- **Vertical Integration Conflicts**: PBMs increasingly own pharmacies and insurers, creating systematic conflicts of interest that harm independent pharmacies and competing health plans.
- **Patient Cost Exposure**: The share of Medicare Part D plans using coinsurance for preferred branded drugs increased from 9.9% in 2020 to 71.9% in 2024, meaning patients increasingly pay full list prices inflated by PBM rebate demands.

The Path Forward

PCMA's letter represents a poor attempt to protect an opaque and profitable business model at the expense of Oregonians' health and financial well-being. Their arguments fail to acknowledge the widespread harm documented by independent researchers and government audits.

The Prescription Drug Affordability Board was established to "protect Oregon residents and stakeholders from the financial burdens associated with exorbitant drug prices." To fulfill this critical mission, the Board must look beyond the PBM industry self-serving claims and recognize that incremental reforms have failed.

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I urge the Board to reject PCMA's misleading assertions and instead recommend comprehensive legislative action to ban harmful PBM operational models, as outlined in OSPA's June 14, 2025 submission:

- **Prohibit vertical integration and PBM ownership of pharmacies**
- **Eliminate spread pricing and opaque reimbursement models**
- **Require 100% rebate pass-through to payers and patients**
- **Establish fiduciary responsibility for PBMs to act in clients' best interests**
- **Implement price transparency benchmarks for key transactions**
- **Restrict formulary practices that prioritize PBM profit over patient care**

Oregonians cannot afford to wait for federal reform while PBMs continue extracting billions in economic rents from our healthcare system. The time for bold, state-level action to create a truly patient-centered drug supply chain is now.

Sincerely,

Brian Mayo
Executive Director