HIV+HEP
POLICY INSTITUTE

October 16, 2026

Oregon Prescription Drug Affordability Board
Division of Financial Regulation
350 Winter Street NE
Salem, OR 97301

Submitted electronically to pdab@dcbs.oregon.gov

Re: Comments on Oregon PDAB's Proposed Policy Recommendations on PBM Practices and Continuity of Care

Dear Members of the Board:

The **HIV+Hepatitis Policy Institute** is a national organization promoting quality and affordable healthcare for people living with or at risk of HIV, hepatitis, and other serious and chronic health conditions. We appreciate the opportunity to comment on the Oregon Prescription Drug Affordability Board's proposed policy recommendations concerning pharmacy benefit manager (PBM) practices and commercial health plan continuity of care.

We strongly support both policy recommendations and commend the Board for recognizing the important role PBM practices and insurance coverage policies play in prescription drug affordability and patient access. For people living with chronic conditions like HIV and hepatitis, affordable and uninterrupted access to prescribed medications is essential to maintaining their health and preventing disease progression.

I. Policy Recommendation on Pharmacy Benefit Manager Practices

We strongly support the Board's recommendation to strengthen PBM oversight through standardized financial reporting, disclosure of affiliated businesses, independent audit authority, and greater public transparency. PBMs play a significant role in determining which medications patients can access and how much they pay at the pharmacy counter. Yet complex financial arrangements make it difficult to determine whether negotiated rebates and discounts ultimately benefit patients.

In 2023 alone, manufacturers paid an estimated $334 billion in rebates to PBMs and insurers for brand-name drugs, underscoring the scale of financial flows that remain difficult for patients, policymakers, and regulators to fully understand.[1] Greater transparency is essential to ensuring these arrangements support lower costs and improved access.

We support the Board's proposal to require more detailed reporting on PBM financial arrangements, including amounts charged to health plans, payments to pharmacies, patient cost-sharing, manufacturer rebates, and compensation retained by PBMs and affiliated businesses. Reporting should capture all direct and indirect compensation, including payments to group purchasing organizations (GPOs), rebate aggregators, and other

affiliated entities, regardless of how payments are characterized or which entity receives them. In addition to rebates, PBMs and their affiliated GPOs collected an estimated $7.6 billion in fees from drug manufacturers in 2022, double the amount in 2018.[2] We also recommend that PBMs report compensation received in actual dollar amounts, rather than relying solely on formulas or percentages, to ensure disclosures are meaningful and comparable across PBMs and health plans.

Collecting this information at the claim and drug level, rather than relying solely on statewide aggregates, would allow regulators to better understand how rebates, fees, and other financial arrangements affect prescription drug costs and patient access. We also support providing the Department of Consumer and Business Services (DCBS) with the authority and resources to audit these arrangements, verify reported information, and enforce compliance. DCBS should make aggregated data publicly available, including, where feasible and consistent with appropriate confidentiality protections, information by drug or therapeutic class. This would help policymakers, researchers, and patient advocates better understand how PBM practices affect prescription drug costs and patient access.

We supported similar PBM transparency proposals earlier this year in comments to the U.S. Department of Labor on its proposed rule for self-insured employer health plans. Oregon's recommendation would complement these federal efforts by strengthening oversight of PBMs serving state-regulated health plans.

II. Policy Recommendation on Commercial Health Plan Continuity of Care

We also support the Board's recommendation to establish a 90-day transition period requiring commercial health plans to honor existing prescription drug prior authorizations when patients change coverage. As outlined in the Board's memo, these protections should apply both when patients switch between different insurers and when they change plans offered or administered by the same insurer. This proposal is consistent with recommendations we made earlier this year in comments to CMS on its proposed Interoperability Standards and Prior Authorization for Drugs rule (CMS-0062-P). For people living with HIV and other chronic conditions, maintaining uninterrupted access to prescribed medications is essential to preventing treatment disruptions and adverse health outcomes.

We appreciate the Board's work to increase transparency around prescription drug pricing and urge it to advance both recommendations to the Legislature. Greater transparency and accountability in PBM practices, combined with stronger continuity-of-care protections, will help ensure that prescription drug policies deliver meaningful benefits to patients.

If you have any questions or need additional information, please contact our Government Affairs Director, Zach Lynkiewicz, at zlynkiewicz@hivhep.org.

Sincerely,



Carl E. Schmid II
Executive Director

[1] Kristi Martin, "What Pharmacy Benefit Managers Do, and How They Contribute to Drug Spending," Commonwealth Fund, March 17, 2025. https://doi.org/10.26099/fsgq-y980.

[2] Eric Percher, Trends in Profitability and Compensation of PBMs & PBM Contracting Entities, Nephron Research, September 18, 2023.