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July 18, 2018

Gov. Kate Brown
Office of the Governor
900 Court Street NE, Suite 254
Salem, OR 97301-4047

Re: Joint Interim Task Force On the Fair Pricing of Prescription Drugs – OR4AD Calls for Resignation of AARP–UnitedHealth Lobbyist from Role as Task Force 'Consumer Representative'

Dear Gov. Brown:

I write to you as a director of Oregonians for Affordable Drug Prices Now. I am also a named plaintiff in *Boss v. CVS Health Corporation*[1] and two other putative class actions on pharmaceutical pricing that name UnitedHealth Group ("United") as a defendant. United sells AARP co-branded Medicare plans in the State of Oregon with benefit designs that these lawsuits, pending in federal district court in New Jersey, allege increase the prices patients pay for prescription drugs (as insurers capture manufacturer rebates) and directly cause list prices of heavily rebated pharmaceuticals like analog insulin to skyrocket—increasing in apparent parallel with United's profit distributions to its shareholders.

An AARP lobbyist cannot act as "consumer representative" on a Task Force investigating the prices paid by Oregonians, including Oregonians on AARP–United Medicare plans, for pharmaceuticals. We now hope that Jon Bartholomew will have the decency to recuse himself and that you will finally appoint to this Task Force an actual consumer representative.

Following the resignation of OSPIRG's Jesse O'Brien, you appointed AARP lobbyist Jon Bartholomew to serve as the "consumer representative" on the Joint Interim Task Force On the Fair Pricing of Prescription Drugs created by HB 4005. Mr. Bartholomew, also formerly with OSPIRG, and Mr. O'Brien, in close coordination with Strategies 360's Patty Wentz[2] and others, drove that bill through the legislature partly via a scare campaign about a manufacturer-funded "fake patient advocacy" organization that claimed to speak for patients. If drug manufacturers cannot speak in patients' voice, then by the same token, neither can insurers and their business associates like AARP.

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1 *Boss, et al. v. CVS Health Corporation et al.*, Case No. 3:17-cv-01823-BRM-LHG filed in the United States District Court of the District of New Jersey. This case has now been consolidated under *In re Insulin Pricing Litigation,* Case No. 3:17-cv-00699-BRM-LHG.

2 An unregistered lobbyist and a vice president with PR firm Strategies 360, Ms. Wentz apparently controls the website (www.affordablerx.org), Twitter account and Facebook page that were used to entice Oregonians to "call their legislators to #voteyesonHB4005" using a Phone2Action account (now disabled). This operation, conducted under the cover of an incorporated nonprofit that failed to register with the Oregon Department of Justice's Charitable Activities Section and to file annual reports with the Corporation Division, should be investigated for breach of nonprofit, corporation, lobbying and possibly political campaign laws—disclosure and compliance breaches of which, as AARP's chief lobbyist and point man for HB 4005, Mr. Bartholomew was or should have been aware.

As the new Oregonians for Affordable Drug Prices Now, we have reclaimed a patient and consumer voice previously appropriated by payers' own astroturfing operation—an operation apparently intended to persuade patients that a genuine consumer nonprofit existed to advocate on their behalf. Oregonians for Affordable Drug Prices Now is committed to bringing a genuine patient and consumer voice to Oregon's conversation on drug pricing in general and to this Joint Interim Task Force On the Fair Pricing of Prescription Drugs.

As Governor, you have the power under HB 4005 to appoint Task Force members; it is now your responsibility to allow Oregonians to reclaim their place and their voice in this process.

If Mr. Bartholomew were to remain on this Task Force, he would serve as an additional representative of "Insurance companies offering health insurance in this state,"[3] along with Moda Health's Robert Judge and BlueCross Blue Shield's Abigail Stoddard.[4] Your administration would thus remain in breach of its duty to name to the Task Force individual(s) representing consumers per HB 4005's Section 11(2)(D)(v).

The consumer representative on this Task Force can't have a duty of loyalty to an insurance company. This Task Force is concerned with the "prices paid by Oregonians for pharmaceutical products."[5] These prices include the prices health insurers ask health plan members to pay in the form of premiums, copays, and coinsurance payments. In 2017, payers' benefit design[6] controlled the prices paid for prescription drugs by 93.8% of Oregonians under ACA, Medicare, and other plans.[7] The pharmaceutical prices paid by the other 6.2% of Oregonians who are uninsured are also controlled by an insurance company—Moda Health, OPDP's third party administrator. The Oregon Prescription Drug Program (OPDP), a public program, was supposed to give under- and uninsured Oregonians access to the low net prices paid by commercial insurers. As recently acknowledged by the co-chair of this Task Force, Dr. Hargunani, OPDP, under Moda Health's management, has failed to deliver the benefit of manufacturer rebates to its individual discount card holders. Again, point-of-sale pricing to OPDP individual discount card holders is jointly controlled by a private insurer.

As the chief lobbyist for AARP in Oregon, Jon Bartholomew is bound to advance the interests of AARP/United's Medicare-related insurance business against legal liabilities, regulatory oversight and public scrutiny. United is a named defendant in multiple putative class action lawsuits brought by the Type 1 Diabetes Defense Foundation (pending in New Jersey federal court) relating to payer benefit design that bases patient payment and premium rates actuarial assessment on unrebated pharmacy claims expenses or list prices. Mr. Bartholomew's duty of loyalty to the AARP-United Medicare joint venture—which is now adverse to consumers in pending litigation—

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[3] HB 4005, Section 11(2)(D)(ii).

[4] Ms. Stoddard joins the Task Force as an employee of PBM Prime Therapeutics. Prime Therapeutics is fully owned by 20 Blue Cross Blue Shield "owner-client" organizations—including Regence, which operates BSBC plans in Oregon and Blue Shield plans in Washington. Prime does not represent independent pharmacy benefit managers. To avoid over-representation of insurance companies on the Task Force, PBM representation would more appropriately have been entrusted to a representative of an independent PBM such as Express Scripts, MedImpact, Navitus Health Solutions or Ventegra, Inc. (a California Benefit Corporation).

[5] HB 4005, Section 11(10).

[6] Insurer benefit designs that base patient payments on inflated list prices for drugs on which payers obtain very large rebates are directly responsible for the high prices currently paid by many Oregonians. Oregon insurance commissioner and co-chair of this Task Force Andrew Stolfi has oversight responsibility over these issues.

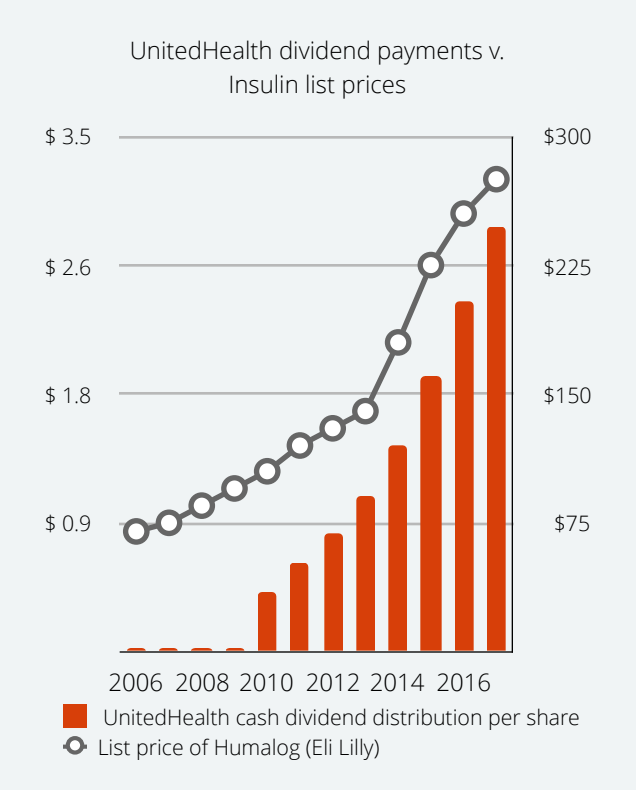
[7] 2017 Oregon Health Insurance Survey, V7 (6/8/2018).

precludes him from serving as a "consumer representative" in any government body that is dedicated to investigating drug pricing and hence the role of payer benefit design in inflating point-of-sale prices and encouraging list price inflation.[8]

Mr. Bartholomew's conflict is intrinsic to his position with AARP and thus his duty of loyalty to a health insurance joint venture. Health insurers (including AARP/ASI business partner United) appear to have capitalized on high list prices via benefit design and thus increased insurer profits at patients' expense. Any serious investigation of factors influencing drug prices paid by Oregonians would be adverse to the business interests of Mr. Bartholomew's employer.

Health insurance companies have, in recent years, become increasingly profitable. Profits have risen on a trajectory that tracks closely with—not against—rising list prices for prescription drugs like Eli Lilly's Humalog analog insulin (see graph):

- **Cigna** had an exceptionally strong 2017 performance, with total revenues for 2017 of $41.6 billion, an increase of 5% over 2016 supported by strong margins in its commercial healthcare business.[9]
- **Aetna**'s adjusted earnings increased by 13%, supported by "moderate medical cost trend" that resulted in better than projected total company results.[10] Aetna made $1.21 billion and beat Wall Street earnings expectations in 2018 first quarter, as the health insurer moved closer to sealing its roughly $69 billion combination with CVS Health.[11]
- **Anthem**'s profit soared by 234% to $1.2 billion in its 2017 fourth quarter, compared to $368 million for the same period in the prior year. Full-year 2017 financial results were also strong. Anthem reported a 55% increase in net profits year-over-year of $3.84 billion, compared to $2.47 billion in 2016.[12]
- **UnitedHealth Group**'s full year 2017 revenues of $201.2 billion grew 8.8% or $16.3 billion year-over-year—driven by fourth-quarter profit that more than doubled over 2016. United's adjusted net earnings grew 25.1%. In 2017, Optum Rx, United's PBM, saw its revenues grow by $7.6



[8] See, e.g., Lawrence W. Abrams, "Pharmacy Benefit Managers As Conflicted Countervailing Powers," blog post December 24, 2007. Available at: http://www.nu-retail.com/PBM-Countervailing-Power.pdf

[9] https://www.cigna.com/newsroom/news-releases/2018/cigna-delivers-strong-2017-results-expects-continued-revenue-and-earnings-growth-in-2018

[10] https://news.aetna.com/news-releases/aetna-reports-fourth-quarter-and-full-year-2017-results/

[11] https://wtop.com/business-finance/2018/05/aetna-swings-to-a-first-quarter-profit/

[12] https://www.healthcarefinancenews.com/news/anthem-profits-skyrocket-234

billion or 9.1% to $91.2 billion.[13] If 2017 was a good earnings year for United, 2018 second quarter results are expected to be even more profitable.[14]

As a whole, the health insurance industry posted improved earnings for 2016, with net income rising by 46% to $13.1 billion compared with $9.0 billion in 2015.[15] 2017 proved even more lucrative for health insurance companies,[16] and 2018 has seen health insurers reporting even stronger financial results—attributed in part to improving profits from individual HDHP products offered under the Affordable Care Act.[17] ACA policies, as a group, have high deductibles and employ benefit designs that calculate many health plan members' payments for prescription drugs on the basis of unrebated list price (not the payers' much lower net cost). Insurers have thus found a way to profit from high drug list prices.[18]

There is increasing evidence that private insurers, other third-party payers, and their regulators have played a contributory role in the unfair pricing of prescription drugs to Oregonian consumers. While the scope of insurers' contributory role to the current crisis is still being debated, there is no longer any doubt that insurers are not victims similarly situated with individual consumers. Individual consumers, on the one hand, and commercial payers with their government regulators, on the other hand, have adverse interests and must therefore receive separate representation on a Task Force responsible for "expos[ing] the cost factors that negatively impact prices paid by Oregonians for pharmaceutical products" as required under HB 4005's Section 11(10).

Consideration of benefit design aside, AARP's/ASI's control over and revenue from co-branded United insurance products means any AARP lobbyist would serve on this Task Force as an additional representative of "Insurance companies offering health insurance in this state," rather than as a representative of consumers.

AARP's contractual relationship with United indicates AARP may share responsibility for United benefit designs that have directly impacted the prices some Oregonians pay for brand drugs. As of the end of December 2016, the number of Americans on AARP/United Medicare Supplement Insurance Plans exceeded 4 million.[19] The scope

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[13] https://finance.yahoo.com/news/unitedhealth-group-reports-2017-results-105500521.html

[14] "Earnings from Operations Increased 13% to $4.2 Billion in Second Quarter and Second Quarter Adjusted Net Earnings of $3.14 Per Share Grew 28% Year-Over-Year." https://research.tdameritrade.com/grid/public/research/stocks/news/article?dockey=100-198b1957-1. See also "UnitedHealth tops earnings estimates, raises forecast": https://www.compuserve.com/pf/story/0002/20180717/KBN1K7114_4.

[15] "A.M. Best Special Report: U.S. Health Insurance Industry Earnings Up 46% in 2016," June 15, 2017: http://www3.ambest.com/ambv/bestnews/presscontent.aspx?refnum=25374&altsrc=23.

[16] "Profits are booming at health insurance companies," May 24, 2017: https://www.axios.com/profits-are-booming-at-health-insurance-companies-1513302495-18f3710a-c0b4-4ce3-8b7f-894a755e6679.html.

[17] Bruce Japsen, "Rising Insurer Profits Boost Obamacare's Long-Term Prospects," November 12, 2017: https://www.forbes.com/sites/brucejapsen/2017/11/12/rising-insurer-profits-boost-obamacare/#4001f9fc7b9a

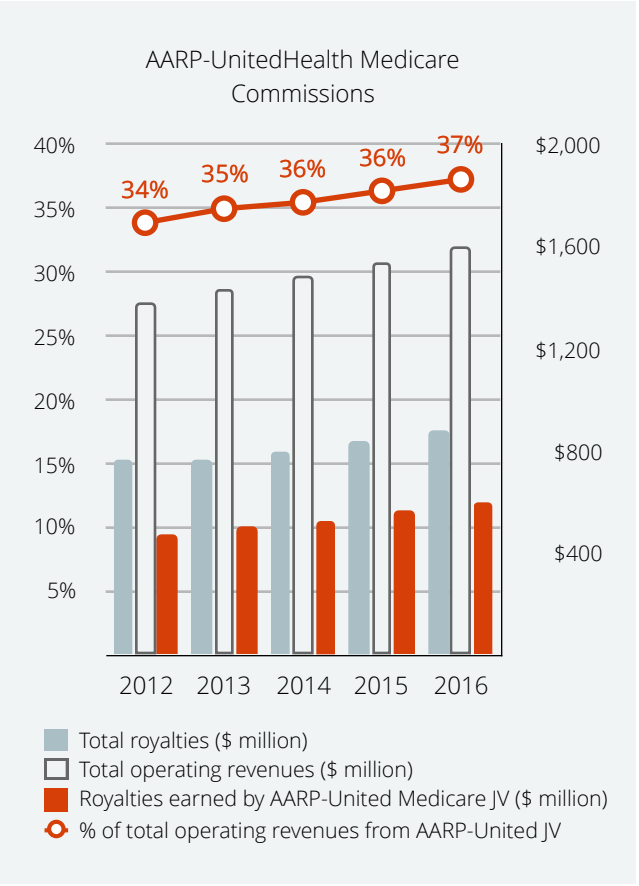
[18] "Dr. Marc Siegel: Health insurers earn billions, while patients and doctors suffer under ObamaCare," October 27, 2017: http://www.foxnews.com/opinion/2017/10/27/dr-marc-siegel-health-insurers-earn-billions-while-patients-and-doctor-suffer-under-obamacare.html," and Chris Larson, "Humana has billions in cash on hand — did Obamacare really hurt that much?" *Louisville Business First,* July 25, 2017: https://www.bizjournals.com/louisville/news/2017/07/25/humana-has-billions-in-cash-on-hand-did-obamacare.html.

[19] https://www.aarpsupplementalhealth.com/content/dam/uhcmedsupstats/claim-substantiation-reports/WB26166ST_ORC_report_2017.pdf.

of AARP's involvement in the Medicare program and the substantial financial benefits AARP derives from its health insurance ventures (see graph) create in itself an insurmountable conflict of interest between AARP and Oregonian consumers.

AARP Services, Inc. ("ASI"),[20] a wholly-owned for profit subsidiary of AARP, is primarily an insurance business that derives a substantial share of its $880 million in revenue from its business partnerships with United[21] and The Hartford.[22] For the year ended December 31, 2016, AARP processed $10.3 billion of premium payments paid by member participants for group health insurance and other health-related products and services available to AARP, Inc. members.[23]

The service provider United accounted for approximately 68% of total royalties earned in 2016 ($880.15 million)— or about $598.5 million.[24] In 2016, AARP also derived $46 million from investment income generated by health insurance premiums collected by AARP.[25] AARP revenue from the health insurance and other health-related products and services consumed by its members for 2016



[20] AARP created ASI in 1999 pursuant to a settlement agreement with the U.S. Internal Revenue Service ("IRS") resulting from an investigation by the IRS into the large amount of income that AARP, Inc., a "non-profit" tax exempt organization, earned through its business deals with for-profit businesses.

[21] AARP markets three types of United Medicare-related insurance: Part D prescription drug insurance, Medicare Advantage, and Medigap. United Medicare premiums are collected by AARP Insurance Plan ("AARP Trust"), a grantor trust organized by AARP, Inc. AARP Trust is the vehicle through which AARP, Inc. collects, invests and remits premium payments for AARP United Medicare policies. The AARP Trust also collects a 4.95% commission.

[22] The AARP Automobile & Homeowners Insurance Program has been underwritten since 1984 by Hartford Fire Insurance Company and its affiliates. In 2017, The Hartford derived $3.1 billion in underwritten premiums from AARP policies—or 86% of its Personal Line and 33% of its combined Personal and Commercial Lines.

[23] "Consolidated Financial Statements Together with Report of Independent Certified Public Accountants: December 31, 2016 and 2015," Note 3, p.14.

[24] See "Consolidated Financial Statements Together with Report of Independent Certified Public Accountants: December 31, 2016 and 2015," Note 2, p.11: https://www.aarp.org/content/dam/aarp/about_aarp/about_us/2017/2016-financial-statements-AARP.pdf. Insurance products are offered through AARP Services, a wholly-owned taxable subsidiary of AARP. See also Charles Elmore, "AARP gets $762M from royalties. Do seniors get best insurance deal?" *Palm Beach Post,* November 30, 2015: https://www.palmbeachpost.com/business/personal-finance/aarp-gets-762m-from-royalties-seniors-get-best-insurance-deal/BT6vDwMx2khlP2Klp06u4O/

[25] Medicare premiums collected by AARP are subsequently remitted to the third-party insurance carriers, but United gives AARP the right to retain any gains on those investments. In 2016, net investment income amounted to $45,766,000. See "Consolidated Financial Statements Together with Report of Independent Certified Public Accountants: December 31, 2016 and 2015," Note 3, p.14.

thus amounts in total to $644.5 million—40.2% of AARP total operating revenues ($1.604 billion in 2016) are thus generated by AARP insurance business with United.

AARP's choice to partner with United, which has been frequently criticized for anti-consumer behaviors, further undermines any claim an AARP lobbyist might make to represent consumers.[26]

United has been accused of using its association with AARP to increase premiums on products aimed at seniors, even when these products are no better than their cheaper counterparts. The AARP reputation gives seniors a false sense of value and quality, even when there is little difference in services and AARP co-branded products have higher premiums.[27] Consumers are currently suing AARP for misleading business practices in California,[28] Connecticut[29] and Florida,[30] alleging AARP has breached insurance laws by calling brokerage revenues 'marketing royalties.'

Significantly, AARP/ASI's involvement with United Medicare plans extends to control over plan management and benefit design, which may thus directly involve AARP in any lawsuit filed by consumers against United regarding drug pricing.

Benefit design directly involves AARP in increasing the prices consumers pay for prescription drugs when United Medicare plans' benefit designs link patient obligations to rising list prices, not commercial payers' much lower cost net of manufacturer rebates. This rebate capture enterprise is at the core of the RICO scheme alleged in T1DF's lawsuits.

AARP's relationship with United is not limited to collecting royalties. United's obligations under the three contracts governing United's marketing and sale of AARP branded Medigap, Medicare Advantage, and Medicare Part D policies detail AARP and ASI's extensive influence over United's involvement in for-profit business activities, most notably in the Medigap business, and several instances in which United is required to take specific actions, beyond making "royalty" payments, to the benefit of AARP.[31]

AARP also acts in the role of quality control contractor and overseer of United's operations, as those relate to Medigap, Medicare Advantage, and Medicare Part D. ASI must approve United's appointments to the joint "Senior Leaders" team that oversees all aspects of performance under the contracts. No decision can be taken by the joint "Senior Leaders" team without AARP's approval.

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[26] See, e.g., American Association for Justice, "The Ten Worst Insurance Companies in America" (2008), and Mary Williams Walsh, "United Health Overbilled Medicare by Billions, US Says in Suit," *The New York Times,* May 19, 2017.

[27] American Association for Justice, "The Ten Worst Insurance Companies in America" (2008), p. 19

[28] Robert Kahn, "Class Accuses AARP of Elder Financial Abuse," *Courthouse News,* November 20, 2017: https://www.courthousenews.com/class-accuses-aarp-elder-financial-abuse/

[29] Mike Stankiewicz, "UnitedHealth, AARP sued for diverting $400M a year to illegal rebates," *FierceHealthcare,* May 10, 2018: https://www.fiercehealthcare.com/payer/unitedhealth-aarp-sued-diverting-400m-a-year-to-illegal-rebates.

[30] *Sacco v. AARP et al.*, Case 2:18-cv-14041-JEM (Feb. 8, 2018).

[31] December 21, 2011, Letter from the Ways and Means Committee to the IRS, available at: https://waysandmeans.house.gov/UploadedFiles/Letter_to_IRS-Shulman_12-15-11.pdf. The letter concludes that "AARP has extensive decision making authority and is deeply involved in United's business operations."

More critically, AARP, via ASI, has "consultation, review, and consent rights related to any proposed plan design changes" (emphasis added) including, but not limited to, premium levels and rates.[32]

In Lane County, AARP, through its partnership with United, markets 17 co-branded Medicare plans.[33] At least some of these AARP/United Medicare plans currently overcharge AARP members by using inflated list prices (not payers' net rebated cost) as the basis for beneficiary cost-sharing in Medicare Part D—e.g. $275.20 to $293.80 as the basis of consumer cost-sharing for a 10 ml vial of Humalog.[34] Payers' net price for the same 10 ml vial of Humalog insulin may be as low as $47.20 per vial (based on Veterans' Administration schedules and manufacturer-reported average net prices).[35]

United is named as a defendant in three putative class action lawsuits on the pricing of insulin, glucagon, and test strips filed by the Type 1 Diabetes Defense Foundation in early 2017 and currently pending in New Jersey federal court.[36] Medicare Part D beneficiaries are among these lawsuits' named plaintiffs, potentially implicating AARP in liability for the injuries alleged against United in these consumer actions. The T1DF lawsuits focus on payers' (with their PBM agents') failure to pass through to consumers in the form of reduced point-of-sale prices the rebates and other price concessions that insurers receive from manufacturers. With AARP partner United and consumers as adverse parties in pending actions in federal district court, an AARP lobbyist would be required to advocate for his employer's interests in any evaluation of factors affecting drug pricing; any statement from Mr.

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[32] See, e.g., *Sacco v. AARP et al.*, Case 2:18-cv-14041-JEM (Feb. 8, 2018), p. 12. Available at: https://www.truthinadvertising.org/wp-content/uploads/2018/02/Sacco-v-AARP-complaint.pdf . On October 15, 2013, AARP and United announced that they were extending the Agreement to run through December 2020. See statement at: https://www.optum.com/about/news/unitedhealth-grouptoextendbroadenitsrelationshipwithaarptofocusm.html

[33] Part D prescription drug insurance and Medicare Advantage plans. See: https://www.aarpmedicareplans.com/health-plans.html#/plan-summary. AARP Medigap is the dominant player in the Medigap market. Nationwide, over 32% of beneficiaries enrolled in a Medigap insurance plan were enrolled in AARP Medigap and the only Medigap plans insured by United, again the largest health insurer in the country, are AARP Medigap plans.

[34] 2018 Medicare Advantage copay guidelines provided for United's "Oregon AARP® MedicareComplete® Plans" inform consumers that "Insulin and insulin syringes are covered under the Medicare Part D prescription drug benefit." OR4AD spot checks of AARP/United's Part D Drug Cost Estimator for Humalog in the "donut hole" and catastrophic phase: $293.80 per 10 ml vial. A Lane County–specific spot check of AARP/United's Part D costs for 10ml vial of Humalog yielded $275.20. See https://www.uhcprovider.com/content/provider/en/viewer.html?file=%2Fcontent%2Fdam%2Fprovider%2Fdocs%2Fpublic%2Fhealth-plans%2Fmedicare%2FMA-Copayment-Guidelines.pdf and https://www.uhcprovider.com/en/health-plans-by-state/oregon-health-plans/or-medicare-plans/or-aarp-medicarecomplete-plans.html. That same vial is currently priced in Oregon by OPDP at $271 (before rebates but including pharmacy dispensing fee).

[35] See T. Joseph Mattingly et al, "How do Manufacturer Net Prices Compare with Other Common US Price References?" *PharmacoEconomics* https://doi.org/10.1007/s40273-018-0667-9 (May 12, 2018): https://link.springer.com/content/pdf/10.1007/s40273-018-0667-9.pdf.

[36] The T1DF class actions against United, among other defendants, include: (1) *Boss, et al. v. CVS Health Corp. et al*. (analog insulin), filed in United States District Court, District of New Jersey, No. 3:17-cv-01823-BRM-LHG and consolidated under *In re Insulin Pricing Litigation,* No. 3:17-cv-00699-BRM-LHG, in December 2017. A motion for reconsideration of the consolidation order was filed in March 2018 to initiate a parallel litigation track against insurers and their PBM agents (pending). See https://www.t1df.org/projects/ and Mary Caffrey, "Out-of-Pocket Costs for Insulin Are a Problem. Litigants in Case Disagree on Who Is at Fault," AJMC March 22, 2018: https://www.ajmc.com/newsroom/out-of-pocket-costs-for-insulin-are-a-problem-litigants-in-case-disagree-on-who-is-at-fault. (2) *Bewley, et al. v. CVS Health Corporation, et al.* (glucagon), United States District Court, District of New Jersey, No. 3:2017-cv-12031-BRM-LHG. ON test strips; and (3) *Prescott, et al. v. CVS Health Corporation, et al.* (test strips)United States District Court, District of New Jersey, No. 3:2017-cv-13066-BRM-LHG.

Bartholomew to this Task Force that advanced patients' interests against payers' could potentially be used against United and/or AARP in current or future legal action.

Mr. Bartholomew's professional relationship to AARP, and thus to United, is an insurmountable conflict of interest and he should immediately resign from this Task Force. You must, in any event, recognize that Mr. Bartholomew cannot serve in the role of "consumer representative" and name an independent consumer representative to replace him in this role.

Naming as "consumer representative" a lobbyist from an organization that derives 37.3% of its total operating revenues from an insurance company currently sued for inflating prices on insulin and other pharmaceuticals is an insult to hundreds of thousands of Oregonians who desperately need relief from the high list prices they now pay for prescription drugs—including the many who now pay those prices solely due to their health insurers' discretionary benefit design.

Using this Task Force and the state's regulatory authority to hold insurers and OPDP responsible for basing patient cost-sharing on commercial payers' actual net cost—as state and federal laws likely already require them to do—would immediately save lives and right a wrong that has been ignored for far too long. Instead, you are making the problem worse by skirting HB 4005's statutory requirements to balance representation on this Task Force and, yet again, giving more power to the overwhelmingly profitable health insurance companies, their executives,[37] and business partners like AARP.

You have failed to comply with HB 4005's statutory requirement in Section 11(2)(D)(v) to name an individual representing consumers to the Joint Interim Task Force On Fair Pricing of Prescription Drugs. Nominating as "consumer representative" to this Task Force on fair pricing the chief lobbyist from AARP, an entity that currently directly benefits from price gouging of retired Oregonians via United adds insult to the injury already sustained by under- and uninsured Oregonians who are forced to compromise their health thanks to high drug prices sustained in part by decisions made by AARP and its partner United.

This appointment is not only a breach of the letter of HB 4005, it once again privileges powerful corporate interests over the lives of the most vulnerable Oregonians, including retirees, people on high-deductible and high cost-sharing plans, the uninsured, and the undocumented immigrants for whom OPDP might be the only available prescription drug program.

Oregon is facing simultaneous crises over education, housing, PERS, a lack of living-wage jobs and access to affordable pharmaceuticals. Under- and uninsured rates are going back up, especially in rural counties. Uninsurance was highest in traditionally Republican frontier areas at 11.0%, nearly double the uninsurance rate in Democrats' urban stronghold (5.8%). Oregon Health Authority and Moda Health were supposed to offer these uninsured Oregonians access to the same net low prices for prescription drugs that commercial insurers negotiate for themselves—they are instead overcharging individual discount card holders while exclusively

[37] United former CEO William McGuire, who orchestrated the lucrative deal with AARP in 1998, left United with $800 million in stock options and $530 million in compensation. American Association for Justice, "The Ten Worst Insurance Companies in America" (2008), p. 18.

passing the manufacturer rebates Moda and OPDP obtain to Moda's plans offered to public employees and union members.

To make this rigged healthcare system work for under- and uninsured Oregonians, we need principled leadership from politicians who will put Oregonians' needs first. A vague constitutional amendment[38] mandating that Oregon ensures access to "cost-effective… and affordable health care as a fundamental right" will remain totally ineffective if your administration continues to let health insurers and OPDP/Moda Health define "cost-effectiveness" and "affordability" on their own terms. Far too many Oregonians remain uninsured, or insured but unable actually to afford health services and the inflated, unrebated list prices for prescription drugs that insurers now incorporate into many health plan designs.

What the Poor People's Campaign has defined as "the attention violence that refuses to see these injustices and acknowledge the human and economic costs of inequality"[39] is nowhere more troubling than in this wholly preventable prescription drug pricing crisis. Here the imperative health needs of individuals, and the longterm economic interests of society, are both served by making prescription drugs affordable at the point of sale, particularly when those drugs are already available to commercial insurers at very low net cost. And that "attention violence" can be expressed in no more troubling way than by denying patients who are dying for lack of access to medicine even their statutory right to representation on a Task Force dedicated to the fair pricing of prescription drugs.

Your appointment of a lobbyist for the "market leader in Medicare" as a 'consumer representative' is an issue that strikes to the core of Oregon's deepening social crisis. Mr. Bartholomew should now recuse himself as consumer representative and resign his position on the Task Force. And you should now finally bring a genuine patient and consumer voice to Oregon's conversation on drug pricing.

Regards,

Julia Boss
Director
Oregonians for Affordable Drug Prices Now

[38] Oregon House Joint Resolution 203.

[39] https://www.poorpeoplescampaign.org/demands/