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National ADAP Working Group (NAWG)

March 2, 2026

The Honorable Abigail Spanberger
Office of the Governor, Commonwealth of Virginia
1111 East Broad Street, 3rd Floor
Richmond, VA 23219

Dear Governor Spanberger,

The **Community Access National Network (CANN)** is a 501(c)(3) national nonprofit organization focusing on public policy issues relating to HIV/AIDS and viral hepatitis. CANN's mission is to define, promote, and improve access to healthcare services and support for people living with HIV/AIDS and/or viral hepatitis through advocacy, education, and networking.

CANN respectfully requests a VETO of SB271/HB483

We recognize the good intentions behind **SB271** and **HB483**. Those intentions should be commended and pursued with legislation that adequately protects access to care for Virginians, especially patients living with chronic and rare health conditions, in a fashion that protects independent pharmacies, and in ways that do not ultimately divest from the healthcare interests of marginalized communities. Unfortunately, **SB271** and **HB483** do not protect patients, will cause harm to the state's healthcare infrastructure and sustainability, and ultimately will not reduce the costs patients face at the pharmacy counter.

Virginians deserve an effective remedy to affordability concerns sooner rather than later. The Prescription Drug Affordability Board (PDAB), as established under **SB271** and **HB483**, would waste valuable years of time and resources with no solution for patients or the system. Several states with operating PDABs have been in operation for years, yet have generated no savings for patients or the system despite substantial fiscal investments.

For example, the Colorado PDAB has cost the state more than $2 million to date, beginning with its initial appropriation of $730,711 in FY 2021-2022. There have been no savings for patients or the state, and there is currently no projection of when or even if there will be. This is especially pertinent given that the board is **currently entangled in litigation** and that the recent Upper Payment Limit it decided upon for its first drug is not set to take effect until 2027.

Upper Payment Limits (UPL) are not affordability solutions. They are structured as reimbursement caps that not only do not directly improve patients' prescription drug affordability but can also cause harm. Ultimately, this unproven reimbursement cap would benefit only Pharmacy Benefit Managers and their associated insurance companies, at the expense of patients and the state.

Early on in its operations, the Oregon PDAB commissioned the consulting firm Myers and Stauffer to examine the costs and benefits of imposing a UPL in Oregon. Through the UPL Report (UPL Draft Board Report), the Board found that a UPL would result in limited to no financial savings for the state's Medicaid program and would have adverse fiscal effects on 340B and safety-net providers. The reduction in rebate values would destabilize the Medicaid program due to the loss of value to the state's Medicaid Drug Rebate Program, **necessitating additional appropriations to make programs and providers whole**. Similarly, rebate revenue reduction would also harm 340B program providers, including crippling the ability of the AIDS Drug Assistance program and safety-net providers such as FQHCs to serve the vulnerable populations that depend on them to survive.

After an operational pause for re-evaluation, the Oregon PDAB adopted a paradigm shift in focus toward considering non-UPL solutions that would more immediately and effectively protect patients and the state budget. The board even acknowledged last year that it does not support Upper Payment Limits as effective and voted against recommending UPLs to the legislature for inclusion in their policy proposal report. Additionally, one of the members of the Oregon PDAB recently resigned and was one of two members who vocally expressed support of recommending the dissolution of the Board to the legislature before her departure. Moreover, because of the ineffectual nature of a PDAB and the lack of meaningful benefit a UPL could offer to any stakeholder, the New Hampshire PDAB was recently dissolved.

SB271 and **HB483** delay effective affordability remedy even further by instituting the first action as conducting affordability reviews of the first set of drugs selected for the first Medicare drug negotiation list. This list was chosen by the federal government using its own specific reasoning based on national-level Medicare concerns, not those specific to the needs of Virginians. Additionally, **SB271** and **HB483** set UPLs matching the Maximum Fair Price (MFP) of drugs. Again, this ignores the specific needs and characteristics of Virginia consumers and the complexities of state system dynamics. This statute does not address whether the MFP is in Virginia's best interests. In **SB271 and HB483,** attempts to examine the affordability of drugs specifically aligned with Virginia patients' concerns and the Virginia healthcare infrastructure are not defined as occurring until July 2028. This mindset and trajectory of actions focus on system spending, with patient welfare and savings as afterthoughts.

Utilizing MFP as a cost-containment cap endangers pharmacies because, unlike the federal MFP program, the state of Virginia, through **SB271** and **HB483**, has no way to make pharmacists whole when a UPL set to MFP is lower than acquisition costs. Moreover, a January 2025 New York Times article also explains the unintended harms of the Inflation Reduction Act's insulin price caps, which operate **in the same manner as Upper Payment limits**. As a result, many of the lowest-income patients lost access to needed medications because their clinics were unable to provide them in an affordable manner. Policy designs that inadvertently drain revenues from programs meant to serve low- and middle-income patients in an effort to provide paltry savings to the state or high-income families are not outcomes of "improving affordability" or "increasing access"; they're upward wealth redistribution.

Endeavors such as various aspects of PBM reform, in addition to the prohibition of copay maximizers and accumulators, are evidence-based solutions that would directly help patients in a much more timely manner. Additionally, since patient costs are directly a function of insurance plan design, considering copay cap legislation is another worthwhile solution to pursue. Notably, the Federal Trade Commission just released the settlement in its administrative complaint against pharmacy benefit manager Express Scripts. It is an exemplary example of ways patient and government payor costs can be lowered in ways a PDAB-UPL does not achieve. Highlights of the mandatory changes Express Scripts must enact are:

- No longer favoring high WAC drugs over low WAC alternatives
- Patient out-of-pocket costs based on net price, not list price
- Access to DTC pricing
- Fees delinked from list prices
- Substantially more transparency for plan sponsors
- Cost-plus reimbursement for retail pharmacies

Importantly, it mandates that Express Scripts also has to provide plan sponsors with Express Scripts programs that cap patient responsibility for participating drug products at set dollar amounts.

Ultimately, CANN respects the work and effort of the Virginia Legislature. We know you care about your constituents, your neighbors, and even your own families. We also understand that you want to address the complexities of our healthcare system, which leaves far too many patients behind. In these issues, we agree. However, a PDAB by any name, especially one with the power to impose an upper price limit and utilizing unproven MFP, is not the way to get there.

It is for these reasons that we urge you, Governor Spanberger, to **VETO SB271 and HB483.**

Respectfully submitted,

Ranier Simons
Director of Patient-Centered Drug Pricing and Healthcare Access Policy
Community Access National Network (CANN)

On behalf of
Jen Laws
President & CEO
Community Access National Network