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Upper-payment limits; Drug "affordability" boards risk medication access

By Jen Laws

To successfully combat the HIV epidemic and defeat other chronic conditions, patients must have uninterrupted access to the most effective medicines recommended by their doctors. As efforts to ensure patients can access their medicines are being defined in the public sphere, many state legislatures continue to advance policies and proposals focused on addressing patient affordability challenges.

However, many such actions fail to address high out-of-pocket costs and instead focus on lowering costs for other stakeholders within the health care system, like lowering costs and increasing profits for health insurers neglecting the patients they were intended to protect.

In Colorado and several other states across the country, lawmakers have empowered Prescription Drug Affordability Boards (PDABs) to address the rising costs that patients pay for prescription medicines. PDABs have the authority to select and review drug list prices and can recommend policies for drugs deemed "unaffordable." These list prices aren't something patients generally pay, rather we pay co-pays or are able to manage costs with patient assistance programs.

Despite this, one such policy being considered by the Colorado PDAB and similar boards in other states is an upper-payment limit (UPL). A UPL is a payment limit or ceiling that applies to all purchases and payments for certain high-cost drugs and does not necessarily translate into a "cost limit" for patients.

When UPLs are set, reimbursement rates are lowered for hospitals or clinics giving them less incentive to purchase specific drugs even though it may be the most effective medication to help a patient manage a chronic condition. When reimbursement rates are lowered through a UPL, it can also lead to barriers to biopharmaceutical companies investing in and supplying new innovative medicines to health facilities, making it difficult for doctors to prescribe treatments they think are best suited for their patients. While well intentioned, patients often bear the brunt of the challenges with such policies.

The impacts of the UPL process are only compounded when we consider the potential impact on the 340B Drug Pricing Program, a federal safety-net program that helps health facilities serve low-income and uninsured patients by offering them discounted drugs. Under the program, qualified clinics and other covered entities buy treatments at a discount to help treat vulnerable patients and get to keep the difference between the reimbursement rate and the discounted price leveraging those dollars to provide needy patients with medications and care they might not otherwise be able to afford.

Under a UPL, health facilities such as hospitals or clinics will receive lower reimbursements for prescribed treatments and therefore generate fewer dollars to support patients and the care we need to live and thrive. If the PDAB sets restrictive UPLs for drugs for chronic conditions like HIV, health facilities and the health professionals tasked with providing care will be faced with the decision to potentially stop prescribing these medicines and face having to cut support services that patients have come to rely on.

At a recent meeting of Colorado PDAB stakeholders, following the board's unanimous approval of the list of drugs eligible for an affordability review process, I voiced concerns about the approach to determining the value of lifesaving treatments for patients living with or at risk for HIV, hepatitis C (HCV), and other complex conditions. My concerns have only grown since, most recently, the state PDAB selected five drugs to undergo a formal affordability review including a treatment for HIV.

Many patients and other stakeholders have raised alarm to other drugs that are now subject to review to treat complex conditions such as psoriasis, arthritis, psoriatic arthritis, and cystic fibrosis. The implications of the Colorado drug "affordability" board's recent actions on patient access are grave and set a dangerous precedent. Ten states including Colorado have already established PDABs, and many others are following suit.

Those support services and continuity of care are critical to empower communities and improve the quality of life for people living with and managing conditions like HIV and hepatitis C. Despite the PDAB being "sold" to the public as a measure to improve patient experiences and access to care, the current model fails to prioritize patients at all.

Colorado is home to more than 13,000 people living with HIV and has been at the forefront of combating the disease. This year, state lawmakers advanced model legislation that protects patients' access to HIV prevention medication. However, the recent actions from the drug "affordability" board and short-sighted policies like the UPL process or mandatory generic switching could derail progress toward ending the HIV epidemic.

Price controls are, and will continue to be, a short-term, short-sighted "fix" with long-term consequences for patients living with chronic conditions. Policy efforts to address affordability must prioritize patient access and the ability for doctors to prescribe effective treatments. Colorado's PDAB, as it currently stands, falls short of that.

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