COMMUNITY ACCESS NATIONAL NETWORK

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**VIA Electronic Mail**

Michigan Legislature
Michigan Senate Committee on Finance, Insurance, and Consumer Protection

**RE: SB 3, SB4, and SB5: In opposition**

Honorable Chairperson Senator Cavanagh and Members of the Michigan Senate Committee on Finance, Insurance, and Consumer Protection,

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.

## Background: Other States' PDAB Efforts Continue to Fail

CANN has been deeply engaged with our advocacy partners across other states as they navigate the results of passing similarly situated legislation - none of which have produced positive results, one of which has provided a cost-benefit report demonstrating the threat to sustainable public health programs and state budgets (Oregon), another which subsequently refused to offer any cost-benefit analysis (Colorado), and another which is learning the hard way that federal regulatory application must also be respected (Maryland); all of which were repeatedly forewarned by patient and public health advocates for literally years prior to these results. This produces a strain on the budget of these states, taxes the emotional and physical capacity of patients, and none of these have produced a meaningful result benefiting patients.

CANN urges opposition to SB3 and all associated legislation on this moral budgetary basis and discuss further design flaws below. Michigan has the opportunity to provide patients with real protections and greater access to care by way of passing pharmacy benefit manager reform. Respectfully, your efforts and the tax dollars of Michiganders would be better served as such.

## SB 3 Is Framed Upon A Faulty Foundation

The language of the bill focuses heavily on the wholesale acquisition cost (WAC) as part of the selection criteria by which to select drugs for cost and affordability

review. The list price of a drug does not directly correlate with affordability for patients or the healthcare system. The 2024 administrative complaint filed by the Federal Trade Commission (FTC) gives evidence that PBMs predatorily manipulate the WACs of medications for their own profit. When manufacturers offer lower WAC medications that are clinically identical to the high WAC versions, PBMs categorically assign the high WAC versions to their formularies marketed to health plans to the exclusion of low WAC options.

The FTC released another report in 2025 focused specifically on PBMs' influence over specialty generic drugs. The report explains how PBMs marked up numerous specialty drugs by thousands of percent and some by hundreds of percent. This analysis of drugs covered the years 2017-2022, showing how patients, employers, and health plan sponsors incurred increasing costs as PBMs generated significant profits while dispensing drugs in excess of the drugs ' anticipated acquisition costs.

Since PBMs artificially inflate WAC, and engage in other related manipulations, it is faulty reasoning to use WAC as a data point for affordability selection.

**SB 3 Does Not Consider the True Costs of Its Execution**

The Upper Payment Limit (UPL) is the tool the bill presents as the solution to affordability. Data indicates that instituting an "Upper Payment Limit" (UPL) will not result in savings worth the risk of enforcing it. The Oregon Prescription Drug Advisory Board (PDAB) utilized the consulting firm Myers and Stauffer to examine the costs and benefits of imposing a UPL in Oregon.

The resulting report indicated that a UPL would result in limited financial savings and possibly adverse fiscal effects, particularly as it relates to the state's Medicaid program and 340B safety net providers via reduced values of rebates, **necessitating additional appropriations to make programs and providers whole.**

Utilizing several theoretical UPL price points, the analysis showed that in the best-case scenario, the imposition of a UPL would produce less than half a million dollars in "savings" to Oregon's Medicaid program due to reductions in rebate values applied to the program. Additionally, there would potentially be a reduction of federal matching dollars (FMAP) or program-sustaining revenues from the Medicaid Drug Rebate Program (MDRP), weakening the Medicaid program's ability to meet vulnerable populations' needs.

Similarly, UPLs would reduce 340B revenue values because of rebate reductions. This would harm the financial sustainability of 340B covered entities, providers, such as Federally Qualified Health Centers, and the state's AIDS Drug Assistance Program (ADAP), which serves marginalized communities operating as a safety net.

Reductions in funding would require Michigan to seek additional appropriations to compensate for the financial losses caused by a UPL. Additionally, the financial expenditure of the planning, subsequent execution, and continued enforcement of a UPL could outweigh the meager savings "possibly" generated, as evidenced by every other state that has implemented a PDAB having generated $0 in "savings" but otherwise costing those states millions of dollars, years-worth of labor, and nothing to show for it other than deeply frustrated patients.

For example, the Colorado PDAB has spent over $2 million in taxpayer dollars without achieving any savings for patients or the state on prescription drugs. Not only are there operating and implementation costs with instituting a

PDAB in the manner SB 3 provides, but there are costs associated with the litigation that can result in response to a PDAB's actions.

## SB 3 Does Not Prioritize Patient Input or the Patient Experience

The language of the bill states the resulting Board shall determine whether or not to conduct a cost and affordability review for any drugs selected as meeting the statutory criteria by considering input from the advisory council and looking at the average patient cost share for each prescription drug product. While the bill requires the inclusion of 3 members of the public as part of the 21-member defined advisory council, that is not sufficient for the thorough consideration of patient concerns.

Affordability is not defined by the list price of drugs. Moreover, without a tangible definition of what affordability means regarding the goals of the legislation, moving without thorough patient feedback will result in consequences that can harm instead of help patients. Patient input is necessary to inform patient experiences with payor (health insurer and pharmacy benefit manager) practices, like prior authorizations, step-therapy, or other benefit design concerns patients face (including but not limited to insufficient provider and pharmacy networks or patient steering amounting to self-dealing by "vertically integrated" companies and their associated subsidiaries).

The reality of some of the current PDABs in other states is that there is a level of disconnect between the Boards and their advisory councils. At times, the Boards are unsure of how to effectively utilize the expertise of the advisory councils, the advisory councils have concerns with the Boards' foundational understanding of issues such as the many aspects of the drug supply chain, and there is no guarantee that a Board would effectively heed the advice of an advisory council.

Given that there are no patient representatives on the actual board, in combination with there only being three mandated on the advisory council, significant outreach for patient engagement would be required. Speaking directly to patient experiences with these boards and their processes, those patients engaged in Colorado are regularly and routinely frustrated at the Board's failure to adhere to the recommendations of the Advisory Council, failure to adequately and substantially engage with patients affected by "affordability" review selection and the potential impacts of imposing an upper price limit, and the failure to coordinate with state agencies with more substantial community connections – be it with patients or providers themselves.

## Upper Payment Limits Are Not the Best Solution

Prescription drug affordability and implementing means of saving money for the system and patients are extraordinarily important goals. However, the UPL is not the best way to go about it. In March of 2025, Avalere Health Advisory updated previous research on health plans' perceptions of PDABs and UPLs. The latest report consisted partly of interviewing and surveying health plan employees. The respondents indicated adverse effects on formulary design, cost sharing, rebates, pharmacy and provider reimbursement, and ultimately, patient access to medications.

PBM reform effort is the more effective way to create beneficial affordability changes for patients and the state. Additionally, Medicaid audits are another effective means to realize savings. Indiana discovered several hundred million dollars in Medicaid fraud after auditing its program and its MCOs.

Many questions remain regarding the potential negative impacts of an upper reimbursement limit on programs and providers dependent upon revenues and savings generated from the 340B Drug Discount Program in order to provide life-saving and life-improving care for marginalized populations, particularly people living with HIV, rare diseases, disabilities, and chronic conditions. Ensuring safety-net providers are well supported in providing reduced-cost and/or no-cost care and treatment to the patients who need it most is critical to ensuring Michigan meets its highest ideals in caring for its residents. A UPL undermines these essential funding mechanisms.

Most importantly, cost and affordability are not wholly represented by "price". There is the cost associated with a patient evolving to a more advanced disease state if they are unable to access a medication as a result of a UPL. Patients may incur additional transportation costs if a UPL results in the closure of a local pharmacy or pharmacy steering by a PBM as a result of a UPL. The patient-physician relationship is hindered by potential UPL-driven utilization management practices enacted by PBMs as a result of UPLs. As PDABs in other states have also discussed, the drug supply chain is convoluted and in many areas opaque.

Experimenting with UPLs to the detriment of Michigan's patients is not worth the risk for public health, patients' pockets, or the healthcare system. We urge you not to enact SB 3 nor its accompanying bills, SB 4 and SB 5.

Respectfully submitted,

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Director of State Policy, PDABs
Community Access National Network (CANN)

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On behalf of
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President & CEO
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