COMMUNITY ACCESS NATIONAL NETWORK

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VIA Electronic Mail

Virginia Legislature
House of Delegates Committee on Labor and Commerce

RE: HB 1724 Establishing a Prescription Drug Affordability Board neglects to ensure priority on patient voices and experiences, and risks harming access to care; In opposition.

Honorable Chairperson DelegateWard, Vice Chair Delegate Herring, and Members of the Virginia House of Delegates Committee on Labor and Commerce,

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.

HB 1724 Does Not Consider The *True* Costs Of Its Execution

Recent 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.

In a similar fashion, a UPL 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), serving marginalized communities operating as a safety net.

Reductions in funding would require Virginia 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.

HB 1724 Is Structured On Problematic Premises

The language of the bill focuses heavily on the wholesale acquisition cost (WAC) as part of the selection criteria for the affordability review of drugs. This is an exemplary example of how list price does not directly correlate with affordability. The recent administrative complaint filed by the Federal Trade Commission 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.

Since PBMs artificially inflate WAC, it is faulty reasoning to use it as a data point for affordability selection.

HB 1724 Does Not Prioritize Patient Input, Experiences, Or Outcomes Above Other Interests and Poses The Potential For Meaningful Harm To Patient Access, Continuity of Public Health Programs, And Provider Entity Financial Stability

CANN is gravely concerned about HB 1724 and, more generally, the speed in which several states have adopted "Prescription Drug Affordability Boards," often neglecting to require patient input on each board, patient experience in required evaluative and monitoring measures, and failing to consider the unintended, but quite predictable, consequences of these boards. Prescription Drug Affordability Boards or any other board empowered as same, regardless of name, as described in HB 1724, do not consider patient experiences with payor (health insurer and pharmacy benefit manager) practices, like prior authorizations or 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).

We appreciate the intent of the bill in trying to help families, people with disabilities and chronic conditions, and those with limited incomes from feeling like they're "forced to choose between the medicine they need and basic necessities." As patients ourselves, we agree with this noble effort and the necessity of reducing patient out-of-pocket cost and administrative burdens on patients and our healthcare providers.

To achieve this goal, the means and process of getting there must center on those who are supposed to benefit – patients and our families. HB 1724, as currently designed, fails to consider the most direct costs to patients and healthcare providers and, ultimately, focuses on choosing favored industry interests versus other industry interests rather than focusing on patient experiences.

For these reasons, we urge members of the Senate Commerce and Labor and Education and Health Committees to oppose HB 1724 in its current form.

CANN has worked in support of patient advocates and people living with HIV (PLWH) in several other states which have passed similarly situated legislation. Colorado, for example, is a state that has advanced quite swiftly in selecting medications for "affordability" review and continues in that process today. Indeed, Colorado is the most often referenced state for legislatures considering a PDAB or similarly situated board to take up authority to establish an upper payment limit. Despite touting Colorado as a "success", documentation of public comment shows consistent identification of poor board choices and regular frustration from patients as the Board fails to address concerns and legitimate questions about implementation and potential impacts.

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. Extraordinarily, legislators in states considering a PDAB or granting upper payment limit powers to another board fail to mention or consider these frustrations. CANN is certain the Virginia legislature does not wish to have its good works undermined but a similar process. Safeguards must be included in any legislation impacting the public to ensure the public is truly heard and served. HB 1724, as written, does not achieve this end.

"Affordability," as Framed by HB 1724, Does Not Speak to Patient Experiences

The issue of "affordability" is strictly from the end-user's or patient's perspective and does not start or end with list prices or reimbursement rates of medications. Rather, these are issues related to industry stakeholder interests, particularly those of pharmacy benefit managers (PBMs), and their profit margins; "Affordability" especially within the frame of various rebate structures, most directly translates to how much profit a PBM makes off of any particular medication. PBMs "get compensated" by a combination of spread pricing – or charging more than what they pay for particular medications, retaining rebates, and administrative fees. However, those rebates offered by pharmaceutical manufacturers are designed to reduce the costs of medication to patients, not pad the profit margins of PBMs or their vertically integrated mail-order or physical pharmacy locations.

Rather, patient experiences in accessible healthcare, and treatment, particularly medication access, is far more complicated. Barriers to care begin with high deductible and high premium health plans and are complicated by issues of insufficient provider networks, patient steering in pharmacy selection, and utilization management practices which operate to allow health plans to disrupt the provider-patient relationship by way of administrative burdens. Compounding these concerns, consolidation in the provider, hospital, and pharmacy markets reduces the number of access points of care, with *particular* harm toward rural communities wherein accessing even an emergency room might leave patients hours away from life-saving care in rural communities.

Actions to Protect Patients and Improve Access to Care and Treatments

The Virginia legislature is well positioned to address these barriers to care and meaningfully make care and treatment more meaningfully accessible to Virginians by examining and addressing the role of these interests by any of the following actions, all of which work to provide protections to patient interests:

- Prohibiting unfair trade practices (particularly regarding hospital consolidation and patient steering)
- Prohibiting spread pricing (wherein PBMs may not charge a patient or plan sponsor more than the cost of acquiring a medication)
- Prohibiting so-called "co-pay accumulator" or "co-pay maximizer" programs (wherein financial support from manufacturer patient assistance programs must be applied directly to a patient's deductible and/or maximum out-of-pocket limit)
- Prohibiting certain utilization management practices (such as prior authorizations or step therapy – adopting "provider prevails" program)
- Requiring plans to offer pass-through savings directly to patients preventing them being held by insurers
- Prohibiting patient steering (wherein patient choice of pharmacy is equally reimbursed and protected from vertically integrated entities which profit from the self-dealing nature of PBMs requiring patients to utilize mail order or physical pharmacies owned by or associated with the PBM)

Questions Remain, Virginians Should Not Answer by way of Experimentation

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 Virginia meets its highest ideals in caring for its residents. A UPL undermines these essential funding mechanisms.

Similarly, no state has yet to answer the question of what happens when a UPL is imposed and the cost to acquire a particular medication is higher than the allowable reimbursement rate? Who pays? Will it be patients? If an exemption is allowed, what process burdens will patients face to get the treatments our providers have identified best suit our individual care needs? Social media feeds are filled with pharmacists complaining about how low reimbursement rates are already harming patients' access to care because those same pharmacies cannot afford to distribute certain medications to patients. Along the same lines, those pharmacists and

providers administering medications are sharing that PBMs no longer making sufficient revenues from *particular* medications have removed those same lower-cost medications from formularies, leaving patients in the lurch. Something is rotten in this henhouse.

Will the Virginia legislature need to appropriate additional public health dollars to make up for reduced rebate savings for hospitals and federally qualified health centers serving poor and indigent patients? Will the state's AIDS Drug Assistance Program find itself in a budget shortfall as a result of reduced reimbursements? What about the Medicaid program?

Evidence is already mounting that reimbursement limits are harmful to these programs, even if, admittedly, this seems "counterintuitive to a straightforward answer to drug price concerns and patient access. In a recent article in the publication 340B Report, Colleen Meiman, a national policy advisor for the State & Regional Associations of Community Health Centers, shared a "neat" allegory to an upper reimbursement limit as manufacturers reduced insulin costs to $35; "Before 2024, most insulins had list prices of $300-$500 or more and were 340B penny-priced, so 340B providers earned savings of $300-$500 per prescription, Meiman said. However, now that many insulin list prices are $35, the 340B savings could drop to around $8 per prescription, she said. Historically, 340B savings on insulin have accounted for around 10% of community health system 340B revenue, she said."

Lastly, what are the costs to the "system" of care of ultimately denying access to the personalized care patients require to meet our health outcome goals? As one patient in Colorado recently stated during a stakeholder meeting, "Is it more costly to give me the medication I need now or is it more costly for me to end up in the hospital for three weeks, attempting to be stabilized?" These questions are very, very real, especially in the frame of medications selected for review by the Colorado PDAB – rare disease and antiretroviral medications are among those selected. PLWH and cystic fibrosis patients are quite familiar with what happens to us, our friends, and our families when our treatment access is disrupted – people die, families struggle through transplant waitlists, and higher viral loads due to disruptions in care mean new HIV diagnoses. That's not an exaggeration. But is our fear.

Conclusion

While CANN is primarily focused on policy matters affecting access to care for people living with and affected by HIV, we stand in firm support of all people living with chronic and rare diseases and recognize the very reality of those living with multiple health conditions and the necessity of timely, personalized care for every one of those health conditions. State Prescription Drug Affordability Boards are of profound importance to our community.

Ultimately, CANN respects the work and effort the Virginia Legislature is trying to achieve here. We well know you care about your constituents, your neighbors, and even your own families. And we know you want to address the complexities of our healthcare system which leave far too many patients behind. In these issues, we agree. A PDAB by any other name, especially one with the power to impose an upper price limit, is simply not the way to get there.

We are readily available to answer any questions you may have and look forward to future discussion on improving access to care for Virginians. Jen Laws, CEO, can be reached at 313-333-8534 or by email at Jen@tiicann.org.

Respectfully submitted,

Sincerely,
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On behalf of
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