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HIV/HCV Co-Infection Watch

**National Groups:**

Hepatitis Education, Advocacy & Leadership  
(HEAL) Group  
Industry Advisory Group (IAG)  
National ADAP Working Group (NAWG)

February 26, 2024

The Honorable Glenn Youngkin  
Office of the Governor, Commonwealth of Virginia  
1111 East Broad Street, 3<sup>rd</sup> Floor  
Richmond, VA 23219

Dear Governor Youngkin,

**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 supports for people living with HIV/AIDS and/or viral hepatitis through advocacy, education, and networking. CANN's coalition-based work is done on behalf of the patient advocacy groups, pharmaceutical partners, and government agencies.

**CANN respectfully requests veto of SB 274/HB 570!**

We recognize the good intentions behind SB 274 and HB 570. Those intentions should be commended and pursued with legislation that adequately protects access to care for patients in Virginia, especially residents 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. SB 274 and HB 274 simply do not adequately protect patients, communities, or pharmacists from harmful unintended consequences.

Indeed, if the Virginia legislature were interested in saving patients' dollars at the pharmacy counter, lawmakers could have advanced bills that prohibit abusive utilization management practices – such as prior authorization and prohibit step therapy – or require rebates to be passed through to patients. Again, SB 274 and HB 570 do not do these things.

Instead, SB 274 and HB 570 establish a “Prescription Drug Affordability Board” without requiring patients themselves be represented on the Board, without ensuring conflicts of interest are prohibited among consultants hired to conduct reviews or advise the Board, without meaningfully evaluating access concerns, or even the whole of the healthcare delivery system. Instead, both bills would prescribe a “solution” to a very real and pressing concern that already threatens independent pharmacies by way of under-reimbursement and could potentially harm Virginia’s safety net hospitals, federally qualified health centers, and the state’s AIDS Drug Assistance Program by reducing the 340B rebate values realized by these entities.

Community Access National Network (CANN)  
[www.tiicann.org](http://www.tiicann.org)

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Evidence from Colorado is not promising and the model should not be repeated. Last week, patients testified before the Colorado legislature pleading for an exemption to the Board’s authority because the first medications selected for review are orphan drugs and medications used to treat (and control) HIV. The process to getting there has been dozens of hours of meetings, patients pleading with an unresponsive Board to consider issues of access, and even the state’s own Rare Disease Access Council expressing significant concern about access to care for patients who have no other choice in care. These are experiences Virginians should not have to face.

The hard truth is rare and chronic care is expensive. The whole point of health insurance is to spread that cost concern across a larger population to reduce the individual cost, making healthcare more accessible. The unfortunate reality is capping the allowable reimbursement price for any rare or chronic health condition management is an effort to eliminate these costly concerns – eliminate access to care for many disabled persons.

Elsewhere, we’ve seen “experts” espouse a rank falsehood: “An upper payment limit will not impact 340B”. This could not be further from the truth and the repeated insistence is, on its best day, a very lawyered lie. While it is true the 340B acquisition price of a medication will not be impacted, 340B’s value is found in the reimbursement rate. The spread between acquisition and reimbursement should then be reinvested into marginalized communities who would not otherwise have access to care or in federally funded, state administered programs like the AIDS Drug Assistance Program. Reducing reimbursement rates is directly robbing 340B of its value and communities and programs served by 340B of those revenues.

Lastly, independent pharmacists across the country are facing a crisis of under-reimbursement from Pharmacy Benefit Managers (PBMs). An under-reimbursement is a PBM paying “back” a pharmacy less than it costs the pharmacy to acquire a medication, ensuring that independent pharmacies are operating at a loss every time they fill and dispense a medication. This is not a sustainable model, which is why some projections expect to see the end of non-chain, independent pharmacists in as early as the next 3 years. An upper payment limit would only exacerbate this crisis, to the detriment of the communities served by independent pharmacies.

As a patient advocacy organization for people living with HIV and viral hepatitis, we well know the challenges faced in working to ensure patients have meaningful, timely access to affordable medications meeting our individual medical needs. SB 274 and HB 570 simply masks reducing access under the mirage of “affordability” and ultimately leaving patients, our families, and our communities left to pick up both the pieces and the price.

It is for these reasons, we urge you, Governor Youngkin, to **VETO SB 274 and HB 570**.

Ever yours in service,



Jen Laws  
President & CEO