COMMUNITY ACCESS NATIONAL NETWORK

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October 11, 2024

Oregon Prescription Drug Affordability Board
Department of Consumer and Business Services
350 Winter Street NE
Salem, OR 97309-0405

**RE: Oregon Prescription Drug Affordability Board Guidelines**

Dear Honorable Members of the Oregon Prescription Drug Affordability Board,

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.

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.

Today, we write with commentary regarding your ongoing thorough efforts to set up the Prescription Drug Affordability Board (PDAB) for success.

## The Cost-Benefit of a UPL Does Not Serve Oregon Patients

In expressing our support for certain recommendations from the PDAB, we also wish to highlight concerning findings from the PDAB's own contracted consultants reviewing the cost-benefit of imposing an "Upper Payment Limit" (UPL). In the Stauffer-Meyers UPL Draft Report, authors noted a few concerns which are particularly important to under-served and marginalized communities highly impacted by health disparities. The most noted being that imposition of a UPL on a best-case basis may produce less than half a million dollars in "savings" to Oregon's Medicaid program due to reductions in rebate values applied to the program (pg. 27). This does not consider the negative fiscal impact of potentially reducing federal matching dollars (FMAP) in assisting the state of Oregon in meeting its Medicaid population's needs.

Furthermore, as the report notes, an analysis could not be made regarding any impact on 340B covered entities, however, given the estimation relative to Medicaid rebate reductions, a similar reduction in 340B discount values should be expected. For 340B covered entities serving marginalized populations and otherwise operating as safety net entities, such a reduction would likely prove damaging to patient affordability and access and harmful to the financial sustainability of these entities, particularly federally qualified health centers.

Simply put, a UPL does not serve either the "health system" as a whole or patients living in Oregon. CANN continues to urge the Oregon Legislature and the PDAB to weigh the potential of such a minor benefit relative to significant concerns in these regards.

**2024 Proposed Policy Recommendations**

We applaud the three items you refer to in your policy analysis as "Potential Senate Bill clean-up." Changing the language from locking in a mandatory set number of drugs for review empowers the Board to focus on medicines that effectively meet the future affordability challenge criteria the Board sets instead of forcing designations of drugs merely out of statute, potentially unnecessarily causing access issues for patients.

We also thank you for considering the reporting changes regarding removing the requirement of the generic drug report and the quarterly DCBS prescription drug list requirement. Accurate and relevant data is required to serve your citizens and your health system beneficially. This is important to ensure your KPIs or metrics truthfully address your concerns.

**Additional Recommendations**

Your recommendations, which you labeled 'additional recommendations', are also practical.

We support your recommendations for enhanced reporting regarding copay accumulators and maximizers and other benefit design issues. Requiring PBMs to assume the burden of responsibility for reporting will improve transparency, strengthen the quality of the collected data, and remove the onus of data collection from the Board.

We support the recommendation of a statewide preferred drug list for all classes of prescription drugs for OHP FFS. This not only reduces the administrative burden for providers but improves patient access. Ensuring all patients have the same access to all approved drugs agnostic of the FFS plan results in all patients benefiting from the well-researched drug list and helps them maintain consistency as their circumstances change, which could result in plan migration over time.

We support the recommendation of the OHP, FFS, and CCOs purchasing through a statewide purchasing group. In addition to cost savings and logistical efficiency, the purchasing group could provide funding. Administrative fees charged to the participating vendors could be used to support programs and other needs of the various members, resulting in reduced system expenditures and, ultimately, cost savings being passed on to patients.

We support the suggestion of minimum dispensing fees across all payers and the prohibition of below-cost pharmacy reimbursement. This will shield the financial stability of pharmacies from being adversely affected by any market response to future drug affordability policy actions.

We support the uniform reimbursement rate recommendation for CAPs and the PBMs that contract with them. CAPs service underserved areas and do not benefit from high-volume purchasing. This recommendation would protect the stability of operation. Protecting them from actions, such as PBMs restricting reimbursement or forcing mail-order utilization, which could potentially prevent pharmacy closures that would create pharmacy deserts and harm patient access.

## Additional Potential Considerations

We would also like to propose potential considerations to be added as policy recommendations as reflected by the recent Federal Trade Commission (FTC) complaint against three specific PBMs:

- Prohibit PBMs from designing benefit plans that base patients' cost-sharing (i.e., deductibles or coinsurance) on list price rather than the net costs after rebates.
- Prohibit contracting resulting in PBM compensation being tied to a drug's list price or related metric or "de-linking" rebate structures from PBM profitability.
- Prohibit PBMs from discouraging the use of or excluding low WAC versions of drugs made by the same manufacturers opting to favor the high WAC drug on formularies.
- Imposing a critical eye at price reporting data such as WAC and AMP. The FTC report referenced herein details how PBMs manipulate both ecosystem and state-specific data by prioritizing high WAC medications over low WAC medications, even when manufactured by the same company. Thus, the price metrics considered by the PDAB are "contaminated" and the PDAB's conclusions will similarly be tainted by this data flaw.

CANN remains steadfast in urging PBM reform and enforcement of same as the most direct means to aiding patients and Oregon's health system. The unfortunate reality is the state's PDAB is not currently empowered to address these issues. We look forward to continuing to work with the Board, sharing our experiences from other states regarding PDABs, and ensuring that the best outcomes for patients remain a priority.

Respectfully submitted,

Sincerely,
Ranier Simons
Director of State Policy
Community Access National Network (CANN)

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

HIV+HEP
POLICY INSTITUTE

October 11, 2024

Oregon Prescription Drug Affordability Board
350 Winter Street NE
Salem, OR 97309-0405
pdab@dcbs.oregon.gov

**Re: Public Comment for October 16, 2024 Board Meeting-Policy Recommendations for Oregon Legislature**

Dear Members of the Oregon Prescription Drug Affordability Board:

The **HIV+Hepatitis Policy Institute** is a leading organization advocating for quality, affordable healthcare for individuals living with or at risk of HIV, hepatitis, and other serious or chronic health conditions. As the legislature considers modifications to SB 844, **we write to express our support for proposed legislative recommendations including enhancing transparency around the use of copay accumulators, copay maximizers, and alternative funding programs.**

In recent years, insurers and their PBMs have implemented harmful policies that shift financial responsibilities for prescription costs to patients by not applying copayment assistance from drug manufacturers and sometimes charitable organizations. Cost-shifting mechanisms, such as copay accumulators, copay maximizers, and alternative funding programs (AFPs), have become increasingly common in commercial insurance plans. By 2022, it was estimated that 39% of beneficiaries under commercial insurance were enrolled in plans with copay accumulators[i], 41% in those with copay maximizers[ii], and 12% in plans using AFPs.[iii] In Oregon, five out of six insurers on the marketplace are implementing these programs.[iv] These programs introduce additional cost barriers for patients and healthcare providers, complicating timely access to necessary medications.

People living with HIV, hepatitis, and other serious chronic conditions rely on medications for their health and survival. Individuals with HIV and hepatitis B must follow lifelong drug regimens, while those with hepatitis C can be cured within 8 to 12 weeks. However, despite having health insurance, access to these medications can be delayed or even denied due to these insurance practices.

**Support for Reporting on Copay Accumulators and Maximizers**

Requiring insurers to report on the use of copay accumulators and maximizers is crucial for transparency and accountability in healthcare cost-sharing. These programs shift costs onto patients by excluding manufacturer copay assistance from deductibles and out-of-pocket limits,

which often leads to higher expenses and reduced adherence to medication. Additionally, insurers and PBMs are collecting the copay assistance and keeping it for themselves. Since the copay assistance does not count towards the beneficiary's cost-sharing obligations, they then turn to the beneficiary to collect additional funding and therefore, are "double billing". By mandating detailed reporting, the Board can assess the impact of these programs on patient affordability and access to medications.

**Add Reporting Requirements on Alternative Funding Programs**

We also recommend the Board consider extending these reporting requirements to include Alternative Funding Programs (AFPs). AFPs are used by self-funded employer health plans to shift the cost of expensive specialty medications away from the insurance plan. These programs typically classify specialty medications as "non-essential," excluding them from regular insurance coverage. Patients needing these medications must navigate third-party assistance programs, which is meant for people without insurance coverage. This often involves complex and time-consuming processes to access medications, sometimes through manufacturer patient assistance programs or international pharmacies. AFPs selectively avoid covering individuals with higher health risks, such as those with pre-existing conditions, disproportionately impacting people with chronic or rare diseases who rely on specialty medications, raising serious concerns about health equity.

AFPs can lead to significant treatment delays, which can have serious consequences for patients with HIV and hepatitis and broader public health implications. Even a brief delay in treatment can trigger viral resistance, rendering that medication and the entire class of medications like it an ineffective option for that patient. Consistent use of these treatments helps suppress viral load counts and reduce the chances of spreading these infectious diseases.

Requiring insurers to disclose the extent and impact of AFPs would allow the Board to better understand how these programs affect patient affordability and access to these critical medications. This reporting would also highlight how many patients are denied timely access to medications and expose ethical concerns, such as the diversion of charitable resources intended for the uninsured or underinsured. Increased transparency would help ensure that AFPs do not compromise patient care under the guise of cost savings.

We also support the proposed change relative to the number of drugs to be reviewed per year and the consideration of patient assistance programs, which substantially contribute to patient affordability of medications.

**These recommendations promote fairness, transparency, and accountability in the pharmaceutical and insurance sectors, prioritizing patient well-being. We urge you to support the adoption of these measures to improve access to affordable prescription medications for all Oregonians.**

Thank you for considering these important policy proposals. We look forward to your support in advancing these recommendations. If you have any questions or need any additional information, please do not hesitate to reach out via phone at (202) 462-3042 or email at cschmid@hivhep.org.

Sincerely,

Carl E. Schmid II
Executive Director

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[i] Fein AJ. Copay Accumulator and Maximizer Update: Adoption Plateaus as Insurers Battle Patients Over Copay Support. Drug Channels.

[ii] Pharmaceutical Strategies Group. 2023 Trends in Specialty Drug Benefits Report.

[iii] Fein AJ. Employers Expand Use of Alternative Funding Programs—But Sustainability in Doubt as Loopholes Close. Drug Channels.

[iv] The Aids Institute: Copay Assistance Diversion Programs in Oregon