

Prescription Drug Affordability Boards: A Threat to Ending the HIV Epidemic?

State AIDS Drug Assistance Programs, or ADAPs, are largely dependent on savings and revenues from the 340B Drug Pricing Program to “stretch scarce Federal resources as far as possible reaching more eligible patients and providing more comprehensive services.”

Prescription Drug Affordability Boards, or PDABs, are considering “**price controls**” to set the cost of prescription drugs by setting an “**upper payment limit**” (UPL).

But here are some facts on why UPL price controls are bad for providers...and patients:

- 340B's value is found in the “spread” between the reimbursement rates and a reduced acquisition cost by way of drug manufacturer 340B rebates
- Reducing reimbursement rates by way of an “upper payment limit” will reduce the value realized by 340B rebates
- Providers end up with less money, which means they can afford to fund less services
- That's only *IF* a pharmacy can still afford to fill the medication
- Will your copay change? NO

Ex.

Antiviral B Hypo:

- Normal reimbursement: \$550
- 340B Price: \$50
- Value of rebate: \$500 - to be reinvested in HIV programming/providing medications

Under a UPL:

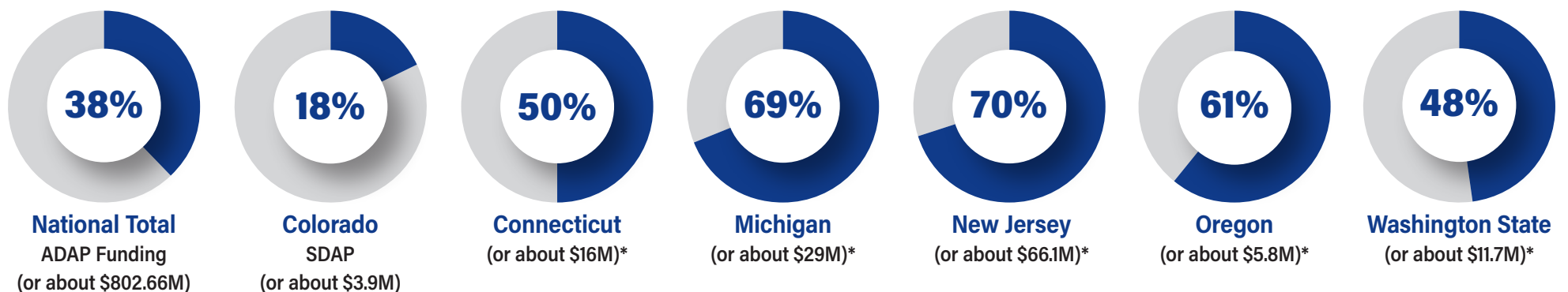
- UPL reimbursement: \$350
- 340B Price: \$50
- Value of rebate: \$300 - to be reinvested in HIV programming/providing medications



What happens if the UPL is set below the cost of the medication?

Will your pharmacy be able to fill it?

This is particularly striking when we think about State ADAP Budgets, and NASTAD's 2023 RWHAP Part B ADAP Monitoring Report provides insights. Take a look:



* ADAP State Contribution = \$0

● = % of budget that is rebate

According to NASTAD, for most states, **a majority of ADAP clients live at or below 300% of the Federal Poverty Level**, meaning even when they're Medicaid Qualified, they still need help. Taking dollars out of ADAP by reducing the value of the rebates is a **DISINVESTMENT from HIV-related funding**.