COMMUNITY ACCESS NATIONAL NETWORK

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Senate Health and Welfare Committee
Louisiana State Senate
900 N. 3rd Street,
Baton Rouge, LA 70804

RE: SB401 - OPPOSE

Dear Chair Talbot Vice Chair Andrews, members of the Senate Health and Welfare Committee, and your well-respected staff,

We write today to express extreme concern regarding **SB401**, which seeks to establish a so-called "Prescription Drug Affordability Board" that offers no meaningful benefit for Louisianans, as evidenced by their failure to benefit patients in the other states that have enacted similarly situated legislation.

ABOUT CANN: **The Community Access National Network (CANN)** is a 501(c)(3) national nonprofit organization (formerly incorporated under the "Ryan White CARE Act Title II Community AIDS National Network") 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.

11 States have Established "PDABs" and Saved Less than Zero Dollars

CANN has actively represented patient interests at several PDABs across the country for multiple years. The first PDAB was established in 2019, in Maryland. **To date, no PDAB has saved either patients or states any money.** Indeed, whereby cost of state employee salaries allocated to serve as staff to these boards, litigation, fees paid to highly conflicted consultants, or the lost wages of patients having to give up their working hours to attend and participate in meetings, these boards have only ever cost states money.

The structure of SB401 stands to do the exact same thing when our state needs it the least.

SB401 Precludes Patients, Betraying This Boady's Work to Address PBMs

Several Members of this body and the Louisiana State House have brought forth bills this session which seek to meaningfully address some of the most prominent healthcare cost drivers and largest barriers to patient access to services and medications. This is not one of those bills.

As written, the design of this board will meaningfully exclude patient voices, as has every other similarly situated board across 11 states. Relying solely on the representation of system voices imposes the complaint in chief patients have repeatedly confronted in healthcare systems – decisions being made without us.

Directly, one cannot reasonably or rationally conclude to find solutions for a population without explicitly ensuring that population is driving the search for solutions, much less excluding those same voices entirely. As structured, SB401 excludes the very voices it proports to serve" patients.

The Louisiana Legislature has rightly provided a multitude of avenues to address both patient and state drug spending this session by way of reforming the operations of Pharmacy Benefit Managers (PBMs) to ensure their functions actually align with their advertise purpose – saving patients and systems time and money and expanding access.

The reality of Louisiana's frustrations on medication and healthcare access has been voiced time and again – those things which seek to "contain cost" but ultimately operate to solely contain care to the detriment of the community's health, from abusive prior authorization and predatory benefit and formulary design to unaffordable deductibles and premiums, we know where harm is occurring. We know which "alligator" is closest to us.

Structure of the Bill is Discriminatory, Neglects Already Known Confounders

The "cost" analysis of the bill explicitly relies on Wholesale Acquisition Cost (WAC). This design, as witnessed in 11 other states, necessarily ***requires*** the board to focus on exceptional medications serving small populations – meaning those rare, chronic, complex, and disabling health conditions. Focus on "cost drivers" neglects ***why*** certain medications serve fewer patients and how significant the health benefits of those medications are.

For example, no state PDAB has ever proposed to address statins or offered a policy solution for $1200 ibuprofen (as charged by some hospitals). Each PDAB, by design – exactly as it is in SB401, has only ever considered medications that return cystic fibrosis patients to society, or cure Hepatitis C virus, or treat HIV, or significantly improve rheumatoid arthritis better than older medications.

Yet and still, SB401 as currently designed points toward manufacturers rather than PBMs. The Federal Trade Commission (FTC) has already dispelled the myth SB401 seeks to codify into Louisiana law: PBMs have and do reject low-WAC products in favor of high WAC versions of the exact same products:

> *In addition to insulin, the PBM Respondents exclude or disadvantage low WAC versions of other drugs in favor of the high WAC versions. For example, in January 2019, Gilead Science (through a subsidiary) launched low WAC versions of its Hepatitis C medications Harvoni and Epclusa at significant discounts to the high WAC versions. Although brand companies sometimes offer low WAC versions of their drugs in response to competition from generic drugs, Gilead launched these low WAC versions unprompted by that prospect: Harvoni and Epclusa were years away from the threat of generic entry. The PBM Respondents all preferred the high WAC versions of both drugs on their 2024 flagship formularies and excluded the low WAC alternatives.*

Next Steps are Known and Harmful

In other states with PDABs, we know the design follows a pattern: supply chain-blind price controls. Other states are actively seeking to impose an "upper payment limit" and are thusly directed by statute to reach predetermined conclusions regarding undefined "affordability". The goal post moves constantly by these boards and the staff that serve them to reach a specific position without regard to professional and personal feedback from patients and pharmacists and even safety-net providers or their own Medicaid consultants.

Upper payment limits harm rebate retention for 340B providers and the state's Medicaid program by reducing reimbursement, or where the spread between actual acquisition cost (not WAC) and reimbursement is upwardly divergent for the purposes of generating program sustaining revenues. Likewise, that same design reduces sustainability of pharmacies and even their ability to acquire these critical medications.

All of these and more are the exact reasons **New Hampshire disbanded its PDAB** and why **Vermont has abandoned the idea**. These reasons are exactly **why Oregon's PDAB has actively discussed recommending addressing PBM reform and benefit design and disbanding the PDAB itself**.

While this idea may seem new or novel to Louisiana, it is not new or novel to CANN or any other patient advocacy organization that has had to divert our extremely limited resources to these very tedious and myopic boards. **Louisiana does not need to repeat the failed experiments of other states and we strongly encourage this Committee to oppose SB401**.

There are tangible, real solutions that will be coming before this Committee. Your time and energy is better served navigating those solutions and ensuring your actions and the policy of this great state reflect the needs of our neighbors.

If ever CANN may be of service to your office on issues of public health or healthcare policy from the patient perspective, please, feel free to reach out.

Thank you,

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