Virginia Prescription Drug Affordability Board FAQs

Why is a Prescription Drug Affordability Board (PDAB) Important?

- **The price of drugs, long a concern for Virginians, continues to escalate – even faster than the rate of inflation.** In 2021 alone, drug companies hiked the price of more than 1,100 medicines and 90% of the increases were above the rate of inflation. This is especially concerning for consumers because list prices are the basis of what pharmacies, plans, and patients all pay.
- **Virginians feel the burden of expensive medicines acutely.** 1 in 4 Virginians report not taking medicines as prescribed solely due to their outsized cost. Prescription drug costs are simply taking up a bigger and bigger portion of Virginians' economic burdens. **According to America's Health Insurance Plans (AHIP), prescription drugs now represent the single biggest portion of your health insurance premium** – more than hospital costs, emergency room visits, doctor and provider visits, or other outpatient care.
- Rising medicine costs have a dangerous series of consequences. As the cost of prescription drugs increases, it leads to higher insurance premiums for everyone. As costs rise, it causes more taxpayer dollars to go to drug spending to support public spending like Medicaid or state and local employees.
- Put simply, while much of the drug market involves the federal government, **a PDAB is the best tool in Virginia's arsenal to take control over the ever-rising cost of healthcare for consumers and take direct action to lower the economic burden for Virginia families.**

How Would a PDAB Work:

- A PDAB would operate much like a state's public service commission – determining what consumers will pay and what suppliers can charge for vital public services. PDABs, like public service commissions, would balance consumer affordability with revenue needs of suppliers – revenues that allow service improvements. The public service commission analogy is apt because the drugs of concern to a PDAB will most likely be drugs that hold a relative monopoly position – drugs with only one or few competing manufacturers where the price increase of one company is followed by the other drugs with similar therapeutic effects.
- A PDAB would NOT set prices for medicines. Rather, it would set the in-state charges and payments made for a particular drug among state-licensed healthcare entities – wholesalers, other distributors, pharmacies, hospitals, physicians, and insurers.

What is an upper payment limit (UPL) and why is it important?

- **The PDAB would set an "upper payment limit" (UPL) for certain high-cost drugs.** UPLs are common in the healthcare industry – limits to what providers and suppliers charge and what insurers will reimburse. A statewide UPL limits what can be billed and paid statewide. The UPL uses the standard operating procedures of the existing supply

chain where supply chain participants negotiate what they will charge and what they will pay. Manufacturers routinely respond to this market dynamic every day for every drug in every market. Manufacturers routinely adjust their charges through negotiations with providers or the supply chain when payer reimbursement does not cover the providers' cost to stock the product.

- The overarching goal of any PDAB is to find a UPL at which insurers, purchasers, and governments can afford to provide the drug to everyone in the state who should get the drug. **The point of a UPL is to expand sales and patient access.** The purpose is not to reduce manufacturer revenue.
- Without a UPL, a PDAB effectively just becomes a study commission that would prompt discussion about promoting affordable medicines without any mechanism to actually impact the affordability of medicines.

How would a PDAB decide a UPL?

- A PDAB would access publicly available pricing and cost information – some of which will come from subscription data services that track drug prices and price increases (called pricing files). There are many such services but these two links give a sense of the service available: Medispan or FirstDataBank. There is also a dataset from SSRHealth that estimates the commercial rebates in the US market for brand name drugs.
- In 2021, the General Assembly unanimously passed prescription drug price transparency legislation. For the first time starting January 1, 2022, the Department of Health is collecting pricing data on medicines used in the Commonwealth. **A PDAB would build on that work and ensure that we are putting that data to good use and deploying it to understand which medicines are creating the greatest financial burdens for Virginians.**
- A PDAB will also consult with state payers and purchasers to learn, confidentially, their net costs for a drug the PDAB is studying. Another data point would the Veterans Administration National Contract Price and Federal Supply Schedule (FSS)[1] prices, each of which are publicly available.
- All these public and publicly available data points will help a PDAB establish an affordable cost that is benchmarked against current US market conditions. This is a quite different approach than benchmarking US prices to international prices. It is also vastly different from price controls. A PDAB would examine what is already available in the US market and be able to discern the best discounts in the existing market to set a statewide upper payment limit based on existing US market information.

Would a PDAB threaten health innovation or availability of prescription drugs?

- **It's important to note that a PDAB would have a limited scope and ability to review only very expensive prescription drugs.** The legislation has a very specific set of

[1] Sometimes the FFS price might be higher than market but that could be due to changes in the market during the period of the FFS contract.

guidelines for when a PDAB would have the ability to review the cost of a medicine, such as if a brand-name drug has a wholesale launch acquisition cost of $30,000 or more per year or has a year-to-year price increase of more than $3,000 per year. To use another state as reference, in Colorado, which passed a PDAB in 2021, **policymakers there anticipate that only 12 drugs each year will meet the threshold to justify an affordability review by the Board.**

- In the event that a medicine's cost is so expensive that it triggers an affordability review, the Board would convene stakeholders to better understand why that cost increase occurred. During thorough public meetings and review, manufacturers can explain the reasoning behind a drug's cost. **If the Board deems those increases to be justified and not burdensome on consumers, then the price would not change.**
- Often, price increases can be justified due to the intensive nature of research & development. **However, some price increases are not justified. For example, the biggest contributor to drug prices is often advertising.** Pharmaceutical companies in 2020 had a $6.4 billion budget for marketing and advertising their drugs. To use the world's top selling drug, Humira, as reference, an AHIP analysis showed that only 7% of the drug's revenues have been for R&D.
- AHIP also found that 7 of the 10 largest pharmaceutical companies spend more money on marketing than on developing new drugs; this includes manufacturers with registered lobbyists in Virginia including Pfizer, GlaxoSmithKline, Sanofi, Bayer, and Novartis
- A similar AHIP study found that when drug companies set the price of a new drug, they do so to maximize future revenues net of manufacturing and distribution costs. A drug's R&D costs that have already been incurred in developing that drug do not influence its price.
- Beyond threatening innovation, when responding to threats about a drug no longer being provided in the state because it would be too expensive, let's remind ourselves what that threat means: **Pharma would have to be unwilling to provide medicine for people at a more reasonable cost as established through the board's extensive stakeholder process for this to happen.**

How would a PDAB affect other stakeholders, like insurance plans?

- **It's important to note that having an upper payment limit benefits plans because they will be able to get lower costs for drugs, which leads to lower premiums.** Some might claim that if a UPL is set too high, the manufacturer would leave the market, leaving the plan liable for providing the drug without being able to procure it. **In order for that scenario to occur, let's remember what would have to happen in this scenario: a boycott by Pharma.**
- As stated above, manufacturers have little incentive to leave the market and lose market share over a drug product, so they have a lot of reason to make threats about boycotting the market. **But again, out of all drugs sold in Virginia, a PDAB would only ever even consider setting upper payment limits on 10-15 per year.** And every hearing will allow manufacturers, plans, and others the chance to describe what would happen if a UPL was set. If the Board - remember, these are healthcare industry veterans, not

politicians or citizen Board members - was concerned about that risk, they would simply decide not to set a UPL
- Prescription drug costs are the most expensive part of your health insurance premium, and represent a growing burden to the plans themselves. **So when we talk about affordability, we're not just talking about making drugs more affordable, we're even talking about making insurance more affordable**

What would the impact of a PDAB be on the state budget?

- A PDAB would help the Commonwealth save millions of dollars on prescription drug costs. **We know that between the state's Medicaid program and the state employee health plan, Virginia spends $2 billion annually on prescription drugs.** That is a massive sum of taxpayer dollars spent on a product that, we should reiterate, is seeing cost increases well above the rate of inflation.
- On our current trajectory, taking no action to lower prescription drug costs doesn't just harm patients or providers or plans – it hurts all of us by wasting Virginia's taxpayer dollars.
- **Some of the drugs that the Commonwealth currently spends the most money on, such as Humira and Stelara, which are used to treat arthritis, psoriasis, ulcerative colitis, and Chrohn's disease, would be likely to see upper payment limits set that reduce costs by anywhere from 10-40% annually. These savings can provide the Commonwealth with millions of extra dollars.**
- According again to the plans themselves, AHIP, higher government spending driven by large price increases in prescription drugs will affect everyone in the form of higher taxes, cuts to public programs, or both

How would a PDAB be different from existing entities like HIRC?

- Virginia established the Health Insurance Reform Commission, or HIRC, to bring together policymakers in the offseason to study trends and pressing concerns in healthcare, especially health insurance. Given the complexity of the health insurance market, HIRC has played a key role in providing legislators with the space to learn from stakeholders and each other outside of session, and often to make recommendations on policy that inform later legislative sessions.
- While HIRC, as well as the Joint Commission on Health Care, includes legislators on the Commission and works as a policy recommending body, a PDAB's members would be citizen health care experts who understand the prescription drug industry. They would specifically be barred from having any financial interest in the drug market, and would be appointed by the House, Senate, and Governor. A PDAB though would actually set regulation and policy that impact Virginians' economic lives.