COMMUNITY ACCESS NATIONAL NETWORK

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Maryland Prescription Drug Affordability Board
16900 Science Drive, Suite 112-114
Bowie, MD 20715

RE: Affordability Challenge Determinations

Dear Honorable Members of the Maryland 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. State Prescription Drug Affordability Boards are of profound importance to our community.

Affordability Goals Need Clarity

The purpose of the cost review studies is to determine whether the use of a medication "has led or will lead to affordability challenges for the state health care system or high out-of-pocket costs for patients." As such, the main reasons the Board deemed both Jardiance and Farxiga to both be determined as posing affordability challenges are due to WAC increase over time, the percentage of the drug spend compared to overall prescription drug spend, and the cost burden to patients compared to the amounts payers are paying after rebated amounts.

It is unclear how WAC increasing faster than the cost of inflation is something the Board can effectually change and how that relates to patient affordability. Before even considering the commercial market, deliberations on Jardiance, for example, pointed out that its spending represented over 1.8% of total overall prescription drug spend for state and local government. For Farxiga, the amount was greater than one percent. The data point of 1.8% of spend is being defined as an affordability challenge without defining what is and is not acceptable or what is plausible as a goal. Additionally, the cost burden to patients in comparison to

payer net spend is a function of plan design. It is unclear how a UPL could improve plan design and also what other actions the board plans to implement to mandate plan design changes that benefit patients directly.

Overall, the Board's paradigm of affordability appears nebulous, thus making it hard to envision how specific remedies can be created without well-defined concerns.

Missing Information is a Hindrance to Analysis

There is information needed that the Board currently does not have. For example, the Board did not receive input from state and local government entities for the cost review study of Farxiga. There was also an acknowledgement that out-of-pocket cost considerations associated with patient expenditures, such as transportation and childcare, were not readily available. Additionally, it was acknowledged that a detailed investigation into how plan design affects costs to patients and the system is needed. Moreover, the Board recognized that it would be beneficial to see an analysis showing the level of state spending for both drugs over time. There is also a paucity of data concerning copay programs and how Marylanders are utilizing them.

We are concerned, as there seems to be a significant amount of data gathering and analysis needed before things can effectively move forward in a manner that positively changes the current state of "affordability".

Potential Policy Suggestions

In terms of policies that would ensure patients with high deductibles and coinsurance rates are not paying a large proportion of the drug's cost, that is a plan design issue, which would be unaddressed by the implementation of a UPL, as discussed in more detail below. It would be helpful to set base levels of acceptable plan design by working with the state CMS coordinators for Medicaid and setting specific benchmarks for ACA plans (EHB, for example) of how and what should be covered.

Concerning how a UPL will affect formulary placement for a drug, ongoing research by Avalere Health indicates that there would be adverse effects. Avalere interviewed and surveyed health plans. Eighty percent of the respondents stated that patients would be the most impacted stakeholders of UPL implementation. Payers expect the impact to vary depending on the drugs selected for a UPL, but most respondents anticipated moderate to significant disruption to formulary design. This includes moving drugs to higher tiers, which would increase out-of-pocket costs through increased copays and coinsurance.

Half of the survey respondents also foresee increased utilization management on UPL drugs, which would create delays and barriers to necessary treatment and increase administrative burden on physicians. For clarity, Avalere only interviewed payers in states that passed legislation for PDABs that are required to conduct affordability reviews. Also, regarding formularies, it would be beneficial to have legislation in place to guarantee plans cannot remove drugs from formularies once a UPL is applied. If a drug is covered now, then that should not change. Whether or not a patient can afford a drug is not even a question if it isn't on the formulary to start with.

We also understand that Maryland legislation requires the carve-out of 340B claims from a UPL. We encourage the Board and staff to consider ways to guarantee a UPL is not applied to any 340B claims before the implementation of any UPL. Thus far, no such functional guarantee has been discussed - "trust us" is not sufficient.

We appreciate that the Board acknowledges it does not want to do anything to adversely affect access to medications, especially ones that have already been proven to be effective and widely used. However, a significant level of analysis needs to occur before any 'solutions' are implemented.

Respectfully submitted,

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Community Access National Network (CANN)

On behalf of
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Community Access National Network