COMMUNITY ACCESS NATIONAL NETWORK

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Colorado Prescription Drug Affordability Board
Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

RE: Ongoing Board Activity

Dear Honorable Members of the Colorado 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.

New Eligibility Criteria and Required Reporting Leave Questions

The new drug eligibility criteria in HB23-1225 add the selection of prescription drugs with a WAC per unit of $3,000 or more, in addition to the previous stipulation that considers prescription drugs with a WAC of $30,000 per year for an average course of treatment. Patients may be dealing with affordability challenges with drugs that do not meet either of those thresholds, nor have an increase of 200% or $300 or more above WAC for the preceding 12 months. How will those drugs be included for review? Patients' coinsurance cost-share interacts with deductibles and out-of-pocket maximums, so patients often pay the full allowed cost until the deductible is met, then continue paying a percentage afterward.

Upper payment limits do not improve patient affordability if coinsurance requirements, as a result of formulary-tier placement and plan structure, still leave

patients with unaffordable out-of-pocket expenses. If a theoretical UPL results in some semblance of reduced drug spending for a plan, what is the statutory remedy for patients if the required carrier reporting of savings allocation does not improve patient affordability? In that same vein, what is the defined amount of acceptable reduction of system spending that does not improve patient affordability? Conversely, what is the defined acceptable level of improvement in patient out-of-pocket affordability that does not drastically reduce system spending?

Given that there has not been a cost-benefit analysis, no proverbial 'goalposts' have been set. This is notably pertinent regarding affordability analysis when issues such as utilization drive expenditure, since high utilization of an effective drug resulting in a seemingly high level of spend does not necessarily mean a drug poses an affordability issue. High utilization usually indicates effective treatment. Irrespective of the price of a particular effective drug, engaging in effective treatment results in reduced hospitalization and progression of disease states. This effectively reduces system and patient costs. Thus, the guiding principles of ongoing review are unclear, given that markers of success or failure have not been defined for patients or the system.

Additionally, plans are required to report any changes made to plan formularies resulting from the establishment of a UPL. If a drug is removed from a formulary as a result, it is our understanding that there is no statute in place to protect patients from this omission, as long as the removal was carried out within the statutorily defined proper notice. Previously, the Board acknowledged that this type of patient protection would require additional legislative action.

Beyond passively assuming PBM/plan compliance with reporting tier changes or drug omissions, will there be proactive steps to identify adverse changes? Some patients adversely affected by changes may not have the cognitive bandwidth to reach out to report harm. Additionally, while there is a process for patients to work with physicians to appeal to gain access to medications through acquisition higher than an assigned UPL, how would patients report access harm due to adverse formulary modifications?

Proposed Efforts To Increase Patient Engagement Are Encouraging

We support the proposed efforts to utilize the PDAAC to solicit feedback from patients regarding which drugs pose affordability issues after the publication of the eligible drug lists. Including patient feedback during the drug selection phase enfranchises patients and gives the Board more patient-centered guidance. One area of concern is that patients may wish to report affordability issues for drugs that do not fall under the statutorily defined metrics for selection.

We also support the PDAAC recommendation of establishing a PDAB patient engagement toolkit. In the same vein, we also support the proposal to establish a Community Partner Network. Pharmacists, providers, and consumer organizations would also benefit from understanding the PDAB's scope of work and authority. Additionally, such outreach may bring new perspectives to the Board that are not already being considered, as a result of informed discourse from healthcare professionals who do not yet have a full understanding of the PDAB and its purview.

Ongoing Legal Activity Raises Questions

We understand the confidential nature of the current litigation. However, as the Board is able, it would be helpful if it could share any insight as to whether any ongoing active Board work is or will be affected by any of the current legal activity. This is particularly pertinent regarding issues such as implementation and timelines.

We thank you for all of your ongoing hard work and deliberations.

Respectfully submitted,

Ranier Simons
Director of Patient-Centered Drug Pricing and Healthcare Access Policy
Community Access National Network (CANN)

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