COMMUNITY ACCESS NATIONAL NETWORK

Prescription Drug Advisory Boards (PDABs)

Response Project for People Living with HIV

INTRODUCTION

The high cost of healthcare is a significant concern for most Americans. The total national health expenditure in 2021 increased by 2.7% from the previous year to 4.3 trillion dollars, which was 18.3% of the gross domestic product. The federal government held the majority of the spending burden at 34%, with individual households a close second at 27%. A cornerstone component of medical treatment is the access to prescription drugs. According to a recent poll by the Kaiser Family Foundation (KFF), 1 in 4 adults report difficulty affording their medication. Due to co-pay costs or insurers not offering coverage of their medications, some people must ration their medication, decide between paying for their prescriptions or paying their bills, or forego taking their medication entirely. Despite catchy phrases that poll well and "simple" solutions by politicians that promise to fix the problem—such as Prescription Drug Advisory Boards (also known as Drug Pricing Advisory Boards)—it is crucial to remember one thing: if it sounds too good to be true, then it probably isn't true.

BACKGROUND

To reduce the burden of drug costs, some states have created or introduced legislation for PDABs. They are marketed as the solution to lowering the prices patients pay for prescriptions. However, the functioning reality is problematic.

- PDABs are created through state legislation.
- They are small boards appointed by the governor or legislators.
- Board members are professionals with advanced degrees and experience in matters like health economics or are healthcare professionals with no expertise in how dollars flow in the drug channel.
- They have advisory boards consisting of other healthcare professionals with limited or no representation of laypeople, such as patients. Advisory boards to the PDABs do not have decision-making power.

WHAT IS THE PROBLEM?

PDABs are problematic because they are not primarily patient-focused.

- Because of the makeup of the boards, their discussions and meetings are not patient focused.
- They are not associated with the federal Ryan White Program, which mandates community outlets in planning activities, or any other state or federal program more closely connected to patients and communities.
- No currently passed PDAB statute requires engagement with patient-oriented groups.
- They make decisions using metrics and perspectives that don't directly translate into value for patients but DO translate to increased profits for pharmacy benefit managers, insurers, and theoretical savings for states.

Visit CANN's Prescription Drug Advisory Boards Action Center at https://www.tiicann.org/pdab-project.html.

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WHY GET INVOLVED – POTENTIALLY HARMFUL UPPER PAYMENT LIMITS

The most prevalent tool of cost control PDABs are focused on utilizing is the upper payment limit (UPL). The UPL is the maximum reimbursement or price purchasers will pay for a prescription drug. It does not determine what drug companies charge for drugs. It only tells them the maximum insurance plans will pay for them and none mandate those savings be passed onto patients by way of reduced out of pocket costs. Potentially harmful consequences include:

- UPLs only apply to what plans are allowed to reimburse for specified medications.
- UPLs do not directly benefit what patients pay out of pocket.
- UPLs potentially cause harm to the 340B Drug Discount program by reducing funding to safety-net entities that depend on it.
- Reduced safety-net funding means loss of services to the vulnerable populations they serve.
- There are other barriers to care that are more critical to accessibility than the price of a drug, like pharmacy and hospital consolidation.
- PDABs are increasingly targeting life-saving medications for diseases like Cancer, HIV, and Hepatitis C.
- Targeting drugs for aggressive cost containment can result in decreased patient access by incentivizing insurers to implement more prior authorizations and step therapy.
- Decreased access threatens the patient-provider relationship.

SOLUTIONS

There are affordability and accessibility solutions that are more effective than focusing on drug price. Access is more broadly defined than 'affordability', especially when affordability applies to entities other than patients. Several other solutions deserve advocacy and support:

- Legislation is necessary to battle pharmacy benefit manager and insurer tactics that harm patient access to individualized and timely treatments.
- An innovative subscription-based drug reimbursement model is currently being used for Hepatitis C in Louisiana and Washington state. A similar model was suggested by Ohio's exploratory committee as a better solution than PDABs.
- Patients need protection against harmful insurance practices like prior authorization practices and step therapy and low value benefit design with restrictive formularies.

WHAT YOU CAN DO

It is essential for patients and advocates to engage with state legislatures considering a PDAB or that already have passed PDAB legislation. Additionally, patients and our advocates can engage PDABs to give them a proper patient-centered consumer perspective to contrast with their insurance industry-leaning metrics and data gathering. State PDABs publish procedures for providing public written comments as well as in-person representation at their public meetings. Engaging with state and local government leadership is also imperative.

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