



VIA EMAIL

February 26, 2025

The Honorable Glenn Youngkin, Governor
Commonwealth of Virginia
State Capitol, Third Floor
Richmond, VA 23219

RE: Veto H.B. 1724 establishing the Prescription Drug Affordability Board

Dear Governor Youngkin,

I am writing on behalf of the Ensuring Access through Collaborative Health (EACH) and Patient Inclusion Council (PIC), a two-part coalition uniting patient organizations and allied groups (EACH) with patients and caregivers (PIC) to advocate for drug affordability policies that benefit patients.

H.B. 1724 is largely identical to the S.B. 274 legislation you vetoed last year. It would create a prescription drug affordability board (PDAB) with the authority to set upper payment limits (UPLs) on high-cost medications that are critically-needed to protect Virginians from severe, disabling, or life-threatening health outcomes.

In your S.B. 274 veto message, you noted that “imposing arbitrary UPLs could limit access to life-saving pharmaceuticals and harm patients’ health”, as well as the fact that other state experiences with PDABs have led to “high implementation costs, including higher taxes, without significant savings to those in need.” Because PDABs have continued over the past year to be a costly and ineffective experiment, we urge you to likewise veto H.B. 1724 on the same grounds.

PDABs Are Unproven and Expensive

Despite claims that they will lower patient costs, PDABs have so far produced **no savings** for patients, yet have cost the taxpayers across the nation millions of dollars in operational costs.

For example, Maryland PDAB (in its sixth year of operation) was projected in its [authorizing legislation](#) to cost \$4 million and [budget requests](#) include another \$1.28 million for 2026. The Oregon PDAB is [projected](#) to cost over \$1 million per year and the Colorado PDAB was [projected](#) to cost \$800,000 for its first year (but already [requested](#) a supplement of \$260,000).

Based on the experience in each of these early states, it is clear that PDAB operations alone will cost states around \$1 million each year. There is no guarantee that savings to the state will exceed this \$1 million per year outlay or that any such savings will be realized by patients.

Cost Reviews and UPLs Could Compromise Patient Access to Medications

UPLs create a new incentive structure for payers that could compromise patient access to the selected medications due to increased utilization management or reshuffling of formularies. Insurers and pharmacy benefit managers (PBMs) could place drugs subject to UPLs on higher formulary tiers or implement other utilization management tactics to steer patients away from these drugs. This could lead to higher out-of-pocket costs for patients who could face higher copay or coinsurance rates to retain access to that drug or be forced to switch to a more expensive drug to achieve higher profits for their PBM.

These types of non-medical medication switches can cause unnecessary complications for patients. At a minimum, a switch in medication will require more doctor visits to monitor the efficacy of a new medication. Furthermore, if the switch results in side effects or worsened outcomes, patients could face medical interventions or hospitalization and bear the burden of the additional costs for both.

Focusing solely on the price of drugs ignores the many complicated factors that ultimately drive costs up for patients and oversimplifies a very complex process. Instead, we strongly urge the Commonwealth of Virginia to focus on known, patient-reported issues and address the causes of their affordability and access challenges (including prior authorization, alternative funding programs, and PBM reform).

Upper Payment Limits Do Not Automatically Translate to Patient Savings

Assuming UPLs directly translate to lowered costs for patients ignores the complicated nature of our healthcare system, in which patients are not responsible for paying the full cost of their prescription medications nor are they allowed to freely select from the full range of treatments medically approved for their condition. Instead, these decisions are determined by their health plan and PBM. It is also these dominant players that determine if cost-savings realized by the payer are subsequently shared with patients. Unfortunately, in most cases they are not.

Payers in our health system do not necessarily derive the most value from the lowest cost drugs. According to [reporting on PBMs by the New York Times](#):

“Even when an inexpensive generic version of a drug is available, PBMs sometimes have a financial reason to push patients to take a brand-name product that will cost them much more. For example, Express Scripts typically urges employers to cover brand-name versions of several hepatitis C drugs and not the cheaper generic versions. The higher the original sticker price, the larger the discounts the PBMs can finagle, the fatter their profits — even if the ultimate discounted price of the brand-name drug remains higher than the cost of the generic.”



Ultimately, this could mean insurers and PBMs place drugs subject to UPLs on higher tiers of the formulary, which results in higher out-of-pocket (OOP) costs for patients who would face increased copay or coinsurance rates to retain access to that drug (or be forced to switch to a more expensive drug for which the PBM could extract a higher rebate and more profit).

Patient Access Cannot Be Compromised

Once diagnosed with a chronic condition, patients and their physicians start an often life-long journey to identify the correct treatments that best manage their symptoms and improve their health. Many patients will ultimately rely on multiple medications to effectively treat their condition(s), due either to comorbidities/side effects or the progression of their disease.

For these reasons, patients with chronic conditions rely on an often complicated and personalized course of treatment that is not easily altered. Substituting or requiring patients to change drugs based solely on cost considerations instead of medical needs can greatly disrupt continuity of care and lead to complications, worse health outcomes, and dramatically higher overall medical costs. These decisions are thus best left to patients and their physicians.

Identify and Resolve Patient-Reported Obstacles to Care

While our health system is complicated, one principle is simple: every change and policy we implement should ultimately benefit patients. We urge legislators to keep this principle as a singular focus as it evaluates health reform proposals and new legislation.

Although well-intentioned, UPLs fail to address many of the underlying causes and complicated factors that result in higher prescription drug costs for patients. Therefore, we urge lawmakers to focus their time on identifying and addressing *patient-reported obstacles* to drug affordability.

Failing to resolve the underlying factors that lead to higher costs for patients can result in short-term relief and uneven benefits – aiding some but potentially leaving others with higher costs and drug accessibility challenges.

Conclusion

The EACH-PIC coalition shares with you the goals of lowering OOP drug costs and ensuring access to quality care for all Virginians. However, PDABs do not accomplish either goal for the reasons detailed above. Instead, PDABs cause more harm than good by creating added barriers between patients and medically necessary drug therapies. Therefore, please veto this ineffective and very expensive reform proposal once more and urge lawmakers to instead focus on more productive *patient-driven reforms* that ensure patients have a voice in identifying and removing existing barriers to care.



We look forward to working with you in the future on initiatives that address the broader concerns of patients. Thank you for considering our input and do not hesitate to reach out to me at mark@aiarthritis.org with any questions or for additional information.

Sincerely,

A handwritten signature in black ink, appearing to read "Mark Hobarzck".

Mark Hobarzck, JD, MPA
Director of Public Policy, AiArthritis
Legislative Lead, EACH-PIC Coalition
Person living with Ankylosing Spondylitis