EACH PIC COALITION

VIA EMAIL

May 1, 2025

The Honorable Brian BeGole, Chair
House Government Operations Committee
124 North Capitol Avenue
Lansing, MI 48933

RE: Oppose S.B. 3-5 Creating a Prescription Drug Affordability Board

Dear Chairman BeGole,

The Ensuring Access through Collaborative Health (EACH) and Patient Inclusion Council (PIC) urge you to oppose Senate-passed legislation to be heard in your committee (S.B. 3-5) that would create a Prescription Drug Affordability Board (PDAB) in Michigan.

EACH/PIC is a two-part coalition that unites patient organizations and allied groups (EACH), as well as patients and caregivers (PIC), to advocate for drug affordability policies that benefit patients. While we share with you the goals of lowering unaffordable out-of-pocket (OOP) drug costs and ensuring all Michigan residents can access critical medications, we believe PDABs have proven in other states to be costly and ineffective at achieving these goals and will ultimately cause more harm by creating added barriers between patients and needed care..

Our coalition respectfully urges your committee to consider the concerns of patient organizations outlined in this letter. We offer our organization as a resource to any legislator that seeks to connect and better understand the impact PDABs will have on access to care.

Cost Reviews and UPLs Could Compromise Patient Access to Medications

While we applaud legislators' commitment to supporting patients and lowering the costs of prescription medications, we are concerned creating a PDAB with authority to set upper payment limits (UPLs) for selected drugs will result in worse outcomes for patients.

At their core, cost reviews necessitate identifying individual drugs for review and implementing market interventions for the selected drugs. This alone puts PDABs in a position of creating inequities between patient populations by selecting and reviewing individual drugs, rather than evaluating systemic health costs.

While UPLs are intended to lower costs for patients, the reality is they could 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. This eventuality was outlined by the Centers for Medicare and Medicaid Services in their May 3, 2024 Guidance on Medicare Drug Price Negotiation "CMS is concerned that Part D sponsors may be incentivized in certain circumstances to disadvantage selected drugs by placing selected drugs on less favorable tiers compared to non-selected drugs, or by applying utilization management that is not based on medical appropriateness to steer Part D beneficiaries away from selected drugs in favor of non-selected drugs."

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Additionally, many of the drugs under cost review are administered directly by physicians under a “buy and bill” model. Physician reimbursement rates are already being squeezed, and UPLs could additionally lower opportunities for treatment costs to be recouped. As a result, it is likely that physicians would adjust treatment recommendations to avoid facing financial deficits, leaving patients with fewer treatment options.

Finally, creating a unique pricing structure in Michigan could create state-specific conditions for coverage. We don’t know yet how either insurers or manufacturers will react to state-by-state exceptions, but this has potential to cause either of these stakeholders to limit availability in the state and could cause confusion for patients and providers in the state.

Upper Payment Limits Don’t Necessarily Translate to Patient Savings

Assuming that UPLs directly translate to lowered costs for patients ignores the complicated nature of our healthcare system. In our system, 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 insurance company and pharmacy benefit manager (PBM). It is also these stakeholders 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. This could ultimately lead to higher OOP costs for patients who could face higher copay or coinsurance rates to retain access to that drug or alternatively be forced to switch to a more expensive drug that results in higher profits to their PBM. This is also supported by the concern raised by CMS above.

Additionally, non-medical switches in medication can cause unnecessary complications for patients. At a minimum, a switch should require more doctor visits to monitor the efficacy of a new medication. Further, if the switch results in side effects or worsened outcomes, patients could face medical interventions or hospitalization and the additional costs borne out by both.

Patient Access Cannot Be Compromised

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Once diagnosed with a chronic condition, patients and their physicians start an often life-long journey to identify the correct treatments to successfully manage their symptoms and improve their health. Many chronic disease patients will ultimately rely on multiple medications to their condition. Some will face multiple chronic conditions or even need additional medications to treat the side effects of either their condition or the medication that keeps their condition manageable.

For these reasons, patients with chronic conditions often rely on a complicated and personalized course of treatment that is not easily altered. Substituting or requiring patients to change drugs based on cost considerations instead of medical needs can disrupt continuity of care and result in complications and higher overall medical costs. These decisions are better 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 legislators 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.

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, the Maryland PDAB (in its sixth year of operation) was predicted in authorizing legislation to cost $4 million yet budget requests for fiscal year 2026 already appropriate another $1.28 million. The Oregon PDAB is projected to cost over $1 million per year, while the Colorado PDAB was projected to cost $800,000 for its first year but already requested a supplement of $260,000.

Based on the experiences of these early states, the cost estimate prepared by the Michigan Senate Fiscal Agency projects that creating a PDAB with UPL authority under S.B. 3-5 will impose even greater cost on Michigan and **"require significant appropriations estimated at about $4.0 to $5.0 million per year"**.

For all the above-referenced reasons, the EACH/PIC coalition urges the committee to forego this ineffective and costly reform proposal and instead work with patient and provider groups to enact more productive patient-driven reforms that remove affordability barriers to care. Thank

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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,

Mark Hobraczk, JD, MPA
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EACH/PIC Coalition Legislative Lead
Person living with Ankylosing Spondylitis (an AiArthritis disease)

cc: Members of the House Government Operations Committee