



VIA EMAIL

January 21, 2026

The Honorable Barbara Favola, Chair
Virginia Senate Education and Health Committee
General Assembly Building
201 North 9th Street
Richmond, Virginia 23219

RE: Oppose S.B. 271 creating a Prescription Drug Affordability Board

Dear Chair Favola,:

The Ensuring Access through Collaborative Health (EACH) and Patient Inclusion Council (PIC) urges your committee to oppose or amend legislation sponsored by Senator Creigh Deeds (S.B. 271) that would create a Prescription Drug Affordability Board (PDAB) in Virginia with the authority to set upper payment limits (UPLs) for selected drug therapies.

Who We Are

EACH/PIC is a unique 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. We share your priority of lowering out-of-pocket (OOP) drug costs so that patients can access critically-needed medications to maintain their health.

EACH/PIC advocates against artificial price controls at both the state and federal level as they are the wrong approach to effectively lower OOP drug costs and can ultimately cause more harm by creating added barriers between patients and their medically-needed care.

Existing PDABs Have Not Lowered Costs for Patients

EACH has been actively working with PDABs in multiple states and has seen firsthand the limitations of the PDAB model. Based on our experience, we believe PDABs are ineffective in identifying and solving the actual problems patients with chronic conditions face when attempting to access their medications. Furthermore, they cost states millions of dollars per year¹ and have yet to show any savings to the state or patients (resulting in the full repeal of the New Hampshire PDAB in 2025).

The PDAB model provides a board of unelected officials the authority to review prescription drug costs and set UPLs for those they deem unaffordable. Contrary to the claims of PDAB supporters, UPLs **do not directly lower patient OOP costs** and have little impact on overall patient costs. In reality, setting UPLs for drugs might endanger patient accessibility or limit appropriate reimbursement for the physicians and pharmacists.

¹ Maryland spends \$1.2 million per year on its PDAB (see [HB350](#) from 2025) while the [fiscal estimate](#) for PDAB bills in Michigan project costs of \$4-5 million per year.



Additionally, 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 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 OOP costs for patients who face higher copay or coinsurance rates to retain access to that drug or alternatively be forced to switch to a more expensive drug which results in higher profits for their PBM. Recent research from the Pioneer Institute has shown this is already occurring under the Medicare Drug Price Negotiation Program, where patient **OOP costs have increased by an average of 32 percent** even before the maximum fair price caps for the first round of drugs went into effect on January 1st.²

These plan-prompted changes to patient treatments are collectively known as non-medical switching. Non-medical medication switches can further drive-up OOP costs by causing unnecessary complications for patients. At a minimum, a switch in medication will 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.

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 patient-reported issues, including prior authorization and alternative funding programs. We urge legislators to address the causes of patient unaffordability and access challenges, especially by reforming anticompetitive PBM practices that drive-up drug costs

Patient & Caregiver Testimonies (Patient Inclusion Council)³

Direct input from patients also bears out that alternative reforms would be more advantageous for patients and address their reported concerns related to affording and accessing their prescription medications.

For example, [patient testimonies provided to the PDAB in Colorado demonstrated](#) how access and affordability issues commonly stem from the utilization management policies of insurers. In fact, many patients with chronic diseases pay little to nothing for biologics due to charitable or manufacturer assistance programs.

We have found similar testimonies from residents of Virginia (two examples provided below), who either did not report struggling with drug affordability because manufacturer assistance programs are available to them or those who did cite costs as a barrier report being subject to high coinsurance or other insurer policies that inhibit access.

² See [Pioneer Institute Launches Tracker Showing Drug Price Controls Are Raising Out-of-Pocket Costs for Medicare Patients | Pioneer Institute](#) (May 9, 2025).

³ Testimonies provided have not been edited.



We agree that a focus on addressing healthcare barriers to patient access and affordability is necessary, but choosing to establish a high-cost program with no demonstrated positive outcomes for patients is not the best use of time and resources.

Stephanie, VA resident. *I have been on biologic infusions for 24 years. Through a variety of insurance plans I have paid different amounts, however, because of manufacturer assistance programs, most of the time it is zero. Even for a brief time when I had a high deductible plan I used the manufacturer patient assistance program so I paid nothing other than \$100 for my first infusion of the year then met my out of pocket max and the entire rest of the year everything was free.*

Prior to starting this biologic, I was 22 and recommended for full disability. This drug keeps me working, parenting, and living a mostly normal life! If access was pulled, especially given it's completely affordable to me, I would be devastated.

After learning a bit more about the new government appointed boards that could be established to review certain high cost drugs, I would be alright with this if the board consisted of doctors (who understand our diseases), researchers, and patients. If politicians or those supporting the insurance companies were part of the decision makers, no way.

Bree, mother of Tenley, VA residents. *Tenley is living with Juvenile Idiopathic Arthritis (JIA) with Uveitis (inflammatory eye disease, a result of JIA). She is 11 and has been on Humira for 3 years now. Both the Uveitis and JIA have been under control for almost 2 years now, thanks to this medication.*

We got a new insurance plan in 2024, but with the same carrier. I started calling to get the ball rolling to fill her Humira on January 4th, 2024. It was not "approved" and sent to fill until January 21st. We then received the medication on the 23rd, almost 3 whole weeks when we already had the prescription and a Prior Authorization on file.

In the past with the manufacturer copay assistance plan, we only paid \$5 out of pocket. Our new insurance plan charges us 30% out of pocket until the deductible is met (up to the max out of pocket) and has no copay plan included. So we had to pay initially \$2,285.12 to fill January's prescription and the assistance card was credited \$3,500 (so a total cost of \$5,785). So after paying, we submitted our payment directly to the manufacturer of Humira, who reimbursed us everything but the \$5. This model would be very problematic for families who cannot afford to spend this money and then, due to insurance protocols, ask the assistance program for a refund.

She is currently in an active flare and ended up being a few days late on her injection due to the delay in the refill. If we couldn't get this medication for her, I would worry that the ongoing joint damage would become permanent and cause damage that could lead to blindness in her eyes.



For these reasons, EACH/PIC urges your committee to forego an ineffective and expensive reform proposal and instead work with our coalition and others to pursue more productive patient-driven reforms. At a minimum, we ask the committee to **delay the authority for the PDAB to set UPLs** (or other artificial price caps) until the Assembly completes a study on the unintended consequences for patients (similar to the approach taken in Maine and Oregon).

EACH/PIC appreciates your committee's focus on issues that impact patient access to care and provide patients with every opportunity to have a voice in matters involving our healthcare. We look forward to working with you on alternative initiatives that can address patient OOP costs. Please feel free 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 Hobraczek", is positioned above the typed name.

Mark Hobraczek, JD, MPA
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Legislative Lead, EACH/PIC Coalition
Person living with Ankylosing Spondylitis