VIA EMAIL

March 10, 2026

The Honorable Don Scott
General Assembly Building
201 North 9th Street
Richmond, Virginia 23219

Dear Mr. Briet,

I am writing on behalf of the Ensuring Access to Collaborative Health (EACH) and Patient Inclusion Council (PIC) Coalition to urge Speaker Scott to oppose/block the substitute to H.B. 483 approved today by the Senate Commerce and Labor and Senate Finance committees.

I serve as the legislative lead for EACH/PIC, a two-part, nationwide disease agnostic coalition that ensures efforts related to government drug affordability reviews put patient needs first. EACH/PIC is very concerned about proposals like the H.B. 483 substitute that focus only on artificial price caps for prescription drugs, as they **entirely miss the root causes of patient hardship.**

This legislation would set artificial price caps under state-regulated health plans for drugs subject to Medicare Drug Price Negotiation Program. We have met with both the H.B. 483 patron and the Governor's office, both of whom acknowledge that these price caps could have adverse impacts on patients in Virginia by limiting access to drugs with price caps or increasing the out-of-pocket costs patients must pay.

However, the last-minute substitute introduced and passed today does nothing to address these concerns. Contrary to statements by Del. Delaney (the bill patron) during today's Commerce and Labor hearing, the maximum fair prices (MFPs) set by Medicare are neither "tested" or "proven" to reduce patient costs. Instead, actual data compiled last spring by the Pioneer Institute demonstrate that Medicare Part D enrollees have already seen their **out-of-pocket drug costs increase an average of 32 percent** for the first set of drugs subject to the new MFPs due to Part D plans promptly shifting MFP drugs to higher cost-sharing tiers even before the caps went into effect January 1st.

MFPs and other price caps fail to address the **"why"** behind drug unaffordability, as they fail to alter plan cost-sharing designs or utilization management controls that create direct barriers to affordable, high quality care. Please see the attached document summarizing the latest results from the EACH/PIC Patient-Reported Affordability and Unaffordability Survey, which demonstrates that affordability is not dictated by the list price of a drug but is instead driven by health insurance barriers, income, and evolving life situations.

This research is the only study to date that asked patients to explain "why" they can or cannot afford their medications, with the goal to identify drivers so policymakers can enforce solutions that put patient needs first. This data also revealed existing and often stark **health inequities** that will only be exacerbated by price caps, as people of color are far less likely to be prescribed or have access to the highest-cost brand name or specialty medications.

In addition, recent research from Avalere Health confirms that more than 3/4 of health plans believe **price caps will disrupt patient access to needed medications** through higher cost-sharing, rebate adjustments, or other supply chain issues (such as pharmacies not stocking those drugs). The Value of Care Coalition survey of rheumatologists and other specialty doctors shows that nearly all of them believe price caps will result in **non-medical switching**, where patients are forced on to inferior and often ineffective/harmful therapies due solely to an upper payment limit and not the prescribed product. In fact, more than half of rheumatologists would avoid prescribing a drug with an upper payment limit.

For patients like myself with rare autoimmune/autoinflammatory disorders, the consequences of a non-medical treatment disruption can be severe, including permanent damage to joints or body organs. As I noted, our conditions are unique and we have often endured years of trial and error just to be diagnosed, much less find the treatment that works best for us. To force patients to go through that arduous process again can cause adverse health outcomes that not only harm patients but increase healthcare costs systemwide.

For these reasons, we would urge the Speaker to oppose the H.B. 483 substitute until the harm/benefit to patients can be fully evaluated and the following questions answered:

1) How will patients see any savings from MFP limits when health insurers can respond to price caps (and lower rebates) by removing those drugs from their formularies or moving them to higher cost-sharing tiers where patients pay higher copay/coinsurance?

2) What authority does the Virginia Insurance Commissioner have to modify cost-sharing/benefit designs used by state-regulated health plans in order to prevent cost-shifting for drugs with price caps? (In most states, insurance regulators can only modify/reject premium increases).

EACH/PIC shares the Speaker's goal of lowering drug costs for patients and applauds Virginia for being out-front on reforms that actually benefit patients, such as banning copay accumulator/diversion programs and reforming many anti-competitive pharmacy benefit manager (PBM) practices. We urge lawmakers to continue their focus on these non-UPL reforms, by passing legislation allowing patients to choose plans with capped copayments (S.B. 161) and strengthen provisions in S.B. 669 that "delink" PBM compensation from the price of the drug. This reform (already enacted in Colorado and by Congress for Medicare Part D) is estimated by the USC Schaeffer Institute to save up to **15 percent in annual net drug spending** if implemented nationwide, simply by removing the perverse incentive for PBMs to cover the highest-cost drugs for which they can extract the highest drug rebates.

We would welcome an opportunity in the coming days to meet with you to discuss our concerns about H.B. 483. Please feel free to use the EACH/PIC Coalition as a resource for any questions or additional information regarding the adverse impact on patients from artificial price caps for prescription drugs.

Sincerely,

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