EACH/PIC COALITION

VIA EMAIL
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March 31, 2026

The Honorable Kirk Talbot, Chair
Senate Insurance Committee
Louisiana State Senate
P.O. Box 94183
Baton Rouge, LA 70804

RE: Oppose S.B. 401 (creating a Prescription Drug Affordability Board) and S.B. 369 (limiting drug payment to Medicare maximum fair price)

Dear Chairman Talbot,

The Ensuring Access through Collaborative Health (EACH) and Patient Inclusion Council (PIC) urges your committee to legislation in your committee that would set upper payment limits for selected drugs therapies, either through the creation of a Prescription Drug Affordability Board (S.B. 401) or by defaulting to Medicare payment rates (S.B. 369).

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 patient out-of-pocket (OOP) drug costs so that patients can access critically-needed medications to maintain their health.

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

PDABs Have Not Realized Savings for Patients or States

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 barriers patients face when attempting to access high-cost medications. Furthermore, PDABs cost states millions of dollars per year to operate[1] and have yet to show any savings to the state or patients (resulting in the full repeal of the New Hampshire PDAB in 2025).

Contrary to the claims of PDAB supporters, setting a UPL for a drug **does not directly lower patient OOP costs** and have little impact on overall patient costs. In reality, UPLs can

[1] Maryland spends $1.2 million per year on its PDAB (see HB350 from 2025) while the fiscal estimates for Michigan PDAB bills project costs of $4-5 million per year, while Virginia is currently estimating their version of a PDAB will cost more than $8 million per year.

endanger patient accessibility and limit appropriate reimbursement for the physicians and pharmacists.

Why Upper Payment Limits Increase Patient Costs

The adverse impact of UPLs on patients is not speculative. As shown below health plans are likely to place drugs subject to UPLs on higher formulary tiers or implement other utilization management tactics to steer patients away from these drugs. This leads to higher OOP costs for patients who face increased copay or coinsurance rates to retain access to that drug (or be switched to costlier drug for which the plan receives higher reimbursement). 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 in January.[2]

The results of EACH/PIC's Patient-Reported Affordability and Unaffordability Survey further demonstrates why price setting is the "wrong tool" to reduce patient drug costs, as responses from more than 500 patients clearly shows that **affordability is not dictated by the list price of a drug** but instead driven by health insurance barriers, income, and evolving life situations. The results also confirmed **health inequities** that could be exacerbated by price setting**,** as people of color were less likely to have access to 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 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/price cap.

For patients like myself with autoimmune/autoinflammatory disorders, the consequences of a non-medical treatment disruption can be severe, including permanent damage to joints or body organs. 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 all members of your committee not to support S.B. 401 or S.B. 369 until the harm/benefit to patients from UPLs can be fully evaluated and the following questions answered:

1) How will patients see any savings from UPLs 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] See Pioneer Institute Launches Tracker Showing Drug Price Controls Are Raising Out-of-Pocket Costs for Medicare Patients | Pioneer Institute (May 9, 2025).

EACH/PIC COALITION

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

Louisiana Should Continue Focus on Patient-Centered Reforms

EACH/PIC shares in your goal of lowering drug costs for patients and applauds the legislature 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 committee members to continue their focus on these non-UPL reforms and strongly support legislation sponsored by yourself and Vice Chair Bass (S.B. 387) that **"delinks" 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.

EACH/PIC appreciates your committee's focus on issues that impact patient access to care and look forward to working with you on alternative initiatives that can actually reduce OOP drug costs. Please feel free to reach out to me at mark@aiarthritis.org with any questions or for additional information.

Sincerely,

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

Cc: Members of the Senate Insurance Committee