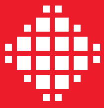


PARTNERSHIP TO FIGHT
CHRONIC DISEASE

PRESCRIPTION DRUG AFFORDABILITY BOARDS

PROMISE ≠ REALITY

Lowering overall costs for people managing one, and often multiple, chronic conditions is a common goal. Legislators on the state and federal level can lead the way, but many promises made to patients on affordability reforms do not match up with reality. Prescription Drug Affordability Boards or PDABs are another example where promises do not align with reality for patient affordability and access.

Several states have or are considering PDABs promising that PDABs will lower drug costs for people in the state. "Affordability" after all is in the title, but affordability to whom is not clear. The reality is that PDABs aim at lowering costs for insurers, PBMs, and other payers – not patients – as insurers themselves confirm in new research.

Source: www.fightchronicdisease.org/sites/default/files/FINAL%20PFCD%20Avalere%20PDAB%20Insurer%20Research.pdf

Important questions surface as PDABs come into practice…

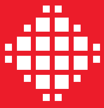
1 How are the PDAB representatives selected?

2 What medicines are being considered and why?

3 Will these efforts interfere with patients' access to the medicines they are currently taking?

4 Will patients pay less?

5 Who will receive the proposed savings, if any result?



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SO, TO SET THE RECORD STRAIGHT…

MYTH: PDABs WILL LOWER DRUG COSTS FOR PATIENTS.

FACT: Savings, if any, are NOT required to be shared with patients. Research shows that insurers do not expect to pass along savings to patients – not in lower premiums or deductibles or cost-sharing for medicines.

MYTH: ONLY DRUGS SUBJECT TO A PDAB's UPL WILL BE AFFECTED.

FACT: Insurers predict that utilization management, like step therapy or prior authorization, WILL INCREASE for drugs under a UPL and for drugs within the same therapeutic class.

MYTH: PDABs WILL NOT SET DRUG PRICES IN MY STATE.

FACT: Some PDABs will set drug prices, but for payers not patients. PDABs with upper payment limits (UPLs) dictate what insurers can reimburse for a drug. Whether that drug is attainable by a pharmacy or doctor's office at that payment limit is uncertain and could affect access.

The risks to patient access would be further compounded if a physician, hospital, or pharmacy cannot obtain a medication at the PDAB-set reimbursement rate. At that point they will: stop providing that medication; provide it but lose money on it; or charge the patient the difference to recover the cost. For people living with rare diseases, diseases with marked differences in responses to medicines, and those managing multiple chronic conditions having access to the medicines that work for them is critical and actions that restrict access place their health at risk.

Putting PDABs between patients, their doctors and their prescribed medicines is not the answer for better overall health outcomes or reducing costs of medicines for patients.

TO LEARN MORE ABOUT THE COLLATERAL DAMAGE FOR CHRONIC DISEASE PATIENTS RESULTING FROM THE UNINTENDED CONSEQUENCES OF PRESCRIPTION DRUG AFFORDABILITY BOARDS, VISIT WWW.FIGHTCHRONICDISEASE.ORG