Suggested Talking Points
Colorado PDAB

PDABs Exacerbate Health Disparities and Jeopardize Efforts to Promote Health Equity

<u>In Multiple Ways PDABs Exacerbate Health Disparities and Jeopardize Efforts to Promote Health Equity:</u>

- While the promise of using PDABs and UPLs may sound appealing as a means to help patients afford their medications, actual implementation of these efforts typically fails to ensure patient cost-savings and can worsen existing health disparities.
- Health equity factors are included in the fifteen criteria that the PDAB must consider when making decisions.
- The affordability review content and discussions by PDAB members and staff demonstrate a lack of effort, substantive data and focus on health equity issues.
- Individuals from racial and minority populations have been noticeable absent during PDAB meeting public comment periods.
- Additionally, groups representing medical professionals from racial and ethnic communities have not engaged in the PDAB process.
- Yet, there has been no mention about targeted outreach to Black/African, Hispanic/Latino, Asian or Native American communities, or organizations representing these populations, which are disproportionately affected by the health conditions treated with the medications being reviewed.
- The PDAB and staff are “checking the box” and claiming to consider health equity issues but the facts, data, meetings and reports show otherwise.
- This type of behavior is exactly why both the National Caucus of State Legislators (NBCSL) and the National Minority Quality Forum (NMQF) have sounded the alarm about these PDAB efforts and the potential threat to advancing health equity.

Major Concern #1:
<u>Minority and racial populations are generally not represented on the PDAB:</u>

- During a recent National Minority Quality Forum to discuss PDABs, Dr. Desmond Banks, PhD, MPH, Public Policy Research Institute Fellow at NBCSL stated,
    - PDABs and health equity can exist together BUT, you must read the legislation and look at the fine print. In many cases the authorizing language is divisive and does not encourage collaboration or allow participation of individuals from across the health care system; these actions do not promote health equity.
    - Since PDAB positions are appointed by the Governor, you should ask… Do the PDAB members in your state look like the leadership in your state. Is the PDAB composition representative of your population?
    - Because most PDABs lack adequate representation of racial and ethnic communities, Dr. Banks notes that “It is flat out frightening who is going to be on these Boards determining what medications are too expensive for Black people to be access.”

- Colorado's PDAAC and PDAB fall short on diversity and do not include appropriate representation from racial and ethnic groups. And these individuals were appointed by the Governor.
- Within the health equity factors the PDAB is to consider when making decisions, Black people, indigenous people, and people of color; American Indians and Alaska natives are specifically mentioned but these populations are not represented on the PDAB or PDAAC.
- Furthermore, for specific medications, such as Genvoya for managing HIV/AIDS, the PDAB decisions will have a disproportionate impact on the Black/African as well as Hispanic/Latino communities based upon disease prevalence.
- Based upon the information shared so far, it appears that no outreach has been conducted to representatives of these communities to explain the PDAB process, potential impact of a UPL and to incorporate their concerns. (may delete this depending on when public comments is taken and how the PDAB is advancing with the affordability reviews)

Major Equity Concern #2:

<u>PDAB "patient focused" claims being usurped in the interest of saving "the system money":</u>

- The PDAB was "sold" to legislators and voters as an effort to help consumers.
- Yet, if a medication is deemed unaffordable and a UPL is established, supporters of the PDAB never bothered to add a requirement that any of the "cost-savings" to be passed along to the consumer.
- Additionally, if a UPL is imposed, there is no requirement to monitor for the how the supply and distribution channels will be affected, or how these changes will adversely impact patient access and health outcomes.
- Gretchen Whartman, VP Center for Public Policy, NMQF, recently commented that the nature of the impact of these PDABs on the health and populations is masked by the lexicon that is being used; We must be very clear about how and where the affordability is manifesting and how those cost savings will be refunneled into a system that broadens access and encourages innovation.
- Comments made by Kim Bimestefer, Executive Director of the Health Care Policy and Financing at the January PDAAC meeting are in direct conflict with that intend of fostering access and clearly capture that the state wants to alter the focus of the PDAB to control drug prices for the benefit of state programs, insurers and PBMs – not patients.
- Gretchen Whartman further cautioned that "What we have seen over decades is that efforts that are designed as patient risk reduction are actually financial risk reduction efforts.
    - The PDAB movement is at risk, and possibly designed, to fall into that same category.
    - Efforts to establish a PDAB may not be well-intentioned through the lens of patient risk reduction.
    - We must pursue efforts to ensure that PDABs are improving access to [medicines], rather than constraining that access in the interest of financial risk mitigation.
- While espoused as an effort to help patients, pressure from the Administration is now forcing Colorado's PDAB to prioritize financial risk mitigation for the state, health insurers and PBMs without any consideration of the adverse impact on patient access.
- If the PDAB was truly to benefit patients, the legislation would have included evaluation and quality metrics to ensure that health outcomes of the affected patients were improving.

Major Equity Concern #3:

The CO affordability reviews contain data and many resources that are based upon discriminatory criteria such as Quality Adjusted Life Years (QALYs):

- With passage of the Affordable Care Act in 2010, QALYs were prohibited from being used in Medicare make decisions related to coverage, reimbursement and incentive programs.
- In Congress, legislation is progressing to apply this policy to all federal programs.
- If the discriminatory nature and harm of using QALYs was recognized 14 years ago by our federal government, why is Colorado incorporating numerous sources in the affordability review which reference QALYs?
- QALYs worsen health disparities and clearly do not promote health equity.
- Does CO not value individuals with disabilities, or those who are older or with mental illnesses?
- Many of these sources which reference QALYs are from foreign countries which have different, and generally lower quality standards of medical care than in the US.
- Additionally, some of the affordability review data is from countries with reference pricing and a completely different health care system.
- Patients in countries with price controls wait longer or lack complete access to new therapies – especially for cancers and rare conditions; as a result, people become sicker and or succumb to their diseases.
- Is this how Colorado wants to be known? For devaluing the state's most vulnerable patients affected by very complex health conditions by denying them access to innovative life essential therapies?
- Why should CO patients have the quality of care they receive be compromised and reduced to the lower medical standards that exist in foreign countries with reference pricing?
- Again, decisions based upon these discriminatory criteria are not aligned with ensuring health equity.

Recommendations:

- For each medication reviewed, the PDAB must be expanded to include a patient and health care provider from a racial and ethnic community that represents the population most affected by the related health condition.
- The PDAB staff must conduct outreach and hold meetings with patient and health care provider representatives from the populations mentioned in the "criteria" explanation for health equity. Findings and a summary of concerns, data, etc. must be shared publicly within 5 business days of the meeting or sooner if a PDAB meeting is occurring.
- All QALYs data and clinical information from countries with reference pricing must be excluded from affordability review materials and can not be consideration by the PDAB.