COMMUNITY ACCESS NATIONAL NETWORK

Mailing Address:

Attn: Jen Laws
PO Box 3009
Slidell, LA 70459

Chief Executive Officer:

Jen Laws
Phone: (313) 333-8534
Fax: (646) 786-3825
Email: jen@tiicann.org

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Washington Prescription Drug Affordability Board
Washington Health Care Authority
PO Box 42716
Olympia, Washington 98504-2716

RE: UPL Rulemaking Draft Comments

Dear Honorable Members of the Washington Prescription Drug Affordability Board,

The **Community Access National Network (CANN)** is a 501(c)(3) national nonprofit organization focusing on public policy issues relating to HIV/AIDS and viral hepatitis. CANN's mission is to define, promote, and improve access to healthcare services and support for people living with HIV/AIDS and/or viral hepatitis through advocacy, education, and networking.

While CANN is primarily focused on policy matters affecting access to care for people living with and affected by HIV, we stand in firm support of all people living with chronic and rare diseases and recognize the very reality of those living with multiple health conditions and the necessity of timely, personalized care for every one of those health conditions. State Prescription Drug Affordability Boards are of profound importance to our community.

We are writing today with comments on aspects of the proposed rules for WAC 182-52-0010, Definitions, and 182-52-0100, Upper Payment Limits.

182-52-0010 Definition Concerns

The definition of "Excess costs" is overinclusive and vague. It does not imply a systematic, repeatable formula to define the "costs of appropriate utilization of a prescription drug that exceed the therapeutic benefit relative to other alternative treatments; or, costs of appropriate utilization of a prescription drug that are not sustainable to public and private health care systems over a 10-year time frame". This is the same concern that has been expressed about the arbitrary manner in which the affordability review discussions have been presented.

182-52-0100 Upper Payment Limit Rule Concerns

Section 2(c) states that the upper payment limit "is expressed as the cumulative amount paid by the patient out-of-pocket and the amount reimbursed by a payer on behalf of the patient, for the prescription drug product in the unit of measure, package size, and dosage form." This statement needs clarification, as it conflicts with the definition of an upper payment limit, which is a reimbursement cap on what state government purchasers pay and on what state-regulated commercial plans are reimbursed. Patient out-of-pocket amounts vary greatly as a product of plan design. Thus, it is unclear how section 2(c) defines the upper payment limit to include patients' out-of-pocket costs.

Section 6 does not foster public trust because it does not provide for board and staff accountability. It states methodology that must be taken into consideration, "depending on the board's ability to obtain the necessary data". This would imply that the thoroughness of methodology will vary, including the possibility of operating with a paucity of data. This is unacceptable. Every analysis should be thoroughly executed with the same metrics. Board discussions have already addressed the difficulty of obtaining some of the data it desires. Thus, it would be prudent to specifically identify what considerations will operationally be plausibly obtainable for every analysis, not just some.

Section 8 lists a 'blend' of methodologies that may be used to determine upper payment limits:

Reference pricing includes MFP reference pricing, therapeutic reference pricing, international reference pricing, and VA reference pricing. The Medicare Maximum Fair Price was developed specifically based on the characteristics of the national Medicare population and the federal government's desired budgetary framework. These needs are not the same as the specific needs of the state of Washington or its residents, and they ignore specific analysis and identification of Washington's status quo and subsequent desired change. International reference pricing is based on countries with vastly different economies and regulations, including drug negotiation. Additionally, international reference pricing would subsequently utilize QALY paradigms, which Section 9 prohibits. VA reference pricing, like MFP, involves federal contracting along with fiscal and demographic characteristics that are not indicative of the needs of Washington State. Moreover, if a selected drug does not have an associated MFP or the VA pricing schedule is not obtainable, how are these metrics useful?

Net pricing is opaque, and board discussions have already indicated how difficult it is to assess. Additionally, since a great deal of net pricing is proprietary information, how would that be expressed as part of UPL development in regard to the ability of the public to comment?

The term 'Budgetary pricing' is also vague. Assuming the term refers to the March 2026 meeting's discussion of Premium Growth Thresholds, the discussion already noted that assessing the insurance premium impact of a specific drug is prohibitively difficult. Assuredly, it does not lend itself to standardization.

Part (d) of the section states "other methods as appropriate". This continues the undercurrent of generality and imprecision, especially with no indication of the sources of other methods, whether contracted consultants or otherwise.

Sections 15, 16, and 17, although well-intentioned, are also problematic. They present appeals processes that are actually an administrative disruption of the physician-patient relationship. The processes would result in treatment delays that could adversely affect the health outcomes of patients involved. Additionally, it is a burdensome taxing of physician time to navigate appeals when appeals processes are not a standard part of patients' care plans.

Respectfully submitted,

Ranier Simons
Director of Patient-Centered Drug Pricing and Healthcare Access Policy
Community Access National Network (CANN)

On behalf of
Jen Laws
President & CEO
Community Access National Network