The Healthcare Revitalization Act for the Commonwealth of Virginia

The Greater Good Initiative
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POLICY BRIEF

The Problem

Healthcare and health insurance comprise one of the most significant household expenditures for American citizens. Because of its absolute importance and necessity compared to other consumer goods and services, the demand for healthcare is considered to be price inelastic, meaning that patients will keep paying higher prices until they cannot.[1] In recent years, pharmaceutical corporations have taken this consumer relationship for granted by exponentially increasing the prices of their drugs — termed "price gouging." Across the industry, many executives continue to justify price increases with the need to properly fund research and development of future drugs. However, as healthcare is becoming more of a burden to the average American, it becomes evident that the industry cannot continue price gouging in the name of profit.

The most notable case within the last decade was Mylan's price increases of EpiPens, their signature epinephrine auto-injector (EAI). Epinephrine is used to treat anaphylaxis, one of the most common, frequent, and serious medical conditions among the population. After exposure from a trigger, a person's respiratory and other organ systems may begin to quickly shut down in a matter of minutes. Breathing will slow, blood pressure will fall, and the skin will often become covered with hives. Without prompt treatment from an EAI, it can potentially become a fatal allergic reaction. Even though several brands of EAIs exist, Mylan's EpiPens are most frequently prescribed by doctors. The pharmaceutical drug manufacturer owned as much

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[1] Ringel, J., Hosek, S., Vollaard, B., & Mahnovski, S. (2002, April 29). *The Elasticity of Demand for Health Care: A Review of the Literature and Its Application to the Military Health System*. Retrieved August 17, 2020, from https://www.rand.org/pubs/monograph_reports/MR1355.html.

as 90% of the EAI market share in the United States.[2] As a result, the manufacturer has developed a virtual monopoly on the vital device. Prior to 2010, the average retail price for autoinjectors was below $100, but in recent years, the average has exponentially increased to well over $600 in some cases. In 2016, the company's price gouging stirred national headlines after hundreds of families complained that they were unable to afford the rising prices. The National Institute of Health (NIH) cited that the prices were "very high for a device that uses technology developed in the 1970s and was subsidized by the US government, delivers a very cheap drug that is centuries old, and was available for $100 or less prior to 2010." [3] Even as Mylan released a generic option in December of 2016, the price for such an option costs around $400.[4]

Price gouging, however, is not the only ongoing issue in the healthcare industry. In 2017, Brian, a social worker in his late 30s, was recovering from a rare form of cancer in his appendix when he relapsed. His oncologist gave him a good prognosis and ordered a routine prescription for oral oncolytics from his local pharmacy. His regular pharmacy said that while they had the pills Brian needed, his insurance and Pharmacy Benefit Manager (PBM) barred them from filling it, and required that the pharmacy forward it to another PBM-mandated specialty pharmacy. From there, the new pharmacy forwarded it to another PBM-specialty pharmacy, which was also unable to fill the prescription. After 11 days of confusion, Brian finally got his prescription from the first PBM-mandated pharmacy, but Brian was beyond help and had to be rushed to the

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[2] Henry, M. (2020, February 12). *EpiPens still costly despite generic alternatives, other reforms*. Medical Xpress - medical research advances and health news. https://medicalxpress.com/news/2020-02-epipens-costly-alternatives-reforms.html.

[3] Shaker, M., & Greenhawt, M. (2018, November 2). *Association of Fatality Risk With Value-Based Drug Pricing of Epinephrine Autoinjectors for Children With Peanut Allergy: A Cost-effectiveness Analysis*. JAMA network open. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6324395/.

[4] Marsh, T. (2019, August 7). *2 Years After the EpiPen Price Hike, Here's What's Changed - GoodRx*. The GoodRx Prescription Savings Blog. https://www.goodrx.com/blog/epipen-price-change-since-mylan-released-generic-epinephrine/.

emergency room. His oncologist discovered an infection that had grown while he was off his oncolytics, which now prevents him from future chemotherapy, ultimately worsening his prognosis.[5] Because Brian's state allowed PBMs and insurance companies to override so-called "Any Provider Willing" provisions and regulate who was able to dispense the prescription, the quality of his care worsened, and he will be forever impacted by this bureaucratic logistical nightmare.

PBMs typically are toted for their ability to keep drug prices and premiums lower as they promote competition between the manufacturers. This is due to companies vying to get their products on the insurance company's formulary — a list of prescription drugs that are carried by the insurance plan. While PBMs serve as a "middle-man" in drug distribution, cutting out the administrative waste for the insurance companies, they still markup the prices in order to receive a worthy gross profit. In many cases, PBM interactions are found to endanger patients by driving up consumer costs, putting unnecessary burdens on pharmacies, overcharging insurance plans, and continuously defending the drug manufacturers.[6] There are also substantial conflict-of-interest concerns when an insurance company's PBM owns a pharmacy or has a stake in one.[7] This presents a major problem for patients as they can be overcharged while lacking immediate accessibility and relief by being forced to use a PBM by an insurance company. With heavily specialized drugs, if patients were able to receive their medications from their doctor's office or even their regular pharmacy without interference, the quality of care, speed of care, and monitoring of care would increase, while costs would decrease overall.[8]

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[5] Community Oncology Alliance, 4 April 2019. *Pharmacy Benefit Manager Horror Stories--Part IV*. https://communityoncology.org/pharmacy-benefit-manager-horror-stories-part-v/.
[6] Pharmacy Benefit Manager Watch. *How PBM's affect cost*. http://www.pbmwatch.com/how-pbms-affect-cost.html.
[7] Pharmacy Benefit Manager Watch. *Conflicts of Interest*. http://www.pbmwatch.com/conflicts-of-interest.html.
[8] Frier Levitt. *Pharmacy Benefit Managers' Attack on Physician Dispensing and Impact on Patient Care*. https://communityoncology.org/wp-content/uploads/2018/08/PBMs_Physician_Dispensing-WhitePaper_COA_FL.pdf.

As healthcare spending keeps increasing year-over-year for the average citizen, states across the nation are seeking to protect consumers from the industry itself. Recently, activist groups, patients' rights organizations, and ordinary families have collectively lobbied to create more transparency in the healthcare industry and are requesting more oversight from the government in order to deter price gouging and rising costs. Within the Commonwealth of Virginia, delegates and senators have collaborated to form bipartisan solutions in recent months, but the issues will not cease any time soon. Stop-gap measures can only benefit residents in so many ways that it becomes necessary to seriously consider major healthcare reform within the state.

The Solution

Therefore, we propose a three-pronged legislative approach to reduce the cost burden towards patients. Roughly six million Americans suffer from some allergy or allergic reaction to a food, material or substance. With such demand for EAIs, lower prices are imperative for equity of access and ensuring maximum safety for those who suffer from allergies. Therefore, we propose that the Commonwealth should enact legislation prohibiting health insurance companies and other carriers from setting an amount exceeding $100 per annual supply that a covered person is required to pay at the point-of-sale. The proposed measure would prohibit distributors of epinephrine from charging "cost-sharing payments" higher than $100 for those who have health insurance (defined by §38.2-3438) through a carrier (defined in subsection A of §38.2-3407.15). Moreover, this limit on the amount that an insured person is required to pay shall increase or decrease by a percentage equal to the percentage change from the preceding year in the medical care component of the Consumer Price Index (CPI) from the Bureau of Labor

Statistics of the United States Department of Labor. This long-term approach allows the price ceiling to be indexed to inflation, ensuring that future legislation is not needed to update the limit. This method would not only adjust yearly to account for inflation, but it would not be unprecedented, as a similar policy, Illinois S.B. 667, was recently signed into law by Governor Pritzker. This allowed a $100 limit on the cost-sharing payment of insulin; the legislation also included a provision to index the limit to the CPI in order to be annually adjusted and scaled to inflation.[9] In total, over 10 states have either instituted a price limit to insulin or have legislation on the table since 2019.[10] A price limit on cost-sharing payments for EAIs not only provides immediate relief to Virginian patients, but it also ensures that families are not over-allocating portions of their income to solely cover the medication. For individuals who suffer from dangerous allergies, affordable access to epinephrine is a must.

Secondly, we propose adding §30-391 to create the Virginia Healthcare Affordability Commission to study, evaluate and monitor healthcare prices from across the Commonwealth. We also propose that the Healthcare Affordability Commission have the authority to regularly adjust and take into account the Consumer Price Index. This method would be the most affordable and reliable tool the General Assembly has to ensure lasting lower prices and increased affordability. Similar to the Virginia Crime Commission, it would have similar rules for its composition, meeting frequency, style of meetings, and powers. This would allow the General Assembly and the Governor to stay readily focused on resolving price gouging. Furthermore, this proposed commission could continually meet to track proposals, hear testimony, and make recommendations to the General Assembly on pending policies or trends

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[9] Manar, A. (2020, January 24). *2019 IL S 667*. National Conference of State Legislatures. http://custom.statenet.com/public/resources.cgi?id=ID%3Abill%3AIL2019000S667.

[10] Salomon, S. H. (2020, April 20). *Minnesota Becomes Latest U.S. State to Pass Insulin Pricing Cap: Everyday Health*. EverydayHealth.com. https://www.everydayhealth.com/type-1-diabetes/new-mexico-becomes-third-us-state-to-pass-insulin-pricing-cap/.

across the country in the realm of healthcare policy. In Vermont, S.B. 246 allowed for a similar oversight board to track name-brand drug prices, see if any significant price increases occurred, determine if such increases were warranted, and set a new price cap if deemed necessary. Our proposed Healthcare Affordability Commission would follow similar parameters and duties in addition to finding other ways to reduce the price of healthcare for Virginians.

Lastly, we propose that all Pharmacy Benefit Managers, defined under §38.2-3465 and licensed under §38.2-3466, shall be prohibited from interfering in a patient's rights under §38.2-3407.7 by amending § 38.2-3467 to explicitly bar Pharmacy Benefit Managers delaying prescriptions from getting to patients, intentionally or otherwise, interfering in a patient's right to receive their medications from wherever the patient choses, have a vested interest in a pharmacy, and not acting as a medical "fiduciary." These three primary changes to the existing laws would ensure that PBMs would truly benefit the patients and not themselves or their contracted insurance company. These new laws would also ensure that the existing "Any Provider Willing" law (APW) is enforced, thus preventing patients from being restricted from where they get their prescriptions. Additionally, it would ensure that PBMs actually work to get medications to patients and not "prop up" insurance companies or their bottom lines. Furthermore, these new laws would ensure PBMs cannot earn additional money off of their moral obligations by directing prescriptions to pharmacies with which the PBMs have a financial relationship.

With these five new proposed measures, patient care will increase overall, as the speed at which they receive their medications will increase, and the costs overall will decrease as Virginia will constantly update its laws to reduce prices, and PBMs are barred from driving up prices for the patients. These methods would ensure that pharmacies, doctors' offices, clinics, or wherever prescribed medications are given to patients are truly able to help those in their care and not be

entangled in logistical deadlocks. The number of patient deaths as a result of delayed prescriptions will decline, and quality of care, especially for those on oral oncolytics or other specialized treatment or drugs, will increase. These measures are important for the future of healthcare and patients' rights overall and should be enacted to reform the healthcare industry and nature of patient care across the Commonwealth.

PRELIMINARY REPORT

What problems exist in the current healthcare system?

There are a myriad of problems that currently exist within the United States and Virginia healthcare systems; however, The Greater Good Initiative wants to target two key issues at hand. Such issues negatively affect consumers — particularly those who are most vulnerable — and should be remedied immediately. The first problem is so-called "price gouging," wherein drug manufacturing companies exponentially increase the price of their product, taking advantage of the inelastic demand nature of medicine and the lack of generic versions widely available. This forces consumers to purchase the drug no matter the price, hurting those who have inadequate insurance coverage. The most notable example of price gouging in the healthcare industry was Mylan's sudden increase of their epinephrine auto-injector "EpiPen." Epinephrine, also known as adrenaline, is a first-aid treatment for anaphylaxis; without the security of having an EpiPen on-hand, many allergy sufferers are at an extremely heightened risk of a reaction turning deadly. Virginia passed an insulin price cap to prevent this kind of price gouging, but it could also be applied to many more medications like epinephrine. Secondly, another major problem with healthcare systems in the United States and Virginia is the business model and activities of Pharmacy Benefit Managers, commonly called PBMs. PBMs are companies that operate in the middle of the distribution chain for prescription drugs, and their main functions are to develop lists — called formularies — of which drugs an insurance company is willing to cover, negotiate rebates and discounts from drug manufacturers, and contract with pharmacies directly to dispense drugs. They should not receive any compensation from individual pharmacies for doing so. One of the key issues with PBMs is they exploit the competition in the healthcare market to gain higher rebates, which do not always get returned in proportion to the insurers, driving up the

burden of cost onto the consumer. Moreover, even though there are already rules and regulations which should prevent them from doing so, PBMs may sometimes have a financial relationship with pharmacies, which, in some cases, forces consumers to only receive medications from pharmacies with which a PBM has a financial stake.

What are the proposed solutions?

The goal of all three proposed solutions is to lower the price burden for Virginian consumers.

Indexed Price Cap for Epinephrine Auto-Injectors (EAIs)

The first of our proposed solutions is an indexed price cap for epinephrine. Following the example set by similar insulin price caps in Virginia and other states across the country, this price cap would set the maximum amount that can be charged by a healthcare provider for an annual supply of epinephrine auto-injectors at $100. This price cap would also change yearly according to the percentage change in the medical care component of the Consumer Price Index from the previous year.

Virginia Healthcare Affordability Commission

The second proposed solution is the creation of the Virginia Healthcare Affordability Commission to study and evaluate Virginia's healthcare marketplace conditions and offer solutions to the governor and General Assembly as they see fit. It would have similar rules and structure to the Virginia Crime Commission, and it would regularly review legislation from the General Assembly surrounding healthcare and track the price increases of medications. This dedicated body would help to ensure that future healthcare legislation and the actions of pharmaceutical companies will be in the best interest of Virginians.

PBM Reform

The third proposed solution is to reform the practices of Pharmacy Benefit Managers. This change to existing legislation would explicitly bar PBMs from delaying prescriptions from getting to consumers, have a vested financial interest in a pharmacy, and not acting as a medical fiduciary. In the current landscape, PBMs play a very crucial role in the consumer experience. As of now, PBMs directly influence the total cost of medicine and drugs for insurance companies, which impacts access to certain medicines for the consumer, along with the payment for pharmacies. Under our policy, PBMs would no longer be able to play such a direct role in this process, and the pathway to get the medicine to the consumer would become a lot more transparent and accessible.

Why should healthcare reform be undertaken? What is the urgency of the situation?

Healthcare is an increasingly problematic and contentious issue that a significant portion of Americans encounter on a daily basis. According to the Pew Research Center, 83% of surveyed Americans say that the costs of medical treatment has made quality healthcare unaffordable,[11] and 68% consider healthcare to be very important to their vote in the upcoming general election.[12] Moreover, as the median age of Americans increases with the aging of the "baby boomer" generation,[13] older individuals are more likely to face higher costs due to their

[11] Milanez, I., & Strauss, M. (2020, May 30). *Most in US say high costs of medical treatments are a big problem*. Retrieved September 9, 2020, from https://www.pewresearch.org/fact-tank/2018/07/09/americans-are-closely-divided-over-value-of-medical-treatments-but-most-agree-costs-are-a-big-problem/.

[12] *Important issues in the 2020 election*. (2020, September 04). Retrieved September 9, 2020, from https://www.pewresearch.org/politics/2020/08/13/important-issues-in-the-2020-election/.

[13] *65 and Older Population Grows Rapidly as Baby Boomers Age*. (2020, June 25). Retrieved September 10, 2020, from https://www.census.gov/newsroom/press-releases/2020/65-older-population-grows.html.

susceptibility to chronic illnesses. With medicinal prices[14] outpacing wage growth[15] and the ensuing long-term effects of the COVID-19 pandemic and economic recession, it is absolutely paramount that state governments adopt policies to make healthcare more equitable for all Americans.

What were the broad questions that guided research into this issue?

After states, like Virginia, passed insulin price caps, are there other medications that the government should set a price cap on? The Virginia insulin cap bill (H.B. 66) set precedent that cost-sharing payment plans cannot exceed $50 per monthly supply of the prescription insulin drug. Another example in Illinois, S.B. 667, limits the increase in cost of a 30-day supply of prescription insulin equal to the percentage change from the previous year of the medical care component of the Consumer Price Index of the Bureau of Labor Statistics of the United States Department of Labor. These pieces of legislation, among others, indicate that the Commonwealth has the ability to regulate drug and medication prices, preventing consumers from the burdens of industrial "price gouging." Companies have been able to exploit the current relationship between consumers and the pharmaceutical supply chain because of the natural necessity for certain medication such as EpiPens. Approximately 32 million Americans have a food allergy, making access to EpiPens essential to thousands of people across the Commonwealth. Quality access to an EAI can be the difference between life and death.[16]

[14] *Why Are Americans Paying More for Healthcare*? (2020, April 20). Retrieved September 30, 2020, from https://www.pgpf.org/blog/2020/04/why-are-americans-paying-more-for-healthcare.
[15] DeSilver, D. (2020, May 30). *For most Americans, real wages have barely budged for decades*. Retrieved September 29, 2020, from https://www.pewresearch.org/fact-tank/2018/08/07/for-most-us-workers-real-wages-have-barely-budged-for-decades
[16] *Food Allergy Facts and Statistics for the U.S.* [PDF]. (2020, June 06). Food Allergy Research & Education.

How can price caps remain relevant, so they do not need to be amended session after session? An EpiPen price cap can provide the necessary bridge between desperate patients and insurance companies, but the value of the price cap must represent a value that is both fair to both parties. The price cap will stay relevant by being adjusted accordingly by the proposed Healthcare Affordability Commission, based on the rate of the medical care component of the Consumer Price Index (CPI). Similarly, Vermont S.B. 246 called for an oversight board to determine if price caps were necessary for significant price increases. The proposed Healthcare Affordability Commission will ensure the amended amount of $100 per annual supply to remain relevant and effective for both parties as the Consumer Price Index fluctuates.

How can new laws ensure PBMs are working for the patients, rather than the insurance companies? Pharmacy Benefit Managers act as the “middle-man” between drug manufacturers and pharmacies by cutting out administrative waste by making the process more efficient for all parties involved. However, PBMs have the ability to disrupt the relationship between drug manufacturers, pharmacies, and patients under current regulations by adjusting insurance and payment plans, hurting consumers who ultimately face the burden of higher prices. Also, they have the authority to bar pharmacies from filling prescriptions, preventing patients from receiving essential medication in a timely manner. The proposed legislation would allow the Commonwealth to prevent PBMs from denying or delaying medication for patients and ensure PBMs act as an effective “middle-man” to help patients receive medication in the fastest and cheapest manner possible.

Why is this an issue that requires governmental response?

There is an immediate need of assistance for Virginians that lack affordable access to EAIs and other essential medications. Although Virginia did in fact expand the Medicaid program that helped over 600,000 Americans acquire healthcare coverage, there are still areas of improvement with regard to the total cost of healthcare and even medical debt. According to a survey 6 months after Virgina had enacted Medicaid expansion, 63% of the Virginians felt that the cost of medical expenses were still a financial burden. Many medications are outdated with little to no technological advancements, set way above the recommended sales price, or are delayed to patients due to a PBMs intervention. If government action is taken by the Commonwealth of Virginia, established laws will allow lower and middle class families to better afford EAIs and other vital life-saving medications. Furthermore, a concerted effort by both chambers of the General Assembly will help to prevent future price gouging in the healthcare supply chain.

What ongoing questions may you have?

What other issues will the Virginia Healthcare Affordability Commission reveal within the healthcare industry? As the Virginia Healthcare Affordability Commission conducts research into medication costs, they will uncover other possible acts of price gouging hurting consumers within the industry. The commission will suggest legislative action to the General Assembly by reviewing and analyzing drug prices that appear to be overly expensive. Similar to Vermont S.B. 246, the commission will ensure that all drugs and medications satisfactorily meet the labeling standards of the U.S. Food & Drug Administration.

Will this commission offer resources to the Virginia General Assembly to develop other price caps when needed? The Virginia Healthcare Affordability Commission will offer recommendations and guidelines on appropriate legislative measures for the General Assembly to conduct. The commission will follow The Green Mountain Care Board, established by Vermont S.B. 246. This legislation allows the Vermont oversight board to review fluctuating drug prices and determine whether an upper payment limit should be established. The Virginia Healthcare Affordability Commission will have similar authority to recommend the Virginia General Assembly institutes or adjusts price caps.

Will a price cap stunt innovation or incentivize the industry to improve their drugs? Surprisingly, the status quo stunts innovation in the industry. Because many companies in the pharmaceutical industry are considered patent monopolies, horizontal integration has been often noted as a common feature of the industry. According to Harvard Business Review, "research and development (R&D) within merged entities declines substantially after a merger, compared to the same activity in both companies beforehand. On average, R&D expenditures of non-merging competitors also fell by more than 20% within four years after a merger."[17] Also, according to a research study published in the *Drug Discovery Today*, annual growth in R&D spending decreased annually when a major merger and acquisition (M&A) took place. For example, in 2009, annual growth in R&D spending dropped by 2.2% when the fifth (Pfizer bought Wyeth for $78 billion) and ninth (Merck & Co. bought Schering-Plough for $54 billion) largest M&A occured.[18] M&A have only proven to reduce R&D spending, thus decreasing

[17] Haucap, J., & Stiebale, J. (2016, August 03). *Research: Innovation Suffers When Drug Companies Merge.* https://www.hbr.org/2016/08/research-innovation-suffers-when-drug-companies-merge
[18] Ringel, M. S., & Choy, M. K. (2017, June 21). *Do large mergers increase or decrease the productivity of pharmaceutical R&D?* Drug Discovery Today. https://www.sciencedirect.com/science/article/abs/pii/S1359644617301927.

innovation. Moreover, academic centers do 85% of R&D. Drug companies only contribute 1.3% towards R&D. According to an analytical report by Visiongain, drug discovery outsourcing will continue to grow over the next decade and will rise to a $43.7 billion dollar industry by 2026, as compared to an estimated $19.2 billion in 2016 (or $21.2 billion according to Kalorama Information). This is in line with Vantage's fresh alliance benchmarking study, revealing that over 80% of bio-pharma respondents report increased alliance activity compared to five years ago. Getting ideas and expertise from external sources is a well-established practice in the pharmaceutical industry with about one-third of all drugs in the pipelines of the top ten pharmaceutical companies initially developed elsewhere, according to a 2014 WSJ article by Jonathan D. Rockoff.[19]

How will Pharmacy Benefit Managers and pharmaceutical companies react? Pharmaceutical companies and PBMs will challenge these regulations as infringement on their authority, citing that PBMs ensure competition. According to the Supreme Court case that consisted of 47 state Attorney Generals against a pharmaceutical organization that represents some of the largest corporations, *Rutledge v Pharmaceutical Care Management Association*, states governments argue that PBMs have overstepped their authority with anti-competitive practices that drive pharmacies out of business. The Supreme Court's decision will ultimately set precedent whether state authority can regulate healthcare or whether PBMs can act freely as the "middle-men" of the pharmacy process.

[19] Buvailo, A. (2020, January 13). *Pharma R&D Outsourcing Is On The Rise*. https://www.biopharmatrend.com/post/30-pharma-rd-outsourcing-is-on-the-rise/.

POLICY PROPOSAL AND ANALYSIS

What is the basic form of our policy response?

To ensure that prices for live-saving drugs are affordable and PBMs do not jeopardize patients' rights and safety, we have developed a three-pronged policy approach. First, the Virginia General Assembly should pass a measure to prohibit healthcare insurance companies and epinephrine distributors from charging more than $100 per annual supply worth of co-payments for those who are insured. This price cap would adjust accordingly based on the yearly percentage change of the Consumer Price Index's medical care component. The General Assembly should then pass a secondary measure that would establish a Healthcare Affordability Commission, who will monitor and evaluate healthcare prices in the Commonwealth. The commission will also provide guidelines and proposals to the General Assembly if they deem that the cost of a medical drug or treatment reflects an act of price gouging. Lastly, the General Assembly should pass a third measure that will outlaw PBMs from having a vested financial interest in a pharmacy, inferring in the patient's choice to obtain their medications from any place they choose, and delaying prescriptions from being sent to patients, either intentionally or otherwise. Ending such practices would restrict PBMs from profiting greatly at the expense of Virginians.

How will our policy proposal be implemented? What administrative changes are required?

Following the passage of this legislation, the Virginia Healthcare Affordability Commission would be established and given similar powers, composition, style of meetings, and frequency to the current Virginia Crime Commission. The Crime Commission is a criminal justice agency established under the legislative branch by section 30-156 et seq. of the Code of

Virginia.[20] It consists of 13 members, composed of 9 legislative members, 3 non-legislative citizens, and the Attorney General or their designee. 6 of the 9 legislative members are appointed by the Speaker of the House of Delegates in accordance with the rules of proportional representation written in the Rules of the House of Delegates, while the other 3 are appointed from the Senate by the Committee on Rules. The Governor finally appoints the 3 non-legislative citizen members, who must be citizens of the Commonwealth. Besides the Attorney General and the legislative members, who serve terms coincident with their terms of offices, all other appointees serve 2-year terms. The Crime Commission is able to accomplish its purpose of studying, reporting, and recommending on all areas of public safety and protection[21] by cooperating with all Commonwealth and local agencies, consulting with other states,[22] appointing an executive director,[23] and conducting both private and public hearings and taking witness testimony. This culminates with the Commission submitting an annual recommendations report to the General Assembly and Governor and an executive summary of the interim activity.[24]

The Healthcare Affordability Commission would examine the state of the Commonwealth's healthcare industry compared to other states and the national level and advise the General Assembly on health issues based on its findings. To accomplish this, the Commission would have the ability to propose and track recommendations to the General Assembly, conduct hearings and take witness testimony, and most importantly recommend adjustments to medical prices within the Commonwealth based on the Consumer Price Index. The first price alteration to be implemented will be a cap on EAIs set at $100, outlawing health insurance companies and other carriers from charging above such figure for insured individuals

[20] *Virginia State Crime Commission*. (n.d.). Retrieved September 29, 2020, from http://vscc.virginia.gov/index.asp.
[21] Virginia State Crime Commission; purpose; membership; terms; compensation and expenses; quorum; voting on recommendations,Va Code § 30-156 (2004).
[22] Cooperation of state agencies; consultation with other states, Va Code § 30-159 (2001).
[23] Executive director, counsel and other personnel, Va Code § 30-157 (2001).
[24] Powers and duties of Commission, Va Code § 30-158 (2004).

and families. Furthermore, each year this limit would change by percentage equal to the percentage change from the preceding year in the CPI's medical component. Finally, pharmacy benefit managers would be barred from having a stake in any particular pharmacy, acting on their behalf by — intentionally or not — interfering with the ability of patients to receive medications from anywhere they choose, or delaying the delivery of prescriptions to patients beyond 72 hours.

Are there alternative responses that should be taken into consideration?

One alternative to price caps for medication, including EpiPen, would be to incentivize pharmaceutical companies and drug manufacturers to keep prices lower for consumers and patients by adding additional taxes on medications that are determined to be too expensive, according to the Healthcare Affordability Commission. Once the commission declares that a drug is too expensive, a tax is activated on the medication until the price is adjusted. This tax would be a specific percentage of the disparity between the fair drug cost and the current price gouging cost, according to the Healthcare Affordability Commission.

Without an oversight body, such as the Healthcare Affordability Commission, unfair price gouging will continue throughout the healthcare industry. The General Assembly will have to spend resources to research and monitor consumer costs, where their work should be prioritized on policy based on research conducted by external services. All parties would benefit with the commission because each party can function more effectively to keep costs low and provide universal access for consumers in the Commonwealth.

If legislation is not passed to limit and regulate PBMs, they will continue to prevent patients from receiving their drugs quickly and cost-effectively. The current law allows them to

adjust insurance and payment plans without much limitation. They will continue to impede on relations between pharmaceutical companies and consumers. Without adequate regulation, PBMs can hurt consumers through price gouging and delaying times for drug prescriptions to be filled.

Why is our proposed policy an appropriate response to the identified problem?

The EAI price cap addresses a critical issue within the healthcare crisis as thousands of families in the Commonwealth will be able to receive their life-saving epinephrine medication at a much more affordable cost. Pharmaceutical companies will not have the ability to drive up costs, alleviating a previous burden that many Virginians faced. The price cap is also an appropriate solution because the $100 cap on co-payments will adjust in proportion to the medical care component of the CPI. This necessary addition removes the need to amend the value of the price cap in the future.

The Healthcare Affordability Commission is an effective response to high drug costs across the industry because a third-party body will be able to study, evaluate, and monitor various prices to ensure they are affordable and accessible throughout the Commonwealth. Virginia has shown precedent of establishing similar advisory entities as the General Assembly established the Virginia Crime Commission, proving that such a tool should be at the disposal of the Commonwealth. Public health can also be positively affected by the establishment of a commission to monitor drug costs. The commission's authority will allow it to act as an oversight board that identifies problems, but cannot overstep its authority and regulatory powers.

Restricting PBMs from representing "conflicts-of-interests" allows consumers to be prioritized so that they can receive medication and treatment as efficiently and affordably as

possible. This policy response genuinely shifts the focus to Virginians, so the drug manufactures and insurance companies cannot take advantage of citizens who need their treatment.

What are the resources that will be needed to carry out this policy response?

To carry out the EpiPen price cap and the Healthcare Affordability Commission policy solutions, the General Assembly must commit legislators to monitor drug prices through analytical research as members of the Healthcare Affordability Commission. This legislation would not require funding as the epinephrine price cap will hold pharmaceutical companies accountable and the commission will ensure that patients are being put first, keeping money in the pockets of Virginians without a direct monetary expense from the Commonwealth.

Which parties will conduct implementation oversight? What criteria will they use to determine if the policy is successful?

As part of our proposed solutions, the Healthcare Affordability Commission will be established to monitor the conditions of the healthcare industry, review legislation put forth regarding healthcare by the General Assembly, and make recommendations to the General Assembly on the ways proposed legislation can most benefit Virginians. Therefore, this commission will be able to evaluate the success of both the epinephrine auto-injector price cap and the PBM reforms. If the commission were to indicate that either piece of legislation is no longer needed, then they can submit a recommendation to the General Assembly for a repeal of the policies. This action should only be taken if the commission has reasonable doubt in the effectiveness of the policies or that the policies have exhausted their usefulness.

The Healthcare Affordability Commission will be considered successful if specific criteria are met after the commission begins monitoring drug costs and ensuring that drug

manufacturers, pharmacies, and physicians are representing the patients and not their own interests. Specific criteria that will measure the success of the Healthcare Affordability Commission include lower drug prices for consumers in Virginia. Regulating PBMs and monitoring drug prices will prevent future price gouging under the commission. Another metric that would indicate the success of the Healthcare Affordability Commission is a declining number of patient deaths from delayed medication. These metrics will objectively determine the success of the Healthcare Affordability Commission.

What would happen if no action is taken by the government and the problems were to persist?

If no action is taken by the General Assembly, the thousands of Virginians that suffer from potentially life-threatening allergies will still not be able to afford EAIs; the status quo of price gouging will continue to burden the consumer. The pharmaceutical company Mylan — whose EpiPen products constitute the vast majority of the EAI market — has created a monopoly over the vital drug. By raising the price from $100 to over $600 for only a two-pack of EpiPens over the course of the last decade, the company has forced many to reconsider even purchasing the drug. While EAIs are known for being a price inelastic product like most other medicines, families are increasingly deterred away from the high price. Individuals who do not have an EAI near them are at an increasingly higher risk of compromised health if he or she were to suffer an allergic reaction. Many Virginians will continue to be put in harm's way as companies like Mylan reap the benefits of high profit margins. Government intervention could mitigate the effects that Mylan's monopoly poses on Virginians by capping the co-payments on an annual supply of epinephrine to $100.

Secondly, if the General Assembly does not establish the Healthcare Affordability Commission, then Virginians as a whole could be susceptible to price gouging in other medications and treatment other than epinephrine. It is paramount that the Commonwealth provides a long-term solution that can provide reasonable recommendations and hold the healthcare industry accountable to its consumers. Maintaining the status quo will allow for healthcare problems as a whole to linger and continue to affect those most vulnerable to price gouging and other faults of the system. Unfortunately, there are specific groups who are disproportionately affected by out-of-range health care prices including eldery citizens, persons of color (POC), and low-income families. For example, it is said that the aging population for citizens 65 years and older will significantly increase from 16% to surpass 20% by the year 2028.[25] The growing number of enrollees 65 years and older will increase the total amount to acquire Medicare, and statistics show that aging Americans pay more in healthcare expenses than any other population in the country.

Another group at risk of not being able to afford out-of-pocket healthcare costs are persons of color. The gap between white ethnic groups and marginalized communities regarding the ability to afford medical coverage has been continuously increasing over the years, resulting in many POCs to be uninsured. In 2018, it was found that the uninsured rate among African Americans was 9.7%, compared to 5.4% with white populations.[26] Specifically, this disproportionality of health care costs between white Americans and POC Americans is most prominent in urban centers.

[25] Peterson, Peter. (2020, April 20). *Why are Americans paying more for health care?* Peter G. Peterson Foundation .https://www.pgpf.org

[26] Taylor, Jamila. (2019, December 19). *Racism, Inequality, and Health Care for African Americans.* Report Healthcare. https://tcf.org/

Lastly, low-income families are deeply affected by the ever-increasing price standards of vital medications and healthcare coverage. Due to the COVID-19 pandemic and the subsequent economic recession, price gouging in healthcare can severely strain financially disadvantaged families. Statistics reveal that in the past year a total of 44% of Amercians did not pay for a necessary medication due to high sales prices that were not in range of their budget. Unfortunately, about 12% of Ameicans had to cut a medical bill in half or skip a dose in order to make their prescription drugs last until adequate funds were available.[27]

A lack of government regulation against PBMs hinders a patient's ability to receive essential medications in a timely and ethical manner. At a time where Virginians are in disastrous economic strain as a result of the COVID-19 pandemic, PBMs pose a much greater risk to patients with specialized medicine or treatments. In the status quo, research has shown that PBMs control about 89% of the United States market price for prescription drugs.[28] In addition, even though consumers are provided rebates — which were initially instituted to decrease the out-of-pocket costs to acquire medications — it does not substantially lower the total amount for EAIs specifically due to the PBMs decision to increase the market price, among other tactics.

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[27] Leonhardt, Megan. (2020, February 27). *Americans are skipping medically necessary prescriptions because of the cost. CNBC*. https://www.cnbc.com/

[28] Singer, Thea. (2016, August 26). *Epi Pen's Pricing Debacle and its impact on patient, Insurers.* News@Northesatern. https://news.northeastern.edu

How can lower out-of-pocket healthcare costs economically help individuals and their families?

Families having the ability to afford lower out-of-pocket healthcare costs will provide them with the opportunity to be less economically strained. Having lower out-of-pocket costs means lower deductibles and lower maximums. Essentially, this is one of the first steps of progress with regard to lifting financially strained families out of dark and stressful times. Less money spent on healthcare can enable a family to divert funds towards other important endeavors. Logically, a $300 out-of-pocket payment for a prescription could have been used for paying utility bills, education supplies for children, or food and other necessities for the family. The possibilities are endless when it comes to reforming consumer spending habits so that healthcare expenditures do not compose a significant portion in a family's monthly budget. For pregnant women, before and after delivering a baby, expenses for nursery supplies are very high; the addition of a child to a family compounds mental and fiscal stress on the parents. If a mother needs specific medication for the infant and herself, how can she afford the essential prescriptions that are extremely overpriced? Parents have a clear obligation to care for their children, and rising healthcare costs only prevent families from living an economically stress-free life. In addition to this, the Commonwealth and federal governments spend millions a year in social welfare programs such as SNAP and local food security programs.[29] If healthcare costs were minimized, it would allow people to avoid having to resort to these programs, resulting in less government spending in current welfare programs in the long-term.

This proposal will lift a burden off of families who will not need to decipher between paying for medications or paying for basic needs such as: rent, utility bills, food, water, childcare, education, transportation and many other necessaries to sustain a healthy family. On

[29] Pavlenko, Tonya.(2018, June 18). *Many low-income pregnant women don't have enough to eat, despite food programs.* Center for Health Journalism.https://www.centerforhealthjournalism.org/

the other hand, food banks and the federal government do offer assistance to individuals who meet the minimum financial qualifications. Although, there are still middle class families who are taken advantage of by outrageous healthcare costs that at times feels as a financial burden to their own households. In order to solve the ongoing issue of economically-disadvantaged families, we as the people of the United States have an obligation to put our legislation into action, for the betterment of future generations to come.

CONCLUSION

Upon passage, the Healthcare Revitalization Act will reduce healthcare expenditures for thousands of Virginians. The proposed policy will implement a three-pronged legislative approach aimed at creating long-term healthcare affordability within the Commonwealth. The first measure of the Healthcare Revitalization Act imposes an index-based price cap for EAIs.

This limit on co-sharing payments will result in consumers only having to pay a maximum of $100 for a year's supply of epinephrine. In order to provide a long-term solution to healthcare affordability, the second measure establishes a proposed Virginia Healthcare Affordability Commission that will evaluate price levels across the industry and recommend future measures to the General Assembly for further consideration. The third measure will bar PBMs from interfering with any given patient's rights, including: non-fiduciary medical action, medication access interference and vested pharmaceutical interest.

In the status quo, monopolized healthcare sectors, harmful PBM interactions, and acts of price gouging culminate in a heavy cost burden on the average Virginian. Finding an immediate solution, rather than the typical stop-gap measures, is imperative as healthcare spending across the country increases year-over-year. Americans across the country are forced to deal with exponential price increases at the expense of corporate profit. In many cases, a lack of affordable healthcare is a matter of life or death. Continuing status quo policies would harm Virginians at-large in the long-term. The Healthcare Revitalization Act will provide solutions to current healthcare pricing issues — namely for epinephrine and fairly regulating PBMs — while also laying the groundwork for future progress with a legal advisory committee to the General Assembly and governor. Delegates and state senators should work across party lines to ensure affordable and accessible healthcare for all Virginians. Life-saving medications should not be a luxury, but rather a common commodity. With the Healthcare Revitalization Act, Virginia moves one step closer towards that reality.

To conclude, a government response is paramount to alleviate those suffering under the current conditions of the healthcare industry. Ordinary people and families experience the unnecessary consequences of price gouging, PBM interference, and high out-of-pocket

payments. For example, Edward Flores — a man in his 50s who had life-threatening injuries such as a broken neck and a fractured spinal cord — went to his local pharmacy to purchase essential medications such as fentanyl. Unfortunately, he was not able to acquire his medications due to a deductible that was overpriced and a delay in filling his prescription. The pharmacists told Edward it would have taken two days in order for him to receive his medications, but after the two days Edward went into withdrawal symptoms and was rushed to the hospital for emergency medical treatment. He went into shock and was treated separately for aggravating pain. The next day, Edward received a phone call from his pharmacy who were remarkably able to fulfill his order before any more health complications arose. In another instance, Edward went again to his pharmacy to purchase prescribed fentanyl patches, but his preauthorization apparently was overdue, and the out-of-pocket costs were exorbitant. While waiting for the preauthorization to be approved, he went home and waited a total of two days once again. In the meantime, Edward decided to reuse his fentanyl patches in order to prevent going into withdrawal symptoms. It is unfortunate that many civilians have to endure more health complications or stress because of the unaffordability of life-saving medications and the intervention of PBMs. Thousands of citizens like Edward come from already struggling communities or minorities. Action is necessary to improve their health in the short-term and to ensure economic prosperity in the long-term.

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APPENDIX I

Code of Virginia Amendments

***Epinephrine Auto-Injector Price Cap*:**
§ 38.2-3407.22 Limit on cost-sharing payments for prescription insulin drugs

A. As used in this section:

"Carrier" has the same meaning ascribed thereto in subsection A of § 38.2-3407.15.

"Cost-sharing payment" means the total amount a covered person is required to pay at the point of sale in order to receive a prescription drug that is covered under the covered person's health plan.

"Covered person" means a policyholder, subscriber, participant, or other individual covered by a health plan.

“Epinephrine Auto Injectors” means any automatic injector of the allergy relief medication epinephrine

"Health plan" means any health benefit plan, as defined in § 38.2-3438, that provides coverage for a prescription insulin drug.

"Pharmacy benefits manager" means an entity that engages in the administration or management of prescription drug benefits provided by a carrier for the benefit of its covered persons.

"Provider contract" has the same meaning ascribed thereto in subsection A of § 38.2-3407.15.

B. Every health plan offered by a carrier shall set the cost-sharing payment that a covered person is required to pay for a covered prescription Epinephrine Auto Injector device at an amount that does not exceed $100 of the prescription Epinephrine Auto Injector device.

C. Nothing in this section shall prevent a carrier from setting a covered person's cost-sharing payment for a covered prescription Epinephrine Auto Injector device at an amount that is less than the maximum amount permitted pursuant to subsection B.

D. No provider contract between a carrier or its pharmacy benefits manager and a pharmacy or its contracting agent shall contain a provision (i) authorizing the carrier's pharmacy benefits manager or the pharmacy to charge, (ii) requiring the pharmacy to collect, or (iii) requiring a covered person to make a cost-sharing payment for a covered prescription insulin drug in an amount that exceeds the amount of the cost-sharing payment for the covered prescription insulin drug established by the carrier pursuant to subsection B.

E. This section shall apply with respect to health plans and provider contracts entered into, amended, extended, or renewed on or after January 1, 2021.

F. Pursuant to the authority granted by § 38.2-223, the Commission may adopt such rules and regulations as it may deem necessary to implement this section.

***Virginia Healthcare Affordability Commission*:**

Established, Virginia Healthcare Affordability Commision

*An Act to amend the Code of Virginia by adding in Title 30 a chapter numbered 62, consisting of sections numbered **30-391** through **30-396**, relating to Virginia Healthcare Affordability Commision*

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Title 30 a chapter numbered 62, consisting of sections numbered **30-391** through **30-396**, as follows:

CHAPTER 62.

Virginia Healthcare Affordability.

*§ **30-391**. Virginia Healthcare Affordability Commission; purpose.*

The Virginia Healthcare Affordability (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to develop and provide guidance and resources to the General Assembly and Governor to lower healthcare out of pocket costs for Virginians

*§ **30-392**. Membership; terms.*

The Commission shall have a total membership of 14 members that shall consist of eight legislative members, three non legislative citizen members, and six ex officio members. Members shall be appointed as follows: three members of the Senate, to be appointed by the Senate Committee on Rules; five members of the House of Delegates, to be appointed by the Speaker of the House of Delegates in accordance with the principles of proportional representation contained in the Rules of the House of Delegates; one non legislative citizen member to be appointed by the Senate Committee on Rules; one non legislative citizen member to be appointed by the Speaker of the House of Delegates; and one non legislative citizen member to be appointed by the Governor. The Secretary of Health and Human Resources, State Health Commissioner, and Chairman of the State Corporation Commission, or their respective designees, shall each serve ex officio with voting privileges. Nonlegislative citizen members of the Commission shall be citizens of the Commonwealth. Unless otherwise approved in writing by the chairman of the Commission and the respective Clerk, non legislative citizen members shall only be reimbursed for travel originating and ending within the Commonwealth for the purpose of attending meetings.

Legislative members and ex officio members of the Commission shall serve terms coincident with their terms of office. Appointments to fill vacancies, other than by expiration of a term, shall be for the unexpired terms. Vacancies shall be filled in the same manner as the original appointments. All members may be reappointed. Nonlegislative citizen members shall be appointed for a term of two years.

The Commission shall elect a chairman and vice-chairman from among its membership, who shall be members of the General Assembly.

*§ **30-393.** Quorum; meetings; voting on recommendations.*

A majority of the members shall constitute a quorum. The meetings of the Commission shall be held at the call of the chairman or whenever the majority of the members so request.

No recommendation of the Commission shall be adopted if a majority of the Senate members or a majority of the House members appointed to the Commission (i) vote against the recommendation and (ii) vote for the recommendation to fail notwithstanding the majority vote of the Commission.

*§ **30-394**. Compensation; expenses.*

*Legislative members of the Commission shall receive such compensation as provided in § **30-19.12**, and nonlegislative citizen members shall receive such compensation for the performance of their duties as provided in § **2.2-2813**. All members shall be reimbursed for all reasonable and necessary expenses incurred in the performance of their duties as provided in §§ **2.2-2813** and **2.2-2825**. Compensation to members of the General Assembly for attendance at official meetings of the Commission shall be paid by the offices of the Clerk of the House of Delegates or Clerk of the Senate, as applicable. All other compensation and expenses shall be paid from existing appropriations to the Commission or, if unfunded, shall be approved by the Joint Rules Committee.*

***§ 30-395.** Powers and duties of the Commission.*

The Commission shall have the following powers and duties:

1. Assessing the out-of-pocket costs for Virginians for healthcare

2. Identifying causes of increasing out-of-pocket costs

3. Establishing best practices in the health care system and insurance industry to reduce costs

4. Monitor name brand drug prices as well as other biosimilar drug prices as determined by the FDA yearly, and identify price increases that it determines to be more than $3,000 for a 12 month supply or treatment, increased 200 percent in the previous 12 month period, or outside the newly adjusted Consumer Price Index

5. Determine if the price increases found are duly justified and necessary for Research, Development, or other necessary costs

6. Set price caps for the name brand drug and other biosimilar drugs if the price increase outlined in subsection 4 did not meet the requirements in subsection 5 that shall be re-evaluated yearly and updated if the Commission sees fit

7. Submitting to the General Assembly and the Governor an annual report for publication as a report document as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports. The chairman of the Commission shall submit to the General Assembly and the Governor an annual executive summary of the interim

activity and work of the Commission no later than the first day of each regular session of the General Assembly. The executive summary shall be submitted for publication as a report document as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

*§ **30-396.** Staffing.*

Administrative staff support shall be provided by the Office of the Clerk of the Senate or the Office of the Clerk of the House of Delegates as may be appropriate for the house in which the chairman of the Commission serves. The Division of Legislative Services shall provide legal, research, policy analysis, and other services as requested by the Commission.

***Pharmacy Benefit Manager Reform*:**

§ 38.2-3467. (Effective January 1, 2022) Prohibited conduct by carriers and pharmacy benefits managers

A. No carrier on its own or through its contracted pharmacy benefits manager or representative of a pharmacy benefits manager shall:

1. Cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal, or offer that is untrue;

2. Charge a pharmacist or pharmacy a fee related to the adjudication of a claim other than a reasonable fee for an initial claim submission;

3. Reimburse a pharmacy or pharmacist an amount less than the amount that the pharmacy benefits manager reimburses a pharmacy benefits manager affiliate for providing the same pharmacist services, calculated on a per-unit basis using the same generic product identifier or generic code number and reflecting all drug manufacturer's rebates, direct and indirect administrative fees, and costs and any remuneration;

4. Penalize or retaliate against a pharmacist or pharmacy for exercising rights provided pursuant to the provisions of this article;

5. Knowingly interfering in a patient's rights under §38.2-3407.7;

6. Cause a delay in a patient obtaining prescribed medication;

7. Prevent a patient from obtaining their prescribed medication from any pharmacy licensed by the Board of Pharmacy;

8. Coerce or advocate for a patient to obtain their prescribed medication from a pharmacy in which the Pharmacy Benefits Manager has a financial relationship with; or,

9. Act in opposition to the Patient's best interest or desires.

B. No carrier, on its own or through its contracted pharmacy benefits manager or representative of a pharmacy benefits manager, shall restrict participation of a pharmacy in a pharmacy network for provider accreditation standards or certification requirements if a pharmacist meets such accreditation standards or certification standards.

C. No carrier, on its own or through its contracted pharmacy benefits manager or representative of a pharmacy benefits manager, shall include any mail order pharmacy or pharmacy benefits manager affiliate in calculating or determining network adequacy under any law or contract in the Commonwealth.

D. No carrier, on its own or through its contracted pharmacy benefits manager or representative of a pharmacy benefits manager, shall conduct spread pricing in the Commonwealth.

E. Each carrier on its own or through its contracted pharmacy benefits manager or representative of a pharmacy benefits manager shall comply with the provisions of this section in addition to complying with the provisions of § 38.2-3407.15:1. 2020, cc. 219, 1288.
The chapters of the acts of assembly referenced in the historical citation at the end of this section may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

APPENDIX II

Press Release

The Greater Good Initative's Healthcare Revitalization Act Secures Healthcare Stability for Virginians in the Immediate Future

FAIRFAX, VA (November 2, 2020) - As healthcare gradually becomes one of the largest household expenditures for American citizens, it has become typical for pharmaceutical executives to justify drastic increases in drug prices. With price gouging and other business tactics employed by Pharmacy Benefit

Managers in order to expand profit margins as much as possible, harmful price gouging and the growing monopolization of the healthcare industry render consumers financially helpless while also resulting in cases of poor quality and effectiveness of their healthcare. Virginian consumers are among many across the nation who struggle to cope with this ever-increasing cost burden, making life or death decisions when there should be no question of one.

The Greater Good Initiative therefore proposes a three-pronged legislative approach that provides immediate and long-term legislative solutions to the General Assembly of the Commonwealth of Virginia. This includes: a $100 indexed price control on the co-sharing payments of epinephrine auto injectors, revising the role in which Pharmacy Benefit Managers can affect patients' rights — such as securing medication on a timely basis and ensuring non-fiduciary medical access — and the creation of the Virginia Healthcare Affordability Commission to oversee and recommend further measures regarding healthcare and medication price controls to the General Assembly and Governor. By implementing all three of these legislative proposals, the Commonwealth can take a giant leap towards ensuring the protection of patients' rights across marginalized communities and open the door for economic opportunities for low-income families who are currently hindered by high out-of-pocket healthcare costs.

About The Greater Good Initiative: The Greater Good Initiative (GGI) is a youth-led, nonpartisan policy think tank working to create sustainable solutions to our nation's most pressing issues. The organization is currently focusing on addressing critical issues in the realms of civil rights, economy, education, environment, and public health. GGI has coordinated with local, state, and federal legislators, policy professionals, and community leaders to craft realistic and effective policies that actively respond to the public's greatest concerns.