SB 388_PJC_Favorable_FIN.pdf
Uploaded by: Ashley Black
Position: FAV

Ashley Woolard, Staff Attorney
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SB 388
Prescription Drug Affordability Board – Upper Payment Limits & Funding
(Lowering Prescription Drug Costs for All Marylanders Act of 2024)
Hearing of The Senate Finance Committee
February 7, 2024
2:00 PM

SUPPORT

The Public Justice Center (PJC) is a not-for-profit civil rights and anti-poverty legal services organization which seeks to advance social justice, economic and racial equity, and fundamental human rights in Maryland. Our Health and Benefits Equity Project advocates to protect and expand access to healthcare and safety net services for Marylanders struggling to make ends meet. We support policies and practices that are designed to eliminate economic and racial inequities and enable every Marylander to attain their highest level of health. **PJC strongly supports SB 388**, which would require the Prescription Drug Affordability Board's to establish a process for setting upper payment limits on prescription drug products in the State that the Board determines have led or will lead to affordability challenges. It would also require the Governor to include in the annual budget bill an appropriation of $1,000,000 for the Board in fiscal year 2025 and each fiscal year thereafter.

Many consumers have trouble affording their prescription drugs. Nationwide, approximately 1 in 4 Americans has trouble affording their prescription drugs, even with health insurance.[1] High prescription drug costs are a significant barrier to improving health and maintaining good health for many Marylanders, especially for low-income, under-insured and uninsured consumers and senior consumers with chronic medical conditions. Our healthcare system is not accessible if consumers are put in the position of having to choose between paying for their prescriptions or other necessities, like food and shelter. Without a means to control the increasing costs of prescription drugs, many Marylanders are left unable to follow the treatment recommendations of their physicians and may be at risk of further health complications.

SB 388 would help ensure that Marylanders have access to affordable prescription drugs. The Maryland General Assembly's groundbreaking passage of the 2019 Prescription Drug Affordability Board law has served as a model for other states and SB 388 seeks to build on this success by strengthening the authority of the Board. SB 388, if passed

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[1] Cynthia Cox, *Recent Trends in Prescription Drug Costs*, JAMA Network (2016), https://jamanetwork.com/journals/jama/fullarticle/2510894.

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would restore the Board's authority to set upper payment limits for certain prescription drugs and provide a stable source of funding for the Board. The legislation promotes transparency in drug pricing and would help eliminate high prescription drug costs as a barrier to good health for Marylanders. While Maryland has made great strides in ensuring more Marylanders can access timely healthcare, we must ensure that consumers can financially afford to follow their physician's recommendations to attain their highest level of health.

SB 388 is consistent with Maryland's mission to promote the health of all Marylanders through access to care and community engagement. For these reasons, the Public Justice Center urges the committee to issue a **FAVORABLE** report for **SB 388** to provide relief to Marylanders who cannot afford rising prescription drug costs. If you have any questions about this testimony, please contact Ashley Woolard at 410-625-9409 ext. 224 or woolarda@publicjustice.org.

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_Support- SB 388- Prescription Drug Affordability

Uploaded by: Ashley Egan

Position: FAV

Testimony in Support SB 388 /HB 340 Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding (The Lowering Prescription Drug Costs For All Marylanders Now Act)

TO: Pamela Beidle, Chair, and Members of the Finance Committee
FROM: Ashley Egan, District 26
DATE: February 8, 2023

As a Unitarian Universalist, I believe in body autonomy. I believe in the sacred bond between a patient and their doctor. As a mother, I believe that my child deserves the best shot for a normal life. I worry about how she can chase her dreams, if she has to worry about paying for the medications that are, literally, keeping her alive. That is why I am asking you to support **SB 388 Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding.**

We need the Prescription Drug Board to have full authority to set upper payment limits for high cost drugs for all Marylanders, because drugs don't help people if they can't afford them. I learned this first-hand taking care of my oldest child who has epilepsy. She was fine if she was medicated, but every time she missed a dose, she had a seizure.

In 2019, we switched my daughter from a generic 12 hour medication (Trileptal) to a 24 hour dose of the same medication (Oxtellar). While it was basically the same drug, the 24-hour coating kept the amount of medicine in her system stable for longer. Plus, she had less missed doses which reduced her breakthrough seizures. However, due to the amount of medication she needed to be on she was having dizzy spells and eye twitches so being able to take her Oxtellar at bedtime reduced her discomfort and allowed her to function in the morning.

All of this changed last summer. After being strong-armed into the realm of mail-order medication, the company then decided that my daughter's medication was too expensive. They would cover other medications, but I had to get a Prior Authorization to keep her on Oxtellar. Then I had to get additional authorizations as my doctor adjusted her medication, since my daughter was actively having seizures and preparing to leave for college.

I understand, this medication cost my insurance over $2,000 dollars a month. Plus, she needs both 600 mg and 300 mg tablets to make up her nightly dose. Unfortunately, the insurance company counted this as two separate medications, so what should have been a simple manipulation in dosage, became a full-on negotiation. Unfortunately, their cost-saving measures in reaction to the skyrocketing costs of prescription drugs were in direct conflict with what my daughter needed to live.

Thankfully, we have been able to negotiate with the insurance company to keep her on her medication. But, last summer, when my child's epilepsy started acting up, I had to spend months negotiating with my daughter's doctor and her insurance to keep her medicated.
Having a Prescription Drug Affordability Board that could could look at options, negotiate prices, and set upper payment limits would have been incredibly helpful in helping my daughter get the medication she needed as soon as she needed it, because she can't wait because of costs.

SB0388-FIN-FAV-BMS.pdf
Uploaded by: Brandon Scott
Position: FAV

BRANDON M. SCOTT
MAYOR

Office of Government Relations
88 State Circle
Annapolis, Maryland 21401

SB0388

February 7, 2024

TO: Members of the Senate Finance Committee

FROM: Brandon M. Scott, Mayor of the City of Baltimore

RE: Senate Bill 388 – Prescription Drug Affordability Board -Authority for Upper Payment Limits and Funding
Lowering Prescription Drug Costs For All Marylanders Now Act

POSITION: FAVORABLE

Chair Beidle, Vice Chair Klausmeier, and Members of the Committee, please be advised that on the behalf of my Baltimore City Administration (BCA) and the Commission on Aging, Resources and Empowerment (CARE), I fully **support** Senate Bill (SB) 388.

SB 388 requires the Governor to appropriate money to support the Prescription Drug Affordability Board and enables the Board to set upper payment limits for prescription drugs that present an affordability challenge.

Members of the CARE are appointed by the Mayor and City Council to advise the City on issues of concern to older Baltimore City residents. The high cost of prescription drugs is an important issue for our Commission. Older adults in Baltimore City are more than twice as likely to live below the poverty line as their counterparts in other jurisdictions.[i] They are also significantly more likely to have a disability, including one that affects mobility, vision, or self-care.

High prescription prices compound these risk factors. Older City residents are often forced to choose between paying for food, housing, and their prescription costs. If an older patient is trying to manage a chronic medical condition, taking medications consistently is an important part of their treatment regimen. If patients fail to maintain prescription schedules because they cannot afford the drugs, they expose themselves to the possibility of acute care episodes, which in turn may increase health care costs through increased hospitalizations and emergency department utilization. This is especially true when high-cost specialty drugs are prescribed.

SB 388 empowers the Prescription Drug Affordability Board to begin to address the high cost of prescription drugs, which will help reduce a major challenge to the health and wellbeing of Baltimore City's older adults.

For the above reasons, I request a **favorable** report on SB 388.

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[i] US Census Bureau. (n.d.). QuickFacts Baltimore City, Maryland. Retrieved from https://www.census.gov/quickfacts/fact/table/baltimorecitymaryland/PST045222

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CE Ball 2024 - SB 388 Lowering Prescription Drug C
Uploaded by: Calvin Ball
Position: FAV

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February 7, 2024

Senator Pamela Beidle, Chair
Senate Finance Committee
Miller Senate Office Building, 3 East
Annapolis, Maryland 21401

Re: **TESTIMONY OF SUPPORT**: SB 388: Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs for All Marylanders Act of 2024)

Dear Chair Beidle, Vice Chair Klausmeier, and Members of the Committee,

I commend Senator Gile for sponsoring Senate Bill 388 which would lower prescription drug costs for all Marylanders. Now, more than ever with rising prescription drug prices, we must work together to guarantee that all Marylanders can affordably access their needed prescriptions.

The Prescription Drug Affordability Board was established in 2019 and was the first in the nation to control soaring drug costs to make prescriptions more affordable for all Marylanders. Currently, the Board only has authority to negotiate prices for county and state government employees. However, recent poll results tell us that 45% of our residents are struggling to pay for their prescription drugs. The Prescription Drug Affordability Board needs broader authority to help lower prescription drug costs for *all* Maryland residents.

In Howard County, the health and wellbeing of our residents is a shared priority and commitment. In 2021, we were only one of four counties in the nation awarded with the prestigious Robert Wood Johnson Foundation 'Culture of Health Prize.' In addition, we have been ranked among the Top 10 Healthiest Counties in the nation according to rankings by U.S. News & World Report. In the most recent Open Enrollment season, we worked hard to help ensure a notable 14 percent increase in the number of Howard County residents who enrolled in health insurance. This significant uptick serves as a clear indicator that our residents prioritize their well-being.

Marylanders should not be forced to choose between paying for their medication or paying for other necessities like feeding their families or paying for housing. We are a model and a leader in the nation on showcasing our commitment to the health of Marylanders. While we have made great strides in building a strong and healthy community, we must do better because prescription drugs don't work if residents can't afford them. I welcome your support and urge a favorable report on Senate Bill 388.

All the Best,

Calvin Ball
Howard County Executive

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MLU written testimony - HB 388 - Perscription Drug

Uploaded by: Carlos Orbe, Jr.

Position: FAV

February 6, 2024

Position: SUPPORT
HB 388 - Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs for All Marylanders Act of 2024)
Finance Committee:

I am writing on behalf of Maryland Latinos Unidos (MLU), a dedicated network of organizations, businesses, and individuals working tirelessly to support and advocate for the Latino and immigrant communities across Maryland. Our mission is to address the disparities and inequities faced by these communities and to champion equity, justice, and access to essential resources, including healthcare.

We are writing to express our enthusiastic support for the Prescription Drug Affordability Board – Authority for Upper Payment Limits and Funding bill, also known as the "Lowering Prescription Drug Costs for All Marylanders Act of 2024." This bill, currently before your legislative body, represents a vital step in addressing the pressing issue of rising prescription drug costs and ensuring that all Marylanders, regardless of their background or economic status, have access to affordable prescription medications.

Here are the key reasons why we believe this bill is crucial for the Latino communities in our state and for the well-being of all Maryland residents:

Affordable Healthcare Access: Access to affordable healthcare, including essential prescription medications, is a fundamental human right. The rising costs of prescription drugs have placed a significant burden on many Latino families, making it challenging to maintain their health and well-being. This bill takes proactive steps to alleviate this burden and ensure that healthcare remains accessible.

Empowering the Prescription Drug Affordability Board: The bill grants the Prescription Drug Affordability Board the authority to establish upper payment limits for prescription drug products that are causing or will cause affordability challenges. This empowerment allows for swift and effective action to protect the interests of Marylanders, particularly those in the Latino community who may be disproportionately affected.

Equitable Funding Mechanism: The bill introduces a fair and equitable funding mechanism by assessing annual fees on manufacturers, pharmacy benefits managers, carriers, and wholesale

distributors. This funding ensures that the Prescription Drug Affordability Board has the necessary resources to carry out its mission effectively.

Prescription Drug Affordability Fund: The establishment of the Prescription Drug Affordability Fund ensures transparency and accountability in managing the collected fees, assuring Maryland residents that these funds will be exclusively used to support the goals outlined in this legislation.

Legislative Commitment: By appropriating a minimum of $1,000,000 annually for the Fund, the Maryland General Assembly demonstrates its unwavering commitment to making healthcare accessible and affordable for all residents, irrespective of their socio-economic backgrounds.

In conclusion, the Prescription Drug Affordability Board Bill is a critical piece of legislation that aligns with the values and objectives of Maryland Latinos Unidos. We believe it represents a significant stride toward achieving healthcare equity and justice in our state. We respectfully urge you to support and authorize this bill for the betterment of our communities and the state as a whole.

Thank you for your attention to this important matter, and we look forward to witnessing the positive impact that this legislation will have on the lives of Maryland residents.

Respectfully,
Carlos Orbe, Jr.
Communications and Public Affairs Specialist
Maryland Latinos Unidos

SB0388_Lowering_Prescription_Drug_Costs_For_All_Ma
Uploaded by: Cecilia Plante
Position: FAV

TESTIMONY FOR SB0388
The Lowering Prescription Drug Costs for All Marylanders Now Act

Bill Sponsor: Senators Gile, Feldman, Beidle, Ellis, Guzzone, Hester, Hettleman, Jackson, Klausmeier, Kramer, and Lam
Committee: Finance
Organization Submitting: Maryland Legislative Coalition
Person Submitting: Aileen Alex, co-chair
Position: FAVORABLE

I am submitting this testimony in favor of SB0388 on behalf of the Maryland Legislative Coalition. The Maryland Legislative Coalition is an association of activists - individuals and grassroots groups in every district in the state. We are unpaid citizen lobbyists, and our Coalition supports well over 30,000 members.

The cost of prescription drugs for the citizens of Maryland is so completely out of control. Our members were happy to see Maryland create a first in the nation Prescription Drug Affordability Board. It was a bold step forward to stabilize prescription drug costs and keep the drug companies and insurance companies from gouging families across the state as they struggle to afford medications that they rely on to stay healthy and productive.

It has been several years since the Board was established, but due to the shortsightedness of the previous Governor, it had been languishing without full funding and without a complete roster of board members. Last year, those problems were corrected.

Now we need legislation to expand the authority of the Prescription Drug Affordability Board. SB0388 would allow the five-member board to use upper payment limits to make high-cost medications more affordable for all Marylanders — not just those who work for state and local governments.

Marylanders have no use for drugs that are too expensive. Almost all of our Coalition members struggle with high drug prices. They can't afford the copays. They can't afford to take medications that they need because those medications are priced out of reach. We want to see the Board fulfill its promise to all Marylanders and we need the legislature to expand their mandate.

We support this bill and recommend a **FAVORABLE** report in committee.

CE Ball 2024 - SB 388 Lowering Prescription Drug C

Uploaded by: County Executive Calvin Ball
Position: FAV

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February 7, 2024

Senator Pamela Beidle, Chair
Senate Finance Committee
Miller Senate Office Building, 3 East
Annapolis, Maryland 21401

Re: **TESTIMONY OF SUPPORT**: SB 388: Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs for All Marylanders Act of 2024)

Dear Chair Beidle, Vice Chair Klausmeier, and Members of the Committee,

I commend Senator Gile for sponsoring Senate Bill 388 which would lower prescription drug costs for all Marylanders. Now, more than ever with rising prescription drug prices, we must work together to guarantee that all Marylanders can affordably access their needed prescriptions.

The Prescription Drug Affordability Board was established in 2019 and was the first in the nation to control soaring drug costs to make prescriptions more affordable for all Marylanders. Currently, the Board only has authority to negotiate prices for county and state government employees. However, recent poll results tell us that 45% of our residents are struggling to pay for their prescription drugs. The Prescription Drug Affordability Board needs broader authority to help lower prescription drug costs for *all* Maryland residents.

In Howard County, the health and wellbeing of our residents is a shared priority and commitment. In 2021, we were only one of four counties in the nation awarded with the prestigious Robert Wood Johnson Foundation 'Culture of Health Prize.' In addition, we have been ranked among the Top 10 Healthiest Counties in the nation according to rankings by U.S. News & World Report. In the most recent Open Enrollment season, we worked hard to help ensure a notable 14 percent increase in the number of Howard County residents who enrolled in health insurance. This significant uptick serves as a clear indicator that our residents prioritize their well-being.

Marylanders should not be forced to choose between paying for their medication or paying for other necessities like feeding their families or paying for housing. We are a model and a leader in the nation on showcasing our commitment to the health of Marylanders. While we have made great strides in building a strong and healthy community, we must do better because prescription drugs don't work if residents can't afford them. I welcome your support and urge a favorable report on Senate Bill 388.

All the Best,

Calvin Ball
Howard County Executive

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SB388_ Written Testimony by U.S. Senator Chris Van

Uploaded by: Hanna Vohra

Position: FAV

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United States Senate

APPROPRIATIONS

BANKING, HOUSING, AND URBAN AFFAIRS

BUDGET

FOREIGN RELATIONS

February 6, 2024

Honorable Pamela Beidle
Chair
Finance Committee
3 East
Miller Senate Office Building
Annapolis, Maryland 21401

Honorable Katherine Klausmeier
Vice Chair
Finance Committee
3 East
Miller Senate Office Building
Annapolis, Maryland 21401

Dear Chair Beidle and Vice Chair Klausmeier:

I write to share my support for Senate Bill 388, the Lowering Prescription Drug Costs for All Marylanders Act of 2024, and I thank Senators Gile, Feldman, Beidle, Ellis, Guzzone, Hester, Hettleman, Jackson, Klausmeier, Kramer, and Lam for leading this effort. I appreciate the opportunity to advocate on behalf of my constituents in Maryland and request that this written testimony be included in the record.

According to public surveys recently conducted by the Kaiser Family Foundation (KFF), 82% of respondents indicated that the cost of prescription drugs in the U.S. are unreasonable, over 30% of adults reported not taking their medications as prescribed in the last year because of cost, and individuals with an annual household income of less than $40,000 and those taking four or more prescription medications reported greater affordability challenges.[1]

I commend the State of Maryland's leadership in taking the first step to address affordability challenges and the increasingly high costs of prescription drugs for Marylanders by passing the nation's first state prescription drug affordability board in 2019 (PDAB).[2]

I am proud to have worked with President Biden and colleagues in the Senate and House to enact the Inflation Reduction Act of 2022, which continues to lower out-of-pocket health care and prescription

[1] Kaiser Family Foundation (KFF), "Public Opinion on Prescription Drugs and Their Prices," https://www.kff.org/health-costs/poll-finding/public-opinion-on-prescription-drugs-and-their-prices/.
[2] Maryland General Assembly (MGA) Health and Government Operations/Finance, "Health Prescription Drug Affordability Board," https://mgaleg.maryland.gov/2019RS/bills/hb/hb0768e.pdf.

drug costs for Marylanders.[3] I am also proud to have introduced the We Protect American Investment in Drugs Act (We PAID Act) in the 116th Congress, which would establish an independent drug affordability and access committee to ensure prescription drug prices are set at reasonable levels for all Americans.[4]

I strongly urge the Maryland General Assembly to continue to serve as an example at the state level to ensure that all Marylanders and families have equitable and affordable access to the prescription drug medications that they need. I also look forward to reintroducing the We PAID Act in the 118th Congress to address prescription drug prices nationally.

I support the passage of SB 388 and request the Committee give it full consideration.

Sincerely,

Chris Van Hollen
United States Senate

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[3] In 2024, the IRA reduces premiums by hundreds of dollars per person, on average, for approximately 153,000 Marylanders, caps out-of-pocket costs for insulin at $35 per month for Medicare Part B and Part D beneficiaries for nearly 21,000 Marylanders, and eliminates Medicare Part D vaccine cost-sharing requirements for more than 55,900 Marylanders. United States Senate Special Committee on Aging, "Inflation Reduction Act: Lowering Rx Costs: How Maryland Benefits," https://www.aging.senate.gov/imo/media/doc/Maryland%20IRA%20Implementation.pdf.

[4] Congress.gov, "S. 2387 – We Protect American Investment in Drugs Act," https://www.congress.gov/bill/116th-congress/senate-bill/2387/text?s=7&r=1&q=%7B%22search%22%3A%22we++protect+american+investment+in+drugs+act%22%7D.

SB 388 -SUPP - FIN - Feb 7 - Prescription Drug Aff

Uploaded by: Henry Bogdan

Position: FAV

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Phone: 410 - 727 - 6367 | 800 - 273 - 6367 | Fax: 410 - 235 - 2190

February 7, 2024

Testimony on Senate Bill 388
Lowering Prescription Drug Costs for All Marylanders Act of 2024
Senate Finance Committee

Position: Favorable

With our nearly 2,000 members, Maryland Nonprofits as the only association advocating for the 40,000 nonprofit organizations in Maryland, strongly supports Senate Bill 388, the Lowering Prescription Drug Costs for All Marylanders Act of 2024, that promises transformative change in Maryland's healthcare landscape.

According to the latest Bureau of Labor Statistics research, nonprofit organizations in Maryland employ nearly 13% of all non-governmental workers in our state. The 2021 Maryland Nonprofits Salary and Benefits Survey revealed:

- Approximately 65% of nonprofits offer health insurance to their employees
- 23% of nonprofits offering health insurance to employees cover 100% of insurance costs
- 47% of nonprofits extend coverage to their employees' families

Maryland's nonprofit sector is dedicated to providing quality healthcare benefits as part of their employee compensation packages. However, the relentless and unpredictable ascent of prescription drug costs has cast a long shadow over our financial stability through rising health insurance premiums. Escalating drug expenses compel nonprofits to allocate an ever-growing portion of our budgets to cover healthcare costs, offer competitive benefits and safeguard the well-being of our committed workforce. This, in turn, diminishes the resources available for our core missions and other critical programs that serve our communities.

The impact of this legislation extends far beyond the balance sheets of nonprofit organizations. At the heart of this issue lies the well-being of nonprofit employees—the tireless champions of their organizations' missions. Affordable access to prescription medications is not a mere luxury; it is a fundamental pillar supporting the health and well-being of these dedicated individuals. When prescription drug costs soar, nonprofit employees often find themselves grappling with the daunting challenge of affording necessary medications. This financial strain not only jeopardizes their health but also gives rise to increased absenteeism and decreased productivity, ultimately affecting the nonprofit's operations and its ability to fulfill its mission effectively.

The Lowering Prescription Drug Costs for All Marylanders Act of 2024 offers a promising solution by empowering the Prescription Drug Affordability Board to establish upper payment limits for all Marylanders on prescription drugs that are deemed unaffordable, taking into account various associated

costs. It also addresses funding mechanisms for the Board and modifies relevant sections of Maryland's Annotated Code to support these efforts. Importantly, the bill exempts drugs listed on the FDA's shortage list from these limits to prevent potential shortages. To ensure accountability and approval, the implementation of these upper payment limits requires the support of key stakeholders, including the Legislative Policy Committee, the Governor, and the Attorney General. Additionally, the bill proposes a new framework for levying annual fees on entities in the drug supply chain, with the generated revenues contributing to the Prescription Drug Affordability Fund.

Senate Bill 388 holds the potential to bring transformative change to Maryland's healthcare landscape, offering essential relief to nonprofit employers, employees, and all residents facing the burden of high prescription drug costs. By supporting this legislation, we can collectively work towards a healthier, more equitable future for all Marylanders.

We urge a favorable report on Senate Bill 388.

SB388_MdPHA.pdf
Uploaded by: Ilona Kabara
Position: FAV

Mission: *To improve public health in Maryland through education and advocacy* ***Vision:*** *Healthy Marylanders living in Healthy Communities*

TESTIMONY IN SUPPORT OF SENATE BILL 388
Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding
(Lowering Prescription Drug Costs for All Marylanders Act of 2024)
Before the Senate Finance Committee
By: Maryland Public Health Association (MdPHA)
February 7, 2024

Chair Beidle, Vice-Chair Klausmeier, and Members of the Finance Committee, thank you for this opportunity to testify in favor of SB 388, which would give the Prescription Drug Affordability Board the authority to set upper payment limits to make high-cost drugs affordable for ALL Marylanders. Special thank you to Senator Gile and Senator Feldman for sponsoring this life-saving legislation.

It is a major public health issue when patients cannot afford their medications. Recent polling shows as many as 45% of Marylanders report struggling to afford the medicines they need, with one third of Marylanders skipping a dose or rationing medication due to cost. At the same time, skyrocketing drug costs are contributing to all of our health insurance premiums, making quality coverage less affordable for our residents. Meanwhile, prescription drug corporations use far more resources on self-enrichment and advertising than they do on research and development. Marylanders should not have to choose between their prescription drugs and other necessities like housing or food.

We strongly urge you to give a favorable report to SB 388.

The Maryland Public Health Association (MdPHA) is a nonprofit, statewide organization of public health professionals dedicated to improving the lives of all Marylanders through education, advocacy, and collaboration. We support public policies consistent with our vision of healthy Marylanders living in healthy, equitable, communities. MdPHA is the state affiliate of the American Public Health Association, a nearly 145-year-old professional organization dedicated to improving population health and reducing the health disparities that plague our state and our nation.

Maryland Public Health Association (MdPHA)
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SB 388 PDAB_Authority for Upper Payment Limits and

Uploaded by: James Gutman

Position: FAV

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SB 388 Prescription Drug Affordability Board – Authority for Upper Payment Limits and Funding (Lowering Prescription Costs for All Marylanders Act of 2024)
Senate Finance Committee
FAVORABLE
February 7, 2024

Good afternoon, Chair Beidle and members of the Senate Finance Committee. I am Jim Gutman, a Columbia resident and lead health care advocacy volunteer for AARP Maryland. I'm also a member of the Stakeholder Council of the Maryland Prescription Drug Affordability Board (PDAB). Today I'm here representing AARP Maryland and its over 850,000 members in the state in supporting SB 388, which will enable the PDAB to take its needed next step toward lowering prescription drug prices for all Maryland residents. AARP thanks Senators Gile and Feldman for introducing this key legislation.

The PDAB, by any yardstick, has done an outstanding job since it came into being following pioneer legislation enacted by the Maryland General Assembly in 2019. The board has painstakingly built, with input from all parties and via skillful management of its modest budget, the infrastructure and procedures by which it will begin this year putting Upper Payment Limits (UPLs) on what state and local government bodies will pay for some important prescription drugs. The results of these measures will be significant and much-needed savings for those government entities.

So now is the right time to authorize the expansion of the PDAB's mission to include all residents of Maryland. This is a step that was contemplated in the original statute, which I testified for, as well as one strongly supported by AARP Maryland since last summer for passage this session. It also is a step that several other states, which modeled their drug price boards on Maryland's first-in-the-nation PDAB, already have authorized.

This step is needed in Maryland because, despite the new federal law that could bring much-needed relief on a few drugs for Medicare recipients starting in 2026, prices still are rising at a high rate on many vital drugs used by AARP Maryland's constituency of residents aged 50 and above. Pharmaceutical manufacturers remain in strong financial shape, as shown by how much they can spend on marketing and advertising to boost market demand for their products.

It is vital to note that SB 388 retains the key role of the General Assembly's Legislative Policy Committee in overseeing PDAB's expansion. Moreover, UPLs could be suspended or altered under the Maryland legislation if a drug gets on the FDA's shortage list, so the availability of key Rx drugs for state residents should not be an issue.

Importantly, the determination of whether to seek UPLs under this legislation for all purchases and payer reimbursements would depend on the PDAB first finding "an affordability challenge" for the drugs involved. This finding would be backed by data, when such data become available, of the savings beginning to accrue to government purchasers in Maryland from the UPLs for the drugs already put under price-payment caps adopted by the PDAB.

Moreover, the expansion to all purchasers could not occur until at least Oct. 1 and is likely to be later so that the evidence on initial results is clear. The PDAB, in making a decision to seek to expand UPLs to all purchases in the state, would need under the legislation to consider any available data on the savings results of its initial UPLs for government entities. Also, the PDAB's multi-constituency Stakeholder Council, on which I'm proud to serve, would be directly involved in the whole process.

Equally significant, this legislation would give the PDAB, which has achieved so much with just a very small staff and budget, an annual appropriation of at least $1 million that it so clearly needs to fund the vital new work that the bill authorizes as well as its current work. The PDAB has shown itself to have sound financial management and already has repaid ahead of schedule all the money it needed to borrow from the Maryland Health Care Commission to fund its successful launch. The new funds would be certain to be used wisely as well. Any funds left over would revert to the state's general fund.

Maryland consumers are suffering, even more than when the PDAB law was enacted, by soaring costs, which they can't afford, or prescription drugs that are vital for their health. This state, an acknowledged leader in bringing a responsible regulatory regimen to dealing with this impossible life-threatening situation, has an opportunity to craft another responsible step that will bring much-needed relief on unwarranted Rx drug costs. And Maryland can do this via the PDAB, which has shown itself to be a knowledgeable, hard-working and fair-handed steward of the vital price-relief efforts. For all those reasons AARP-Maryland and I urge you to give SB 388 a favorable report. If you have questions or need follow-up, please contact Tammy Bresnahan at tbresnahan@aarp.org or by calling 410-302-8451. Thanks very much.

SB388_JaneHorvath_FAV
Uploaded by: Jane Horvath
Position: FAV

Testimony in Support of Senate Bill 388

Prescription Drug Affordability Board – Authority for Upper Payment Limits and Funding

Lowering Prescription Drug Costs for All Marylanders Act of 2024

Madam Chair, Vice Chair Klausmeier, and members of the Senate Finance Committee, thank you for the opportunity to discuss SB 388 that would give our Prescription Drug Affordability Board authority to set payment rates on what all Maryland consumers will pay for certain high-cost drugs.

Maryland has been a leader and innovator when it comes to healthcare access, thanks in large part to the vision of members of this Committee past and present. A statewide payment rate will address many of the most anti-consumer market behaviors in drug coverage and payment for drugs for which an upper payment limit is created. Statewide prescription drug rate setting is akin to our leadership in statewide all-payer hospital rate setting that began many years ago. We need your leadership to build on the Prescription Drug Affordability Board's set of problem-solving tools and leadership to bring more drug cost relief to more people.

There is a great deal of market dysfunction created in response to rising manufacturer drug prices. The level of dysfunction is so significant and harmful to consumers that is hard to know where to begin. States are hobbled by federal statutes and case law that make protecting residents even more complex to solve. Statewide prescription drug rate setting can improve residents' access to more affordable medicines while addressing much of the dysfunction in our current market system.

By way of background, I have worked on prescription drug access and cost containment for many years. I represented the Medicaid Directors when the Medicaid drug rebate program was created. At the US Senate Finance Committee, I designed the Vaccines for Children Program. I spent over a decade working in the pharmaceutical industry and was an industry point person working with Centers for Medicaid and Medicare Services to implement the Medicare Part D program. Currently I consult with many state lawmakers, executive branch officials, and advocacy organizations on prescription drug cost containment policy across the country. Much of this work is funded by foundations. I am also a board member of the Prescription Justice Institute.

I want to start with some data points which explain concern about high US drug costs.

1) The average launch price of new chronic illness medicines jumped from $2115 in 2017 to $180000 in 2021[i]
2) The average launch price of new cancer medicines rose 53% since 2017 to $283000 in 2022.[ii]
3) The median launch price for all new medicines (chronic illness, rare disease, cancer) was $257,000 in 2022.[iii]
4) Net (after rebates) prescription drug costs consume 23 percent of our healthcare premiums,[iv] which slightly exceeds the proportion spent on inpatient hospital services.
5) State taxes support some or all the pharmacy benefits for as many as 25-40 percent of residents depending on the state.

Pharmaceutical costs and pricing are complex issues that touch almost all of us. We all need to understand more about the pharmaceutical marketplace to identify the multiple problems and the policies most able to help individual consumers and the healthcare system afford appropriate access to medicines for all of us.

I want to briefly discuss the array of dysfunction in today's market to level-set on the scope of the problems so we can consider policy approaches appropriate to the problems of the current market.

Drug Makers:

Move from large population diseases to small population disease treatments

- Small population illness treatments ensure greater ability to price and decreased insurer ability to manage costs.
- Rare and small population diseases affect up to 15% of the population even though a rare disease is defined as affecting less than 200,000 people.
- Rare and small population disease markets grow over time – people live longer and take medications throughout their lives precisely because of scientific advances that produce great treatments. The treatments are somatic and do not affect the prevalence of the disease in the population which means these small population markets grow over time owing to the effectiveness of treatments. Cystic Fibrosis is a wonderful example; people with CF used to die in childhood and today survive well into adulthood due to new medicines that must be taken throughout life.[v] Another way rare disease drugs expand market size is treating additional diseases. For example, the number one selling drug in the world until 2023, Humira, started as a rare disease drug. Keytruda, expected soon to be the top-selling drug, started as a rare disease drug. As the treatment portfolio expands, so does the market size. Then there is Trikafta, which treats only Cystic Fibrosis and is the third highest revenue drug in the world. There is much less financial risk in the small disease market than we are generally led to believe as this report describes.

Industry revenue comes from pricing rather than sales volume

- Congress and others have documented that launch price and price increases are used to meet Wall Street expectations –even at the expense of sales and patient access.

Costs to bring drugs to market have declined but prices still skyrocket[vi]

- Costs of R&D have lowered in recent years ($2.7B/drug in 2015, $2B/drug in 2022).
- R&D success rate is higher (10/100 Rx made it to market in 2015, 12/100 Rx make it to market today)
- These positive changes are due to new efficiencies in R&D and new laws that allow faster licensing of rare disease/high unmet need products. All these laws and efficiencies reduce financial risk for companies.
- The costs and risks to bring a rare disease drug are less than drugs for large population illnesses.

Patent thickets

- Companies return repeatedly to the patent office with new, minor modifications to a drug to extend their patent protections and fend off generic or biosimilar competition.
- A 'normal' patent life is 7 to 10 years after a drug comes to market. A patent is 20 years in total but many of those years are used up in the pre-approval research years. Humira had 23 years of patent protection after it came to market by creating a patent thicket. Humira is not unusual, as these charts document.

Pharmacy Benefit Managers:

Do not disclose their business practices to their clients (employers, Medicaid, commercial insurers)

- Ten state Attorneys General investigated Centene Medicaid business practices, ten high-cost settlements.

Rebates are king

- As an industry, PBMs collectively now exclude over 1,000 unique medicines from their formularies, often because of product cost and insufficient rebates. This recent article provides an excellent overview of PBM market strategies relative to formulary exclusions.

- PBMs often refuse to cover lower cost therapeutics (including biosimilars and generics) in a class when there are higher priced, higher rebate innovator products available.
    - Because of this PBM practice, drug manufacturers increasingly launch one product at TWO market prices – a higher price for PBMs/insurers that will not accept lower priced versions of products (with less rebate) and a lower price version either for people without insurance or for insurers/PBMs that will accept the lower cost without large rebates. It is the same product with different national drug code (NDC) identifier.
- Patient cost sharing is based on the list price rather than the net, rebated cost.
- PBMs guarantee health plans a set reduction in total Rx spend (for instance, 19%) after rebates but PBMs do not guarantee efforts to reduce or manage *total spend* before rebates. Clients are often misinformed about the misaligned incentives of their PBM vendors.
- PBMs say they pass 100% of manufacturer rebates back to health plans but there is no way to verify that all rebates received that move through PBM-affiliated entities are reported to payers. Payers likely do not know if there are multiple PBM-affiliated entities managing the rebates – some of which are outside the US.

Industry-wide Vertical Integration:

Corporate linkages operate to the detriment of consumers

- National insurers are corporately linked to national PBMs, national retail pharmacy chains, national specialty pharmacy services, and mail order services. This graphic says it all.
- Alignment is organized to maximize rebate revenue and deny patient access to lower priced generics and biosimilars (CVS whistleblower lawsuit). A more recent investigation by the *Wall Street Journal* demonstrates that this behavior is fairly widespread in the larger corporations.

Hospitals and Medical Specialists:

Significant profit on administered and dispensed drugs

- Profits as a percentage of price means higher priced products produce higher profits.
- Hospitals and medical specialists in many states too often oppose efforts to constrain Rx costs without disclosing their financial interest in maintaining high prices.
- There is also the federal 340B program, where thousands of hospital and community clinics that serve insured and uninsured people buy drugs at very deep discounts not available in the market. They then bill insurers at market price and make a profit on the difference. Many of these entities will charge on a sliding scale for uninsured people, but not all do this. 340B program entities, notably hospitals, oppose drug cost containment as a threat to their revenue stream. For reference, there are about 625[1] participating hospital outpatient clinics (oncology, rheumatology, orthopedics, etc.), and many more general practice, stand-alone community clinics. These entities view drug cost containment as a significant threat to their revenue.

Pharma-Funded Patient Groups

Groups created by/supported by industry reliably oppose efforts to reduce drug costs

[1] This data is calculated from the 340B website of the Health Resources and Services Administration as of 1/25/2024. It is the sum of enrolled clinics of eligible, participating Virginia hospitals. This link can be used to calculate other types of 340B program entities in Virginia.

- Patient groups that support patient access and affordability are few in number. Notably Multiple Sclerosis Society, Leukemia/Lymphoma Society, National Alliance for the Mentally Ill have supported prescription drug rate setting (or upper payment limits) bills in different states.
- Most other groups are neutral or oppositional, and echo pharma threats that industry will hold patients hostage in retaliation for lowering patient costs, even though lowering costs would improve the manufacturer's access to the market for the drug.

Bench Science Institutions:

Universities do basic research and patent promising molecules they develop

- Universities sell or lease their patents to pharma companies which then conduct the go-to-market research and development (human clinical trials).
- Patent price or royalty payments back to the research entity are based on potential for the in-market drug price and revenue. Higher market price yields higher revenues back to the research institution.
- Some universities and research hospital systems have opposed drug cost reduction as a threat to their revenues.

Wholesale Acquisition Cost/Retail Price Subscription Services:

'Pricing services/pricing files' receive manufacturer list price and price increase information.

Pricing services sell subscriptions for launch prices and drug price changes to insurers, researchers, prescription drug affordability boards, state Rx price transparency offices and many others.

- Subscribers cannot reveal the wholesale acquisition cost (WAC) information provided under the subscription even though many state Rx transparency laws require WAC reporting for some drugs, which is then made public.
- In the US, the wholesale price is synonymous with list price (price before price concessions)
- Is there another industry where a product list price is a proprietary secret – and where the entity making list price proprietary does not own the product or control the list price? It seems like it is secret simply for the purpose of pricing file company's profit model. The model puts everyday consumers increasingly in the dark. It would be interesting to know how common this business model may be in other US industries. Imagine if the MSRP for new cars was a secret, accessible only through a service that sold you the information? It seems like this might be the cornerstone of market opacity that harms consumers.

This quick run-down hopefully clarifies a bit why it is so hard to reform the pharmaceutical market in the US. All these business models are built to make money off drug prices. The only market participant without a profit-making business model is the consumer – the consumer who pays dearly for this dysfunction. In this context, the consumer is collateral damage.

All this dysfunction started with rising prices -- when industry realized it had vast ability to price. However, the system no longer even works for manufacturers and they have legitimate gripes about PBMs and 340B business practices. The industry solutions to parts of the dysfunction are too self-serving – intended to put them back in the driver's seat and reset their ability call all the shots on price and access.

In my view, there are a few essential policy elements that can unwind our dysfunctional pharmaceutical marketplace to better serve patients, the healthcare system, and even manufacturers.

1. One essential element is transparency of list price and the average of manufacturer price concessions. Our current system is built on secrecy that allows anti-consumer, anti-competitive behavior to thrive.
2. Another essential element is for transparent prices to move through the supply chain to the point of service – to the consumer.
3. The final essential element is rate setting. The pharmaceutical marketplace cannot change without public policy and public rate setting to establish what consumers will pay for certain high-cost products. With transparent, statewide, all payer, all purchaser rate setting for certain drugs, an upper payment limit (UPL) will move through the supply chain to the consumer at the point of service. People and market participants can pay less, but they cannot pay more.
    - I think of statewide rate setting as a market reset for some high-cost drugs. Upper payment limits (UPLs) are just another type of payment rate which is ubiquitous in US healthcare. No one pays what they are charged. Statewide rate setting for certain high-cost medicines could and should still allow the whole supply chain to continue to make a margin on a drug, but the UPL is where the price concessions start. If a market player can make a better deal than the upper payment limit and improve their profit margin, that is fine but the deal making is not at the consumer's expense. An upper payment limit should be set to reduce the need for rebates since the on-invoice price for suppliers, providers, and insurers will be lower than the previous market price.

The statewide, all-payer, all-purchaser UPL model has been around since 2017. In fact, the new Medicare price negotiation program is very similar to the model in key features. The Medicare-manufacturer negotiation begins with a federally calculated ceiling price – based in part on the price concessions in the Medicare market. The final Medicare 'Maximum Fair Price" must, under federal law, be delivered to the consumer at the point of service. This is how a state upper payment limit will work except it will be less administratively burdensome than the Medicare process for a variety of operational reasons.

The Medicare maximum fair price program is a great start but there will still be a need for complementary state action. Medicare will only look at drugs without biosimilar or generic competition – products that are monopolies owing to excessive use of patents or data exclusivities the stymie competition and there is reason to believe that manufacturers will find ways to create competition that meets the letter of the law but not the spirit of the law. We might start to see business practices that evade negotiation for orphan and other products and maintain very high prices. I believe there will be plenty of need for additional state efforts to wrap around the nascent federal effort.

There are few, if any, policies that create all three necessary conditions mentioned above to lower costs for consumers at the point of service while avoiding new distortions in a dysfunctional market. A well-functioning affordability policy can and should solve the manufacturers' big complaints – that their hefty rebates and patient assistance do not always help individual consumers and that patient out of pocket costs are too high. Unfortunately, the industry solutions to their problems are inadequate because solutions would only increase health system costs while lowering patient out of pocket costs. Therefore, better, smarter, approaches are needed.

There are few policies which can effectively improve patient access to treatment and manufacturer access to the market. The intent of UPL is to generate more sales and more patient access. There is no intent to harm manufacturers.

I hope this Committee and the legislature in general will give the Board authority to move forward to help all Marylanders, not just state and local governments and their employees.

I appreciate the opportunity to provide this information and I am happy to talk in more detail about these issues.

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[i] https://www.bloomberg.com/news/articles/2022-06-07/new-drug-prices-soar-to-180-000-a-year-on-20-annual-inflation?leadSource=uverify%20wall;

[ii] https://www.usnews.com/news/top-news/articles/2022-11-02/new-u-s-cancer-drug-prices-rise-53-in-five-years-report

[iii] https://www.reuters.com/business/healthcare-pharmaceuticals/newly-launched-us-drugs-head-toward-record-high-prices-2022-2022-08-15/

[iv] https://www.ahip.org/your-health-care-dollar-new-ahip-analysis-shows-where-it-goes/, accessed 3/15/21

[v] The CF Foundation 2021 annual report highlights the success of CF treatments. In 1991 adults were 32% of the population of people living with CF; in 2021 adults were 58% of the CF patient population. The median life expectancy of people with CF born between 2017 and 2021 is 53 years. Half of people with CF born between 2017 and 2021 are expected to live longer than 53 years.

[vi] This is a comparison of a 2017 JAMA article where researchers tried to validate industry R&D claims with 2015 data to a 2023 commentary opposing MN PDAB legislation which provided included updated (lower) R&D costs and (higher) rates of R&D success. This shows what we would expect – that new, faster FDA product approval pathways together with new R&D technologies and efficiencies had precisely the desired effect – more products on the market with lower manufacturer development costs. The change in costs and success rates in a relatively short period of time is notable. The fact that these lower costs apply to small population products is noteworthy relative to industry claims that they need excessive pricing for small population products because of R&D and development failures. See also the link to Orphan Drug paper earlier in this testimony.

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Position: FAV

MARYLAND LEGISLATIVE LATINO CAUCUS

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TO: Senator Pamela Beidle, Chair
Senator Katherine Klausmeier, Vice Chair
Finance Committee Members
FROM: Maryland Legislative Latino Caucus
DATE: 2/14/24
RE: SB388 - Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding

The MLLC supports SB388 - Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding, 2024

The MLLC is a bipartisan group of Senators and Delegates committed to supporting legislation that improves the lives of Latinos throughout our state. The MLLC is a crucial voice in the development of public policy that uplifts the Latino community and benefits the state of Maryland. Thank you for allowing us the opportunity to express our support of SB388.

According to the 2023 Prescription Drug Affordability Board report, prescription drug prices are rising at a national level, often quicker than the rate of inflation.[1] A 2022 survey revealed that, on average, 49 percent of Maryland adults felt worried about the cost of prescription drugs, though the percentage increased to 62 percent for adults earning less than $50,000 a year.[2] When looking at the Latino community, the survey showed that 16 percent of adults cut pills in half or skipped a dose, and 15 percent did not fill a prescription.[3] Nationwide, according to a report by the US Centers for Disease Control and Prevention, 9.7 percent of Latinos did not take prescribed medication due to the cost.[4] In addition, Latino adults ages 65 and over have difficulty affording prescription drugs at rates 1.5 to 2 times higher than White adults.[5]

SB388 will require the Prescription Drug Affordability Board, in consultation with the Stakeholder Council, to determine whether to establish a process or setting upper payment limits for all purchases and payor reimbursements of prescription drug products if affordability challenges might arise. The upper payment limits will be in accordance with Article – Health – General § 21–2C–14(A). When making a determination, the Board will consider, if available, contract and budget data that shows the savings to the state or local governments as a result of the upper payment limits.

For these reasons, the Maryland Legislative Latino Caucus respectfully requests a favorable report on SB388.

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[1] Md. Board Hopes to Identify First Round of Prescription Drugs for Price Evaluations in 2024
[2] Maryland Residents Worried about High Drug Costs; Support a Range of Government Solutions
[3] Ibid.
[4] Latino Adults More Likely Than Others to Skip Medication Due to Cost
[5] Inflation Reduction Act Research Series— Projected Impacts for Latino Medicare Enrollees

BaltimoreCounty_FAV_SB0388.pdf
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Position: FAV

JOHN A. OLSZEWSKI, JR.
County Executive

JENNIFER AIOSA
Director of Government Affairs

AMANDA KONTZ CARR
Legislative Officer

WILLIAM J. THORNE
Legislative Associate

BILL NO.: **SB 388**

TITLE: Prescription Drug Affordability Board – Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs For All Marylanders Now Act)

SPONSOR: Senator Gile

COMMITTEE: Finance

POSITION: **SUPPORT**

DATE: February 7, 2024

Baltimore County **SUPPORTS** Senate Bill 388 – Prescription Drug Affordability Board – Authority for Upper Payment Limits and Funding (Lower Prescription Drug Costs For All Marylanders Now Act). This legislation would expand the authority of the Prescription Drug Affordability Board to determine if it is in the state's interest to set up a process to use upper payment limits on the purchases of all prescription drugs, with the goal of reducing drug costs for all Marylanders, not just state employees.

Too many Marylanders are struggling with the high cost of prescription drugs. These costs have forced residents to make difficult decisions, cut back on necessary expenses, and even ration life-saving medications in order to make ends meet. The rising costs of prescription drugs can disrupt both the possibility of retirement and the quality of life that every resident deserves. Baltimore County prioritizes lowering the costs of these essential drugs for all County residents through the Baltimore County Prescription Drug Affordability Board. By setting upper limits on the costs of these medications, the Board has enabled Baltimore County to continue making critical investments in the health and wellbeing of our residents and communities.

Accordingly, Baltimore County urges a **FAVORABLE** report on SB 388 from the Senate Finance Committee For more information, please contact Jenn Aiosa, Director of Government Affairs at jaiosa@baltimorecountymd.gov.

SB 0388, FAV, FCG OCE JF, LS24.pdf

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Position: FAV

Jessica Fitzwater
County Executive

FREDERICK COUNTY GOVERNMENT

OFFICE OF THE COUNTY EXECUTIVE

SB 388 – Prescription Drug Affordability Board – Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs for All Marylanders Act of 2024)

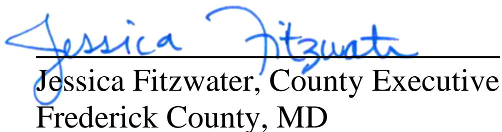
DATE:	February 7, 2024
COMMITTEE:	Senate Finance Committee
POSITION:	Favorable
FROM:	The Office of Frederick County Executive Jessica Fitzwater

As the County Executive of Frederick County, I urge the committee to give SB 388 – Prescription Drug Affordability Board – Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs for All Marylanders Act of 2024) a favorable report.

This bill requires that the annual budget includes an appropriation of at least $1,000,000 for the Prescription Drug Affordability Fund, which will be used to establish a process for setting upper payment limits for prescription drug products. Currently, the Prescription Drug Affordability Board has the authority to set upper payment limits on the most expensive prescription drugs, but not all prescription drugs fall into this category. This leaves a variety of prescription drugs at an unaffordable price.

SB 388 is an important step to ensure that all Marylanders can afford the prescription drugs they need. This leads to further health complications and a lower quality of life. It is crucial that the State takes the necessary steps address this inequity so that all Marylanders may protect their health.

Thank you for your consideration of SB 388. I urge you to advance this bill with a favorable report.



Jessica Fitzwater, County Executive
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SB 388 PDAB Authority Testimony_Jishian Ravinthira
Uploaded by: Jishian Ravinthiran
Position: FAV

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TESTIMONY IN SUPPORT OF SENATE BILL 388
Prescription Drug Affordability Board – Authority for Upper Payment Limits and Funding
(Lowering Prescription Drug Costs for All Marylanders Act of 2024)
Before the Senate Finance Committee
By Jishian Ravinthiran, Access to Medicines Fellow, Public Citizen
February 7, 2024

Madam Chair, Madam Vice-Chair, and Members of the Finance Committee,

Thank you for the opportunity to testify today in support of SB 388. I am Jishian Ravinthiran, a fellow with the Access to Medicines program of Public Citizen. Public Citizen is a national public interest organization with more than 500,000 members and supporters. For more than 50 years, we have advocated for stronger health, safety and consumer protections; for corporate and government accountability; and in more recent years, for affordable access to essential medicines and biomedical technologies.

We strongly urge you to support SB 388, which would expand the authority of the Prescription Drug Affordability Board to make high cost drugs more affordable for all Marylanders. Modeling their legislation after your landmark law creating this Board, three states—Colorado, Minnesota and Washington—have already established Prescription Drug Affordability Boards with full authority to help all residents afford high cost drugs.

The pharmaceutical industry claims that efforts to make drugs more affordable will impact the research and development of new medicines. That claim is flawed for several reasons. First, researchers and the Congressional Budget Office conclude there is no connection between a drug's research and development cost and its future price.[1] Rather, the current price of drugs reflects what companies believe the market will bear in response to their monopolistic pricing power.[2] Second, compared to the rest of the globe, the United States is an outlier that does little to protect its residents from the unfair pricing power of drug companies.[3] Bringing our policy into alignment with those of other countries will not destroy the incentive to innovate new medicines.

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[1] CONGRESSIONAL BUDGET OFFICE, RESEARCH AND DEVELOPMENT IN THE PHARMACEUTICAL INDUSTRY (Aug. 2021) ("In CBO's assessment, current R&D spending does not influence the future prices of the drugs that result from that spending."); Aaron Kesselheim, Jerry Avorn, & Ameet Sarpatwari, *The High Cost of Prescription Drugs in the United States: Origins and Prospects for Reform*, 316 JAMA NETWORK 858 (2016); Vinay Prasad, Kevin De Jesus, Sham Mailankody, *The high price of anticancer drugs: origins, implications, barriers, solutions*, 14 NAT. REV. CLIN. ONC. 381 (2016).
[2] Kesselheim, Avorn, & Sarpatwari, *supra* note 1.
[3] Amy Kapczynski, *The Political Economy of Market Power in Pharmaceuticals*, 48 J. HEALTH POL., POL'Y & L. 215 (2023); S. Vincent Rajkumar, *The high cost of prescription drugs: causes and solution*s, 10 BLOOD & CANCER J. 381 (2020).

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Finally, as our recently released report with Protect Our Care emphasizes, pharmaceutical companies spend in excess on self-enriching activities compared to research and development, cutting against the industry's mistaken impression that it is strapped for resources to innovate new medicines.[4] Looking at the manufacturers of the 10 drugs Maryland payers spent the most on in 2019, the drug corporations spent $9 billion more on share buybacks, dividends to shareholders, and executive compensation than on research and development in 2022. When the $10 billion in advertising expenditures are included to illustrate the lack of resource constraints facing these companies, pharmaceutical manufacturers of the 10 costliest drugs in Maryland spent **$19 billion** more compared to research and development expenses.[5] Attached for your consideration is the full report, which provides further detail on the data set and methodology.

In sum, there is no necessary relationship between making drugs more affordable for millions and harming resources for innovation, and we strongly urge you to support SB 388 to expand the Board's authority to address the financial burden of prescription drug costs for all Marylanders. We thank Senators Dawn Gile and Brian Feldman for introducing this measure and we thank you, Madam Chair, and all the Members of this Committee for your leadership on this issue.

[4] JISHIAN RAVINTHIRAN, PUBLIC CITIZEN & PROTECT OUR CARE, PROFITS OVER PATIENTS: SPENDING ON SELF-ENRICHMENT EXCEEDS RESEARCH AND DEVELOPMENT COSTS FOR MANY MANUFACTURERS OF IRA DRUGS (JAN. 18, 2024).
[5] *Id*.

PROFITS OVER PATIENTS

Spending on Self-Enrichment Exceeds Research and Development Costs for Many Manufacturers of IRA Drugs

By Jishian Ravinthiran

January 18, 2024

PROTECT
OUR CARE

ACKNOWLEDGMENTS

This report was written by Jishian Ravinthiran in Public Citizen's Access to Medicine's Program. Alan Zibel, Megan Whiteman, and Peter Maybarduk edited the report.

ABOUT PUBLIC CITIZEN

Public Citizen is a national nonprofit organization with more than 500,000 members and supporters. We represent consumer interests through lobbying, litigation, administrative advocacy, research, and public education on a broad range of issues including consumer rights in the marketplace, product safety, financial regulation, worker safety, safe and affordable health care, campaign finance reform and government ethics, fair trade, climate change, and corporate and government accountability.

ABOUT PROTECT OUR CARE

Protect Our Care is dedicated to making high-quality, affordable, and equitable health care a right, and not a privilege, for everyone in America. We educate the public, influence policy, support health care champions and hold politicians accountable.

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Executive Summary

The federal and state governments are taking significant steps to deliver much-needed drug pricing relief to millions of Americans. Measures include a historic provision in the Inflation Reduction Act allowing Medicare to negotiate prices for select drugs, draft executive guidance to license generic competition on taxpayer funded drugs, and state Prescription Drug Affordability Boards with the power to limit expenditures on drugs. But as governments rise to the challenge of tackling the decades long problem of excessive drug prices, the pharmaceutical industry raises significant opposition to insulate its profiteering from popular measures. Chief among their claims is that regulating drug prices will reduce industry profits, and thus capacity to invest in the research and development of new medicines. But that claim is belied by these corporations' own expenditures on self-enriching activities, including stock buybacks, dividends to shareholders, and executive compensation, that far exceed their investments in innovation.

- The manufacturers of the first 10 drugs selected for Medicare price negotiation, in aggregate, spent $10 billion more on self-enriching activities than on research and development in 2022.
- For manufacturers of the 10 drugs with the highest expenditures by Maryland payers, including Medicare, Medicaid, and certain commercial insurance plans, companies spent $9 billion more on stock buybacks, dividends, and executive compensation than on research and development expenses in 2022.
- Executive compensation for the manufacturers of the drugs selected for Medicare price negotiation exceeded half a billion dollars in just 2022. The same is true for executive compensation for the manufacturers of the 10 costliest drugs in Maryland. Most of this compensation is keyed to stock prices, which incentivizes short-term measures to inflate share prices, such as stock buybacks, rather than long-term investments in researching and developing new drugs.

Introduction

Price gouging on essential medicines harms the health of millions of Americans every year. In 2021, approximately 9.2 million Americans were unable to take medications as prescribed due to costs.[1] People with disabilities were three times more likely to be unable to take medications as prescribed due to these cost barriers.[2] Nearly one in four uninsured Americans skipped doses, took less medication, or delayed filling a prescription because of costs.[3] Data from 2023 shows that three in ten Americans have not taken their medications as prescribed due to costs, 82% of Americans say the cost of prescription drugs is unreasonable, and 73% say that the government is not doing enough to regulate drug prices.[4]

Considering this drug pricing crisis, the federal and state governments have taken significant steps to make high-cost drugs more affordable and deliver relief for patients everywhere. Several states, starting with Maryland in 2019, have established Prescription Drug Affordability Boards, which are charged with analyzing the excessive costs of prescription drugs and identifying solutions to medicine inaccessibility. Four of these states—Colorado, Maryland, Minnesota, and Washington—have empowered their Boards to set upper payment limits for the purchase of certain prescription drugs.[5] At the federal level, Congressional Democrats passed and President Biden signed into law the Inflation Reduction Act, which includes a provision allowing Medicare Part D to negotiate the price of select drugs for the first time in the program's 20-year history.[6] The law also capped the out-of-pocket costs for insulin at $35 per month for Medicare enrollees and annual out-of-pocket expenses for prescription drugs at $2,000.[7] More recently, the Biden administration announced draft guidance that would empower federal agencies to license

[1] Laryssa Mykyta, and Robin A. Cohen, Centers for Disease Control and Prevention, National Center for Health Statistics, *Characteristics of Adults Aged 18–64 Who Did Not Take Medication as Prescribed to Reduce Costs: United States, 2021*, NCHS DATA BRIEF NO. 470 (June 2023).

[2] *Id*. at 2.

[3] *Id*. at 3.

[4] Ashley Kirzinger, Alex Montero, Grace Sparks, Isabelle Valdes, & Liz Hamel, *Public Opinion Prescription Drugs and Their Prices*, KFF (Aug. 21, 2023), https://www.kff.org/health-costs/poll-finding/public-opinion-on-prescription-drugs-and-their-prices/.

[5] *See e.g.*, CO. Senate Bill 21-175, Sec. 10-16-1407; Md. Code, Health-Gen. § 21-2C-14; Minn. Sess. L. 2023 Ch. 57, art. 2, Sec. 35; Rev. Code Wash. 70.405.050.

[6] The White House, *FACT SHEET: Biden-Harris Administration Announces First Ten Drugs Selected for Medicare Price Negotiation*, STATEMENTS & RELEASES (Aug. 29, 2023), https://www.whitehouse.gov/briefing-room/statements-releases/2023/08/29/fact-sheet-biden-harris-administration-announces-first-ten-drugs-selected-for-medicare-price-negotiation/.

[7] Centers for Medicare & Medicaid, *Anniversary of the Inflation Reduction Act: Update on CMS Implementation*, CMS.GOV (Aug. 16, 2023), https://www.cms.gov/newsroom/fact-sheets/anniversary-inflation-reduction-act-update-cms-implementation.

generic competition to make taxpayer-funded medicines more affordable where drug manufacturers price the medicine excessively.[8]

The pharmaceutical industry has been staunchly opposed to popular reforms designed to constrain their unreasonable profiteering on medicines. The industry has criticized Prescription Drug Affordability Boards, the Inflation Reduction Act's provisions on price negotiation, and the Biden administration's framework for licensing generic competition on taxpayer funded medicines, with most concerns being funneled into the claim that any attempts to rein in their price-gouging tactics will impact the research and development of new medicines.[9]

That claim is flawed for several reasons. First, researchers and the Congressional Budget Office conclude there is no connection between a drug's research and development cost and its future price.[10] Rather, the current price of drugs reflects what companies believe the market will bear in response to their monopolistic pricing power.[11] Second, compared to the rest of the globe, the United States is an outlier that does little to protect its residents from the unfair pricing power of drug companies,[12] and bringing American policy into alignment with those of other countries, including other high-income peers, will not destroy the incentive to innovate new medicines.

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[8] *NIST Releases for Public Comment Draft Guidance on March-In Rights*, https://www.nist.gov/news-events/news/2023/12/nist-releases-public-comment-draft-guidance-march-rights (last visited Dec. 12, 2023).

[9] *See* PhRMA, *States Can Help Patients Pay Less for Their Medicines*, STATE POLICIES AND ISSUES, https://phrma.org/en/States (last visited Jan. 11, 2023); PhRMA, INFLATION REDUCTION ACT'S UNINTENDED CONSEQUENCES,https://phrma.org/inflation-reduction-act?utm_campaign=2024-q1-pri-v6&utm_medium=pai_srh_cpc-ggl-adf&utm_source=ggl&utm_content=clk-pat-v6-v6-v6-all-pai_srh_cpc-ggl-adf-IRAEvergreenSearchWCNational1-evg-v6-v6-lrm-soc_txt-v6-vra-adf&utm_term=inflation%20reduction%20act&utm_campaign=&utm_source=adwords&utm_medium=ppc&hsa_acc=8523309176&hsa_cam=20882819512&hsa_grp=158617381844&hsa_ad=685220095153&hsa_src=g&hsa_tgt=kwd-1705916798609&hsa_kw=inflation%20reduction%20act&hsa_mt=b&hsa_net=adwords&hsa_ver=3&gad_source=1&gclid=Cj0KCQiAwP6sBhDAARIsAPfK_wZ3PhDU-6cvBxNUI9JVXtfl-nZch3LOEQIJQA2j_rY2LRRBqHdL7fQaAkKjEALw_wcB (last visited Jan. 11, 2024); *PhRMA Statement on Proposed March-In Framework* , PHRMA (Dec. 6, 2023), https://phrma.org/resource-center/Topics/Access-to-Medicines/PhRMA-Statement-on-Proposed-March-In-Framework.

[10] CONGRESSIONAL BUDGET OFFICE, RESEARCH AND DEVELOPMENT IN THE PHARMACEUTICAL INDUSTRY (Aug. 2021) ("In CBO's assessment, current R&D spending does not influence the future prices of the drugs that result from that spending."); Aaron Kesselheim, Jerry Avorn, & Ameet Sarpatwari, *The High Cost of Prescription Drugs in the United States: Origins and Prospects for Reform*, 316 JAMA NETWORK 858 (2016); Vinay Prasad, Kevin De Jesus, Sham Mailankody, *The high price of anticancer drugs: origins, implications, barriers, solutions*, 14 NAT. REV. CLIN. ONC. 381 (2016).

[11] Aaron Kesselheim, Jerry Avorn, & Ameet Sarpatwari, *The High Cost of Prescription Drugs in the United States: Origins and Prospects for Reform*, 316 JAMA NETWORK 858 (2016).

[12] Amy Kapczynski, *The Political Economy of Market Power in Pharmaceuticals*, 48 J. HEALTH POL., POL'Y & L. 215 (2023); S. Vincent Rajkumar, *The high cost of prescription drugs: causes and solutions*, 10 BLOOD & CANCER J. 381 (2020).

Finally, as this report will emphasize, pharmaceutical companies spend in excess on executive compensation, share buybacks, and dividends which enrich their shareholders, cutting against the industry's mistaken impression that it is strapped for resources to research and develop new medicines.[13] Stock buybacks enrich investors by reducing the number of outstanding shares in a company. The fewer shares there are in investors' hands, the more each share is worth. When a company buys back and cancels 10% of its shares, that makes each share still held by an investor or insider rise in value, as it represents a greater claim on the company's earnings. Spending money this way allows companies to enrich shareholders silently, as well as the executives often paid in stock.[14] Dividends are another way of returning cash to investors. Each fiscal quarter, publicly traded companies typically issue fixed dividends to shareholders that rise when business is good and shrink or get suspended when business is bad.[15] Drug companies spend billions on stock buybacks and dividends to shareholders each year.[16]

A recent report by Protect Our Care shows that the drug companies marketing the drugs selected for the first round of Medicare price negotiation under the Inflation Reduction Act spent approximately $20 billion on stock buybacks and $54 billion on dividends to shareholders in 2023 as of November.[17] These excessive expenditures on share buybacks and dividends were also highlighted in a 2021 Drug Pricing Report from the House Oversight & Reform Committee, which found the industry argument "that permitting Medicare to negotiate drug prices would stifle innovation is not supported by available evidence or findings from the Committee's multi-year investigation into the pharmaceutical industry."[18] The investigation found that 14 large pharmaceutical companies spent $56 billion more on stock buybacks and dividends compared to research and development expenditures between 2016 and 2020.[19]

This report by Public Citizen and Protect Our Care highlights those findings and recenters the lavish expenditures of the manufacturers of the first 10 prescription drugs selected for Medicare price negotiations as industry renews claims that drug pricing relief will harm innovation. This report also examines the self-enriching activities of the manufacturers of

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[13] Amy Kapczynski, *The Political Economy of Market Power in Pharmaceuticals*, 48 J. HEALTH POL., POL'Y & L. 215, 230 (2023) (citing Aaron Kesselheim & Jeffrey Avorn, *Letting the Government Negotiate Drug Prices Won't Hurt Innovation*, WASH. POST (Sept. 27, 2021), https://www.washingtonpost.com/outlook/2021/09/22/drug-pricing-negotiation-biden-bill/); U.S. HOUSE OF REPRESENTATIVES' COMMITTEE ON OVERSIGHT & REFORM, DRUG PRICING INVESTIGATION: INDUSTRY SPENDING ON BUYBACKS, DIVIDENDS, & EXECUTIVE COMPENSATION (July 2021).

[14] PUBLIC CITIZEN, BAILOUT WATCH, FRIENDS OF THE EARTH, BIG OIL'S WARTIME BONUS 2 (2022).

[15] *Id*. at 8.

[16] PROTECT OUR CARE, GREED WATCH: BIG COMPANIES CONTINUE TO BRING IN BILLIONS WHILE AMERICANS STRUGGLE TO AFFORD SKYROCKETING PRICES 4 (Nov. 2023), GREED-WATCH-Big-Drug-Companies-Continue-To-Bring-In-Hundreds-of-Billions-While-Americans-Struggle-To-Afford-Skyrocketing-Prices.pdf (protectourcare.org).

[17] *Id*.

[18] U.S. HOUSE OF REPRESENTATIVES' COMMITTEE ON OVERSIGHT & REFORM, DRUG PRICING INVESTIGATION: INDUSTRY SPENDING ON BUYBACKS, DIVIDENDS, & EXECUTIVE COMPENSATION 11 (JULY 2021).

[19] *Id*. at 3.

the 10 drugs with the highest expenditures by payers in Maryland, which was the first state to establish a Prescription Drug Affordability Board. As other states consider passing similar legislation to create Prescription Drug Affordability Boards,[20] and as advocates in Maryland press for the expansion of its Board's upper payment limit authority to help more residents,[21] this report shows that the expenditures for the costliest drugs at the state level mirror the excessive spending on self-enrichment at the national level. Ultimately, the data shows these companies are not strapped for resources: they spend billions more on executive compensation, stock buybacks, and dividends to shareholders than research and development activities.

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[20] Drew Gattine & Jennifer Reck, *State House Wrap-Up: States Continue to Tackle High Prices in 2023 Session*, NAT. ACAD. STATE HEALTH POL'Y BLOG (Oct. 30, 2023), https://nashp.org/state-house-wrap-up-states-continue-to-tackle-high-drug-prices-in-2023-session/.

[21] Daniel J. Brown, *Health care legislation preview: Maryland advocates want to focus on access, patients in 2024 session*, MARYLAND MATTERS (Jan. 8, 2024), https://www.marylandmatters.org/2024/01/08/health-care-legislation-preview-maryland-advocates-want-to-focus-on-access-patients-in-2024-session/.

Manufacturers of the Drugs Selected for Medicare Price Negotiation Spent Billions More on Dividends, Stock Buybacks, and Executive Compensation than Research & Development

In August 2023, the Biden administration announced the first 10 drugs selected for Medicare price negotiation under the Inflation Reduction Act.[22] Between June 2022 and May 2023, these ten drugs cost Medicare Part D $50.5 billion.[23] The manufacturers of the drugs and relevant financial information obtained from Form 10-K, 20-F, and proxy statement filings with the Securities Exchange Commission (SEC), and publicly available accounting statements are listed in Table 1. Detailed methodology for all tables is contained in the Appendix. For example, Johnson & Johnson (JNJ) spent $11.682 billion on dividends to shareholders, $6.035 billion on stock buybacks, and $45 million on executive compensation in 2022. In total, JNJ spent $17.762 billion on these self-enriching activities compared to $14.6 billion on research and development.

In aggregate, the manufacturers of the drugs selected for Medicare price negotiation spent $10 billion more on stock buybacks, dividends, and executive compensation than research and development in 2022. If the $12 billion in advertising expenditures are also included to show the significant resources at these companies' disposal, manufacturers of drugs selected for Medicare price negotiation spent $22 billion more compared to research and development expenses.[24]

[22] *HHS Selects the First Drugs for Medicare Drug Price Negotiation*, HHS.GOV (Aug. 23, 2023), https://www.hhs.gov/about/news/2023/08/29/hhs-selects-the-first-drugs-for-medicare-drug-price-negotiation.html.

[23] *Id.*

[24] Manufacturers of the first drugs selected for Medicare negotiation spent 12.241 on advertising according to disclosures in Form 10-K filings with the SEC.

Table 1: Spending by Manufacturers of Drugs Selected for Medicare Price Negotiation (in dollars)

Drug Company	Drug Name	Dividends	Stock Buybacks	Exec. Comp.	Dividends. Stock Buybacks, & Exec. Comp.	R&D
AbbVie	Imbruvica	10.043 billion	1.487 billion	71.91 million	**11.602 billion**	**6.510 billion**
Amgen	Enbrel	4.196 billion	6.360 billion	50.25 million	**10.606 billion**	**4.434 billion**
AstraZeneca	Farxiga	4.364 billion	--	22.27 million	**4.386 billion**	**9.762 billion**
BMS	Eliquis	4.634 billion	8.001 billion	48.04 million	**12.683 billion**	**9.509 billion**
Pfizer	Eliquis	8.983 billion	2.000 billion	107.23 million	**11.090 billion**	**11.428 billion**
JNJ	Stelara, Xarelto, Imbruvica	11.682 billion	6.035 billion	45.19 million	**17.762 billion**	**14.603 billion**
Bayer AG	Xarelto	2.087 billion	--	23.26 million	**2.111 billion**	**6.911 billion**
Merck	Januvia	7.012 billion	--	60.46 million	**7.072 billion**	**13.548 billion**
Novartis	Entresto	7.506 billion	10.652 billion	51.75 million	**18.210 billion**	**9.996 billion**
Novo Nordisk	Fiasp/ Novolog	3.575 billion	3.403 billion	36.84 million	**7.016 billion**	**3.398 billion**
Eli Lilly	Jardiance	3.536 billion	1.500 billion	44.48 million	**5.080 billion**	**7.191 billion**
Total		67.619 billion	39.438 billion	561.68 million	**107.619 billion**	**97.290 billion**

As shown in Table 2, executive compensation for these manufacturers exceeded half a billion dollars in just one year. More than half of executive compensation was based on equity awards, thereby directly linking executive pay to share price. The payment structure incentivizes share repurchases to inflate stock values, which increases executive compensation in the short-term.

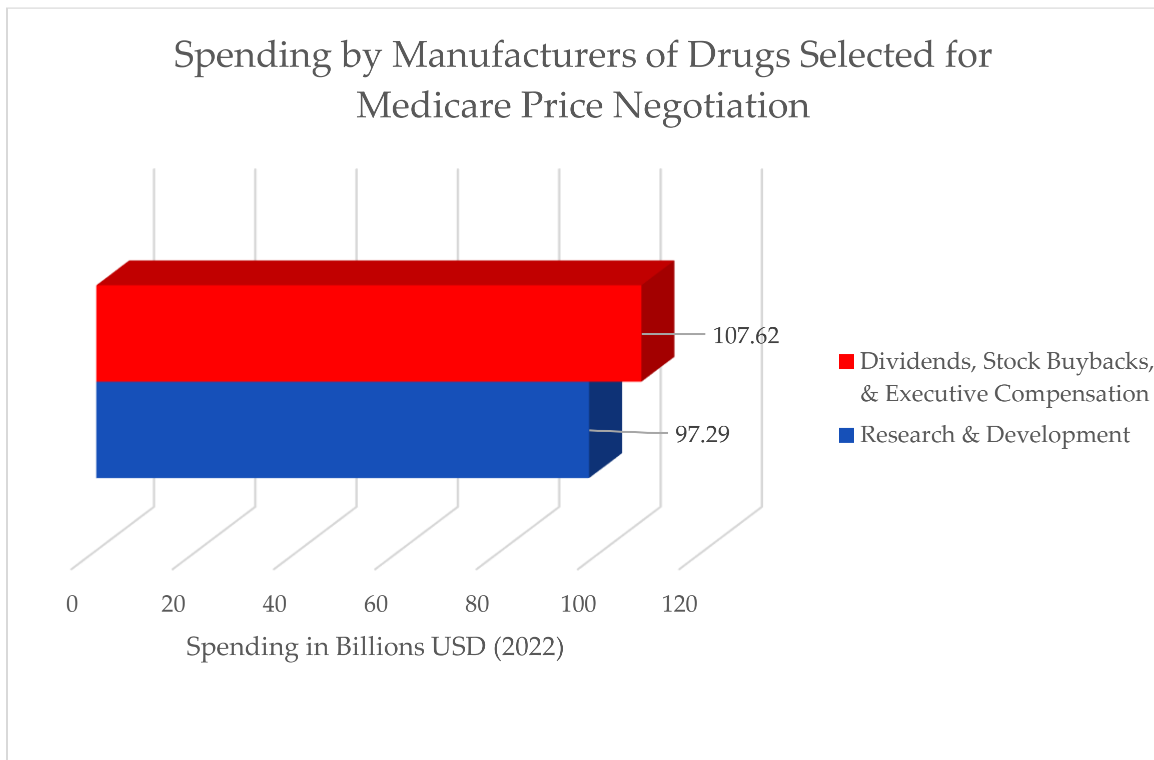
Table 2: Executive Compensation for the Manufacturers of Drugs Selected for Medicare Price Negotiation (in dollars)

Drug Company	Drug(s) selected for Negotiation	Number of Corporate Officers	Executive Base Pay	Equity-Based Awards	Total Compensation
AbbVie	Imbruvica	6	7,041,609	46,525,585	71,913,444
Amgen	Enbrel	5	6,051,861	34,111,067	50,245,442
AstraZeneca	Farxiga	2	2,765,721	13,000,000	22,266,338
BMS	Eliquis	5	6,055,263	31,506,942	48,038,921
Pfizer	Eliquis	6	7,768,166	48,970,106	107,228,894
JNJ	Stelara, Xarelto, Imbruvica	5	5,409,809	32,034,706	45,186,672
Bayer AG	Xarelto	6	6,661,409	4,413,249	23,263,933
Merck	Januvia	6	6,063,476	39,967,603	60,463,107
Novartis	Entresto	16	11,423,342	21,563,333	51,753,687
Novo Nordisk	Fiasp/Novolog	10[25]	11,374,876	14,893,316	36,837,643
Eli Lilly	Jardiance	5	5,258,655	31,193,250	44,477,379
Total		**72**	**75,874,187**	**318,179,157**	**561,675,460**

In sum, these figures suggest that these drug corporations have ample resources to invest in research and development, which belies industry claims that the Medicare price negotiation provisions will stifle innovation.

[25] According to Novo Nordisk's Remuneration Report 2022, there is a category for non-registered executives, which includes 3 named persons. It remains unclear if other individuals are included in this category as well.

Figure 1: Spending by Manufacturers of Drugs Selected for Medicare Price Negotiation (in Billions of Dollars)



Manufacturers of the Costliest Drugs in Maryland Spent Billions More on Dividends, Stock Buybacks, and Executive Compensation than Research & Development

A similar pattern of corporate enrichment emerges for the 10 costliest drugs in Maryland. In 2022, Maryland's Prescription Drug Affordability Board published a report that detailed the 10 drugs payers, including Medicare, Medicaid, and certain commercial insurance plans, spent the most on in 2019.[26] The manufacturers of those drugs and their respective spending on dividends, stock buybacks, executive compensation, and research and development are reported in Table 3 using securities filings and publicly available statements. These drug corporations spent $9 billion more on share repurchases, dividends to shareholders, and executive compensation than on research and development in 2022. When the $10 billion in advertising expenditures are included to illustrate the lack of resource constraints facing these companies, pharmaceutical manufacturers of the 10 costliest drugs in Maryland spent $19 billion more compared to research and development expenses.[27]

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[26] Maryland Prescription Drug Affordability Board, Section 21-2c-09(c) (2022) Annual Cost Review Report 7 (Dec. 31, 2022).

[27] Manufacturers of the 10 costliest drugs in Maryland spent 10.032 billion on advertising expenses in 2022 according to disclosures in Form 10-K filings with the SEC.

Table 3: Spending by the Manufacturers of the Costliest Drugs in Maryland (in dollars)

Drug Company	Drug Name	Dividends	Stock Buybacks	Exec. Comp.	Dividends. Stock Buybacks, & Executive Compensation	R&D
AbbVie	Humira	10.043 billion	1.487 billion	71.91 million	**11.602 billion**	**6.510 billion**
Gilead	Biktarvy, Genvoya	3.709 billion	1.396 billion	53.12 million	**5.158 billion**	**4.977 billion**
BMS	Eliquis	4.634 billion	8.001 billion	48.04 million	**12.683 billion**	**9.509 billion**
GSK	Triumeq[28]	4.275 billion	--	25.85 million	**4.301 billion**	**6.767 billion**
Pfizer	Triumeq, Eliquis	8.983 billion	2.000 billion	107.23 million	**11.090 billion**	**11.428 billion**
Shionogi[29]	Triumeq	.275 billion	.377 billion	3.93 million	**.656 billion**	**.569 billion**
Biogen	Tecfidera	--	.750 billion	86.51 million	**0.837 billion**	**2.231 billion**
Eli Lilly	Trulicity	3.536 billion	1.500 billion	44.48 million	**5.080 billion**	**7.191 billion**
JNJ	Stelara	11.682 billion	6.035 billion	45.19 million	**17.762 billion**	**14.603 billion**
Novo Nordisk	Fiasp/ Novolog	3.575 billion	3.403 billion	36.84 million	**7.016 billion**	**3.398 billion**
Total		50.712 billion	24.949 billion	523.09 million	**76.185 billion**	**67.183 billion**

[28] Triumeq is marketed by Viiv Healthcare, which is a joint venture between Pfizer, GSK, and Shionogi.
[29] Shionogi is a Japanese company that operates on a fiscal year from April 1, 2022 through March 31, 2023. Instead, data for this company on stock buybacks, dividends, and research and development was taken for April 1, 2022 through December 31, 2022 (9 months). However, executive compensation figures are only available on a yearly basis, so that information is taken from the 2022 report spanning April 1, 2022 through March 31, 2023.

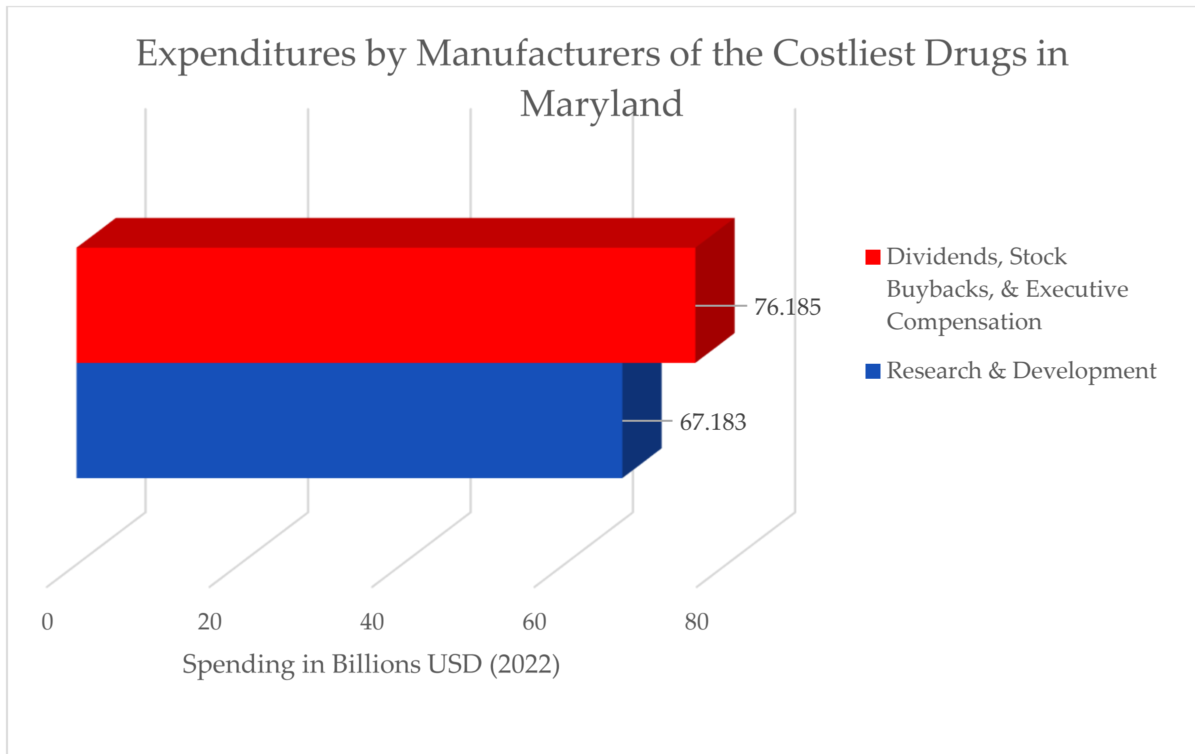
Like the manufacturers of the drugs selected for Medicare price negotiation, manufacturers of the ten costliest drugs in Maryland spent over half a billion dollars on executive compensation in just 2022 (see Table 4). For these companies, 60% of executive pay was based on equity awards, helping drive corporate investment in short-term measures to inflate stock values, such as stock buybacks, as opposed to long-term investments in research and development.

Table 4: Executive Compensation for the Manufacturers of the Costliest Drugs in Maryland (in dollars)

Drug Company	Drug Name	Number of Officers	Base Pay	Equity-Based Compensation	Total Compensation
AbbVie	Humira	6	7,041,609	46,525,585	**71,913,444**
Gilead	Biktarvy, Genvoya	5	5,244,613	34,198,123	**53,120,567**
BMS	Eliquis	5	6,055,263	31,506,942	**48,038,921**
GSK	Triumeq	3	4,324,291	12,208,385	**25,850,801**
Pfizer	Triumeq	6	7,768,166	48,970,106	**107,228,894**
Shionogi	Triumeq	5	1,574,695	958,510	**3,925,327**
Biogen	Tecfidera	7	5,184,996	66,506,517	**86,506,118**
Eli Lilly	Trulicity	5	5,258,655	31,193,250	**44,477,379**
JNJ	Stelara	5	5,409,809	32,034,706	**45,186,672**
Novo Nordisk	Fiasp/Novolog	10	11,374,876	14,893,316	**36,837,643**
Total		**57**	**59,236,974**	**318,995,440**	**523,085,767**

In sum, establishing state Prescription Drug Affordability Boards with the authority to limit the price of drug transactions or expanding these boards' authority to deliver relief to more residents does not constrain industry capacity to invest in drug innovation. Drug companies of the costliest drugs in states, which are often the manufacturers of the costliest drugs nationally, have significant resources to invest in research and development.

Figure 2: Spending by Manufacturers of the Costliest Drugs in Maryland (in Billions of Dollars)



Conclusion

Supermajorities of Americans believe that drug prices are unreasonable and that the government is doing too little to protect its residents from their excessive costs. As federal and state governments rise to the occasion and deliver relief from the price-gouging of their constituents, it is expected that the pharmaceutical industry will raise strong opposition to these efforts to preserve their profiteering. Most commonly, opposition to popular relief centers the claim that reducing their profits in any manner will constrain their resources to invest in new medicines.

As experts, advocates, scholars, and government oversight institutions have reiterated for years, those claims are belied by the lavish expenditures of these companies on activities to enrich their shareholders and executives, which outweigh their investment in the innovation of new drugs. Indeed, this rings true for the corporations manufacturing the first drugs selected for Medicare price negotiation and the costliest drugs in Maryland, with billions spent in excess of research and development expenses on dividends, stock buybacks, and executive compensation. As such, there is no necessary relationship between drug pricing relief for millions and harming resources for innovation, and arguments to the contrary must be contested wherever they abound.

Appendix: Methodology for Obtaining Financial Figures

Table 1: Spending by Manufacturers of Drugs Selected for Medicare Price Negotiation (in dollars)

Data was taken from the latest annual SEC filings for Fiscal Year 2022 of all U.S.-based companies. Advertising figures were taken from descriptive statements offered in these SEC filings.[30] Dividend and stock repurchase figures were taken from Consolidated Cash Flow Statements.[31] For two companies, there was a discrepancy between descriptive statements as to share repurchases in the SEC filings versus information in the cash flow statements on the purchases of treasury stock.[32] For consistency, this report uses the figures reported in the cash flow statements. Research and development figures were taken as reported in Consolidated Income/Earning Statements.[33] Foreign corporations AstraZeneca & Novartis filed Form 20-F with the SEC disclosing the instant data in similar formats, with the exception of advertising figures which do not appear to be descriptively reported.[34]

Research and development, stock repurchase, and dividend figures for Novo Nordisk were obtained from publicly available Income and Cash Flow statements in annual reports.[35] A similar approach was used for Bayer AG, a German company: this data was taken from its publicly available annual report for 2022.[36]

Executive compensation data was taken from the latest proxy statements filed with the SEC (Fiscal Year 2022) of all U.S.-based companies.[37] Figures on executive compensation were obtained from the Summary Compensation Table, which provides a total figure combining base salary, equity-based compensation, non-equity compensation according to the company's incentive plan, appreciation in pension value, deferred compensation, and "other compensation," which includes the cost of providing corporate travel, automobiles, and financial planning services.[38]

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[30] *See e.g.*, AbbVie 2022 Form 10-K, at 57.

[31] *See e.g.*, AbbVie 2022 Form 10-K, at 54.

[32] AbbVie describes that it repurchased $1.1 billion in stocks for 2022, but its cash flow statement shows it expended $1.487 billion on the purchase of treasury stock. *Compare* AbbVie 2022 Form 10-K, at 42 *to* AbbVie Form 10-K, at 54. Novartis described that it spent $10.8 billion on share repurchases, but its cash flow statement shows that it spent $10.652 billion on the acquisition of treasury stock. *Compare* Novartis 2022 Form 20-F, at 79 *to* Novartis 2022 Form 20-F, at F-5. These discrepancies do not affect the findings of this report.

[33] *See e.g.,* AbbVie 2022 Form 10-K, at 50.

[34] AstraZeneca PLC, 2022 Form 20-F, at F-2, F-5, F-46 ("No share repurchases have been made since 2012"); Novartis, 2022 Form 20-F, at F-1, F-4,

[35] NOVO NORDISK, ANNUAL REPORT 2022 54-55 (2023).

[36] BAYER ANNUAL REPORT 2022 2, 87, 90-91, 150 (2023).

[37] *See e.g.*, AbbVie, 2023 Proxy Statement, at 51.

[38] *Id*.

Foreign corporation AstraZeneca filed Form 20-F with the SEC, which incorporates by reference certain pages detailing remuneration from its annual report.[39] Novartis disclosed compensation figures for its Executive Committee in Form 20-F filed with the SEC.[40] Novo Nordisk disclosed executive compensation in its annual Remuneration Report.[41] Bayer AG included its executive compensation figures in its annual report.[42]

Data in foreign currencies were converted to U.S. dollars using the yearly average exchange rates for 2022 posted on the Internal Revenue Service's website.[43]

Table 2: Executive Compensation for the Manufacturers of Drugs Selected for Medicare Price Negotiation (in dollars)

Executive compensation data was obtained using the approach outlined for Table 1. For U.S. based companies, stock-based and option-based awards were aggregated from the Summary Compensation Table to establish equity-based compensation for executives.[44] Foreign corporations often did not detail equity-based compensation in the same manner. They disclosed equity-based compensation in a category termed long-term incentive programs/awards.[45] Base salary was disclosed in a standard manner across companies.[46]

Again, data in foreign currencies were converted to U.S. dollars using the yearly average exchange rates for 2022 posted on the Internal Revenue Service's website.[47]

Table 3: Spending by the Manufacturers of the Costliest Drugs in Maryland (in dollars)

Research and development, stock buybacks, dividend payments, and total executive compensation figures were obtained using the same approach from Table 1. The following manufacturers of the drugs selected for Medicare price negotiation also appeared on the list of manufacturers of the 10 costliest drugs in Maryland: AbbVie, Bristol Myers Squibb, Pfizer, Eli Lilly, Johnson & Johnson, and Novo Nordisk. Therefore, the same data was used from Table 1.

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[39] AstraZeneca, 2022 Form 20-F at 40; ASTRAZENECA ANNUAL REPORT AND FORM 20-F INFORMATION 2022 111 (2023).
[40] Novartis, 2022 Form 20-F, at 105.
[41] NOVO NORDISK, REMUNERATION REPORT 2022 12 (2023).
[42] BAYER ANNUAL REPORT 2022 280-81 (2023).
[43] *Yearly Average Currency Exchange Rates*, IRS.GOV, https://www.irs.gov/individuals/international-taxpayers/yearly-average-currency-exchange-rates (last visited Jan. 8, 2023).
[44] *See e.g.*, AbbVie, 2023 Proxy Statement, at 51.
[45] ASTRAZENECA ANNUAL REPORT AND FORM 20-F INFORMATION 2022 111 (2023); BAYER ANNUAL REPORT 2022 280-81 (2023); NOVO NORDISK, REMUNERATION REPORT 2022 12-14 (2023).
[46] *See e.g.*, AbbVie, 2023 Proxy Statement, at 51; ASTRAZENECA ANNUAL REPORT AND FORM 20-F INFORMATION 2022 111 (2023); BAYER ANNUAL REPORT 2022 280-81 (2023); NOVO NORDISK, REMUNERATION REPORT 2022 12 (2023).
[47] *Yearly Average Currency Exchange Rates*, IRS.GOV, https://www.irs.gov/individuals/international-taxpayers/yearly-average-currency-exchange-rates (last visited Jan. 8, 2023).

Gilead and Biogen's data on stock repurchases, dividends, and research and development figures were obtained from Consolidated Cash Flow Statements and Income/Earning Statements in their 2022 Form 10-K filing with the SEC.[48] Advertising figures for these companies were taken from the descriptive statements within these filings.[49] GSK filed Form 20-F with the SEC disclosing data on research and development, stock repurchases, and dividends.[50] Shionogi is a Japanese company that operates on a fiscal year from April 1, 2022, through March 31, 2023. To examine figures from 2022, data for research and development, stock repurchases, and dividends was taken from its third quarter report covering April 1, 2022, through December 31, 2022.[51]

Executive compensation figures for Gilead and Biogen were disclosed in their proxy statement filings with the SEC.[52] For GSK, this data was obtained from its annual report incorporated by reference in its Form 20-F filing with the SEC.[53] Shionogi discloses executive compensation according to its fiscal calendar, so the latest disclosure covering Fiscal Year 2022 covered April 1, 2022, through March 31, 2023.[54]

Data in foreign currencies were converted to U.S. dollars using the yearly average exchange rates for 2022 posted on the Internal Revenue Service's website.[55]

Table 4: Executive Compensation for the Manufacturers of the Costliest Drugs in Maryland (in dollars)

Executive compensation data was obtained using the approach outlined for Table 3. The following manufacturers of the drugs selected for Medicare price negotiation also appeared on the list of manufacturers of the 10 costliest drugs in Maryland, so their executive compensation figures from Table 2 were used: AbbVie, Bristol Myers Squibb, Pfizer, Eli Lilly, Johnson & Johnson, and Novo Nordisk.

Again, for U.S.-based companies, stock-based and option-based awards were aggregated to determine equity-based compensation for executives.[56] Equity-based compensation fell under the category of long-term incentive awards for GSK executives.[57] Shionogi disclosed

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[48] *See* Gilead, 2022 Form 10-K, at 49, 52; Biogen 2022 Form 10-K, at F-2, F-5.

[49] *See* Gilead, 2022 Form 10-K, at 55; Biogen 2022 Form 10-K, at F-21.

[50] *See* GSK, 2022 Form 20-F, at 16, 34-35.

[51] *See* SHIONOGI, CONSOLIDATED FINANCIAL RESULTS FOR THE THIRD QUARTER FISCAL YEAR 2022 (IFRS) 4,10 (Jan. 30, 2023).

[52] *See* Gilead, Schedule 14A: 2023 Notice of Annual Meeting and Proxy Statement, at 69; Biogen, Schedule 14A: 2023 Annual Notice of Stockholders and Proxy Statement, at 56.

[53] *See* GSK, 2022 Form 20-F, at 51; GSK ANNUAL REPORT 2022 136 (2023).

[54] *See* Shionogi, *Chapter 3: Mechanisms Supporting SHIONOGI's Growth*, from INTEGRATED REPORT 2023, at 93.

[55] *Yearly Average Currency Exchange Rates*, IRS.GOV, https://www.irs.gov/individuals/international-taxpayers/yearly-average-currency-exchange-rates (last visited Jan. 8, 2023).

[56] *See* Gilead, Schedule 14A: 2023 Notice of Annual Meeting and Proxy Statement, at 69; Biogen, Schedule 14A: 2023 Annual Notice of Stockholders and Proxy Statement, at 56.

[57] GSK ANNUAL REPORT 2022 136, 142 (2023).

stock-based compensation under a category termed "non-monetary remuneration."[58] Base salary data was disclosed in a standard manner across companies.[59]

Data in foreign currencies were converted to U.S. dollars using the yearly average exchange rates for 2022 posted on the Internal Revenue Service's website.[60]

[58] *See* Shionogi, *Chapter 3: Mechanisms Supporting SHIONOGI's Growth,* from INTEGRATED REPORT 2023, at 93.

[59] Gilead, Schedule 14A: 2023 Notice of Annual Meeting and Proxy Statement, at 69; Biogen, Schedule 14A: 2023 Annual Notice of Stockholders and Proxy Statement, at 56; GSK ANNUAL REPORT 2022 136 (2023); Shionogi, *Chapter 3: Mechanisms Supporting SHIONOGI's Growth,* from INTEGRATED REPORT 2023, at 93.

[60] *Yearly Average Currency Exchange Rates*, IRS.GOV, https://www.irs.gov/individuals/international-taxpayers/yearly-average-currency-exchange-rates (last visited Jan. 8, 2023).

WDC 2024 Testimony_SB388_FINAL.pdf
Uploaded by: JoAnne Koravos
Position: FAV

Senate Bill 388 – Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs for All Marylanders Act of 2024)
Senate Finance/Budget & Taxation Committees – February 7, 2024
SUPPORT

Thank you for this opportunity to submit written testimony concerning an important priority of the **Montgomery County Women's Democratic Club (WDC)** for the 2024 legislative session. WDC is one of Maryland's largest and most active Democratic clubs with hundreds of politically active members, including many elected officials.

WDC urges the passage of SB388. In 2019 Maryland became the first state to establish a Prescription Drug Affordability Board (PDAB), 'the Board", designed to address the affordability of prescription drugs by analyzing costs, suggesting effective ways to lower spending, and enable the PDAB Board to set upper payment limits for certain high-cost drugs after conducting an affordability review. Currently, six states (Colorado, Maine, New Hampshire, Ohio, Oregon and Washington) have passed similar legislation based on the Maryland model.

The skyrocketing cost of prescription drugs affects all Marylanders. Older adults, who are more likely to have chronic conditions requiring prescription drug treatment and are on fixed incomes, suffer disproportionately from high prescription drug prices. A January 2024 report by AARP Public Policy Institute found that the average price increases for prescription drugs widely used by older Americans, including Medicare beneficiaries, outstripped the price increases for other consumer goods and services between 2006 and 2020. In 2020, the average annual cost for widely used prescription drugs used to treat chronic conditions was more than $26,000 per drug per year. This cost was:

- More than 40 percent higher than the average Social Security retirement benefit ($18,034),
- Nearly 90 percent of the median income for Medicare beneficiaries ($29,650), and
- More than one-third of the median US household income ($69,639).

Furthermore, according to the Maryland Health Care for All! Coalition, polling routinely shows women are more likely than men to skip or ration their medication, causing poor health outcomes. In fact, many of the most prohibitively expensive medicines on the market are used to treat diseases that disproportionately affect women, such as Herceptin, a breast cancer drug costing over $60,000 a year.

The Board's current authority only covers prescription drugs under state and local government health care plans. This bill would expand the board's authority to implement

broader cost controls to private insurers so that everyone, especially women and children, would benefit from reduced drug prices. Protecting pocketbooks of Marylanders, especially those who are underserved, is an important goal of this bill.

Prescription drug affordability boards are growing in popularity as a state tool for reining in drug costs. The effectiveness of prescription drug affordability boards will depend in part on the state of Maryland's ability to ensure sustainable funding. This bill is designed to do just that.

We ask for your support for Senate Bill 388 and strongly urge a favorable Committee report.

Tazeen Ahmad
WDC President

Margaret Hadley
WDC Committee on Health

Cynthia Rubenstein
Chair, WDC Advocacy

Diana Rubin
WDC Committee on Aging

JAS Testimony in SUPPORT of SB 388.pdf

Uploaded by: John Spillane

Position: FAV

Testimony in SUPPORT of SB 388

Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding (The Lowering Prescription Drug Costs For All Marylanders Now Act)

Senate Finance Committee

February 7, 2024

Dear Honorable Chair, Vice Chair, and Members of the Committee,

My name is John Spillane and I live in Hyattsville. I am testifying in support of SB 388.

I recently completed a series of radiation treatments for prostate cancer. Along with that treatment I need to take a drug for more than one year. The charge for the drug is around three thousand dollars a month. With the help of medical support staff, after some weeks I was able to sign up to a program that covers the cost. I'm not sure what I would have otherwise done, as I'm not able to pay that.

Maryland's Prescription Drug Affordability Board has begun to determine ways to make high-cost prescription drugs more affordable, beginning with state and local governments. While this is a great first step, we need to expand the Board's authority to make prescription drugs more affordable for all Marylanders.

John A. Spillane

6110 43rd St.

Hyattsville, MD

SB 388_MD Center on Economic Policy_FAV.pdf
Uploaded by: Kali Schumitz
Position: FAV

MDCEP
MARYLAND CENTER ON ECONOMIC POLICY
FEBRUARY 7, 2024

Expanding the Prescription Drug Affordability Board's authority can reduce medication costs for more Marylanders

Position Statement Supporting Senate Bill 388

Given before the Senate Finance Committee

The creation of the Prescription Drug Affordability Board (PDAB) in 2019 was a significant step towards health equity as it seeks opportunities to make prescription drugs more affordable. However, not all Marylanders are able to reap the benefits of cost reductions to their medicine as current PDAB authority only oversees state health plans. To ensure that all Marylanders are able to afford life-saving medication without the worry of having enough to cover other basic necessities, it's important that their health is prioritized over the profits pocketed by the pharmaceutical industry. The board can create accountability processes to make this happen. **For these reasons, the Maryland Center on Economic Policy supports Senate Bill 388.**

According to a national survey, 8 in 10 adults say the cost of prescription drugs is unreasonable, with many having difficulty affording their medicine, especially if they have more than one prescription expense.[i] When individuals cannot afford prescription drugs, they may forgo or delay necessary medication. Despite leading the nation as one of the few states with a PDAB, Maryland payers are still subject to price hikes enacted by the pharmaceutical industry. A report found that manufacturers for the costliest prescription drugs in Maryland spend billions more on self-enrichment activities, such as stock buybacks and executive compensation, than on research and development of new drugs.[ii] It's important that the state protects Marylanders' health by extending the board's authority to deliver economic relief.

We also know that it's possible for government to create pathways that enable Marylanders of all backgrounds to afford medication. Thanks to provisions in the Inflation Reduction Act of 2022 which capped insulin at $35 a month for Medicare plans starting in 2023, it is expected that out-of-pocket spending for retail prescription drugs will decline.[iii] In fact, these policy changes are predicted to reduce spending on retail prescription drugs by 18.5% than previously projected for those on Medicare. Implementing guidelines to bring down prescription drug costs will help build up healthy communities.

Moreover, appropriating yearly funds for the PDAB will ensure that the implementation of their recommendations is possible and ongoing.

For these reasons, the Maryland Center on Economic Policy respectfully requests that the Finance Committee give a favorable report to Senate Bill 388.

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Equity Impact Analysis: Senate Bill 388

Bill summary

Senate Bill 388 extends the Prescription Drug Affordability Board's (PDAB) authority to set upper payment limits for prescription drugs for all Marylanders, and mandates an annual appropriation of at least $1 million from the state budget for the PDAB Fund starting in fiscal year 2025.

Background

The Prescription Drug Affordability Board (PDAB), created in 2019, is meant to conduct cost review analyses for prescriptions drugs that are expensive, and implement upper payment limits to make these more affordable. However, due to funding issues, the board has not yet achieved its goals and has been slow in creating guidelines and polices to enact change. The board is also limited to setting upper payment limits for prescription drugs on state and local government health plans. As such, there is a need to both ensure that the PDAB has extended authority to advocate on behalf of all Marylanders struggling to afford medications, and for funding to be available to maintain the process.

Equity Implications

Policies in the past have led to a system of unequal opportunities for marginalized groups within Maryland. Although the most obvious racially discriminatory policies have long been overturned or mitigated, the impact of these policies continue to persist in both society and public policy and have led to significant racial and health disparities. People of color experience much higher rates of economic insecurity and poverty and are more likely to struggle paying for their medications.

Because lower socioeconomic status and comorbidities are more prevalent in communities of color, it is imperative that more Marylanders are able to access quality medication at an affordable price. [iv]

Impact

Senate Bill 388 would likely **improve racial and economic equity** in Maryland.

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[i] Kirzinger, A., Montero, A., Sparks, G., Valdes, I., & Hamel, L. (2023, August 21). *Public opinion on prescription drugs and their prices*. Kaiser Family Foundation. https://www.kff.org/health-costs/poll-finding/public-opinion-on-prescription-drugs-and-their-prices/

[ii] Ravinthiran, J. (2024, January 18). *Profits over patients: Spending on self-enrichment exceeds research and development costs for many manufacturers of IRA drugs*. Public Citizen. https://www.citizen.org/article/profits-over-patients/

[iii] Amin, K., Wager, E., Levinson, Z., Cubanski, J., & Cox, C. (2024, January 24). *Health cost and affordability policy issues and trends to watch in 2024*. Peterson-KFF Health System Tracker. https://www.healthsystemtracker.org/brief/policy-issues-and-trends-2024/

[iv] Ellis, K. R., Hecht, H. K., Young, T. L., Oh, S., Thomas, S., Hoggard, L. S., Ali, Z., Olawale, R., Cathron, D., Corbie-Smith, G., & Eng, E. (2020). Chronic disease among African-American families: A systemic scoping review. *Preventing Chronic Disease, 17*. https://www.cdc.gov/pcd/issues/2020/19_0431.htm

SB 388 - Prescription Drug Affordability Board.pdf

Uploaded by: Ken Phelps Jr

Position: FAV

THE EPISCOPAL DIOCESE OF MARYLAND

The Maryland Episcopal Public Policy Network

TESTIMONY IN SUPPORT OF SB 388

Health Insurance - Qualified Resident Enrollment Program (Access to Care Act)

Finance Committee

FAVORABLE

TO: Senator Pamela Beidle, Chair; Senator Katherine Klausmeier, Vice-Chair; and the Members of the Finance Committee

FROM: Rev. Kenneth Phelps, Jr., The Episcopal Diocese of Maryland

DATE: February 7, 2024

The Episcopal Church teaches that access to quality and affordable health care is – along with nutrition and housing – a basic human right and the Church supports those efforts to provide universal and equitable access for all. Our General Convention urges all Episcopalians to advocate for just and adequate health care policies and views this as a mission of the Church and a vital component in the promotion of healthy American communities.

We are all hurt by the high cost of prescription drugs, whether it is at the pharmacy counter, through our insurance premiums, or through government spending of our taxpayer dollars. These skyrocketing costs place considerable burdens on our families and neighbors. Unfortunately, the problem is getting worse, with drug corporations increasing prices for some drugs by more than five times the inflation rate as recently as July 2023. As these costs continue to soar, many Marylanders will continue to face difficult decisions paying for their lifesaving medications or other necessities.

In 2019, the Maryland General Assembly created the first-in-the-nation Prescription Drug Affordability Board (PDAB), a landmark approach to address the skyrocketing costs of medicines which is now being replicated across the country. The PDAB has the authority to implement upper payment limits to make high-cost drugs more affordable for state and local governments. For this we thank you. But now is the time to do more.

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THE EPISCOPAL DIOCESE OF MARYLAND

The Maryland Episcopal Public Policy Network

We strongly urge the Maryland General Assembly in 2024 to expand the authority of the Prescription Drug Affordability Board so that it can implement upper payment limits to make high-cost drugs more affordable for all Marylanders.

The Diocese of Maryland requests a Favorable report

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WWW.EPISCOPALMARYLAND.ORG

SB 388_Horizon Foundation_fav.pdf

Uploaded by: Kerry Darragh
Position: FAV

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David Wolf

Lanlan Xu

February 7, 2024

COMMITTEE: Senate Finance Committee
BILL: SB 388 – Prescription Drug Affordability Board – Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs for All Marylanders Act of 2024)
POSITION: Support

The Horizon Foundation is the largest independent health philanthropy in Maryland. We are committed to a Howard County free from systemic inequities, where all people can live abundant and healthy lives.

The Foundation is pleased to support SB 388 – Prescription Drug Affordability Board – Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs for All Marylanders Act of 2024).

Currently, the state's Prescription Drug Affordability Board has the authority explore ways to set upper payment limits on purchases of prescription drugs for residents on state health plans. SB 388 would expand the Board's authority so that those potential cost reductions can apply to all Marylanders, no matter what kind of health insurance plan they have. The bill would also establish an annual appropriation of $1 million to fund the Prescription Drug Affordability Board.

Health care costs, and prescription drugs in particular, can be one of the biggest sources of financial strain for Marylanders, especially those with lower incomes and people of color. Though Howard County is known as an affluent community, our residents have felt the pain of rising costs and many of our lower income families are struggling to make ends meet. By expanding the Prescription Drug Affordability Board's authority to determine and implement cost savings opportunities, residents across our community and the state can receive a much-needed financial boost.

The Foundation believes that everyone deserves access to quality and affordable health care. SB 388 would help ease the financial strain that

The Horizon Foundation of Howard County, Inc.
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prescription drugs can cause on many families. For this reason, the Horizon Foundation **SUPPORTS SB 388 and urges a FAVORABLE report.**

Thank you for your consideration.

SB 388 Larry Zarzecki FAV.pdf
Uploaded by: Larry Zarzecki
Position: FAV

TESTIMONY IN SUPPORT OF SENATE BILL 388

Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding
(Lowering Prescription Drug Costs for All Marylanders Act of 2024)
Before the Senate Finance Committee
By Larry Zarzecki
February 7, 2024

Chair Beidle, Vice-Chair Klausmeier, and Members of the Finance Committee, thank you for this opportunity to testify in favor of SB 388, which would give the Prescription Drug Affordability Board the authority to set upper payment limits to make high-cost drugs affordable for ALL Marylanders. Special thank you to Senator Gile and Senator Feldman for sponsoring this life-saving legislation.

I have Parkinson's. My prescription drugs cost thousands of dollars per month, even with insurance coverage. I used up my retirement savings. I could not buy nutritious food. I had to sell my home. At times, I have gone without medication when my insurance no longer covered the prescribed drug. When I don't have access to some of my medications, withdrawal produces major physical problems for me and I cannot perform many basic tasks.

Thankfully I am now enrolled in Medicare. The Inflation Reduction Act means that starting in 2025 I will have a $2000 annual out-of-pocket maximum for the drugs that I need to manage my condition. But many other Marylanders are struggling. Recent polling shows as many as 45% of Marylanders report struggling to afford the medicines they need, with one third of Marylanders skipping a dose or rationing medication due to cost. Nobody should have to choose between the medications they need to live and necessities like food and housing. I do not want anyone else to have to live through the challenges I have faced. I have been fighting two battles since my diagnosis: one against Parkinson's and one against extremely high drug costs.

Thank you for your Committee's leadership creating the first-in-the-nation Prescription Drug Affordability Board in 2019. Now I am asking you to please give this Board the authority to help all Marylanders be able to afford their prescription medications. I strongly urge you to give a favorable report to SB 388.

MARYLAND STATE SENATE PRESENTATION ON SBO338.pdf
Uploaded by: Lawrence Diggs
Position: FAV

MARYLAND STATE SENATE PRESENTATION ON SB0388

Lawrence C. Diggs Jr., Member, Caucus of African American Leaders of Maryland.
February 7th & 8th, 2024

Good afternoon Madam Chairperson and the Committee. I appear before you today as a member of the Caucus of African American Leaders of Maryland, in support of Senate Bill 388, which is intended to expand the authority of the Prescription Drug Affordability Board to make high-cost prescription drugs affordable for ALL Marylanders.

As a senior citizen, and a survivor of COVID-19, which I contracted on March 23, 2020 while in New York, I am thankful and grateful to be alive and before you today. I was not expected to get through this plague.

Over the past four years, I have been treated for multiple ailments, some of which I am currently under treatment; significant among those is permanent damage to one of my lungs. I was prescribed ADVAIR 250/50 Discus by my doctor, which I have been using twice daily over four years. The cost for one monthly prescription is $475.00, or $5,700.00 annually without a drug plan. The annualized cost, with Medicare and a supplemental Medicare program, has been $2100.00. With a tertiary prescription benefit program the cost was diminished somewhat. Unfortunately, the tertiary prescription drug company that covered part of my prescription cost, has dropped my coverage. I am back to paying $2100.00 annually, and the manufacturer, Glaxo-Smith-Klein, is projecting a price increase in the near future.

There will come a time when I may not be able to afford the ADVAIR 250/50 Discus if there is a price increase, which will result in a financial hardship for me. Current prescription drug prices generally, are causing hardships on all citizens across the board.

There are thousands of Maryland senior citizens who are suffering with absurdly high prescription drug costs, for which some will have to make a choice whether to compromise their food budget or pay the high cost of prescription drugs; I might be one of them soon. Existing and future drug price increases by billion dollar drug companies like Glaxo-Smith-Klein, will ultimately cause the demise of those of us who rely on daily prescription drugs for our mere existence.

Therefore, I/we strongly and wholeheartedly support HB 388 known as the Prescription Drug Affordability Board Bill. We strongly urge its passage.

Thank you for this opportunity to respond and provide testimony.

Lawrence C. Diggs Jr., Member
Caucus of African American Leaders of Maryland

Revised document 2/6/24

sb388, PDAB-upper limits FIN 2-7-2024.pdf

Uploaded by: Lee Hudson

Position: FAV

Delaware-Maryland Synod
Evangelical Lutheran Church in America
God's work. Our hands.

Testimony prepared for the
Finance Committee
on
Senate Bill 388
February 7, 2024
Position: **Favorable**

Madam Chair and members of the Committee, thank you for this opportunity to support access to adequate and appropriate medical care in Maryland. I am Lee Hudson, assistant to the bishop for public policy in the Delaware-Maryland Synod, Evangelical Lutheran Church in America. We are a faith community with a demographically diverse Maryland constituency from Red House to Ocean City.

Our community has advocated for access to appropriate, adequate, and affordable health care for all people in the United States since 2003 (*Caring for Health*, ELCA). We include medical treatment in "appropriate" and "adequate care", and therefore any calculation of "affordable".

We were among advocates for the passage of the 2019 bill establishing a Maryland Prescription Drug Affordability Board to monitor and address pharmaceutical prices covered under the State's Medicaid program. We, likewise, supported SB202/HB279 of 2023 affirming the authority of PDAB to establish upper payment limits in certain indicated circumstances.

Drug price monitoring for cost containment will benefit almost all medical clients. Expensive drugs can compromise the adequacy of medical treatment for anyone. This is a particular concern of our community for those who are financially disadvantaged. When pricing is chiefly influenced by demand, "most expensive" could also mean "most needed."

Reviewing and regulating prices on the most expensive drugs sold in the State, as PDAB is authorized to do for State programs, would have a containment effect across its pharmaceutical market. Several other states have already done this. The federal Medicare program has recently announced it is beginning to do this for some of the high-cost medications it covers. We believe Maryland, as the state innovator of prescription drug price review, should do the same.

Please make health care in Maryland more affordable for thousands of its residents. Give this bill a favorable report.

Lee Hudson

5699 Meridale Rd. Baltimore, MD 21228 410-230-2860 800-869-5492 fax 410-230-2871

2024 Written Testimony SB0388.pdf

Uploaded by: Lynn Mortoro

Position: FAV

TESTIMONY IN SUPPORT OF SB0388

Requiring the Governor in fiscal year 2025 and each fiscal year thereafter to include in the annual budget bill an appropriation of at least $1,000,000 for the Prescription Drug Affordability Fund which provides funding for the Board; and requiring the Board, under certain circumstances, to establish a process for setting upper payment limits for all purchases and payor reimbursements of prescription drug products in the State that the Board determines have led or will lead to affordability challenges.

FAVORABLE

February 6, 2024

TO: Finance Committee Chair Senator Pamela Beidle, Vice Chair Katherine Klaus

FROM: Lynn R Mortoro, member of Maryland Episcopal Public Policy Network, Diocese of Maryland

DATE: February 6, 2024

Chair Beidle and members of the Finance Committee, thank you for the opportunity to submit testimony on behalf of this bill, SB0388

The Episcopal Church has a policy urging us to advocate for Health Care.
Access to proper and affordable medication is absolutely necessary for care of all people..

As a retired nurse, I have seen many instances of inadequate health care and the need to choose between paying rent, food or medications. The medications which are needed for diabetic control, cardiac issues all get put aside costing the patient, family and community in lost wages and livelihood in addition to increased medical costs.

While the current Board has done wonderful work in efforts to set upper limits for payment for the drugs purchased by the State and Local governments, it is definitely time for that to be applied to every Marylander.

The Diocese of Maryland requests a **Favorable** vote

SB 388 - MoCo_Elrich_FAV (GA 24).pdf
Uploaded by: Marc Elrich
Position: FAV

OFFICE OF THE COUNTY EXECUTIVE

Marc Elrich
County Executive

February 8, 2024

TO: The Honorable Pamela Beidle
Chair, Finance Committee

The Honorable Guy Guzzone
Chair, Budget and Taxation Committee

FROM: Marc Elrich
County Executive

RE: Senate Bill 388, *Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding (The Lowering Prescription Drug Costs For All Marylanders Now Act)*

Senate Bill 388 requires the Prescription Drug Affordability Board to make a recommendation and establish a process for setting upper payment limits for all purchases and payor reimbursements of prescription drug products in the State that the Board determines have led or will lead to affordability challenges. The bill also requires the Governor in fiscal year 2025 and each fiscal year thereafter to include in the annual budget bill an appropriation of at least $1,000,000 for the Prescription Drug Affordability Fund which provides funding for the Board.

Since 2019, Maryland has been a leader in reigning in the cost of prescription drugs with the establishment of the Prescription Drug Affordability Board. Accessing affordable prescriptions is a life or death issue for our residents, which is why I write to you today to urge you to make it a priority of the 2024 Session to expand the authority of the Board so that all Marylanders can receive the benefits of making expensive prescription drugs more affordable.

Currently, the Prescription Drug Affordability Board can set upper payment limits for prescription drugs purchased by state, county, or local governments. We look forward to substantial savings on pharmaceutical expenses in our County budget once the Board's limits are in place. Yet it is only right that everyone in our County enjoy these savings, not just those who work in our government. Therefore, it is critical that the Board should be enabled to expand upper payment limits to all purchases of prescription drug throughout the State.

I respectfully urge the committee to issue a favorable report on Senate Bill 388.

cc: Members of the Finance Committee
Members of the Budget and Taxation Committee

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SB 388_MAP_FAV.pdf
Uploaded by: Mark Huffman
Position: FAV

Member Agencies:

211 Maryland
Anne Arundel County Food Bank
Baltimore Jewish Council
Behavioral Health System Baltimore
CASH Campaign of Maryland
Energy Advocates
Episcopal Diocese of Maryland
Family League of Baltimore
Fuel Fund of Maryland
Job Opportunities Task Force
Laurel Advocacy & Referral Services, Inc.
League of Women Voters of Maryland
Loyola University Maryland
Maryland Center on Economic Policy
Maryland Community Action Partnership
Maryland Family Network
Maryland Food Bank
Maryland Hunger Solutions
Paul's Place
St. Vincent de Paul of Baltimore
Welfare Advocates

Marylanders Against Poverty

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TESTIMONY IN SUPPORT OF SB 388

Prescription Drug Affordability Board – Authority for Upper Payment Limits and Funding

Finance Committee
February 7, 2024, 2pm

Submitted by Mark Huffman, Co-Chair

Marylanders Against Poverty (MAP) strongly supports SB 388, which will enable the Prescription Drug Affordability Board to make high-cost drugs more affordable for all Marylanders – an issue that is especially critical for the health needs of low income residents.

We are all hurt by the high cost of prescription drugs, whether it is at the pharmacy counter, through our insurance premiums, or through government spending of our taxpayer dollars. These skyrocketing costs place considerable burdens on our families and neighbors. Unfortunately, the problem is getting worse, with drug corporations increasing prices for some drugs by more than five times the inflation rate as recently as July 2023. As these costs continue to soar, many Marylanders will continue to face difficult decisions paying for their lifesaving medications or other necessities.

This is an especially critical issue for low-income Marylanders facing impossible choices between paying the rent, putting food on the table, and purchasing life-saving medical care and medicines.

In 2019, the Maryland General Assembly created the first-in-the-nation Prescription Drug Affordability Board (PDAB), a landmark approach to address the skyrocketing costs of medicines which is now being replicated across the country. The PDAB, which is chaired by former Maryland Health Secretary Van Mitchell, has the authority to implement upper payment limits to make high-cost drugs more affordable for state and local governments, but we need for that authority to extend to all drugs for all residents.

We strongly urge the Maryland General Assembly in 2024 to expand the authority of the Prescription Drug Affordability Board so that it can implement upper payment limits to make high-cost drugs more affordable for all Marylanders.

MAP appreciates your consideration and urges the committee to issue a favorable report for SB 388.

Marylanders Against Poverty (MAP) *is a coalition of service providers, faith communities, and advocacy organizations advancing statewide public policies and programs necessary to alleviate the burdens faced by Marylanders living in or near poverty, and to address the underlying systemic causes of poverty.*

SB0388 - Prescription Drug Affordability Board - A

Uploaded by: Matthew Levy

Position: FAV

THE PRINCE GEORGE'S COUNTY GOVERNMENT

OFFICE OF THE COUNTY EXECUTIVE

BILL:	**Senate Bill 388 – Prescription Drug Affordability Board – Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs for All Marylanders Act of 2024)**
SPONSOR:	**Senators Gile, Feldman, Beidle, Ellis, Guzzone, Hester, Hettleman, Jackson, Klausmeier, Kramer, and Lam**
HEARING DATE:	**February 7, 2024**
COMMITTEE:	**Finance**
CONTACT:	**Intergovernmental Affairs Office, 301-780-8411**
POSITION:	**SUPPORT**

The Office of the Prince George's County Executive **SUPPORTS Senate Bill 388**, which expands the authority of the Prescription Drug Affordability Board created in 2019. SB388 would allow the Board to enact upper payment limits for high-cost drugs to ensure they are affordable for residents of Maryland.

Many people rely on prescription drugs to manage their health. Almost half (49%) of all people in the United States use at least one prescription drug, and over one in ten (13%) use five or more prescriptions.[i] Seniors (65+ years) have even higher usage, with almost nine out of ten (88%) using at least one prescription drug.[ii] Despite heavy reliance on prescription drug treatment, cost in this industry is not well-regulated. In 2018, the United States spent over $335 billion dollars on prescription drugs, representing one-tenth (9%) of all national health expenditures.[iii]

As the cost of prescription drugs continues to climb, the financial burden of accessing needed medical treatment increases. In 2018, one in 20 people reported not taking a prescribed medication because they could not afford it.[iv] In 2022, residents of Prince George's County identified the cost of prescription drugs as one of three key barriers to receiving adequate care for their families.[v]

Residents should not face financial hardships to get the prescription medications they need to manage their health. As protectors of the public's health, it is the responsibility of government to regulate and provide accountability for the pharmaceutical industry.

Empowering this Board with authority to manage excessive drug pricing is an important step in regulating an industry that remains largely unchecked.

For the reasons stated above, the Office of the Prince George's County Executive **SUPPORTS Senate Bill 388** and asks for a **FAVORABLE** report.

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[i] Centers for Disease Control and Prevention, National Center for Health Statistics. *Therapeutic Drug Use.* November 3, 2023. https://www.cdc.gov/nchs/fastats/drug-use-therapeutic.htm

[ii] Centers for Disease Control and Prevention, National Center for Health Statistics. *Prescription drug use in the past 30 days, by sex, race and Hispanic origin, and age: United States, selected years 1988-1994 through 2015-2018.* 2018. https://www.cdc.gov/nchs/data/hus/2019/039-508.pdf

[iii] Centers for Disease Control and Prevention, National Center for Health Statistics. *National health expenditures, average annual percent change, and percent distribution, by type of expenditure: United States, selected years 1960-2018.* 2019. https://www.cdc.gov/nchs/data/hus/2019/045-508.pdf

[iv] Centers for Disease Control and Prevention, National Center for Health Statistics. *Delay or nonreceipt of needed medical care, nonreceipt of needed prescription drugs, and nonreceipt of needed dental care during the past 12 months due to cost, by selected characteristics: United States, selected years 1997–2018.* 2019. https://www.cdc.gov/nchs/data/hus/2019/029-508.pdf

[v] Prince George's County Health Department. *2022 Prince George's County Community Health Assessment.* https://www.princegeorgescountymd.gov/sites/default/files/media-document/2022%20Community%20Health%20Needs%20Assessment_Reduced.pdf

Testimony in SUPPORT of SB 388 2024 (1).pdf

Uploaded by: Michael Walsh

Position: FAV

The Lowering Prescription Drug Costs For All Marylanders Now Act / SB 388
Official Testimony
Position: **FAVORABLE**

House Health and Government Operations Committee
February 6, 2024

Dear Members of the Committee,

My name is Michael Walsh, and I'm a resident of Anne Arundel County. I am writing today in support of Senate Bill 388 - The Lowering Prescription Drug Costs For All Marylanders Now Act.

Prescription drugs don't work if you can't afford them. We are all hurt by the high cost of prescription drugs. These skyrocketing costs place considerable burdens on our communities, and unfortunately the problem is only getting worse as drug corporations increase prices for some drugs by more than five times the inflation rate as recently as July 2023. As these costs continue to soar, many Marylanders will continue to be faced with difficult decisions between paying for their life saving medications or other necessities. That is a decision I hope one day truly nobody has to make in their life.

I hope you will support this critical legislation and urge your colleagues in the House to do the same. I respectfully urge this committee to fight for all of Maryland's people by issuing a favorable report with NO weakening amendments on SB 388.

Sincerely,

Michael Walsh
District 30B
walsh2.michael@gmail.com
410-353-2756

SB388 FAV.pdf
Uploaded by: Morgan Mills
Position: FAV

NAMI Maryland
National Alliance on Mental Illness

February 7, 2024

Chairwoman Beidle, Vice Chair Klausmeier, and distinguished members of the Finance Committee,

The National Alliance on Mental Illness, Maryland and our 11 local affiliates across the state represent a statewide network of more than 58,000 families, individuals, community-based organizations, and service providers. NAMI Maryland is a non-profit that is dedicated to providing education, support, and advocacy for persons with mental illnesses, their families and the wider community.

Psychiatric medications are an important part of treatment for many people who live with a mental illness. They improve symptoms and help promote recovery and wellness, but the price for medication can often be an obstacle. NAMI MD recognizes that the cost of not treating serious mental illnesses vastly exceeds the cost of treatment.

It is important for people to be able to afford their medications so they can take them every day. Over 781,000 adults in Maryland have a mental health condition. Of the 252,000 adults in Maryland who did not receive mental health care, 33.7% did not because of the cost. [i] The cost of prescription medication can be a financial burden. We oppose pricing practices that make psychiatric medications unaffordable.

NAMI MD supports SB388, which would establish a process for the Prescription Drug Affordability Board to set upper payment limits for prescription drugs that have led to or will lead to affordability challenges. We fully support SB388 and the Prescription Drug Affordability Board's efforts to make prescription drugs more affordable in the State. NAMI MD envisions a world where all persons affected by mental illness experience recovery and wellness.

NAMI MD urges a favorable report.

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[i] MarylandStateFactSheet.pdf (nami.org)

Kathryn S. Farinholt
Executive Director
National Alliance on Mental Illness, Maryland

Contact: Morgan Mills
Compass Government Relations
Mmills@compassadvocacy.com

SB388 and HB340 Testimony- Sarah Crimmins.pdf

Uploaded by: NAMI Maryland

Position: FAV

Good afternoon,

My name is Sarah Crimmins, I am a member of NAMI, and I am writing today to ask you to support SB388/HB340, the Prescription Drug Affordability Board- Authority for Upper Payment Limits.

In my senior year of college, I was diagnosed with bipolar disorder, and after years of treatment, would eventually be diagnosed as bipolar disorder with mixed mania. This basically means that you take mania-- all the highs and tremendous energy and mood swings that come with the illness, mix it up with tremendous irritability, put it a blender and there-- you have my mood. Sometimes I am tremendously irritable and depressed and sometimes I have this massive energy but nowhere to direct it. I was always one to take medicine as prescribed but often it didn't work, or when I didn't have insurance, the cost kept me from getting the medication I needed.

Throughout the years of living with bipolar disorder, I had many obstacles that stood in the way of my wellness. I didn't have insurance at times, and I couldn't hold down a full-time job because of my illness. I was in and out of the hospital, and there was the constant search to find what medication would work. Then there was the cost of the medication. I had adverse reactions to medication—in some instances, my whole body would shake, my ankles would swell, I would gain weight, and other issues. Finding the right medication that was approved and at a reasonable price was often difficult.

When I started this journey, I was 22. Currently, I am 45 years old, and I am on disability and receive my insurance through Medicare. With extra help provided by Medicare, I can take the medication that works best for me (and has worked well for the last ten years or so). We have had to make some changes, but overall, the medication is keeping me stable. Recently, I lost my Medicaid because I was making too much money. On disability I work very part time to help keep me busy and stay active volunteering and working with NAMI. I don't make a living wage and I live at home with my parents.

It is so important to me that you pass this bill because if I were to lose the extra help provided by Medicare currently, I would be one of those people who would be affected by the cost of the drugs we are speaking of here. The drugs I take which now cost me $4.50 for a three-month supply would likely cost me up to $500 - $1,000 for a three-month supply. The search to find a more affordable medication would be so detrimental to my health and well being because we have worked so carefully to find medications that keep me stable, and it is a trial-and-error process and there is no way of knowing what they may cost as well. I need these medications to keep me well balanced and functioning. At best, the medication keeps my mood stable and keeps me on an even keel and at most it keeps me from having suicidal ideation or worse. I need this medication for a good quality of life as do many others.

So, I ask you please, as you consider this bill, think of all those people who are counting on you to make sure they can afford their medication to live their lives as they do their best to live well with the obstacles that have been placed before them.

Thank you.

Sarah Crimmins 2/5/2024

SB 388- LWVMD- FAV- Prescription Drug Affordabilit

Uploaded by: Nora Miller Smith

Position: FAV

TESTIMONY TO THE FINANCE COMMITTEE

SB0388: Prescription Drug Affordability Board- Authority for Upper Payment Limits and Funding (The Lowering Prescription Drug Costs for All Marylanders Act of 2024)

POSITION: Support

BY: Linda Kohn, President

DATE: February 7, 2024

The League of Women Voters is a nonpartisan organization that works to influence public policy through education and advocacy. **The League believes that healthcare is a human right, and that every resident should have access to affordable, equitable, quality health care, including essential medications.**

The League of Women Voters Maryland supports **Senate Bill 388: Prescription Drug Affordability Board- Authority for Upper Payment Limits and Funding (The Lowering Prescription Drug Costs for All Marylanders Act of 2024)**, which would enable the Board to work on lowering prescription drugs costs for ALL Marylanders, not just those covered by state health plans.

The cost of many prescription medications in the U.S. is extraordinarily high, and is rising. Per JAMA:[1] "**Prescription drug spending in the U.S. exceeded half a trillion dollars in 2020**. **Spending is driven by high-cost brand-name drugs, for which manufacturers freely set prices after approval**…From 2008 to 2021, launch prices for new drugs increased exponentially by 20% per year. In 2020-2021, **47% of new drugs were priced above $150,000 per year…"**

Patients taking high-cost prescription drugs may be unable to afford them, even if they have insurance coverage that pays part of the cost. They may thus delay filling a prescription, cut pills in half, or skip doses altogether to stretch supply. Families may have to choose between paying the rent and paying the pharmacy. **Healthcare providers see the dangerous consequences of their patients' inability to afford essential medications**.

The federal government has recognized the danger (and fiscal impact) of high prescription drug costs for seniors. One of the provisions of the 2022 Inflation Reduction Act was to place an out-of-pocket price cap of $35 per month on the cost of insulin for Medicare recipients, and negotiations are now underway to reduce costs for ten other commonly-used, extremely expensive medications.

But the Inflation Reduction Act's cost reductions are thus far limited to Medicare recipients. Maryland's Prescription Drug Affordability Board's ability to set upper payment limits on

[1] https://jamanetwork.com/journals/jama/fullarticle/2792986

medications considered “unaffordable” is thus far limited only to Marylanders who are covered by state and local government health plans. **Senate Bill 388 would expand the authority of the Board to implement broader cost controls that would benefit all Marylanders**, regardless of insurance coverage, enabling them to better afford the medications needed to maintain their health and their lives. By making upper payment limits available to all, the bill would reduce disparities in healthcare access. This is a matter of equity, as low-income Marylanders are the hardest hit by continually rising drug prices.

The Prescription Drug Affordability Board should have the enhanced authority to set statewide upper payment limits. For this reason, the League of Women Voters Maryland, representing 1,500+ concerned citizens throughout Maryland, strongly urges a favorable report on Senate Bill 388.

Progressive Maryland's Testimony in Support of SB

Uploaded by: Patty Snee

Position: FAV

Testimony in Support of SB 388
Prescription Drug Affordability Board-Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs for All Maylander Act of 2024

Senate Finance Committee

February 6th, 2024

Dear Honorable Chair Pamela Beidle, and Members of the Committee,

Progressive Maryland, a statewide non-profit grassroots organization with 20,000 individual members and supporters, 4 local chapters, and 21 affiliated labor, civil rights, health and environmental groups, is pleased to provide testimony in support of SB 388.

Our organization is eager to see the Committee take up this critical measure at this time. Skyrocketing drug costs have been taking a toll on Maryland families for years, particularly during the past three years, while we were in the throes of a global pandemic. While we all continue to pay more and try to figure out how we can afford the high cost medicines we need, the pharmaceutical companies are enjoying enormous profits and their CEOs are getting record breaking salaries and bonuses.

We believe as does the vast majority of everyday Marylanders we represent, that we need to address the greed in our healthcare system in order to make sure people's healthcare needs are being met when they need them. Too many people are struggling to pay for their medicines and rationing their medications because of cost. No one should be in that position.

This isn't right. Especially in light of what we pay in our country versus what residents of similar countries spend on the same drugs. We applaud The Prescription Drug Affordability Board and the excellent work it has done thus far with its staff, Board and Stakeholder Council. The PDAB gives our state the ability and opportunity to do something significant to curb high cost drugs.

The bill you're considering and that we strongly support will expand their authority and provide funding that will allow the Board to move ahead with an Upper Payment Limits action plan that will benefit our state and local governments and ultimately all Marylanders. PDAB is action in the best interests of our state and our residents.

Industry lobbyists who oppose this bill would have us believe that PDAB's actions, including setting Upper Payment Limits on high cost drugs, will hurt research and development and other advances. That's simply not true. Numerous studies have shown that drug companies are spending more money on advertising and stock buybacks than they are on R&D. It's also the case that it's often taxpayer funded research that drug manufacturers rely on.

Please vote yes on this measure to give Marylanders the financial and health relief they deserve and urge the full Senate to do the same.

SB 388 PKS Testimony .pdf
Uploaded by: Paul Schwartz
Position: FAV

Testimony of Paul Schwartz
February 7, 2024
Senate Finance Operations Committee
SB 388 – Prescription Drug Affordability Board – Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs For All Marylanders Now Act)

I am Paul Schwartz, State Legislation Chair for the National Active & Retired Federal Employees – NARFE.

I testify today in support of SB 388

I served as a government official for three federal agencies for almost 40 years

And I will tell you that one of the primary responsibilities of government is to protect its citizens

NOT ensuring affordable pricing of pharmaceuticals so that our citizens DO NOT have to forego needed medication is an abdication of government responsibility

GRANTED, applying Research & Development costs to domestic sales and not foreign sales of the same product occurs because of price controls in nations such as Great Britain, Canada and Mexico and which do not, for the most part, occur in the U.S.
Clearly, we do NOT want to IMPEDE R&D, but that is NOT the point or the problem, as is made quite clear in the research provided in the study titled **Profits Over Patients**, and, I quote:

"In 2022 manufacturers of the 10 drugs with the highest expenditures by Maryland payers, including Medicare, Medicaid, and certain commercial insurance plans, pharmaceutical companies spent $9 billion more on stock buybacks, dividends, and executive compensation than on Research & Development".

The need to provide the Prescription Drug Affordability Board with the authority to oversee pharmaceutical **profit margins** and ensure ***fair market value*** pricing of pharmaceuticals for all Marylanders is critical to the well-being of our citizens.

I'll leave you with two word: **MARTIN SKRELLI**

sb Prescription Drug Affordability Board - Copy.pd

Uploaded by: ricarra jones

Position: FAV

Testimony for SB 388
Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding
(The Lowering Prescription Drug Costs For All Marylanders Now Act)
Position: **FAV**

Dear Members Committee:

My name is Ricarra Jones, and I am the Political Director with 1199SEIU- the largest healthcare union in the nation, where we represent over 10,000 healthcare workers in Maryland. 1199SEIU United Healthcare Workers East is Maryland's largest healthcare union, representing over 400,000 healthcare workers across the East Coast. We strongly support HB 340 to expand the authority of the Prescription Drug Affordability Board and continue lowering prescription drug costs of all Marylanders.

Since the establishment of the Prescription Drug Affordability Board in 2019, Maryland has been a trailblazer in ensuring lifesaving drugs were affordable and accessible. Recent polling has shown that 88% of Marylanders are in favor of this legislative action, now we just need lawmakers who will continue to stand up to Big Pharma. This legislation aims to ensure we have sustainable investment from the State as the board expands its impact by setting upper payment limits on prescription drugs.

As healthcare workers, 1199SEIU recognizes that prescriptions do little good if our patients cannot afford them. Some of our members are even sharing medications as they struggle with their own budgets. About six in ten adults say they are currently taking at least one prescription drug and a quarter say they currently take four or more prescription medications. According to public surveys, individuals with household incomes of less than $40,000 per year and those taking four or more prescription drugs are likely to report affordability challenges.[1]

Prescription drug price increases place an unsustainable burden on our healthcare system—and that the time to hold pharmaceutical companies accountable is now. What we have today is a healthcare system where pharmaceutical companies drive prices higher through their monopolistic market power—with the largest companies spending far more on advertising than on research.

For these reasons and more, 1199SEIU urges a favorable report from the Committee

Sincerely,

Ricarra Jones
Political Director
1199 SEIU United Healthcare Workers East
Ricarra.jones@1199.org

[1] https://www.kff.org/health-costs/poll-finding/public-opinion-on-prescription-drugs-and-their-prices/

Testimony in support of SB0388.pdf
Uploaded by: Richard KAP Kaplowitz
Position: FAV

SB0388_RichardKaplowitz_FAV
2/8//2024

Richard Keith Kaplowitz
Frederick, MD 21703

TESTIMONY ON SB#/0388 - FAVORABLE

Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding (The Lowering Prescription Drug Costs For All Marylanders Now Act)

TO: Chair Beidle, Vice Chair Klausmeier, and members of the Finance Committee

FROM: Richard Keith Kaplowitz

My name is Richard K. Kaplowitz. I am a resident of District 3. I am submitting this testimony in support of SB#0388, Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding (The Lowering Prescription Drug Costs For All Marylanders Now Act)

My wife and I are aged 75 and 71 respectively. My wife has been battling some health issues and was recently prescribed a new drug that could help alleviate part of those issues. The price for a monthly supply of that drug was hundreds of dollars above what her insurance would pay for a possible life altering treatment. We are both on fixed income and my wife had to decline to fill her prescription.

We live in a senior adult retirement community and, in conversations with my neighbors, find the lack of affordability of drugs is a consistent challenge for many of us. There are more seniors in Frederick County than school age children and we are a fast-growing component of the population.

If we are to have better outcomes medically and a better quality of life, we must create some controls on the prices of drugs we are prescribed. This bill is an attempt to rein in the unconscionable prices of many of the medication's seniors are now being prescribed.

I respectfully urge this committee to return a favorable report on SB#0388.

SB 388 - FAV - MSCAN Testimony.pdf

Uploaded by: Sarah Miicke

Position: FAV

Maryland Senior Citizens Action Network

MSCAN

AARP Maryland

Alzheimer's Association, Maryland Chapters

Baltimore Jewish Council

Catholic Charities

Central Maryland Ecumenical Council

Church of the Brethren

Episcopal Diocese of Maryland

Housing Opportunities Commission of Montgomery County

Jewish Community Relations Council of Greater Washington

Lutheran Office on Public Policy in Maryland

Maryland Association of Area Agencies on Aging

Maryland Catholic Conference

Mental Health Association of Maryland

Mid-Atlantic LifeSpan

National Association of Social Workers, Maryland Chapter

Presbytery of Baltimore

The Coordinating Center

MSCAN Co-Chairs:
Carol Lienhard
Sarah Miicke
410-542-4850

Testimony in Support of SB 388 Prescription Drug Affordability Board-Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs for All Marylanders Act of 2024)
Senate Finance Committee
February 7, 2024

The Maryland Senior Citizens Action Network (MSCAN) is a statewide coalition of advocacy groups, service providers, faith-based and mission-driven organizations that supports policies that meet the housing, health, and quality of care needs of Maryland's low and moderate-income seniors.

SB 388 would allow the Prescription Drug Affordability Board to establish a process for setting upper payment limits for all purchases and payor reimbursements of prescription drug products in the State.

Americans are worried about the high cost of prescription drugs. They are looking for politicians to push for legislative solutions like the Prescription Drug Affordability Board. AARP surveyed a nationally representative sample of more than 1,000 adults 50 and older in September about the price of medications, knowledge of recent Medicare-related legislation, and the likelihood of voting for congressional candidates who support measures to address prescription drug costs.

The survey shows that 60% of respondents are very or somewhat concerned about being able to afford buying the medication they or someone in their family might need. This finding holds regardless of political ideology. Meanwhile, women (63%) are slightly more concerned than men (56%) about the issue.

Older adults need access to affordable prescription drugs. Nobody should have to choose between the drugs they need to live and necessities like housing or food. SB 388 would expand the authority of the Prescription Drug Affordability Board to make high-cost prescription

MSCAN believes that state governments should implement proven programs to increase access to appropriate drug pricing.

MSCAN respectfully requests a favorable report for on SB 388.

SB388 Prescription Drugs .pdf

Uploaded by: Sarah Miicke

Position: FAV

BALTIMORE JEWISH COUNCIL

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Beth Tfiloh Congregation
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B'nai Israel Congregation
B'nai Jacob Shaarei Zion Congregation
Bolton Street Synagogue
Chevra Ahavas Chesed, Inc.
Chevrei Tzedek Congregation
Chizuk Amuno Congregation
Congregation Beit Tikvah
Congregation Tiferes Yisroel
Federation of Jewish Women's Organizations of Maryland
Hadassah
Har Sinai - Oheb Shalom Congregation
J Street
Jewish Federation of Howard County
Jewish Labor Committee
Jewish War Veterans
Jewish War Veterans, Ladies Auxiliary
Jewish Women International
Jews For Judaism
Moses Montefiore Anshe Emunah Hebrew Congregation
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Ner Tamid Congregation
Rabbinical Council of America
Religious Zionists of America
Shaarei Tfiloh Congregation
Shomrei Emunah Congregation
Suburban Orthodox Congregation
Temple Beth Shalom
Temple Isaiah
Zionist Organization of America Baltimore District

WRITTEN TESTIMONY

Senate Bill 388 - Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs for All Marylanders Act of 2024)

Finance Committee

February 7, 2024

SUPPORT

Background: Senate Bill 388, (SB388) would expand on the 2019 Prescription Drug Affordability Board law. This law gave the Board the authority to implement upper payment limits to make high-cost drugs more affordable for state and local governments, which it will soon establish with the approval of the Legislative Policy Committee. SB 388 would expand the Board's authority to make high-cost drugs more affordable for all Marylanders.

Written Comments: Written Testimony: The Baltimore Jewish Council (BJC) has long been concerned about the rising cost of health care, particularly pharmaceutical drugs. Drug costs are a major cause of higher health care premiums and cause significant financial challenges for our community members who live on fixed incomes. In fact, 45 percent of Maryland households struggle to afford their medications. This means that Marylanders are choosing between their needed medications and other basic necessities like food and shelter.

While we appreciate that drug manufacturers must earn enough to cover the underlying research and development costs associated with developing new drugs and bringing them to the market, too many examples exist of manufacturers dramatically increasing prices for life-saving drugs with little or no logical rationale.

For these reasons, we as for a favorable report on SB388.

The Baltimore Jewish Council, a coalition of central Maryland Jewish organizations and congregations, advocates at all levels of government, on a variety of social welfare, economic and religious concerns, to protect and promote the interests of the Associated Jewish Community Federation of Baltimore, its agencies and the Greater Baltimore Jewish community.

BALTIMORE JEWISH COUNCIL
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Member of the Jewish Council for Public Affairs

Baltimore Jewish Council is an agency of The Associated
The Associated
Jewish Federation of Baltimore

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Past President

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Executive Director

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American Zionist Movement
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Jewish Federation of Howard County
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Jewish War Veterans
Jewish War Veterans, Ladies Auxiliary
Jewish Women International
Jews For Judaism
Moses Montefiore Anshe Emunah
Hebrew Congregation
National Council of Jewish Women
Ner Tamid Congregation
Rabbinical Council of America
Religious Zionists of America
Shaarei Tfiloh Congregation
Shomrei Emunah Congregation
Suburban Orthodox Congregation
Temple Beth Shalom
Temple Isaiah
Zionist Organization of America
Baltimore District

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Member of the Jewish Council for Public Affairs

Baltimore Jewish Council is an agency of The Associated

The Associated
Jewish Federation of Baltimore

DG Written Testimony_SB0388

Uploaded by: Senator Gile

Position: FAV

DAWN D. GILE
Legislative District 33
Anne Arundel County

Finance Committee

Chair
Anne Arundel County
Senate Delegation

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THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

Testimony in Support of Senate Bill 388

Prescription Drug Affordability Board – Authority for Upper Payment Limits and Funding

Lowering Prescription Drug Costs for All Marylanders Act of 2024

Madam Chair, Vice Chair Klausmeier, and fellow members of the Senate Finance Committee:

The skyrocketing cost of prescription drugs remains a growing issue for Marylanders across our state, particularly as we continue to reckon with the lasting health and economic impacts of the COVID-19 pandemic. While there has been attention to this issue on both the state and federal level, Marylanders continue to struggle to afford the medicines they need, with one in three residents reporting that they have skipped a dose, rationed medication, or left a prescription at the pharmacy counter due to cost.[i] Even those who are able to afford their medications are left paying a hidden "prescription drug tax," as these excessive prices impact us all. Whether it's through our out-of-pocket costs, our insurance premiums, or our taxpayer dollars, we are all hurt by the high cost of prescription drugs. Senate Bill 388, which would expand the authority of our Prescription Drug Affordability Board to address drug costs for *all* Marylanders, is an opportunity to provide direct relief to our residents and to ensure much-needed cost containment for our state.

What is the issue?

Prescription drug prices are increasingly unaffordable, meaning lifesaving medications sit out of reach for patients and elevate costs across the health care system. With little in the form of existing regulation, the prescription drug pricing system operates in dysfunction and complexity, prioritizing profits over people. Prices regularly rise faster than the rate of inflation, with much of our increased spending coming from price hikes on existing medications, rather than on the introduction of innovative products.[ii] While pharmaceutical corporations claim that these prices are needed to offset the costs of research and development, a recent report from Public Citizen shows that pharmaceutical manufacturers routinely invest significantly more in self-enriching activities than on innovation. Notably, the manufacturers of the ten drugs chosen for review under the Medicare negotiation provisions of the Inflation Reduction Act spent $22 billion more on stock buybacks, executive compensation, and advertising than they did on research and development expenses in 2022 alone.[iii]

With some new drugs coming to market with multi-million-dollar price-tags per single use, it is difficult to see how anyone could call these products affordable.[iv] While it is true that this is not necessarily the price that a patient would pay, it is still cause for public concern. List prices are the basis of what

pharmacies and patients pay, but just as importantly, these exorbitant prices only serve to drive up the costs of our insurance premiums and strain our state and local government budgets. The Maryland Health Benefit Exchange reports that prescription drugs represented nearly thirty percent of the total spending for privately insured markets in Maryland in 2020. Similar numbers were shared by Chet Burrell, former CEO of CareFirst BlueCross BlueShield in 2017, indicating this is a long-standing concern and one that is felt throughout the health insurance market. Specialty drugs are of issue, accounting for nearly 50% of CareFirst's total drug spending, as reported in 2020.[v] This is significant, as specialty drugs represent a growing share of the newly approved medications coming to market. These products are often priced much higher than traditional prescription drugs, increasing the burden to our health plans, government and employer budgets, and patients directly.[vi] Even when out-of-pocket costs are relatively manageable, we are all left paying for these expensive prescription drugs, regardless of whether we personally use them.

What has been done so far?

In 2019, under the direction of this committee, the Maryland General Assembly created the nation's first Prescription Drug Affordability Board.[vii] The Board, which is modeled after state public utility or service commissions, is designed to serve as a watchdog for Maryland and our residents, examining high-cost drugs and determining fair, affordable rates for these products. Despite years of obstruction following the law's passage, the Board has done considerable work to build the necessary infrastructure for a novel state agency, including establishing an independent funding source which has allowed the Board to begin its work.

The prescription drug supply chain is crowded and complicated, with little transparency as to how costs are determined. Importantly, the Board is tasked with reviewing the entirety of the supply chain, ensuring that its decisions balance the need for consumer affordability with the revenue needs of suppliers. Currently, our Board has been granted the authority to address the cost of prescription drugs for state and local governments, pending the approval of the Legislative Policy Committee. We have heard from several local leaders that prescription drug costs present a significant challenge to their budgets, with the cost of employees' prescription drug coverage limiting the other public services that can be provided.[viii] This initial work of the Board will be critical in addressing this issue, alleviating the burden on our taxpayers.

Separate from our state's Prescription Drug Affordability Board, but nearly as important, is the 2022 passage of the Inflation Reduction Act (IRA). Under the leadership of President Joe Biden and Vice President Kamala Harris, the IRA represents the most significant action that Congress has taken to address the cost of prescription drugs, granting Medicare the power to negotiate a maximum fair price for selected medications, in addition to other measures designed to contain costs for Medicare recipients. This law will provide real relief to the one million Marylanders enrolled in Medicare and can serve as a blueprint for our Board's work, as well.

What still needs to be accomplished?

While the Board's initial work to address costs for state and local government entities is commendable, it is not a comprehensive solution to the issue at hand. The legislation as-introduced in 2019, and again here today, envisions a broader authority for the Prescription Drug Affordability Board, allowing it to establish a maximum statewide rate—or upper payment limit— that *all* Marylanders and supply chain entities could pay for selected high-cost medications. Though an upper payment limit seems novel, rate setting is ubiquitous in health care and for prescription drug products. Today, each drug on the market is reimbursed at hundreds of different payment rates across the country; allowing our Board to establish a statewide rate utilizes existing practices to help ensure that all Marylanders have access to the prescription drugs they need.

Much of the work that the Prescription Drug Affordability Board has already done to establish a process for cost reviews and determinations will translate easily to a statewide upper payment limit mechanism. When reviewing a prescription drug, the Board will consider a broad range of economic factors, including allowing pharmaceutical manufacturers to justify existing drug prices. When an appropriate rate is determined following a review of public information, manufacturer-reported data, and other data sources, the upper payment limit will apply to all purchasers and payor reimbursements in Maryland, eliminating the need for the rebate process and ensuring that lower costs benefit consumers.

Why now?

While I applaud our Prescription Drug Affordability Board for its work so far, the truth remains that it can currently do little to help Maryland patients directly. Too many of our families and neighbors have been faced with the impossible decision of choosing between the medication they need and their economic stability. Community organizations and leaders have indicated this remains a is a top issue for their members. Groups like the NAACP, AARP, AFSME, 1199 SEIU, the Legislative Black Caucus and the 450+ member Health Care for All! Coalition have all spoken to the importance of addressing high-cost drugs. Collectively, they are asking the Maryland General Assembly to do more.

As mentioned before, many of the cost review and rate determination processes that the Board has already established will operate seamlessly with a statewide upper payment limit. With these initial state and local government rates likely to go into effect in the next PBM contracting period in 2025, the state should be able to see immediate projected savings from this first step. By granting the Board this expanded authority with the requirement that it again have its plan approved by the Legislative Policy Committee, we are ensuring that the state is well-positioned to act swiftly to address costs more broadly following completion of this pilot phase, rather than forcing Maryland patients to wait yet another year to see relief. By expanding the Board's authority Maryland can join the ranks of Colorado, Minnesota, and Washington states, which have all created Prescription Drug Affordability Boards with full statewide upper payment limit authority.

This session, we have an opportunity to help Marylanders struggling to afford the medications they need. It is time that we insist that patients are put over profits, because drugs don't work if people can't afford them. I respectfully request a favorable report on Senate Bill 388.

What you will hear from opposition

The drug corporations claim that upper payment limits on high drug costs will hinder their ability to fund necessary drug innovation. While drug corporations claim to need these staggering prices to fund research on new prescription drugs, they do not actively prioritize the effort now. In short, if pharmaceutical manufacturers need to trim their budgets, there are several areas they could pull from before research and innovation.

The fact is, they spend billions more on self-enriching activities like stock buybacks, executive compensation, and advertising than they do on research and development.[ix] As a new Report by Public Citizen entitled "Patients over Profits" shows, the corporations which produced the ten drugs chosen by the federal government for Medicare price negotiation under the Inflation Reduction Act spent $22 billion more on advertising and self-enriching expenditures such as stock buy backs and dividends than on research. They also spend considerable amounts of their money trying to influence policy. The Public Citizen report shows 13 of the nation's largest patient advocacy organizations received a combined total of $266 million between 2010 and 2022—notably, many of these same organizations have stayed silent or opposed drug cost containment efforts.[x] In addition, PhRMA donated money directly to political organizations working against federal drug pricing reform, including millions to GOP-linked American Action Network, and over $500,000 to the Heritage Foundation, a right-wing fringe group that has fought against voter access and actively denies the results of the 2020 election.[xi][xii] It is also true that increased drug spending is largely due to price hikes on existing medications rather than the introduction of innovative products.[xiii] Finally, federal taxpayer dollars already subsidize drug research and development, a fact that is underreported in patent filings.[xiv] In fact, the NIH is the largest public funder of biomedical research and development, contributing billions (97 for basic research, 28 for clinical trials, and 9 for workforce development) between 2017 and 2021.[xv] Every single new prescription drug that came to market between 2010 and 2020 had origins in publicly funded research.[xvi] That is why Senator Chris Van Hollen has introduced the We Paid Act to require that drug corporations whose research on a drug is largely funded by the federal government have to go through a review process before they can charge exorbitant prices for that drug.

The opposition also claims that PDABs can hurt the development of orphan drugs. Prescription Drug Affordability Board must have the ability to review and set upper payment limits on products with orphan drug designation to be truly effective. While an orphan drug is a medication intended to treat a rare condition (one that has a patient population under 200,000), the financial incentives of this designation have resulted in drug companies increasingly seeking this status for existing drugs on the market that are used to treat common diseases. As a result, more than half of orphan drug spending is for non-orphan conditions.[xvii] Seven of the top ten selling drugs have orphan drug designation.[xviii] Due to generous federal government benefits and protections, research has shown that orphan drugs have less investment risk and are less costly to develop due to expedited approval reviews, shorter trials, and proxy outcomes.

Another argument the opposition makes is that upper payment limits are unconstitutional. While it is true that Maryland's 2017 anti-price gouging law regarding generic drugs was deemed unconstitutional in the Fourth Circuit, this approach is markedly different from that law. Legal analysis from national firms and Maryland's Attorney General argue that upper payment limits are constitutional. The threat of litigation from PhRMA and the industry cannot keep us from taking meaningful action for our state's

residents. As one of the most well-financed sectors in the world, the industry frequently uses the threat of legal challenges to try to quiet regulation attempts.

The threat of retribution by drug manufacturers leaving the state should not be taken seriously, as many manufacturers have chosen to locate in Maryland for a multitude of reasons, like proximity to NIH and the FDA. Additionally, pharmaceutical corporations have headquarters and operations in countries with rate setting authority, and it is unlikely that groups will spend unnecessary resources to move manufacturing when Prescription Drug Affordability Boards have been established and are being considered in multiple states.

Not surprisingly drug manufactures also try to shift the blame for high drug costs to others in the supply chain like PBMs. A PDAB is uniquely equipped to address this issue, as it is designed to look at the *entirety* of the supply chain when determining upper payment limits. If fault truly lies with one specific party, a UPL will solve this issue by effectively eliminating the rebate determination process that occurs behinds closed doors. Giving our PDAB full upper payment limit authority will allow it to protect Marylanders from high-cost drugs.

While some drug manufacturers use the threat of not selling a drug with an upper payment limit as blackmail in the face of any proposed regulation, it is incredibly unlikely that they would refuse to sell in a state simply due to an upper payment limit on a product. First, pharmaceutical manufacturers already sell their products in countries with robust rate-setting or price-control authorities because a regulated market is still economically more appealing than no market at all. Simply put, they are unlikely to pass up an opportunity for profit, even if it is somewhat reduced. Second, currently these companies operate under a high-cost, low-utilization model, leaving many Americans and Marylanders without the drugs they need. By introducing a UPL and adopting a high-use, lower-cost model as a result, it is possible that manufacturers could see similar profits. And, finally, Maryland has strong consumer protection laws that prevent advertising without intent to sell and withholding supply for purpose of raising prices. With broad regional and national advertising markets for these drugs, this would give us protection against a manufacturer refusing to sell drugs they are advertising.

For all of these reasons, I respectfully request a favorable report on SB388.

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[i] https://healthcareforall.com/wp-content/uploads/2023/09/Statewide-MD-Poll-on-Prescription-Drug-Affordability-PDAB-091123.pdf

[ii] https://www.npr.org/sections/health-shots/2019/01/07/682986630/prescription-drug-costs-driven-by-manufacturer-price-hikes-not-innovation#:~:text=%22Once%20a%20drug%20has%20been,for%20certain%20types%20of%20drugs

[iii] https://www.citizen.org/article/profits-over-patients/

[iv] https://www.drugs.com/article/top-10-most-expensive-drugs.html

[v] https://pdab.maryland.gov/documents/meetings/pdab_prst_carefirst_20201019.pdf

[vi] https://www.healthaffairs.org/do/10.1377/hpb20131125.510855/full/healthpolicybrief_103-1554749221727.pdf

[vii] https://mgaleg.maryland.gov/2019RS/Chapters_noln/CH_692_hb0768e.pdf

[viii] https://pdab.maryland.gov/documents/stakeholders/CEs_memo_to_pdab_complete.pdf
[ix] https://www.citizen.org/article/profits-over-patients/
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[xiv] https://www.gao.gov/assets/gao-23-105656.pdf
[xv] https://www.gao.gov/products/gao-23-105656#:~:text=Fast%20Facts,or%20recognized%20by%20the%20public.
[xvi] https://www.ineteconomics.org/perspectives/blog/us-tax-dollars-funded-every-new-pharmaceutical-in-the-last-decade
[xvii] https://www.optum.com/en/business/insights/pharmacy-care-services/page.hub.orphan-drugs-market-can-we-afford-them.html
[xviii] https://info.evaluate.com/rs/607-YGS-364/images/Evaluate%20Orphan%20Drug%20Report.pdf

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Position: FAV

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HEALTH BENEFIT
EXCHANGE

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February 7, 2024

The Honorable Pamela G. Beidle
Chair, Senate Finance Committee
Senate Office Building, 3 East
11 Bladen St.
Annapolis, MD 21401

Re: Letter of Support – SB 388 – Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs for All Marylanders Act of 2024)

Dear Chair Beidle and Members of the Senate Finance Committee,

The Maryland Health Benefit Exchange (MHBE) respectfully submits this letter of information for Senate Bill (SB) 388 – Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding. SB 388 would expand the authority of the Prescription Drug Affordability Board to establish a process for setting upper payment limits for all purchases and payor reimbursements of prescription drug products in the State, that the Board determines have led or will lead to an affordability challenge.

MHBE supports state-wide efforts to address high costs of prescription drug products and health care costs generally and would also like to address the potential impact reigning in high costs of certain prescription drugs could have on lowering commercial health insurance premiums. A report from the Maryland Health Care Commission cited prescription drugs accounted for almost a third **(29.7 percent)** of total per capita spending for privately insured markets in Maryland in 2020. The report also found a **7.2 percent** increase in per capita spending on prescription drug products between 2019 and 2020, largely accounted for by increased unit cost of products.[1] Lower prices for higher-cost prescription drugs could reduce commercial insurers' per capita spending, putting downward pressure on average monthly premiums, along with out-of-pocket drug costs for consumers.

Lower prices for higher-cost prescription drugs could also reduce consumers' out-of-pocket spending. Recent polling by the Kaiser Family Foundation found that more than a quarter of adults taking prescription drugs report difficulty affording their medication, including 40% of those with annual household incomes below $40,000.[2]

While difficult to estimate, lowering certain prescription drug costs would also potentially decrease costs associated with the State's Reinsurance Program, which works to mitigate the impact of high-cost enrollees on premium rate increases in the individual market. Specifically, lower prescription drug costs could reduce the number of individuals whose annual costs exceed

[1] Maryland Health Care Commission: Spending and Use Among Maryland's Privately Insured Report, 2020 (2022).
[2] Kaiser Family Foundation: Public Opinion on Prescription Drugs and Their Prices (August 2023).

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the threshold at which reinsurance payments made by the State to an individual's insurer kicks in ($20,000 for plan year 2024),[3] and, for those individuals who reach the threshold, reduce the claims costs that Reinsurance Program reimburses.

For further discussions or questions on SB 388, please contact Johanna Fabian-Marks, Director of Policy and Plan Management at johanna.fabian-marks@maryland.gov.

Sincerely,

Michele Eberle
Executive Director

[3] Maryland Health Benefit Exchange: 2022 Reinsurance Results and 2024 Reinsurance Parameters (July 2023).

Support - SB 388 Prescription Drug Affordability B

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Position: FAV

Unitarian Universalist Legislative Ministry of Maryland

Shared Voices for Liberal Religious Values in Maryland

TESTIMONY IN SUPPORT OF SENATE BILL 388

Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding
(Lowering Prescription Drug Costs for All Marylanders Act of 2024)

Before the Senate Finance Committee

By Stephen C. Buckingham, Lay Community Minister and Advocacy Lead
Unitarian Universalist Legislative Ministry of Maryland

February 7, 2024

Chair Beidle, Vice-Chair Klausmeier, and Members of the Finance Committee, thank you for this opportunity to testify in favor of SB 388, which would give the Prescription Drug Affordability Board the authority to set upper payment limits to make high-cost drugs affordable for ALL Marylanders. Special thank you to Senator Gile and Senator Feldman for sponsoring this life-saving legislation.

The Unitarian Universalist Legislative Ministry of Maryland (UULM-MD), an advocacy organization with members in Unitarian Universalist (UU) congregations throughout the state, joins other advocates to support SB 388. Health care has been a priority since our establishment 15 years ago and is supported at our national level because it supports our unifying principles especially the respect for the inherent worth and dignity of each person. We see health care as a right for all human beings, and our government should not allow prescription drug providers to make prescriptions unaffordable in order to maximize profits.

Many individuals rely on affordable prescription medications for their basic health; yet, often these essential drugs are financially out of reach for many people. We support public policies to end outrageous and unfair costs for prescription medications.

When the General Assembly created this first-in-the nation Board in 2020, it limited its authority to reducing drug costs for state and local governments. Since then, the Board has engaged in extensive studies of the pharmaceutical delivery and payment process and has examined several policy options to reduce prices to consumers/patients, including upper payment limits and bulk purchasing. Unfortunately, bulk purchasing would naturally protect only those people whose health coverage comes from state and local governments. This would leave the rest of us at the mercy of drug providers.

While we are still awaiting the Board's recommendations, we are impressed with its objectivity and the level of detail in its work. This gives us confidence that viable solutions will be recommended, but they must include benefits to all Marylanders. Now is the time to allow the Board to use upper payment limits for all purchasers of high-cost prescription drugs, with the goal of reducing prescription drug costs for all, not state and local governments.

We appreciate the opportunity to present our faith perspective and to work with you to make a difference in Maryland.

UULM-MD asks you to continue to lead the nation in making prescription drugs affordable for all. Please vote for a favorable report on SB 388.

Thank you!

Stephen C. Buckingham

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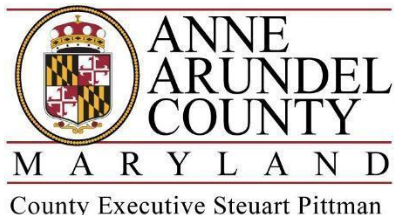
Position: FAV



February 7, 2024

Senate Bill 388

Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs for All Marylanders Act of 2024)

Senate Finance Committee

Position: FAVORABLE

Anne Arundel County **SUPPORTS** Senate Bill 388 – Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs for All Marylanders Act of 2024).

This Bill will significantly enhance efforts to make prescription drugs affordable by requiring the Governor to appropriate at least $1,000,000 to the Prescription Drug Affordability Fund from the annual budget and expand the authority of the PDAB to establish a process that will review and set upper-cost limits for all prescription drug purchases. This will benefit all Marylanders.

In 2022 alone, more than 4,200 drug products in our nation had price increases. And of these increases, 46% were greater than the inflation rate of the same period. Rising drug prices hurt our most vulnerable communities, who are already suffering from other inequalities, by further depriving them of essential medications. Drugs save lives, but they do not work if the people who need them cannot afford them.

High prescription costs are a national issue, and we have the opportunity right now to show everyone that we can tackle this challenge on the local level with the nation's first state Prescription Drug Affordability Board. We must give our full support to ensure its success and establish an effective and fair cost-reduction system. For all of these reasons, I respectfully request a **FAVORABLE** report on Senate Bill 388.

Steuart Pittman
County Executive

Ethan Hunt, Director of Government Affairs Phone: 410-222-3687 Email:exhunt23@aacounty.org

02.06 - SB 388 - Prescription Drug Affordability

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Position: FAV

SB 388 - Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding (The Lowering Prescription Drug Costs For All Marylanders Now Act)
Finance Committee
February 7, 2024
SUPPORT

Chair Beidle, Vice-Chair Klausmeier and members of the committee, thank you for the opportunity to submit testimony in support of Senate Bill 388. This bill would give the Prescription Drug Affordability Board the authority to set upper payment limits to make high-cost drugs affordable for all Marylanders. Special thank you to Senator Gile and Senator Feldman for sponsoring this life-saving legislation.

The CASH Campaign of Maryland promotes economic advancement for low-to-moderate income individuals and families in Baltimore and across Maryland. CASH accomplishes its mission through operating a portfolio of direct service programs, building organizational and field capacity, and leading policy and advocacy initiatives to strengthen family economic stability. CASH and its partners across the state achieve this by providing free tax preparation services through the IRS program 'VITA', offering free financial education and coaching, and engaging in policy research and advocacy. **Almost 4,000 of CASH's tax preparation clients earn less than $10,000 annually. More than half earn less than $20,000.**

According to Prosperity Now's most recent scorecard for Maryland, 20.2% of Maryland households experience income volatility, and 26.7% had difficulty paying for usual household expenses.[1] This shows that at least one fifth of Marylanders struggle to pay for basic expenses, including their prescriptions. Recent polling shows as many as 45% of Marylanders report struggling to afford the medicines they need, with one third of Marylanders skipping a dose or rationing medication due to cost. At the same time, skyrocketing drug costs are contributing to all of our health insurance premiums, making quality coverage less affordable for our residents. Meanwhile, prescription drug corporations use far more resources on self-enrichment and advertising than they do on research and development. Marylanders should not have to choose between their prescription drugs and other necessities like housing or food.

It is clear that Maryland residents, particularly low- to moderate-income communities are facing tremendous cost burdens in accessing medication. SB 388 builds upon Maryland's successful tradition of health care cost scrutiny and protects low- to moderate-income individuals and families from unnecessary price-hikes related to their prescription medications.

<u>Thus, we encourage you to return a favorable report for SB 388.</u>

[1] Prosperity Now: https://scorecard.prosperitynow.org/data-by-location#state/md

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SB 388 PDAB Authority Testimony_FAV_DeMarco_FINAL.

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Position: FAV

TESTIMONY IN SUPPORT OF SENATE BILL 388
Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs for All Marylanders Act of 2024)
Before the Senate Finance Committee
By Vincent DeMarco, President, Maryland Health Care For All! Coalition
February 7, 2024

Madam Chair, Madam Vice-Chair, and Members of the Finance Committee, on behalf of the over 450 faith, community, labor, business and health care organizations which are part of our Maryland Health Care For All! Coalition, we strongly urge you to support SB 388. This legislation builds on the landmark Prescription Drug Affordability Board law you enacted in 2019 which created the nation's first Prescription Drug Affordability Board and gave it the authority, with the approval of the Legislative Policy Committee, to use upper payment limits to make high cost drugs more affordable for state and local governments in Maryland. SB 388 would expand the Board's authority to make high cost drugs more affordable for all Marylanders. Three states, Colorado, Minnesota and Washington State, have enacted legislation modeled on our 2019 law which gives their Prescription Drug Affordability Boards full authority to help everyone in their states afford high cost drugs.

As you know very well, drugs don't work if people can't afford them. As you can see from the attached poll recently conducted by respected pollster OpinionWorks, 45 percent of Maryland households have had trouble affording their necessary medications. As you have heard today this translates into people not taking the medications they need or rationing how much they take or depriving themselves of other necessities. In addition, we all pay because insurers pay an exorbitant amount for high cost drugs, with CareFirst BlueCross BlueShield stating that one third of their premium costs are because of high cost drug costs. Finally, governments and health officials often can't afford the necessary medicines they need to address overdoses or other public health problems because of the skyrocketing costs of naloxone, EpiPen's and other needed medications.

This is why as the OpinionWorks poll shows, over 80 percent of Marylanders support giving the Board the authority it needs to use upper payment limits to make high cost drugs more affordable for all Marylanders. That is also why our broad coalition (see attached logo flyer and list) and Maryland's local leaders urge you to enact SB 388. Attached for you are letters written by many of them in strong support of the legislation.

Though the skyrocketing cost of prescription drugs impacts all Marylanders-- whether at the pharmacy counter, through our insurance premiums, or our taxpayer dollars-- this burden also contributes to glaring racial and ethnic health inequities that continue to persist in our country. Social, political, and economic conditions result in Black and Latino Marylanders being more likely to suffer from certain chronic conditions that require expensive prescription

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medications. Additional social factors like higher risk occupations, higher levels of poverty, and barriers to navigating the health care system exacerbate these issues. In addition, while the state has recently made historic gains in health insurance coverage, Black, Latino, and Asian American Marylanders remain disproportionately represented among the uninsured. All of this means that skyrocketing prescription drug costs cause disproportionate harm by race and ethnicity. Passing SB 388 is a matter of health equity.

While we are pleased with the progress the Board has made under Chair Van Mitchell, this legislation will give them the authority they need to help all Marylanders afford their high cost drugs. We thank Senators Dawn Gile and Brian Feldman for introducing this measure and we thank you, Madam Chair, and all the Members of this Committee for your leadership on this issue which has made our legislation a model for other states across the country.

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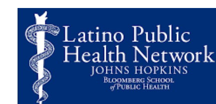
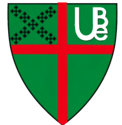
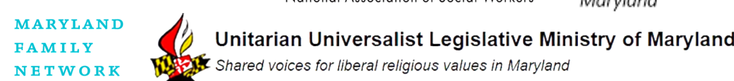
Maryland Prescription Drug Affordability Coalition



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To: Vincent DeMarco, President
Maryland Health Care For All Coalition

From: Steve Raabe, President
OpinionWorks LLC

Date: September 11, 2023

Subject: Maryland Poll: Attitudes about Prescription Drug Affordability Board

OVERVIEW AND SUMMARY

The Maryland Health Care For All Coalition commissioned this statewide poll of Maryland registered voters to assess public opinion on issues surrounding prescription drug affordability and a proposal to expand the authority of Maryland's Prescription Drug Affordability Board.

These findings are based on our statewide poll of 1,090 registered voters, conducted online and by telephone from August 10 to 17, 2023. The poll has a potential sampling error of ±3.0% at the 95% confidence level. A more detailed methodology statement is found at the end of this memorandum.

Summary of Findings

This statewide poll shows widespread concern among Maryland voters about prescription drug costs, resulting in overwhelming support for Maryland's Prescription Drug Affordability Board. Furthermore, voters overwhelmingly favor expanding the Board's authority so it can limit high drug costs for all Marylanders. That support cuts across all party lines, with very strong support from Democrats, Republicans, and Independents.

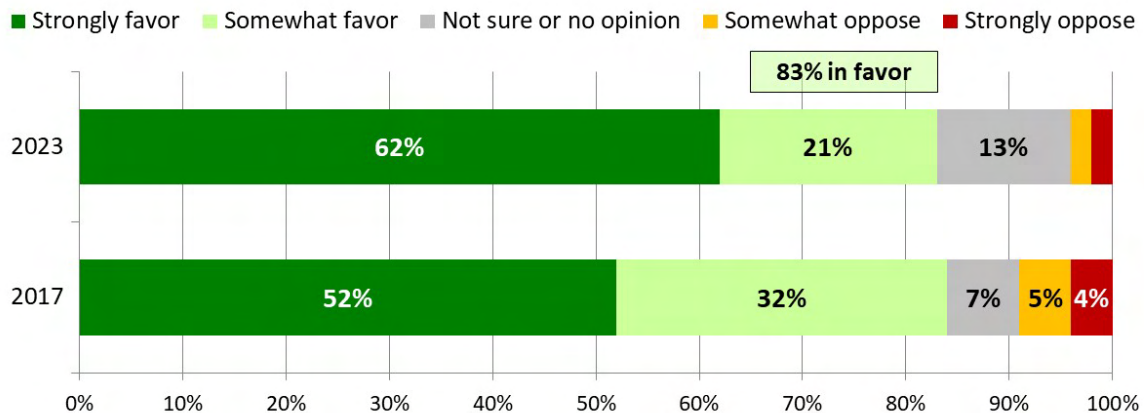
DETAILED FINDINGS

Prescription Drug Affordability Board: Strong and Growing Support among Maryland Voters

More than four out of five voters (83%) favor having a Prescription Drug Affordability Board with the power to make high-cost drugs more affordable. Almost two-thirds (62%) of voters favor the Board *strongly*.

This very strong support for the Board has only increased since we first asked about it in 2017, before the Board was enacted. At that time, 52% percent of Maryland voters strongly favored creating a board and 32% somewhat favored it. Almost one in ten voters opposed the concept, opposition that has nearly vanished today.

Note that only one-fifth (21%) of voters in the current poll said they knew about the Board before hearing it described in the poll, suggesting that there is much more work to do to share the concept with voters.



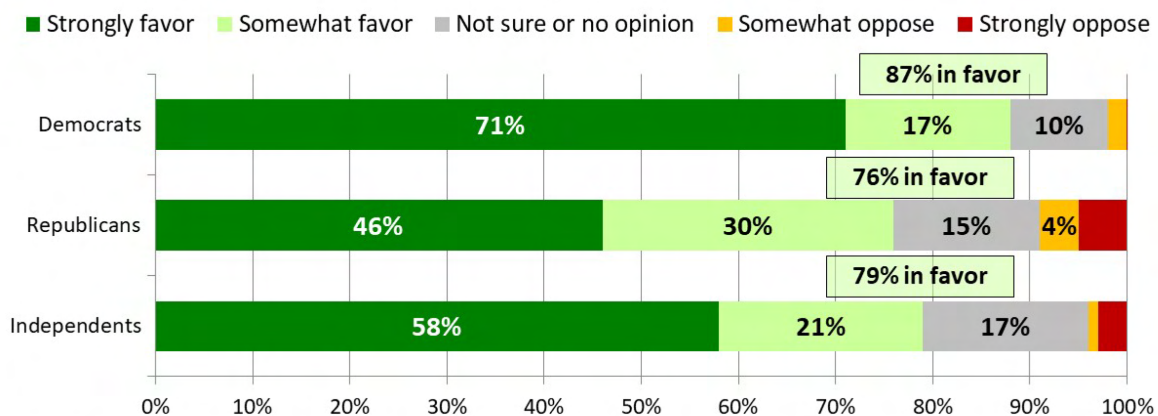
In 2019, Maryland became the first state in the nation to create a Prescription Drug Affordability Board, which is an independent body with the authority to examine the evidence and establish more affordable costs for expensive prescription drugs.

Based on this description, do you strongly favor, somewhat favor, somewhat oppose, or strongly oppose a Maryland Prescription Drug Affordability Board with the power to make high-cost drugs more affordable?

(Question asked with slightly different wording in 2017.)

In this partisan age, it is significant that support for the Affordability Board crosses all party lines:

- More than three-quarters of Republicans (76%) favor the Board, with a near majority of 46% strongly in favor.
- Four out of five Independent voters (79%) favor it, with 58% strongly in favor.
- Among Democrats, support climbs to 87%, with 71% strongly in favor of the Board.

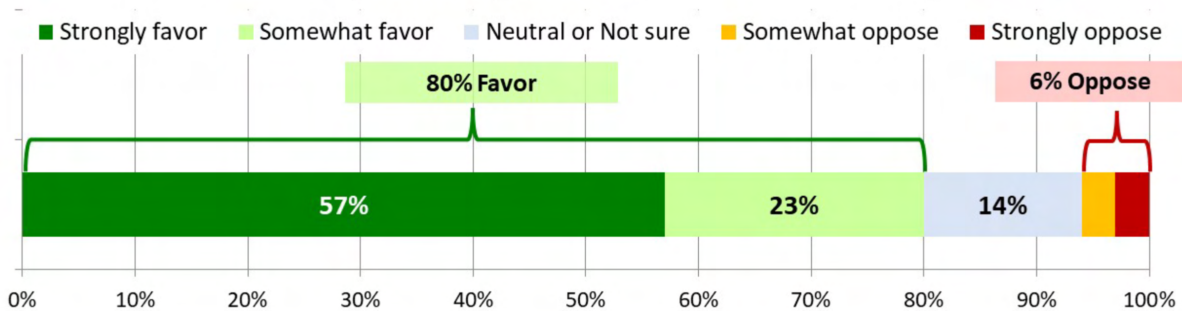


Based on this description, do you strongly favor, somewhat favor, somewhat oppose, or strongly oppose a Maryland Prescription Drug Affordability Board with the power to make high-cost drugs more affordable?

Overwhelming Support for Expanding the Authority of the Prescription Drug Affordability Board

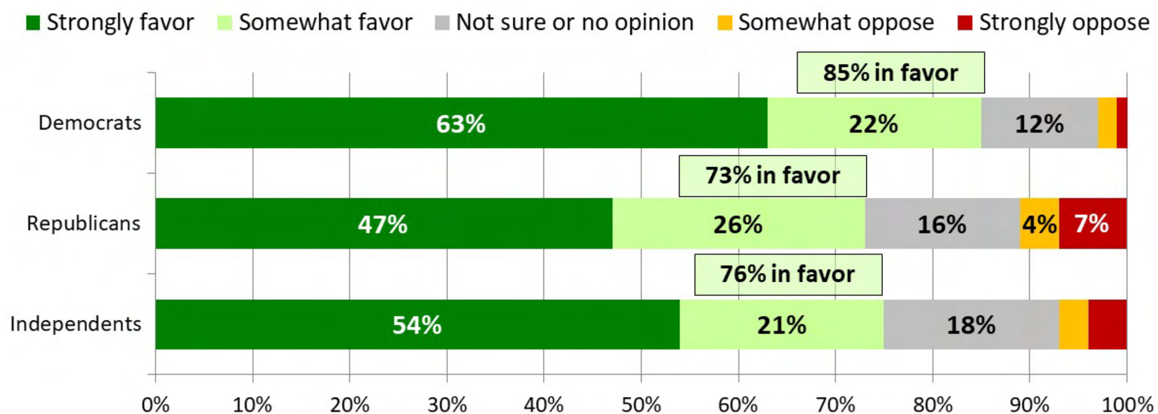
Currently, the Board only has the authority to limit high drug costs for state and local governments, not for most average Marylanders. Thinking forward, voters strongly favor expanding the Board's authority much further to limit high drug costs for all Marylanders.

The support is overwhelming. Eighty percent of Marylanders favor expanding the authority of the Prescription Drug Affordability Board. A solid 57% majority *strongly* favor the expansion. Only 6% of Maryland voters oppose this proposal.



Currently, the Board only has the authority to limit high drug costs for state and local governments – for example, for government employees, jails, and schools. It cannot set limits on what most Maryland residents pay for their prescription drugs. Would you favor or oppose expanding the authority of the Board so it can limit high drug costs for all Marylanders?

Support for this proposal is very strong regardless of political party. Seventy-three percent of Republicans, 76% of Independents, and 85% of Democrats across Maryland support expanding the Board's authority. Opposition is very small, regardless of political party identification.



Currently, the Board only has the authority to limit high drug costs for state and local governments – for example, for government employees, jails, and schools. It cannot set limits on what most Maryland residents pay for their prescription drugs. Would you favor or oppose expanding the authority of the Board so it can limit high drug costs for all Marylanders?

Political Impact of Legislators' Position on Prescription Drug Affordability Board

This overwhelming support for expanding the authority of the Prescription Drug Affordability Board translates into a potential major impact on General Assembly contests next year. This poll found that this issue could cause large swings in voter support – *even causing many voters to oppose legislative candidates of their own party.*

As the table below indicates, on the so-called generic ballot, if the election were held today Democratic legislative candidates would start off with a 29-point advantage based on partisan preferences across the state. Asked who they would support in the next state legislative elections, 53% of voters said they are more likely to vote for the Democratic candidates while 24% would favor the Republicans.

Learning of a hypothetical Democrat in their district who supports expanding the authority of the Board and a hypothetical Republican who opposes that, **the margin for the Democrat rose to a resounding 48 percentage points** (64% for the Democrat vs. 16% for the Republican).

However, in a different matchup where the Republican supports expanding the authority of the Board and the Democrat opposes it, the Democratic advantage was completely reversed, with the Republican receiving support from 43% of voters, compared to only 24% for the Democrat – a 19-point margin for the Republican. **This represents a massive 67-point swing in voter support – an unusual outcome in this partisan age – and a signal about how strongly felt voters' opinions are about prescription drug costs.**

Support for Legislative Candidates Based on Their Position on PDAB

	Support the Democratic Candidate	Support the Republican Candidate	Margin
Generic Ballot in State Legislative Elections	53%	24%	Democrat +29%
Democrat Supports PDAB Expansion; Republican Opposes	64%	16%	Democrat +48%
Republican Supports PDAB Expansion; Democrat Opposes	24%	43%	Republican +19%

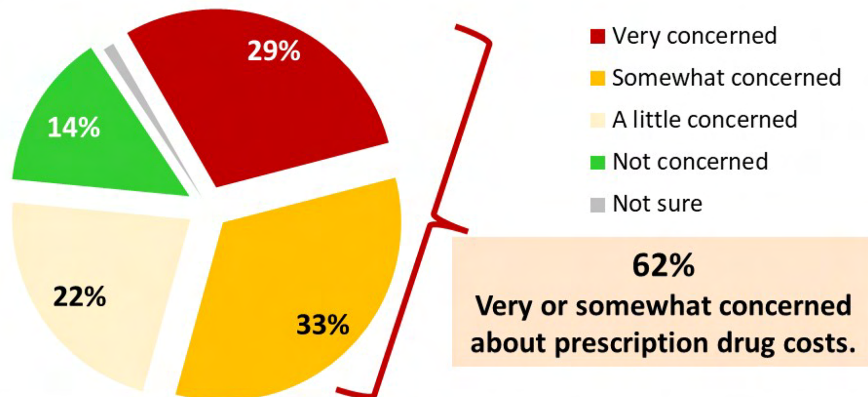
"In the next state legislative elections, are you more likely to vote for… (rotate): the Democratic candidates or the Republican candidates?"

(Rotate order of next two questions):
"If you learned that the Democratic candidate in your legislative district supported expanding the authority of the Prescription Drug Affordability Board while the Republican candidate opposed it, who would you be more likely to vote for (rotate): the Democratic candidate or the Republican candidate?"
"If you learned that the Republican candidate in your legislative district supported expanding the authority of the Prescription Drug Affordability Board while the Democratic candidate opposed it, who would you be more likely to vote for (rotate): the Democratic candidate or the Republican candidate?"

Great Concern About Affording Prescription Drugs

Several factors help explain this overwhelming support and large political impact. One of these is a strong concern among Marylanders about prescription drug costs.

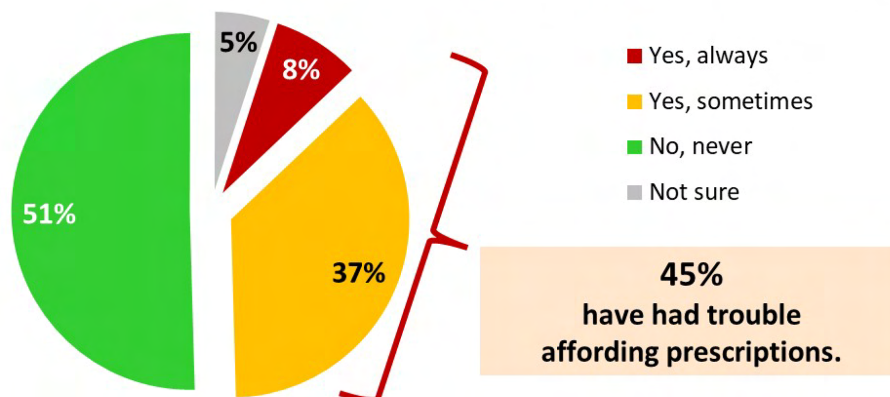
Nearly two-thirds (62%) are very or somewhat concerned "personally" about the cost of prescription drugs. More than a quarter of Maryland voters (29%) said they are "very concerned personally." Only a small minority (14%) are not concerned about drug costs.



How much does the cost of prescription drugs concern you, personally? Would you say you are very concerned personally, somewhat concerned, a little concerned, or not personally concerned about it?

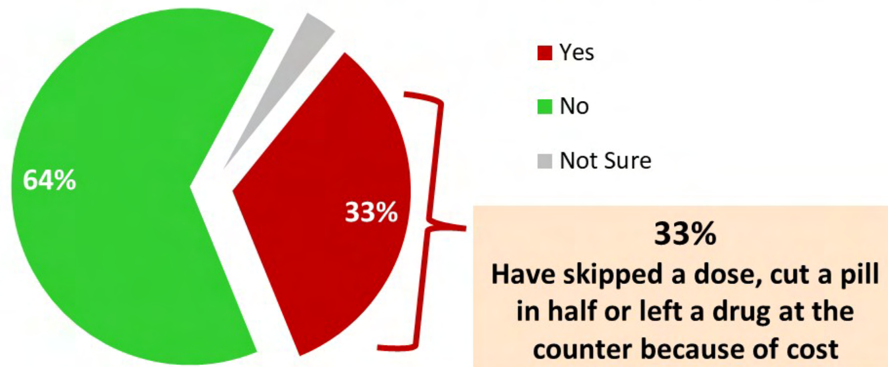
Trouble Affording Prescription Drugs

This concern about prescription drugs is often founded on personal experience. A sobering 45% of Marylanders – nearly half – indicated that they always or sometimes have had trouble affording prescription medications.



Do you or other members of your household ever have trouble affording prescription medications?

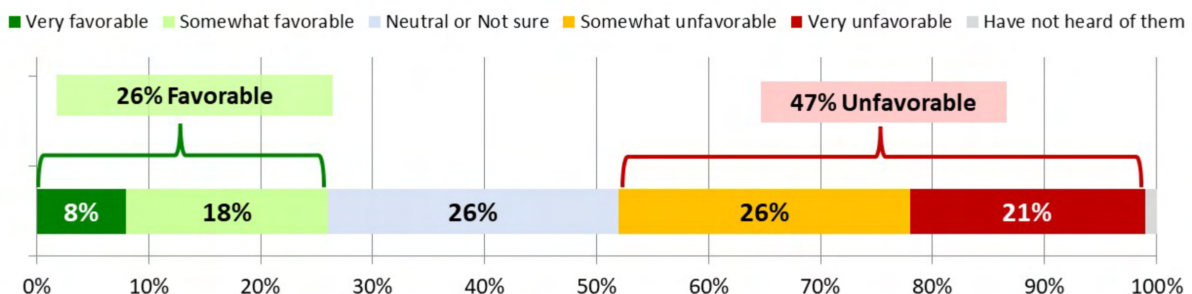
This is manifested in the real-life outcome that one-third (33%) of Marylanders said they have "skipped a dose, cut a pill in half, or left a drug at the counter" *because of cost*.



Because of cost, have you ever skipped a dose, cut a pill in half, or left a drug at the pharmacy counter?

How Marylanders Feel About Pharmaceutical Companies

Another factor that may help explain strong support for the Prescription Drug Affordability Board is voters' attitude toward the pharmaceutical industry. Only 26% of voters view the industry favorably, while nearly twice as many (47%) view it unfavorably. About one-quarter (26%) of Marylanders have neutral views about the pharmaceutical industry.



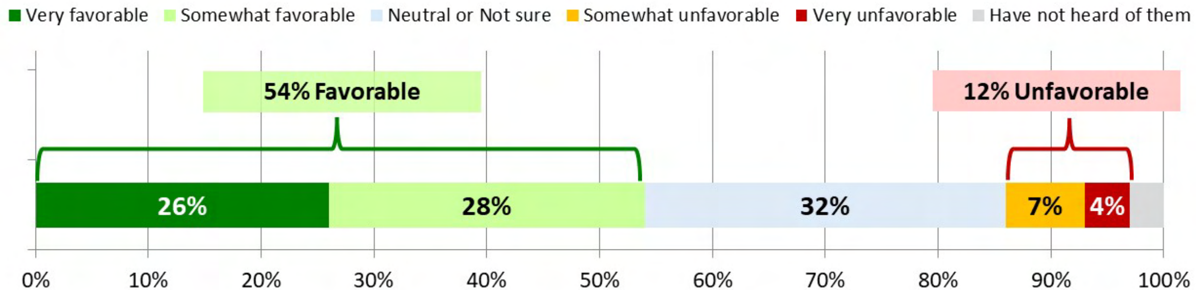
Following is a list of people and groups. For each one, please say if you have a very favorable, somewhat favorable, neutral, somewhat unfavorable, or very unfavorable opinion. If you have not heard of them, just say so.

...The pharmaceutical industry.

The low favorability for pharmaceutical companies cuts across party lines. Democrats and Republicans view the industry nearly identically, with 28% of Democrats and 29% of Republicans with favorable views. Unfavorability towards the industry is 45% among Democrats and 44% among Republicans. Interestingly, Independents were much less favorable towards pharmaceutical companies, with only 15% of viewing them favorably and 53% viewing them unfavorably.

A Contrast with AARP

For purposes of comparison, the AARP has a vastly more favorable standing with voters. Over half of respondents have a favorable view of the AARP (54%). Very few voters have an unfavorable view (12%), while 32% were neutral.



Following is a list of people and groups. For each one, please say if you have a very favorable, somewhat favorable, neutral, somewhat unfavorable, or very unfavorable opinion. If you have not heard of them, just say so.

...AARP.

Key Voter Attitudes

As an additional step in helping explain voter sentiment on prescription drug costs, the poll tested several attitudes, including arguments that the pharmaceutical industry has made in opposing the Prescription Drug Affordability Board. The table on the following page summarizes voter response to these attitudinal questions. This is a summary:

- Marylanders demonstrate a sense of empathy and social justice, with 83% agreeing with the statement, “It bothers me that many Marylanders can’t afford their medicines, sometimes having to choose between paying for their prescriptions or paying for rent and groceries.”
- They indicate that drug companies may have overstepped the boundaries of fairness, with 80% agreeing with the statement, “I don’t object to drug companies making a profit, but their huge markups just aren’t fair.”
- Maryland voters object to high CEO pay, with 78% agreeing with the statement, “Drug companies pay their executives lavish salaries and make enormous profits. Average Marylanders get gouged while CEOs get rich.”
- Meanwhile, most Marylanders do not believe the pharmaceutical industry’s core argument that limiting drug costs will jeopardize research, with only 30% agreeing with the statement, “Controlling prescription drug costs will reduce the ability to fund life-saving research.”
- Relatively few voters believe limiting drug costs could cost jobs in Maryland, with only 23% agreeing with the statement, “Limiting drug costs will hurt jobs, because it will force bio-medical businesses in Maryland to shut down and lay off their employees.”

	Strongly Agree	Total Agree	Democrats	Republicans	Others
It bothers me that many Marylanders can't afford their medicines, sometimes having to choose between paying for their prescriptions or paying for rent and groceries.	62%	83%	88%	78%	79%
I don't object to drug companies making a profit, but their huge markups just aren't fair.	55%	80%	81%	79%	78%
Drug companies pay their executives lavish salaries and make enormous profits. Average Marylanders get gouged while CEOs get rich.	52%	78%	81%	75%	74%
Controlling prescription drug costs will reduce the ability to fund life-saving research.	13%	30%	30%	38%	22%
Limiting drug costs will hurt jobs, because it will force bio-medical businesses in Maryland to shut down and lay off their employees.	9%	23%	23%	28%	17%

Methodology

How This Poll was Conducted

A total of 1,090 interviews were conducted statewide August 10-17, 2023 among randomly selected Maryland registered voters. A cross-section of Marylander registered voters were surveyed online, and live telephone interviewers reached additional voters on both wireless and landline telephones, to ensure the poll best represented all segments of the electorate. Sampling targets were adhered to throughout the interviewing process to ensure that the sample represented the statewide electorate geographically, by political party, gender, age, and race or ethnicity. Following interviewing, statistical weights were applied to ensure the sample most closely mirrored the characteristics of the statewide electorate. This poll produces a margin of sampling error no greater than ±3.0% at the 95% confidence level, meaning that at least 19 times out of 20 the actual results would differ by no more than that margin if every registered voter in the state had been interviewed.

Brief Background on OpinionWorks

OpinionWorks is a non-partisan firm that conducts frequent opinion studies at the state and local level across the country. Since 2007 we have been the polling organization for *The Baltimore Sun* newspaper in Maryland and have polled for numerous other media and advocates throughout the nation. We are engaged by state and local government agencies from Delaware to Oregon to assess public needs and preferences. We measure health attitudes and practices for public health departments and advocates, assess alumni engagement and prospective student expectations for colleges and universities, evaluate donor and volunteer relationships for non-profit organizations, and study human decision-making to inform behavior change efforts on environmental and health questions.

Angela D. Alsobrooks
County Executive

TO: Chair Mitchell, Prescription Drug Affordability Board Members, Council Chairs Diana and Nicole, and Members of the Stakeholder Council

FROM: Prince George's County Executive Angela Alsobrooks, Howard County Executive Calvir Ball, Charles County Commissioner President Reuben B. Collins, Montgomery County Executive Marc Elrich, Frederick County Executive Jessica Fitzwater, Baltimore County Executive John Olszewski, Jr., Anne Arundel County Executive Steuart Pittman, and Baltimore City Mayor Brandon M. Scott

DATE: December 19, 2022

SUBJECT: Prescription Drug Affordability for Maryland's Local Governments

We the undersigned Maryland local elected leaders are writing to reiterate our strong support for Maryland's landmark Prescription Drug Affordability Board, the Stakeholder Council, and the important work you are all doing to address the issue of high-cost drugs. This is an issue that touches all corners of our state, and as such, the Maryland Association of Counties and many of us individually advocated for the enactment of the legislation to create this Board in 2019. We are all very pleased with the progress you have made and look forward to your future work to fully implement the law to ensure all Marylanders are able to afford the medicine they need.

As local leaders, we are especially interested in the Board's initial authority granted by the 2019 law, which gives you the authority to put upper payment limits on what state and local governments pay for high-cost drugs. As the cost of prescription drugs continues to escalate, we strongly urge you to use this authority as soon as possible. These costs hurt our ability to provide comprehensive health coverage for our employees and impact our budgets as we see more and more of the money we should be using to improve county services go to paying ever increasing drug costs.

We also urge you at the appropriate time to ask the General Assembly to broaden your authority to allow you to put upper payment limits on what all Marylanders pay for high-cost drugs. We will be there to back you up. Just as county budgets are hurt by high-cost drugs, so are Maryland families. As you know so well, drugs don't work if people can't afford them, and no one should be forced to choose between their medicine and other necessities, like rent and groceries. Marylanders from across the state joined us for a series of forums hosted in our counties with the Maryland Health Care For All! Coalition and AARP Maryland—there, we heard loud and clear from our constituents how high-cost drugs are hurting them and their families. Many of these stories are featured in the report the Maryland Health Care for All! Coalition has compiled summarizing these forums held this past Fall and in 2020.

We are very proud of Maryland's leadership role in making high-cost drugs more affordable and the fact that other states are following our lead. With your terrific leadership, Maryland can stay at the forefront on this life-saving issue.

THE PRINCE GEORGE'S COUNTY GOVERNMENT

OFFICE OF THE COUNTY EXECUTIVE

October 25, 2023

The Honorable Wes Moore
Governor of Maryland
State House
Annapolis, MD 21401

The Honorable Bill Ferguson
President of the Senate
State House
Annapolis, MD 21401

The Honorable Adrienne Jones
Speaker of the House
State House
Annapolis, MD 21401

Dear Governor Moore, President Ferguson, and Speaker Jones:

The residents of Prince George's County need your immediate help in lowering the price of expensive prescription drugs. Too many of our constituents face daily choices on whether to purchase vital medications, buy food or pay rent. Meanwhile, pharmaceutical CEO's make astronomical salaries and drug companies fill the airwaves with expensive television advertising.

In 2019, the Maryland General Assembly created the Prescription Drug Affordability Board with the authority to set upper payment limits on the most expensive prescription drugs purchased by the State and local governments. We look forward to substantial savings on pharmaceutical expenses in our budget once the Board puts these limits in place.

Yet it is only fair that everyone in our County enjoy these savings, not just those who work in our government. I urge you to make it one of your highest priorities to expand the authority of the Board so that everyone who lives in this State can receive the benefits of making expensive prescription drugs more affordable. The results of recent survey research demonstrate that doing so is a high priority for the public as well.

Wayne K. Curry Administration Building • 1301 McCormick Drive, Largo, MD 20774
(301) 952-4131 • www.princegeorgescountymd.gov

Thank you for your consideration of this important request.

Sincerely,

Angela Alsobrooks
County Executive

HOWARD COUNTY OFFICE OF COUNTY EXECUTIVE

3430 Courthouse Drive ▪ Ellicott City, Maryland 21043 ▪ 410-313-2013 Voice/Relay

Calvin Ball
Howard County Executive
cball@howardcountymd.gov

www.howardcountymd.gov
FAX 410-313-3051

November 13, 2023

The Honorable Wes Moore
Governor of Maryland
State House
Annapolis, MD 21401

The Honorable Bill Ferguson
President of the Senate
State House
Annapolis, MD 21401

The Honorable Adrienne Jones
Speaker of the House
State House
Annapolis, MD 21401

Dear Governor Moore, President Ferguson, and Speaker Jones:

On behalf of the more than 300,000 residents who call Howard County home, we appreciate your partnership in addressing the rising cost of expensive prescription drugs. Too many of our residents face daily choices on whether to purchase vital medications, buy food or pay rent.

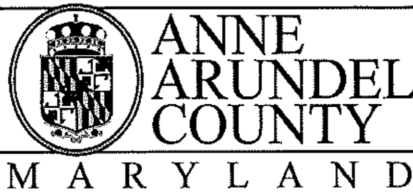
We are grateful that, in 2019, the Maryland General Assembly created the Prescription Drug Affordability Board with the authority to set upper payment limits on the most expensive prescription drugs purchased by the State and local governments. We look forward to substantial savings on pharmaceutical expenses in our budget once the Board puts these limits in place.

Yet it is only fair that everyone in our county enjoy these savings, not just those who work in our government. I respectfully request you to make it one of your highest priorities to expand the authority of the Board so that everyone who lives in this State can receive the benefits of making expensive prescription drugs more affordable. The results of recent survey research demonstrate that doing so is a high priority for the public as well.

I firmly believe that this battle between working people and prescription drug companies has been going on for too long, and it hasn't been a fair fight. Maryland residents don't deserve to go into financial ruin if they or their loved ones face major health issues. We can and we must do better for our all Marylanders. I thank you for your consideration of this important request and look forward to seeing you at the bill hearing.

Sincerely,

Calvin Ball
Howard County Executive



Office of the County Executive
STEUART PITTMAN

November 9, 2023

The Honorable Wes Moore
Governor of Maryland
State House
Annapolis, MD 21401

The Honorable Bill Ferguson
President of the Senate
State House
Annapolis, MD 21401

The Honorable Adrienne Jones
Speaker of the House
State House
Annapolis, MD 21401

Dear Governor Moore, President Ferguson, and Speaker Jones:

The nearly 600,000 residents of Anne Arundel County need your immediate help in lowering the price of expensive prescription drugs. Too many of our constituents face daily choices on whether to purchase vital medications or buy food or pay rent. Meanwhile, pharmaceutical CEOs make astronomical salaries and drug companies fill the airwaves with expensive television advertising.

We are grateful that, in 2019, the Maryland General Assembly created the Prescription Drug Affordability Board with the authority to set upper payment limits on the most expensive prescription drugs purchased by the State and local governments. We look forward to substantial savings on pharmaceutical expenses in our budget once the Board puts these limits in place.

Yet it is only fair that everyone in our County enjoys these savings, not just those who work for our County. I, therefore, urge you to make it one of your highest priorities to expand the authority of the Board so that everyone who lives in this State can receive the benefits of making expensive prescription drugs more affordable. The results of recent survey research demonstrate that doing so is a high priority for the public as well.

Thank you for your consideration of this important request. See you at the bill hearing!

Sincerely,

Steuart Pittman
County Executive

Charles County Commissioners

REUBEN B. COLLINS, II, ESQ., PRESIDENT

The Honorable Wes Moore
Governor of Maryland
State House
Annapolis, MD 21401

The Honorable Bill Ferguson
President of the Senate
State House
Annapolis, MD 21401

The Honorable Adrienne Jones
Speaker of the House
State House
Annapolis, MD 21401

Dear Governor Moore, President Ferguson, and Speaker Jones,

The Charles County residents need your immediate help in lowering the price of expensive prescription drugs. Too many of our constituents face daily choices on whether to purchase vital medications or buy food or pay rent. Meanwhile, pharmaceutical CEO's make astronomical salaries and drug companies fill the airwaves with expensive television advertising.

We are grateful that, in 2019, the Maryland General Assembly created the Prescription Drug Affordability Board with the authority to set upper payment limits on the most expensive prescription drugs purchased by the State and local governments. We look forward to substantial savings on pharmaceutical expenses in our budget once the Board puts these limits in place.

Yet it is only fair that everyone in our County enjoy these savings, not just those who work for our County. I, therefore, urge you to make it one of your highest priorities to expand the authority of the Board so that everyone who lives in this State can receive the benefits of making expensive prescription drugs more affordable. The results of recent survey research demonstrate that doing so is a high priority for the public as well.

200 Baltimore Street • La Plata, Maryland 20646 • 301-645-0553 • 301-870-3000
Fax: 301-648-0544 • E-Mail: Commissioner@CharlesCountyMD.gov
Maryland Relay Service: 711 • Relay Service TDD: 1-800-735-2258 • Equal Opportunity Employer
Visit us online at **www.CharlesCountyMD.gov**

Thank you for your consideration of this important request. See you at the bill hearing. Please contact my Chief of Staff, Ms. Crystal Hunt, at HuntC@charlescountymd.gov or 301-645-0550 if additional information is needed.

Sincerely,

Reuben B. Collins, II, Esq.

OFFICE OF THE COUNTY EXECUTIVE

Marc Elrich
County Executive

DECEMBER 4, 2023

The Honorable Wes Moore
Governor of Maryland
Annapolis, MD 21401

The Honorable Bill Ferguson
President of the Senate
Annapolis, MD 21401

The Honorable Adrienne Jones
Speaker of the House
State House
Annapolis, MD 21401

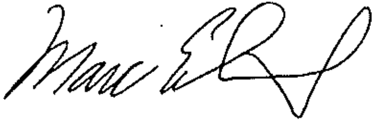
Dear Governor Moore, President Ferguson, and Speaker Jones:

Since 2019, Maryland has been a leader in reigning in the cost of prescription drugs with the establishment of the Prescription Drug Affordability Board. Accessing affordable prescriptions is a life or death issue for our residents, which is why I write to you today to urge you to make it a priority of the 2024 Session to expand the authority of the Board so that all Marylanders can receive the benefits of making expensive prescription drugs more affordable.

Currently, the Prescription Drug Affordability Board can set upper payment limits for prescription drugs purchased by state, county, or local governments. We look forward to substantial savings on pharmaceutical expenses in our County budget once the Board's limits are in place. Yet it is only right that everyone in our County enjoy these savings, not just those who work in our government. Therefore, it is critical that the Board should be enabled to expand upper payment limits to all purchases of prescription drug throughout the State.

Thank you for your consideration of this important request. Should you have any questions, please contact Sonia Mora at Sonia.Mora@montgomerycountymd.gov.

Sincerely,



Marc Elrich
County Executive

One Park Place | Suite 475 | Annapolis, MD 21401-3475
1-866-542-8163 | Fax: 410-837-0269
aarp.org/md | md@aarp.org | twitter: @aarpmd
facebook.com/aarpmd

The Honorable Wes Moore
Governor of Maryland
State House
Annapolis, MD21401

The Honorable Bill Ferguson
President of the Senate
State House
Annapolis, MD21401

The Honorable Adrienne Jones
Speaker of the House
State House
Annapolis, MD 2140

October 12, 2023

Dear Governor Moore, President Ferguson, and Speaker Jones,

The high price of prescription drugs continues to burden the 850,000 members of AARP Maryland and their families. Many of our members must choose between paying for their diabetes injections, heart medication, anti-cholesterol regimes, or other prescriptions or, instead, to buy food or make their rent payment. Too often, important medications are left at the pharmacist's cash register because customers can't afford them.

Fortunately, in 2019, the Maryland General Assembly established the first-in-the-nation Prescription Drug Affordability Board with the authority to set upper payment limits on the most expensive prescription drugs purchased by the state and local governments. The members of the Board and the Stakeholders Council are of the highest caliber, and we applaud their efforts.

With the Board now working to apply upper payment limits to the most expensive prescription drugs, it is the appropriate time to expand its authority to set those limits on the expensive prescriptions purchased by *every* Marylander. Enacting such legislation is among our highest priorities. According to recent survey research, an overwhelming majority of Maryland voters would support this expansion effort.

Thank you for your support for this important matter. We look forward to working with you in the 2024 Legislative Session.

Sincerely,

Jim Campbell

State President

Baptist Pastors' Conference of Baltimore and Vicinity

c/o Greater St. John Baptist Church
209 Walnut Avenue
Baltimore, Maryland 21222
(410) 282-0088

February 1, 2024

The Honorable Governor Wes Moore
Governor of Maryland
State House, 100 State Circle
Annapolis, Maryland 21401-
1925

The Honorable Bill Ferguson
President of the Maryland Senate
State House, H-107, 100 State Circle
Annapolis, Maryland 21401

The Honorable Adrienne Jones
Speaker of the Maryland House of Delegates
State House H-101, 100 State Circle
Annapolis, Maryland 21401

Dear Governor Moore, President Ferguson, Speaker Jones:

I pray this letter finds you well and wish you a prosperous new Year! We, the members of the Baptist Pastors' Conference of Baltimore & Vicinity (BPCBV), appreciate legislators' ongoing efforts to legislate solutions to address health and social disparities impacting the quality of life for Maryland residents. BPCBV membership is comprised of clergy who meet for the purpose of addressing pastoral concerns, as well as the members of our congregations.

As faith leaders and laypersons, we hear stories about the challenges our congregates face having to make a decision on which bills they will pay and/or forgo taking their medicine due to the high-cost of prescription drugs. We appreciate the fact that in 2019 the Maryland General Assembly established the first in the nation Prescription Drug Affordability Board (PDAB) with the authority to set upper payment limits on the most expensive drugs purchased by local and state government. The establishment of the PDAB is a great start; however, more needs to be done to reduce the cost of prescription drugs, such as give the board more authority in 2024. We urge you to expand the authority of the Prescription Drug Affordability Board in 2024 so that it can set upper payment limits for high-cost drugs for all Maryland Residents.

Peace and Blessings!!!

Jamal Foster

Rev. Jamal Foster

Clergy United for the Transformation of Sandtown

1300 N. Fulton Avenue
Baltimore, Maryland 21217
(410) 404-1070

February 1, 2024

The Honorable Governor Wes Moore
Governor of Maryland
State House, 100 State Circle
Annapolis, Maryland 21401-1925

The Honorable Bill Ferguson
President of the Maryland Senate
State House, H-107, 100 State Circle
Annapolis, Maryland 21401

The Honorable Adrienne Jones
Speaker of the Maryland House of Delegates
State House H-101, 100 State Circle
Annapolis, Maryland 21401

Dear Governor Moore, President Ferguson, Speaker Jones:

Since 2015, Clergy United for the Transformation of Sandtown (CUTS), a 501 (c) (3) CDC (Community Development Corp) non-profit organization, has been at the forefront of stabilizing and improving the life of Sandtown residents. CUTS is comprised of twelve faith-based institutions located on the West Side of Baltimore. They have volunteered their time and efforts to improve the Sandtown community through community development initiatives. Each institution has supported the residents of Sandtown by establishing group homes for homeless persons, providing linkage to health care projects, emergency food assistance programs, and partnerships to renovate housing. African American churches have long played a pivotal role in the economic development of Baltimore.

Our mission is to improve the quality of life for Sandtown residents by restoring, replenishing and renovating Sandtown We believe in the holistic approach grounded in principles of empowerment, human rights, inclusion, social justice, self-determination, and collective action (Kenny, 2007). As such, we avail ourselves to be aware of as well as address challenges impacting the quality of life of residents living in the Sandtown community. One known challenge is the high costs of prescription drugs, forcing many residents to have to choose between purchasing their medicine or pay for other social needs.

We know this is not news to you and other legislatures and want to extend appreciative feedback for the action taken in 2019 by the Maryland General Assembly established who the first in the nation Prescription Drug Affordability Board (PDAB) with the authority to set upper payment limits on the most expensive drugs purchased by local and state government. The establishment of the PDAB is a great start; however, more needs to be done to reduce the cost of prescription drugs, such as give the board more authority in 2024. We urge you to expand the authority of the Prescription Drug Affordability Board in 2024 so that it can set upper payment limits for high-cost drugs for all Maryland Residents.

Best Regards,

Dr. Derrick Dewitt

MINISTERS' CONFERENCE OF BALTIMORE AND VICINITY

January 2, 2024

The Honorable Governor Wes Moore
Governor of Maryland
State House, 100 State Circle
Annapolis, Maryland 21401-1925

The Honorable Bill Ferguson
President of the Maryland Senate
State House, H-107, 100 State Circle
Annapolis, Maryland 21401

The Honorable Adrienne Jones
Speaker of the Maryland House of Delegates
State House H-101, 100 State Circle
Annapolis, Maryland 21401

Dear Governor Moore, President Ferguson, Speaker Jones:

The Ministers' Conference of Baltimore & Vicinity (MCBV) is writing to thank you for the work you have done (in 2019 the Maryland General Assembly established the first in the nation Prescription Drug Affordability Board (PDAB) with the authority to set upper payment limits on the most expensive drugs purchased by local and state government to reduce the high costs of prescription drugs); and to encourage you to do more to address this challenge in the 2024 Maryland General Assembly.

The Ministers' Conference of Baltimore & and Vicinity is more than 115 years old and is an organization comprised of more than 150 congregations whose focus is shifting more and more on caring for the "holistic" needs, in particular health care, for its members and the communities it serves. Our Civic Action Committee has an initiative, "And the Church Shall Lead", and one of its goals is to eradicate health disparities/inequalities.

It is not uncommon for us to have members whose congregants are impacted by the hig- cost of prescription drugs, sometimes at the risk of not taking them, getting sick and ending up in the hospital. We realize more and more that our role is not just caring for the spiritual needs of congregants, but the whole person and our doing so is a moral obligation. We urge you in 2024 to continue the work you are doing to lower the high-cost of prescription drugs and expand the authority of the PDAB so that it can set upper payment limits for high-cost drugs for all Maryland residents.

In His Service,

Bishop Reginald Kennedy, bishop@GTBCBaltimore.org. Dr. Sandra Conner, revdrconner@gmail.com (MCBV Correspondence Secretary)

Dear Governor Moore:

The Unitarian Universalist Legislative Ministry of Maryland (UULM-MD) thanks you for your commitment and leadership on health care. We totally agree with you that: "Healthcare is a basic human right that every Marylander deserves." We appreciate your being committed "to protecting and expanding health care access for thousands of folks across Maryland." One way of doing this is to invest in the Prescription Drug Affordability Board so that it has the authority to make high-cost drugs affordable to all Marylanders.

Maryland was a leader in authorizing this innovative state Board to tackle one of the biggest problems for Marylanders—the unfair pricing of prescription drugs. These costs have kept people from obtaining the prescriptions or having to choose paying for them instead of other essential expenses. It is not unusual for people to go into debt to pay what can be extraordinary expenses.

Advocates like ours overcame big Pharma to get the original authorization for the Board but the previous Administration slowed implementation down. We believe we can be successful again with your leadership and a supportive General Assembly.

The UULM-MD is an advocacy organization composed of Unitarian Universalists throughout Maryland. Since our founding in 2005, health care has been a priority and we are an active member of the Health Care for All Coalition.

Betty McGarvie Crowley
Health Care Lead Advocate
Unitarian Universalist Legislative Ministry
333 Dubois Road, Annapolis, MD 21401

Delaware-Maryland Synod
Evangelical Lutheran Church in America
God's work. Our hands.

The Honorable Wes Moore
Governor of Maryland
State House, 100 State Circle
Annapolis, MD 21401-1925

The Honorable Bill Ferguson
President of the Maryland Senate
State House, H-107,100 State Circle
Annapolis, MD 21401

The Honorable Adrienne Jones
Speaker of the Maryland House of Delegates
State House, H-101, 100 State Circle
Annapolis, MD 21401

Governor Moore; President Ferguson; Speaker Jones:

The Delaware-Maryland Synod of the Evangelical Lutheran Church in America is a faith community with a demographically diverse Maryland constituency extending from Red House to Ocean City. Our community has advocated for access to appropriate, adequate, and affordable health care for all people in the United States since 2003 (*Caring for Health*, ELCA). We include medical treatment in "appropriate and adequate care," and therefore in any measure of "affordable."

We were among advocates for the passage of the 2019 bill establishing a Maryland Prescription Drug Affordability Board to monitor and address pharmaceutical prices covered under the State's Medicaid program. We, likewise, supported SB202/HB279 of 2023 affirming the authority of PDAB to establish upper payment limits in certain indicated circumstances.

Drug cost monitoring for price containment benefits almost all medical clients. Expensive drugs can compromise the adequacy of medical treatment for anyone. This is a particular concern of our community when clients are already disadvantaged. When pricing is chiefly influenced by demand, as in the standard business model, "most expensive" could also mean "most needed."

Reviewing and regulating prices on the most expensive drugs sold in the State, as PDAB is authorized to do for State programs, would have a containment effect across its medical market. Several other states have already done this. We believe Maryland, as the innovator of prescription drug price review, should do the same.

Thank you for your public service, and attention.

Lee Hudson
Assistant to the bishop for public policy, DE-MD Synod, ELCA

5699 Meridale Rd. Baltimore, MD 21228 410-230-2860 800-869-5492 fax 410-230-2871

THE EPISCOPAL DIOCESE OF MARYLAND

The Honorable Wes Moore
Governor of Maryland
State House Annapolis, MD 21401

The Honorable Bill Ferguson
President of the Senate
State House Annapolis, MD 21401

The Honorable Adrienne Jones
Speaker of the House
State House Annapolis, MD 2140

December 22, 2023

Dear Governor Moore, President Ferguson, and Speaker Jones,

The high price of prescription drugs continues to burden the residents of Maryland. Many still must choose between paying for their diabetes injections, heart medication, anti-cholesterol regimes, or other prescriptions or, instead, buying food or make their rent payment. Too often, important medications are left at the pharmacist's cash register because customers can't afford them.

Fortunately, in 2019, the Maryland General Assembly established the first-in-the-nation Prescription Drug Affordability Board with the authority to set upper payment limits on the most expensive prescription drugs purchased by the state and local governments. The members of the Board and the Stakeholders Council are of the highest caliber, and we applaud their efforts.

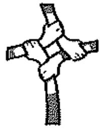
With the Board now working to apply upper payment limits to the most expensive prescription drugs, it is the appropriate time to expand its authority to set those limits on the expensive prescriptions purchased by every Marylander. Enacting such legislation is among our highest priorities. According to recent survey research, an overwhelming majority of Maryland voters would support this expansion effort.

Thank you for your support in this important matter. We look forward to working with you in the 2024 Legislative Session.

Sincerely,

The Rt. Rev. Eugene Taylor Sutton
Bishop, Diocese of Maryland

4 E UNIVERSITY PARKWAY, BALTIMORE, MD 21218-2437
TEL: 410-467-1399 / 800-443-1399 FAX: 410-554-6387
WWW.EPISCOPALMARYLAND.ORG



THE COLLECTIVE EMPOWERMENT GROUP

THE COLLECTIVE EMPOWERMENT GROUP, INC.

Board of Directors

Rev. Dr. Bobby Manning
President

Rev. Dr. Renee Alston
Rev. Dr. Gerald Folsom
Pastor Omari Hughes
Bishop Anthony Maclin
Rev. Dr. Anna Mosby
Pastor Adrian Reeves
Rev. Billy Staton
Rev. Jonathan L. Weaver
Rev. Joshua Kevin White
Rev. Juan Wilder

de Raye Sisco, CCA
Executive Director

Midgett Parker, Esq.
Legal Counsel

January 10, 2024

The Honorable Wes Moore
Governor of Maryland
State House
Annapolis, MD 21401

The Honorable Bill Ferguson
President of the Senate
State House
Annapolis, MD 20401

The Honorable Adrienne Jones
Speaker of the House
State House
Annapolis, MD 20401

Dear Governor Moore, President Ferguson, and Speaker Jones:

I hope this letter finds you well. On behalf of the pastors and church leaders of The Collective Empowerment Group, I am writing to express our deep concern about the exorbitant costs of prescription drugs in our state and to urgently request your support in expanding the authority of the Prescription Drug Affordability Board, established in 2019. The current situation has placed an immense financial burden on countless Marylanders, and I believe it is crucial to take decisive action to alleviate this hardship. As pastors, we see the burden on our members every day. Many must choose between paying for prescriptions and buying food for their families. This is a choice no one in this country and certainly in the state of Maryland should ever have to make.

As you are undoubtedly aware, the rising costs of prescription medications have become a significant barrier to accessing essential healthcare for many individuals and families. The Prescription Drug Affordability Board has played a pivotal role in addressing this issue by evaluating and setting reasonable limits on the prices of certain prescription drugs purchased by state and local governments. However, we believe that it is imperative to extend their authority to cover a broader range of medications purchased by all Maryland residents, ensuring that all Marylanders can access the medications they need without facing financial hardship. By doing so, we can create a more equitable healthcare system that prioritizes accessibility and affordability for all residents of our great state.

Your leadership in this matter is crucial to ensuring that Maryland remains a state where healthcare is accessible and affordable for *everyone*.

Thank you for your attention to this critical issue, and we look forward to witnessing positive change that will enhance the lives of Maryland residents.

Sincerely,

Dr. Bobby Manning
President

Collective Strength for Economic Empowerment

Our mission, as a Christian ministry, is to establish covenant relationships with member churches and community partnership agreements with financial institutions, businesses and other organizations, utilizing our collective strength for economic empowerment for member congregations.

5827 Allentown Road, Camp Springs, MD 20746
• Tel: 301-704-4221
Email: Office@EmpowerDMV.org Website: https://EmpowerDMV.org

PROGRESSIVE MARYLAND

P.O. Box 7595, Largo MD 20792
ProgressiveMaryland.org
Info@progressivemaryland.org

The Honorable Wes Moore
Governor of Maryland
State House
Annapolis, MD 21401

The Honorable Bill Ferguson
President of the Senate
State House
Annapolis, MD 21401

The Honorable Adrienne Jones
Speaker of the House
State House
Annapolis, MD 21401

December 11, 2023

Dear Governor Moore, President Ferguson, and Speaker Jones,

On behalf of our Board of Directors, our thousands of grassroots members across the state, and our affiliates who represent a broad range of labor and community groups I urge you to expand the authority of our state's Prescription Drug Affordability Board.

The high cost of prescription drugs is a significant impediment to the health and well being of everyday Marylanders, putting many people at risk, wondering how they can afford to cover the cost of drugs and still have enough money for other basic household needs. Too many people simply can't afford lifesaving and life supporting medications so they cut medications in half or postpone getting their prescriptions filled.

Our organization was one of the groups who supported the creation of the Board and we've been encouraged by the progress it's making to set upper payment limits on some of the most high-priced drugs that the state and local governments purchase. The implementation of this plan will result in important savings for our government entities, savings that can be applied to other valuable public goods and services.

Extending the upper payment limits to high-cost prescriptions purchased by **every** Marylander should be a top priority for our state in 2024. Please strengthen the authority and power of the Board in its crucial efforts to make medicines more affordable.

Thank you for your consideration of this important matter.

Sincerely,

Patty Snee
Progressive Maryland
Lead Organizer, Statewide Healthcare Campaigns

Baptist Ministers' Night Conference of Baltimore & Vicinity
5405 York Road
Baltimore, Maryland 21212
443.386.4739

January 3, 2024

The Honorable Governor Wes Moore
Governor of Maryland
State House, 100 State Circle
Annapolis, Maryland 21401-1925

The Honorable Bill Ferguson
President of the Maryland Senate
State House, H-107, 100 State Circle
Annapolis, Maryland 21401

The Honorable Adrienne Jones
Speaker of the Maryland House of Delegates
State House H-101, 100 State Circle
Annapolis, Maryland 21401

Dear Governor Moore, President Ferguson, Speaker Jones:

Happy New Year!!!!

We, the Baptist Ministers' Night Conference of Baltimore & Vicinity (BMNCBV), applaud your ongoing efforts to address health and social disparities impacting Maryland residents, negating the fact that one's zip code, race and other social determinants should not dictate the quality of life an individual lives. For your information, the BMNCBV is a faith-based organization designed to serve bi-vocational clergy, persons whose schedule does not permit them to attend conferences that meet during the day. BMNCBV was formed in 2010, and our mission is to educate, and equip members with tools to strengthen themselves, families, communities, and relationships with others and above all with God;' to become advocates to eradicate "social ills," e.g., healthcare, housing, education, workforce/economic development, and public safety, that not only negatively impact and denigrate individual and community quality of life, but also create a sense of hopelessness and despair. Our affiliations, including membership are greater than 200 organizations, consisting of faith and community-based organizations, healthcare providers, civic and government entities, businesses, etc., (this number does not include individual organization membership (constituent) totals).

As faith leaders and laypersons, we hear stories about the challenges our congregates face having to make a decision on which bills they will pay and/or forgo taking their medicine due to the high-cost of prescription drugs. We appreciate the fact that in 2019 the Maryland General Assembly established the first in the nation Prescription Drug Affordability Board (PDAB) with the authority to set upper payment limits on the most expensive drugs purchased by local and state government. The establishment of the PDAB is a great start; however, more needs to be done to reduce the cost of prescription drugs, such as give the board more authority in 2024. We urge you to expand the authority of the Prescription Drug Affordability Board in 2024 so that it can setupper payment limits for high-cost drugs for all Maryland Residents.

Peace and Blessings!!!
Sandra Conner

Rev. Dr. Sandra Conner
BMNCBV President
443.695.2447

The Honorable Wes Moore
Governor of Maryland
State House
100 State Circle
Annapolis, MD 21401

The Honorable Bill Ferguson
President of the Senate
H-107, State House
100 State Circle
Annapolis, MD 21401

The Honorable Adrienne Jones
Speaker of the House
H-101, State House
100 State Circle
Annapolis, MD 21401

December 14, 2023

Dear Governor Moore, President Ferguson, and Speaker Jones,

#MEAction Maryland is part of a patient advocacy group, #MEAction, whose "vision is a world where people with ME are believed, supported by systems that work, and have access to effective medical treatments[1]." Myalgic Encephalomyelitis (ME) is a multi-system disease that causes profound metabolic dysfunction and is accompanied by physical and cognitive limitations. ME affects more than 3.3 million diagnosed Americans according to a recent CDC study[2] (this study acknowledges limitations in counting prevalence including that it requested diagnosed patients in a severely underdiagnosed population).

Skyrocketing prescription drug costs are a public health crisis, affecting patients who cannot afford their medications and contributing to rising health insurance premiums. Fortunately, in 2019, the Maryland General Assembly established the first-in-the-nation Prescription Drug Affordability Board (PDAB). The PDAB has the authority to set upper payment limits on the most expensive prescription drugs purchased by the state and local governments.

Now, we urge you to support expanding the authority of the PDAB in 2024 to be able to set upper payment limits on high-cost drugs for ALL Marylanders. Many Marylanders with ME do not work for state and local governments. Expanding the authority of the PDAB will help patients with ME access the prescription drugs that they need.

Thank you for your leadership. Please support prescription drug affordability this upcoming 2024 legislative session.

Sincerely,

#MEAction Maryland Co-Chair
Maryland@MEAction.net
Twitter/X; IG: @MEActMaryland

[1] #MEAction. https://www.meaction.net/ 20 Dec 2023
[2] Vahratian, Anjel et al. "Myalgic Encephalomyelitis/Chronic Fatigue Syndrome in Adults: United States, 2021-2022" , no. 488, 2023.

The Honorable Wes Moore
Governor of Maryland
State House, 100 State Circle
Annapolis MD 21401-1925

The Honorable Bill Ferguson
President of the Maryland Senate
State House, H-107, 100 State Circle
Annapolis MD 21401

The Honorable Adrienne Jones
Speaker of the Maryland House of Delegates
State House, H-101, 100 State Circle
Annapolis MD 21401

December 11, 2023

Dear Governor Moore, President Ferguson, Speaker Jones:

The Central Atlantic Conference of the United Church of Christ is a faith community comprised of over 150 United Church of Christ congregations stretching from New Jersey to Virginia, over fifty of which are located throughout the state of Maryland. For more than thirty-five years the United Church of Christ ("UCC") has advocated for health care as a right and a priority for all people. As stewards of God's creation, we are called to prioritize the well-being of all individuals, including their access to necessary medications. Ensuring affordable prescription drugs aligns with the principles of justice, compassion, and the promotion of human dignity, as it enables individuals to live healthy and fulfilling lives.

We are pleased that in 2019, the Maryland General Assembly established the Prescription Drug Affordability Board, the first such entity in the country, with the authority to set upper payment limits on the most expensive prescription drugs purchased by state and local governments. We are very grateful for their efforts.

Yet there is more work to be done in this area. Many state residents, including members of our congregations, are still affected by the high cost of prescription drugs. We do not believe it is just that people are forced to make difficult choices between their health care and other essential living expenses because of cost. We urge that the Maryland General Assembly in 2024 move to expand the authority of the Prescription Drug Affordability Board so that upper payment limits can be established, making the high cost of drugs available for all Marylanders. This is a matter of economic justice and equity, and we hope that we can count on your support.

Thank you for your attention to this important issue, and for your dedicated service to the people of Maryland.

Sincerely,

Rev. Freeman L. Palmer
Conference Minister
Central Atlantic Conference

The Honorable Wes Moore
Governor of Maryland
State House
100 State Circle
Annapolis, MD 21401

The Honorable Bill Ferguson
President of the Senate
H-107, State House
100 State Circle
Annapolis, MD 21401

The Honorable Adrienne Jones
Speaker of the House
H-101, State House
100 State Circle
Annapolis, MD 21401

December 14, 2023

Dear Governor Moore, President Ferguson, and Speaker Jones,

Skyrocketing prescription drug costs are a public health crisis, affecting patients who cannot afford their medications and contributing to rising health insurance premiums. Fortunately, in 2019, the Maryland General Assembly established the first-in-the-nation Prescription Drug Affordability Board (PDAB) with the authority to set upper payment limits on the most expensive prescription drugs purchased by the state and local governments.

We urge that Maryland expand the authority of the PDAB in 2024 to be able to set upper payment limits on high-cost drugs for ALL Marylanders. It is critical that the PDAB is given the authority it needs to make expensive medications more affordable for all Marylanders, because drugs don't work if people can't afford them.

The Maryland Public Health Association (MdPHA) is a non-profit, statewide organization of public health professionals dedicated to improving the lives of all Marylanders through education efforts and advocacy of public policies consistent with our vision of achieving healthy Marylanders living in healthy communities. MdPHA is the state affiliate of the American Public Health Association, a 142-year-old professional organization with more than 50,000 members dedicated to improving population health and reducing health disparities that plague our state and our nation.

Sincerely,

The Maryland Public Health Association (MdPHA) is a nonprofit, statewide organization of public health professionals dedicated to improving the lives of all Marylanders through education, advocacy, and collaboration. We support public policies consistent with our vision of healthy Marylanders living in healthy, equitable, communities. MdPHA is the state affiliate of the American Public Health Association, a nearly 145-year-old professional organization dedicated to improving population health and reducing the health disparities that plague our state and our nation.

Maryland Public Health Association (MdPHA)

PO Box 7045 · 6801 Oak Hall Ln · Columbia, MD 21045-9998

GetInfo@MdPHA.org www.mdpha.org 443.475.0242

The Honorable Wes Moore
Governor of Maryland
State House
Annapolis, MD 21401

The Honorable Bill Ferguson
President of the Senate
State House
Annapolis, MD 21401

The Honorable Adrienne Jones
Speaker of the House
State House
Annapolis, MD 21401

November 9, 2023

Dear Governor Moore, President Ferguson, and Speaker Jones,

Public Citizen is a national non-profit organization with more than 500,000 members and supporters. The Access to Medicines program supports expanded access to prescription drugs in the United States and throughout the world through research, technical assistance and advocacy. We write you today in support of expanding availability of lower prices provided through the Maryland Drug Affordability Board.

High prescription drug prices continue to plague Marylanders and their families. Many Marylanders have skipped doses of necessary medications or were unable to fill prescriptions because of the high cost of drugs. In addressing these challenges, Maryland has been at the forefront of prescription drug pricing reform; after enacting the first prescription drug affordability board in the nation, several states have now followed suit. Public Citizen applauds Maryland's leadership in confronting the price gouging of pharmaceutical companies and delivering on popular demands to its residents.

As Maryland's Drug Affordability Board works to set upper payment limits for the most expensive drugs paid by the government, it is critical to extend these reforms to the many Marylanders who obtain their drugs from non-governmental sources. For example, more than half of Maryland's drug volume (56%) is paid for by commercial plans. If upper payment limits apply only to drugs paid on behalf of the government, there is a very real risk that the benefits of Maryland's innovative reforms will fail to materialize for a wide swath of Maryland residents. Drug affordability boards in other states, like Colorado and Minnesota, already have the comprehensive authority to set upper payment limits to the benefit of all residents. Now is the appropriate time to extend Maryland's Drug Affordability Board's authority to set limits on prescription drugs purchased by the majority of Marylanders.

Thank you for your time and consideration of this critical proposal to expand access to prescription drugs and improve the health and financial wellbeing of Marylanders.

Sincerely,

Peter Maybarduk

Director, Access to Medicines Program

Public Citizen

The Honorable Wes Moore
Governor of Maryland
State House, 100 State Circle
Annapolis, Maryland 21401-1925

The Honorable Bill Ferguson
President of the Maryland Senate
State House H-107, 100 State Circle
Annapolis, Maryland 21401

The Honorable Adrienne Jones
Speaker of the Maryland House of Delegates
State House H-101, State Circle
Annapolis, Maryland 21401

January 9, 2024

Dear Governor Moore, President Ferguson, Speaker Jones,

The Caucus of African American Leaders is a community-based coalition of over 150 members stretching throughout the State of Maryland. For more than a decade the Caucus of African American Leaders has advocated for health care as a right and a priority for all people. As stewards of God's creation, we are called to prioritize the well-being of all individuals, including their access to necessary medications. Ensuring affordable prescription drugs aligns with the principles of justice, compassion, and the promotion of human dignity, as it enables individuals to live healthy and fulfilling lives.

We are pleased that in 2019, the Maryland General Assembly established the Prescription Drug Affordability Board, the first such entity in the country, with the authority to set upper payment limits on the most expensive prescription drugs purchased by state and local governments. We are very grateful for their efforts.

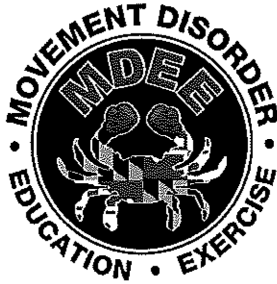
Yet there is more work to be done in this area. Many state residents, include members of our congregations, are still affected by the high cost of prescription drugs. We do not believe it is just that people are forced to make difficult choices between their health care and other essential living expenses because of cost. We urge that the Maryland General Assembly in 2024 move to expand the authority of the Prescription Drug Affordability Board so that upper payment limits can be established, making the high cost of drug s available for all Marylanders. This is a matter of economic justice and equity, and we hope that we can count on your support.

Thank you for your attention to this important issue, and for your dedicated service to the people of Maryland.

A Luta Continua,

Carl O. Snowden

Honorable Carl O. Snowden
Convener, Caucus of African American Leaders
Maryland Civil Rights Activist
Former Civil Rights Director, Office of the Attorney General of Maryland
Author



Movement Disorder Education and Exercise
309A Lots Rd.
Stevensville, Md 21666

The Honorable Wes Moore
Governor of Maryland
State House
100 State Circle
Annapolis, MD 21401

The Honorable Bill Ferguson
President of the Senate
H-107, State House
100 State Circle
Annapolis, MD 21401

The Honorable Adrienne Jones
Speaker of the House
H-101 State House
100 State Circle
Annapolis, MD 21401

January 4, 2024

Dear Governor Moore, President Ferguson, and Speaker Jones,

I am writing on behalf of the thousands of Marylanders and their families who are grappling with the escalating costs of prescription drugs, particularly those essential for managing movement disorders. The financial strain is forcing many to make agonizing choices between vital medications for conditions like Parkinson's disease or essential living expenses such as rent and food.

In 2019, the Maryland General Assembly took a commendable step by establishing the Prescription Drug Affordability Board, providing the authority to set upper payment limits on costly prescription drugs for state and local governments. We acknowledge and applaud the efforts of the Board and the Stakeholders Council.

As the Board works towards setting upper payment limits on expensive prescriptions for all Marylanders, we support an expansion of the Board's authority to include setting limits on expensive prescriptions for all Marylanders. This legislation is of utmost importance to our members who have movement disorders, as well as those facing challenges associated with mental health and aging. Recent survey research indicates overwhelming support from Maryland voters for such an expansion, intensifying the urgency of addressing this matter, particularly for socioeconomically unserved and underserved populations.

The need for affordable prescription drugs for movement disorders is critical, and we urge your support in enacting legislation that addresses this pressing issue. Thank you for your attention to this matter, and we look forward to working together to make prescription drug affordability a reality for those affected by movement disorders in our state.

Sincerely,

Larry Zarzecki

Larry Zarzecki, Founder of Movement Disorder Education and Exercise

Post Office Box 3527
Laurel, Maryland 20709

DR. GARY ROUNDTREE	EDWARD HOLLAND	EDWARD REED	MELODY KEBE	VACANT
PRESIDENT	1st VICE PRESIDENT LEGISLATIVE DIRECTOR	2nd VICE PRESIDENT MEMBERSHIP DIRECTOR	SECRETARY	TREASURER

VIRGINIA BENDER	PATRICIA BELL	LARRY WALTON
ASST. SECRETARY	ASST. TREASURER	REGION II VP

December 8, 2023

The Honorable Wes Moore
Governor of Maryland
State House
100 State Circle
Annapolis, MD 21401

The Honorable Bill Ferguson
President of the Senate
H-107, State House
100 State Circle
Annapolis, MD 21401

The Honorable Adrienne Jones
Speaker of the House
H-101, State House
100 State Circle
Annapolis, MD 21401

Dear Governor Moore, President Ferguson and Speaker Jones:

We write today to request your support for legislation to expand the authority of the Prescription Drug Affordability Board (PDAB) to set limits on the expensive prescriptions purchased by all Maryland residents.

The Maryland Federation of the National Active and Retired Federal Employees Association (NARFE) represents approximately 300,000 Federal employees and annuitants living in Maryland. Maryland NARFE is a strong supporter of the PDAB and testified in the 2023 session for the additional legislation this year that reaffirms the board's authority to issue upper payment limits and extends deadlines from the earlier law.

The PDAB's current authority covers only prescription drugs under state and local government health care plans, for those covered state and local government workers. State health care advocates, such as Maryland AARP and the Health Care for All Coalition, want to expand the board's authority in 2024 so that all Marylanders can see more affordable prescription drug costs.

Such authority will address the high price of prescription drugs faced by many Maryland families. As our partners at Maryland AARP have noted, many Maryland residents must choose between paying for their diabetes injections, heart medication, anti-cholesterol regimes, or other prescriptions or, instead, to buy food or make their rent payment. Too often, important medications are left at the pharmacist's cash register because customers can't afford them.

With the PDAB now working to apply upper payment limits to the most expensive prescription drugs, we support concurrent efforts to expand its authority to set those limits on the expensive prescriptions purchased by all in Maryland. We will work in the 2024 Session with our partners at MD AARP and the Health Care for All coalition to enact such legislation.

Thank you for your support for this important matter. We look forward to working with you in the 2024 Legislative Session. If you have any questions, you can contact Edward Holland, 1st Vice President and Legislative Director of the Federation at (301) 848-3476, or hollandnmd@aol.com.

Sincerely,

Dr. Gary Roundtree Sr. p.p.
President, NARFE MD

Baltimore-Washington Conference

The United Methodist Church

Bishop LaTrelle Easterling

Bishop, Peninsula-Delaware Conference,
Baltimore-Washington Conference

Rev. Antoine C. Love *Assistant to the Bishop*
Rev. Erica Robinson-Johnson *Chief Administrative Officer*

December 6, 2023

The Honorable Wes Moore	*The Honorable Bill Ferguson*	*The Honorable Adrienne Jones*
Governor of Maryland	*President of the Senate*	*Speaker of the House*
State House	*H-107 State House*	*H-101, State House*
100 State Circle	*100 State Circle*	*100 State Circle*
Annapolis, MD 21401	*Annapolis, MD 21401*	*Annapolis, MD 21401*

Dear Governor Moore, President Ferguson, and Speaker Jones:

As the bishop of the Baltimore-Washington and Peninsula-Delaware Conferences, I am writing on behalf of members in 1,000 United Methodist churches who are deeply concerned about the high cost of prescription drugs. As leaders in our state, you have repeatedly demonstrated your compassion and belief that health care should be available to all. I am writing to ask for your assistance.

As people of faith, we are committed to ensuring that health care is provided for everyone, without regard to status or ability to pay. We trace this belief to the story of the Good Samaritan in Luke 10:25-35, where we are called to care for our neighbor. As citizens, the United Methodists view health care as a basic human right.

We recognize your commitment to these same principles and applaud the establishment of the Prescription Drug Affordability Board, which has proven to be a resounding success. In the upcoming legislative session, we ask that you use your influence to pass a bill that will give full authority to the Board, allowing them to use upper payment limits and make high-cost drugs more affordable for all Marylanders. As proponents of this measure often say, "drugs won't work if people can't afford them."

I thank you in advance for your support in this matter, and for all you do. Please know that you are in my prayers – in this holy season – and into the new year. Many challenges await, but I am confident you will meet them with wisdom, political acumen, and a generous spirit.

Blessings and Peace,

LaTrelle M. Easterling

Maryland Office | 11711 East Market Place, Fulton, Maryland 20759 | phone: 410-290-7300 | fax: 301-498-2023
D.C. Office | 110 Maryland Avenue, NE, Suite 501, Washington D.C. 20002 | phone: 202-546-3110 | fax: 202-546-3186

Rev. Dr. Greggory Maddox
President

Rev. Frank Hines
First Vice President

Rev. M. Jamal Foster
Second Vice President

Rev. Quinton Herbert
Third Vice President

Executive Secretary

Rev. Joel Small
Interim Treasurer

The United Baptist Missionary Convention

& AUXILIARIES OF THE STATE OF MARYLAND, INC.
833 North Bond Street ▪ Baltimore, Maryland 21205
Voice: 410.732.5180 ▪ Fax: 410.732.5181
Website: www.ubmcofmd.org

February 6, 2024

Maryland Health Care for All
2600 St. Paul Street
Baltimore, Maryland 21218

Dear Mr. DeMarco:

The United Baptist Missionary Convention and Auxiliaries of the State of Maryland, Inc. fully support the initiatives of Mayland Health Care for All. As Pastors and Christian leaders and educators, we see the impact that improper, poor, and/or no healthcare has on our congregations and the citizens of Maryland, especially the seniors and elderly. We know that without affordable healthcare, our members, as well as the citizens of the State of Maryland will suffer. The rise in the cost of medicines, especially for the elderly and senior citizens, creates problems causing them to choose between food and the medicine needed to maintain their health.

We applaud the work of Maryland Health Care for All as you seek to expand access; continue working to reduce prescription drug cost; and advance health equity. The members of the United Baptist Missionary Convention and Auxiliaries of the State of Maryland, Inc. supports expanding the authority of Maryland's Prescription Affordability Board and allow that Board to use upper payment limits to make high-cost drugs more affordable for all Marylanders.

Sincerely,

Greggory R. Maddox

Rev. Dr, Greggory R. Maddox,
President
UBMC & Auxiliaries of the State of MD, Inc.

"RESTORE"
"Restoring our Convention, Renewing our Culture, and Returning our Community to Christ"
– Nehemiah 2:17-18, 20

SB388.Rx.DAB.24.pdf
Uploaded by: Virginia Crespo
Position: FAV

Maryland Retired School Personnel Association

8379 Piney Orchard Parkway, Suite A ● Odenton, Maryland 21113
Phone: 410.551.1517 ● Email: mrspa@mrspa.org
www.mrspa.org

Senate Bill388
In Support Of
Prescription Drug Affordability Board – Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs for All Marylanders Act of 2024)
Budget and Taxation Committee
Hearing: February 7, 2024 – 2:00 p.m.

Dear Honorable Senator Guy Guzzone, Chair, and Honorable Senator Jim Rosapepe, Vice Chair, and distinguished Budget and Taxation Committee members,

The Maryland Retired School Personnel Association (MRSPA) supports SB 388.

MRSPA members include teachers, administrators, counselors, librarians, custodians, bus drivers and others who worked in the education of our Maryland students. Our health care is provided by the local Boards of Education not by the state or local governments. Enhancing health care is one of our highest priorities. We would like to be included in the people covered by the Drug Affordability Board.

The pensions that have been earned by our members are modest at best and seriously lacking for too many. We do not want our members to be in the position where they must choose between their necessary and life changing medications or paying their mortgages, food, rent, or skipping the medication.

The pharmaceutical industry claims that this will reduce the money available to them for research and development. Yet, they are able to pay exceptionally high salaries to their managers and large profits to their shareholders. They should also acknowledge that much of the research they use is funded by the taxpayers through agencies such as the National Institutes of Health.

This is the appropriate time to expand the authority of the Drug Affordability Board to all Marylanders. On behalf of the 12,000 members of MRSPA, we urge your support for SB 388 The Lowering Prescription Drug Costs For All Marylanders Now Act.

Sincerely,

Carla J. Duls
President

Virginia G. Crespo
Legislative Aide

SB 388_PDAB_SWA.pdf
Uploaded by: Allison Taylor
Position: FWA

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
2101 East Jefferson Street
Rockville, Maryland 20852

February 7, 2024

The Honorable Pamela Beidle
Senate Finance Committee
3 East, Miller Senate Office Building
11 Bladen Street
Annapolis, Maryland 21401

RE: SB 388 – Support with Amendments

Dear Chair Beidle and Members of the Committee:

Kaiser Permanente appreciates the opportunity to provide comment on SB 388, "Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding (The Lowering Prescription Drug Costs For All Marylanders Now Act)." Kaiser Permanente is the largest private integrated health care delivery system in the United States, delivering health care to over 12 million members in eight states and the District of Columbia.[1] Kaiser Permanente of the Mid-Atlantic States, which operates in Maryland, provides and coordinates complete health care services for over 825,000 members. In Maryland, we deliver care to approximately 475,000 members.

We appreciate and support the state's efforts to identify drugs that are causing affordability challenges for Maryland consumers. Pharmaceutical manufacturers' virtually unfettered pricing power has empowered them to set exorbitant prices, leading to a dysfunctional and grossly imbalanced market for prescription drugs.

This bill could be interpreted as targeting drug *purchases* above an upper payment limit, rather than drug *sales*. Unless the law targets drug manufacturers will not solve the problem of unaffordable drug prices. Manufacturers set the price of their drugs, and penalizing purchasers for purchasing drugs above the upper payment limit will only shift the cost burden onto the purchasers.

As the Board implements the underlying legislation, it is unclear how manufacturers and other sellers of prescription drugs will be held accountable when refusing to sell at prices at or below the established upper payment limit. Pharmacies and other purchasers of prescription drugs should not be punished for the pricing decisions of manufacturers and other sellers. To that end, we recommend including the clarifying amendment below to fairly protect purchasers who are unable to purchase prescription drugs at or below the established upper payment limit price.

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[1] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and over 650 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.

This amendment is consistent with the law's purpose, as stated in § 21-2C-02 of the Health – General Article, "to protect State residents, State and local governments, commercial health plans, health care providers, pharmacies licensed in the State, and other stakeholders within the health care system from the high costs of prescription drug products."

Thank you for the opportunity to comment. Please feel free to contact me at Allison.W.Taylor@kp.org or (202) 924-7496 with questions.

Sincerely,

Allison Taylor
Director of Government Relations
Kaiser Permanente

AMENDMENT TO SENATE BILL 388
(First Reading File Bill)

On page 7, in line 27, after "**(C)**" insert "**(1)**"; after line 30, insert:

(2) A PURCHASER THAT IS UNABLE TO PURCHASE A PRESCRIPTION DRUG PRODUCT AT OR BELOW THE UPPER PAYMENT LIMIT ESTABLISHED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL NOT BE SUBJECT TO AN ENFORCEMENT ACTION UNDER § 21-2C-12 OF THIS SUBTITLE".

SB0388 - PDAB - Upper Payment Limits Funding (Low

Uploaded by: Nora Hoban

Position: FWA

TO: The Honorable Pamela Beidle, Chair
Members, Senate Finance Committee
The Honorable Dawn Gile

FROM: Nora E. Hoban, MPA
Chief Executive Officer

DATE: February 7, 2024

RE: **SUPPORT ONLY IF AMENDED** – Senate Bill 388 – *Prescription Drug Affordability Board – Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs for All Marylanders Act of 2024)*

The Mid-Atlantic Association of Community Health Centers (MACHC) is the federally designated Primary Care Association for Delaware and Maryland Community Health Centers. As the backbone of the primary care safety net, Federally Qualified Health Centers (FQHCs) are united by a shared mission to ensure access to high-quality health care to all individuals, regardless of ability to pay. FQHCs are non-profit organizations providing comprehensive primary care to the medically underserved and uninsured. Maryland's sixteen health centers serve more than 340,000 patients annually. Eighty-seven percent live at or below 200% of the Federal Poverty Level, and more than two-thirds of patients are from historically marginalized racial and ethnic groups. MACHC supports its members in the delivery of accessible, affordable, cost effective, and quality primary health care to those most in need. To this end, MACHC **supports** Senate Bill 388, **only if the legislation is amended**.

MACHC supports the goals of Senate Bill 388, recognizing that prescription drug affordability is an issue impacting people statewide. However, if enacted, it is imperative that there are no unintended consequences associated with the expansion of upper payment limits and that the legislation protects Marylanders' access to discounted medications and expanded enabling services through the 340B Drug Pricing Program. Healthcare entities covered under the 340B program include Federally Qualified Health Centers, Ryan White Clinics, and hospitals that treat a disproportionate share of low-income patients.

Since 1992, the 340B Drug Pricing program has helped patients access affordable medications. Additionally, the program supports healthcare entities covered by the program to invest in wrap-around services and programs that best meet community needs. Such services address barriers to care regardless of race, ethnicity, education, or poverty. Health equity starts with legislation that supports access to primary and preventative care for all Marylanders.

Health centers operate on shoestring budgets, spreading limited financial resources to provide complex patients with a wide range of services. Community health centers manage a variety of payors to stretch scarce federal resources to those who need the most care. Health centers are not free clinics and accept all patients regardless of ability to pay. As nonprofit organizations, centers must balance different revenue streams while remaining financially stable, and financial considerations drive what services can be offered. The 340B program is an essential part of this balance.

Due to MACHC's concern about the potential for this legislation, as introduced, to negatively impact the benefits associated with the 340B program, the association's support is contingent upon the adoption of the following amendment to clarify the definition of "Prescription Drug Product" to exclude those products purchased under the 340B program.

Amendment:

§21-2C-01

> (h) "Prescription drug product" means a brand name drug, a generic drug, a biologic, or a biosimilar, UNLESS SUCH DRUG, BIOLOGIC, OR BIOSIMILAR WAS PURCHASED UNDER 42 U.S.C. § 256B.

MACHC wishes to reiterate its support for addressing prescription drug affordability, however the association's support for Senate Bill 388 is contingent on the adoption of the requested amendment to protect the integrity of the 340B Program. The amendment will ensure marginalized communities will continue to receive the benefits of discounted medications and wrap-around services that were made possible with the support of the 340 program as it was legislatively intended.

For More Information:
NHoban@machc.com

SB 388_MDCC_Lowering Prescription Drug Costs for A
Uploaded by: Andrew Griffin
Position: UNF

MARYLAND
Chamber of Commerce

LEGISLATIVE POSITION:
Unfavorable
Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs for All Marylanders Act of 2024)
Senate Bill 388
Senate Finance Committee
Wednesday, February 7, 2024

Dear Chair Beidle and Members of the Committee:

Founded in 1968, the Maryland Chamber of Commerce (Maryland Chamber) is the leading voice for business in Maryland. We are a statewide coalition of more than 6,800 members and federated partners working to develop and promote strong public policy that ensures sustained economic recovery and growth for Maryland businesses, employees, and families.

Senate Bill 388 would require the Prescription Drug Affordability Board (PDAB) to establish a process for setting upper payment limits for all purchases and payor reimbursements of prescription drug products in the state that the Board determines have led or will lead to affordability challenges. It also requires the Governor to include an appropriation of at least $1,000,000 in the annual budget bill beginning in fiscal year 2025 for the Prescription Drug Affordability Fund.

While the Maryland Chamber supports policies that enhance medicine accessibility and affordability, we do not support government-imposed upper payment limits as a means of price setting. This stance is rooted in our concern that such measures will have a chilling effect, stifling innovation and hampering Maryland's capacity to attract new investments, businesses, and talent. Additionally, it may impede the ability of life sciences companies to secure capital to support research and development. To sustain economic competitiveness, it is imperative that our universities, research institutions, and enterprises continue to work together and maintain collaborative efforts to bring new products and technologies to the market faster.

Maryland stands out as a premier destination for life sciences companies. According to data from the Maryland Department of Commerce, the state hosts a community of over 2,700 life science businesses, constituting one of the nation's largest clusters. These companies benefit from exceptional proximity to leading federal institutions such as the National Institutes of Health (NIH), National Institute of Standards and Technology and the Food and Drug Administration. More than 90% of the life sciences companies and strategic partners are located within one hour of each other. The Maryland/Virginia/Washington DC BioHealth Capital Region ranks fourth among the top ten U.S. biopharma clusters, based on metrics including patents, NIH grant

funding, venture capital, lab space and number of jobs. Notably, Maryland receives substantial research and development funding from NIH, with Johns Hopkins University leading the nation in total NIH awards. The state's life sciences sector generates $18.6 billion in economic activity and are awarded over a billion dollars in federal contracts each year.[1]

Government-imposed upper price limits may drive businesses to invest in more friendly states. Interfering with the free market through a price control scheme likely would negatively impact the future of critical medicines. Concerns arise over an unelected, independent board having the authority to set prices for privately produced products that are sold in a competitive, private market, setting a worrying precedent for government intervention. With federal regulation in place, state-level price control would create disparities, hindering access to essential medications for Marylanders.

Lastly, it is important to consider that the PDAB, which was created on July 1, 2019, was tasked with its first action of conducting a study of the entire pharmaceutical delivery and payment process, access data for drug pricing and utilization, and developing regulations that will allow it to achieve its goals. PDAB issued a **draft** working document in December 2023, and accepted comments until January 10, 2024. It seems impetuous for the General Assembly to expand the work and authority of PDAB when they haven't yet completed their initial work or finalized and submitted their report for the legislature to review.

The Chamber understands the intent of SB 388, however we urge the committee to consider alternative solutions that safeguard innovation, preserve access to medications, and uphold the economic vitality of Maryland's biopharmaceutical sector.

For these reasons, the Maryland Chamber of Commerce respectfully requests an **unfavorable report** on SB 388.

[1] https://commerce.maryland.gov/Documents/ResearchDocument/MarylandLifeSciencesIndustryFactSheet.pdf

2024-02-07 - SB 388 - EPIC - UNF - PDAB UPL Author
Uploaded by: Caitlin McDonough
Position: UNF

02/06/2024 **SB 0388**

Letter of concern offered on behalf of:

EPIC PHARMACIES, INC.

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East
Miller Senate Office Building
Annapolis, Maryland 21401

Dear Chair Beidle,

RE: LETTER OF CONCERN: SB0388 – Prescription Drug Affordability Board – Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs for All Marylanders Act of 2024)

EPIC Pharmacies are positioned in hundreds of communities across the state and represent the front line of healthcare providers caring for Maryland communities and your constituents. As the most accessible members of the healthcare team and the drug experts, pharmacists are uniquely positioned to help patients find the most appropriate and affordable medications.

As you well know, the current landscape in pharmacy has hindered our ability to service patients and provide needed services in our communities due to the inability of pharmacies to be appropriately paid by State and local governments, Medicaid, and commercial payors. All these entities set reimbursement levels within pharmacies using the power of their PBM's take it or leave it contracts and often force medications to be dispensed at a loss. No one wants to make medications more affordable than community pharmacies, but we view this bill and the additional authority it grants the Prescription Drug Affordability Board (PDAB) as yet another way to fund discounts through below cost reimbursements to pharmacies. Who is going to guarantee that these Upper Payment Limits are greater than the pharmacy cost to procure the drug, maintain its proper storage, dispense it to the patient, and complete all the unfunded mandates within the MD pharmacy practice act? Up to now, the committee has shown no interest in guaranteeing pharmacy is paid fairly for any one of these, much less the entire cost to provide prescriptions to the community.

My fear is that the State has not contemplated the downstream effects of this bill and what further reimbursement cuts might do to the community pharmacies across the state. We also

have concerns with the mandated perpetual funding of this board without any evidence that they will be able to impact the price of prescription drugs for Maryland consumers. My colleagues and I are always happy to work with the committee and the PDAB on any of these issues to ensure fair consumer pricing and the survival of community pharmacies near the homes of all Maryland citizens.

Sincerely,

Brian M. Hose, PharmD
EPIC PharmPAC Chairman
brian.hose@gmail.com

SB0388_UNF_MDCSCO, ASCO_PDAB - Auth. UPLs & Fundin

Uploaded by: Danna Kauffman

Position: UNF

February 7, 2024

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East
Miller Senate Office Building
Annapolis, Maryland 21401

RE: OPPOSE – Senate Bill 388 – *Prescription Drug Affordability Board – Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs for All Marylanders Act of 2024)*

Dear Chair Beidle:

The Maryland/DC Society of Clinical Oncology (MDCSCO) and the Association for Clinical Oncology (ASCO) are committed to supporting policies that reduce costs while preserving access to quality cancer care. MDCSCO is a professional organization whose members are a community of physicians who specialize in cancer care. ASCO is a national organization representing physicians who care for people with cancer. With nearly 50,000 members, our core mission is to ensure that cancer patients have meaningful access to high quality, equitable cancer care.

We are concerned that the expansion of authority in ***Senate Bill 388: Prescription Drug Affordability Board – Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs for All Marylanders Act of 2024)*** is premature and could jeopardize access to necessary care for Maryland patients with cancer. While we appreciate the commitment to lowering costs, we do not support changing the process that the legislature carefully established and reaffirmed last year during the 2023 Session. Currently, the Prescription Drug Affordability Board (PDAB) is charged with undertaking a process to set upper payment limits (UPLs) for drugs purchased or paid for by a unit of State or local government or an organization acting on their behalf or through the State's Medicaid program. The PDAB is then required to monitor the availability of any prescription drug product for which it sets an UPL, especially whether a shortage results in a particular prescription drug. The second phase is then for the PDAB to study the legality, obstacles, and benefits of setting UPLs on all purchases and payor reimbursements of prescription drug products in the State, not just those drugs purchased or paid for by the State (i.e., Medicaid) or local government. The PDAB is required to report the results of that study by December 1, 2026.

At this time, the PDAB has not yet established UPLs under the first phase of its authority. Therefore, there is no data to determine whether this mechanism will control prescription drug

costs. More importantly, there is no data to determine the unintended consequences or harm that could result from this mechanism. In fact, there is little data from any state that has established this type of board and mechanism, given the newness of these boards and authority. Therefore, prior to granting an expansion, even with legislative oversight, we strongly recommend that the State continue with the process set forth in the original legislation and affirmed last Session, rather than "jump ahead" with no data.

As Maryland continues to examine the use of UPLs, MDCSCO and ASCO request that the following be considered. Life-saving treatments for cancer often include use of high-cost drugs, the very ones targeted by the UPLs. Cancer patients are uniquely vulnerable and often have a narrow window of time for a successful outcome. If doctors and patients must endure an appeal to access treatments subject to an UPL, some of Maryland's sickest patients will suffer severe consequences.

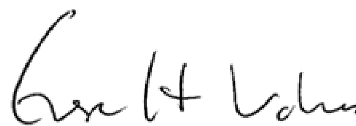
Oncologists do not set or control drug prices; they offer their patients the most appropriate, evidence-based treatment that will ensure the best outcome for an individual cancer patient and their specific disease. However, the landscape for acquiring and delivering cancer medications to patients is much more complex than going to your local pharmacy, given that most cancer drugs are injectables that are physician-administered. Unfortunately, there is little transparency from pharmacy benefit managers (PBMs) regarding the flow of dollars and rebates received. Too often, physicians face paying more to acquire drugs than they are paid by PBMs. This happens because payment amounts do not account for costs associated with special handling, storage, and preparation required for the administration of toxic drugs. Any setting of an UPL must understand this unique position and recognize the need to offset these costs.

In addition, we are eager to discuss other solutions we think could control the appropriate utilization of the highest cost drugs, while protecting cancer patients, including the use of value-based clinical pathways. However, for the reasons stated above, MDCSCO and ASCO do not support expanding the authority of the PDAB before the State has **<u>any</u>** data to demonstrate a benefit or, more importantly, any unintended consequences that could result in patient harm. Therefore, we urge the State to "stay the course," and we request an unfavorable vote on Senate Bill 388. This will then allow additional time for the State to fully understand the benefits and consequences of the use of an UPL and to continue to make necessary revisions to ensure that patients continue to have access to lifesaving medications and that oncology practices are not negatively impacted.

Sincerely

Dr. Paul Celano, MD, FACEP, FASCO
President
MD/DC Society of Clinical Oncology

Sincerely,



Dr. Everett Vokes, MD, FASCO
Chair of the Board
Association for Clinical Oncology

SB0388_UNF_MTC_PDAB - Authority UPLs & Funding (Lo

Uploaded by: Drew Vetter

Position: UNF

MARYLAND TECH COUNCIL

TO: The Honorable Pamela Beidle, Chair
Members, Senate Finance Committee
The Honorable Dawn Gile

FROM: Andrew G. Vetter
Pamela Metz Kasemeyer
J. Steven Wise
Danna L. Kauffman
Christine K. Krone
410-244-7000

DATE: February 7, 2024

RE: **OPPOSE** – Senate Bill 388 – *Prescription Drug Affordability Board – Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs for All Marylanders Act of 2024)*

The Maryland Tech Council (MTC) writes in **opposition** of Senate Bill 388 – *Prescription Drug Affordability Board – Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs for All Marylanders Act of 2024)*. We are a community of nearly 800 Maryland member companies that span the full range of the technology sector. Our vision is to propel Maryland to become the number one innovation economy for life sciences and technology in the nation. We bring our members together and build Maryland's innovation economy through advocacy, networking, and education.

This bill would create a process for the Maryland Prescription Drug Affordability Board (PDAB) to set Upper Payment Limits (UPLs) for "all purchases and payor reimbursements or prescription drug products in the State that the Board determines have led or will lead to an affordability challenge" if it is in "the best interest of the State."

Presently, the authority of the PDAB to set UPLs is limited to State and local government plans. We understood the intent of the General Assembly at the time was to test the concept of affordability reviews and possible cost controls on a more limited basis to evaluate effectiveness, gather data, and refine the process. Rather than letting that process play out, this bill expands the authority of the PDAB before any cost reviews have been completed. The MTC urges the General Assembly to allow the PDAB to continue its work this year in refining a list of drugs to evaluate before authority is expanded.

The MTC has many life science companies among its membership. In fact, Maryland is one of the leading states in the nation for the concentration of life science companies with 54,000 life science jobs, 2,700 life science and biotechnology companies, world class universities, and government agencies. While the life sciences community shares the concerns of the bill's sponsors and proponents about the affordability of necessary medications, there is skepticism whether the PDAB and UPLs, specifically, are the best way to accomplish that goal.

We encourage the committee to consider unintended consequences of price controls. There are companies in the life science industry that believe if they are negatively impacted by PDAB-imposed price controls, it may jeopardize their ability to continue investing resources into research and clinical trials needed to discover breakthroughs for the treatment of cancer and other rare diseases. Policymakers should be looking for ways to incentivize this type of activity, rather than potentially limiting it.

Additionally, this legislation focuses on UPLs as the means to address the cost of drugs that are unaffordable. The committee should examine other practices and policies that could have a direct impact on what patients pay out-of-pocket for their medicines. For example, there are tools that insurance companies and pharmacy benefit managers (PBMs) use that impact out-of-pocket costs. Co-pay accumulator policies prevent manufacturer discounts from counting toward a patient's deductible, increasing a patient's cost. Banning this practice should be considered. The committee should also consider "Share the Savings" policies that require insurance companies and PBMs to share the savings they negotiate with drug manufacturers with patients.

The MTC remains committed to being a part of the conversation about how to reduce the cost of prescription drugs for Maryland patients. However, we believe that the timing is not right for this legislation and that a more comprehensive approach to this issue should be considered rather than focusing solely on the PDAB's authority to set UPLs.

We respectfully request an unfavorable report.

MJFF PDAB - Opposition Statement 2024.pdf
Uploaded by: Julia Pitcher
Position: UNF

Statement in Opposition to
State Prescription Drug Affordability Board (PDAB) Legislation
2024

The Michael J. Fox Foundation for Parkinson's Research (MJFF) respectfully opposes legislation to establish or expand prescription drug affordability boards being considered by state legislatures. MJFF strongly supports access to affordable medications, but the long term and shortsighted consequences of this legislation will have harmful effects on the pipeline for new and innovated medications and life-saving therapies.

As the world's largest nonprofit funder of Parkinson's research, MJFF is dedicated to accelerating research and clinical breakthroughs that will improve therapeutics and treatments for the more than one million Americans living with PD. The Foundation pursues its goals through an aggressively funded, highly targeted research program coupled with active global engagement of scientists, Parkinson's patients, business leaders, clinical trial participants, donors, and volunteers. Since its inception in 2000, the Foundation has funded $1.7 billion in research to date.[1]

There are estimated to be more than 1 million Americans currently living with Parkinson's disease, with about 90,000 more diagnosed each year.[2] According to the Centers for Disease Control and Prevention, Parkinson's disease is the second most common and the fastest-growing neurological disorder in the world. Per year, the cost of PD nationally is at least $58 billion and the direct and indirect costs to care for the approximately 1 million living with Parkinson's in the US and will rise to nearly $80 billion by 2037.[3]

Regulating drug prices through an in-state government-appointed Board will upend a global system of research and development, manufacturing, and delivery that could lead to medication shortages and inappropriate use of utilization management (UM) such as step therapy and prior authorization. This can lead to delays in care with severe medical consequences when a person living with Parkinson's disease is unable to properly take their daily medications to ease symptoms. Patients living with Parkinson's are particularly susceptible to these kinds of insurance practices which do not align with clinical guidelines for what the provider deems is in the patient's best interest and can lead to disease worsening and put their health at unnecessary risk.[4]

Parkinson's patients already experience lengthy time in seeking and receiving their diagnosis, diminished ability to work and lost wages due to early retirement or career impact, and anxiety over costs to find proper treatment, especially in rural areas lacking neurological specialists.

This legislation does not address the adverse variables in state issued insurance benefit design nor seeks to reform predatory practices for other stakeholders in the determination of medication costs such as Pharmacy Benefit Managers (PBMs) and payers who dictate the terms of coverage and availability of access to medications.

For the reasons stated above and behalf of the thousands of researchers and millions of patients in the Parkinson's community, we urge you to reject this legislation.

Julia L. Pitcher, JD
Director of State Government Relations
The Michael J. Fox Foundation for Parkinson's Research

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[1] Michael J. Fox Foundation Announces Significant Breakthrough in Search for Parkinson's Biomarker, PR Newswire, April 2023, https://www.prnewswire.com/news-releases/michael-j-fox-foundation-announces-significant-breakthrough-in-search-for-parkinsons-biomarker-301796029.html.
[2] Destro, Christina, "New Study Shows the Incidence of Parkinson's in the U.S. is Nearly 50 Percent Higher than Previous Estimates." Dec. 2022, https://www.michaeljfox.org/news/new-study-shows-incidence-parkinsons-us-nearly-50-percent-higher-previous-estimates.
[3] "The Economic Burden of Parkinson's Disease," Lewin Group, July 2019, https://www.lewin.com/resources/publications/economic-burden-parkinsons.html.
[4] Nature Portfolio Journal: Care Access and Utilization Among Medicare Beneficiaries Living with Parkinson's Disease, 2023, https://www.nature.com/articles/s41531-023-00523-y.

HDA Opposition Letter MD SB 388.pdf

Uploaded by: Kelly Memphis

Position: UNF

Healthcare Distribution Alliance

HEALTH DELIVERED

February 7, 2024

Senator Pamela Beidle, Chair
Senator Katherine Klausmeier, Vice Chair
Maryland Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, Maryland 21401

HDA Testimony Opposing S.B. 388

Dear Chair Beidle, Vice Chair Klausmeier, and Honorable Members of the Committee:

The Healthcare Distribution Alliance (HDA) offers this letter to share some supply chain concerns with the committee regarding **Senate Bill 388, PDAB UPL Authority.**

HDA is the national trade association representing healthcare wholesale distributors — the vital link between the nation's pharmaceutical and healthcare manufacturers and more than 330,000 pharmacies, hospitals, and other healthcare settings nationwide. Wholesale distributors work around the clock to ship nearly 10 million pharmaceutical products to pharmacies, hospitals, and other healthcare providers daily to keep their shelves stocked with the medications and products they need to treat and serve patients. In Maryland, our members serve over 4,600 such sites of care. Wholesale distributors are primarily responsible for the physical handling and logistics of medicines and healthcare products, and have no role in setting list prices (WAC), nor they do determine the amount patients pay for medicines, which medicines are included on formularies, benefit design decisions, or reimbursement rates for dispensing pharmacies.

While HDA understands and supports the intent of the bill to address the prices that consumers see at the pharmacy counter, we have concerns regarding expanding the PDAB's upper payment limit (UPL) authority. State-level UPLs do not adequately reflect how prescription drugs are bought and paid for in the U.S., which are bought and sold at the national level. Improperly applied, rather than addressing the cost of drugs, UPLs can disrupt patient access to products. This is exemplified by the fact that the Colorado PDAB's first attempt to establish a UPL was abandoned due to the patient community expressing their concerns over the inability to access the product.

Given the concerns a state-level UPL create, HDA believes it would be best for the stability of the supply chain if the Board's current work be completed, fully realized, and evaluated before any legislation to expand the UPL authority or funding is passed. For these reasons, **HDA does oppose S.B. 388 at this time.** Please contact me at kmemphis@hda.org if you have any questions.

Sincerely,

Kelly Memphis

Kelly Memphis
Director, State Government Affairs
Healthcare Distribution Alliance

BIO Letter in Opposition to SB 388.pdf

Uploaded by: Laura Srebnik

Position: UNF

Biotechnology Innovation Organization
1201 New York Ave., NW
Suite 1300
Washington, DC, 20005
202-962-9200

February 6, 2024

The Honorable Pamela Beidle, Chair
Senate Committee on Finance
Miller Senate Office Building, 3 East Wing
11 Bladen St., Annapolis, MD 21401 – 1991

Dear Chair Beidle and Members of the Committee:

On behalf of the Biotechnology Innovation Organization (BIO), I would like to express our **opposition** to SB 388, a bill to expand the scope of the Maryland Prescription Drug Affordability Board (PDAB). BIO opposed the establishment of the PDAB when it was created in 2019 and therefore opposes any expansion of its authority. We continue be concerned about the impact the PDAB will have on patient access to new therapies, as well as the negative downstream impact it's actions will have on investment in Maryland's growing life sciences industry.

BIO is the world's largest trade association representing biotechnology companies, academic institutions, state biotechnology centers, and related organizations across the United States and in more than 30 other nations. BIO members develop medical products and technologies to treat patients afflicted with serious diseases, to delay the onset of these diseases, or prevent diseases from occurring.

We maintain that SB 388 will do very little to lower prescription drug costs for Maryland residents. The Maryland PDAB in general, and SB 388 in particular, fail to address factors related to prescription drug costs, such as patient out-of-pocket costs. Those have been rising steadily for years as health insurers and pharmacy benefit managers shift more cost burden on patients. SB 388 fails to address this problem.

This bill also provides no clear path for lowering prescription drug costs for public or private payers or the healthcare system overall. The price control scheme in SB 388 is designed around the premise that prescription drug costs are increasing at an unsustainable rate, yet prescription drugs, including inpatient medicines, continue to account for only about 14% of national health expenditures—both in the past and projected for the next decade.[1] Spending on prescription drugs on a per-patient-per-year basis, adjusted for inflation, grew by less than 1% between 2009 and 2018.[2]

[1] Roehrig, Charles. *Projections of the Prescription Drug Share of National Health Expenditures Including Non-Retail*. June 2019.
[2] IVQIA Institute for Human Data Science. *Medicine Use and Spending in the U.S.: A Review of 2018 and Outlook to 2023*. May 2019.

BIO is also concerned that actions by the Maryland PDAB to lower prescription drug costs, particularly efforts to impose price controls, disincentivize development of new, more effective therapies. This is especially concerning for patients living with a rare disease who have limited, or no treatment options currently available to them. Economists estimate that government price controls have a significant, damaging effect on the development pipeline for prescription drugs. For example, one study found that an artificial 50% decrease in prices could reduce the number of drugs in the development pipeline by as much as 24%,[3] while another study found investment in new Phase I research would fall by nearly 60%,[4] decreasing the hopes of patients who are seeking new cures and treatments. This bill will only expand the price control authority of the Maryland PDAB and provide an event more significant disincentive for companies to develop new, more effective therapies.

Maryland is emerging as a significant global center for biotechnology innovation, particularly in the biopharma sector. Since 2018, the state's bioscience companies have increased their employment by 14 percent, outpacing national job growth and reaching nearly 50,000 jobs that span 3,104 companies, many of them small startups. Legislation such as SB 388 will jeopardize investment into Maryland's robust and growing biotechnology industry.

For these reasons, we respectfully express our strong opposition to SB 388 and urge you and your colleagues in the Maryland Legislature to not pass this bill.

Sincerely,

Vice President
State Government Affairs

[3] Maloney, Michael T. and Civan, Abdulkadir. *The Effect of Price on Pharmaceutical R&D* (June 1, 2007). Available at SSRN: https://ssrn.com/abstract=995175 or http://dx.doi.org/10.2139/ssrn.995175
[4] Vernon, John A., and Thomas A. Abbott, "The Cost of US Pharmaceutical Price Reductions: A financial simulation model of R&D Decisions," *NBER Working Paper*. NBER, February 2005. https://www.nber.org/papers/w11114.pdf Accessed: April 18, 2019.

Alliance for Health Innovation concerns about Mary

Uploaded by: Michiel Peters
Position: UNF

Global Coalition on Aging

February 6, 2024

Subject: Alliance for Health Innovation concerns about Maryland Prescription Drug Affordability Board (PDAB)

Honorable Members of the Maryland Legislature,

The Alliance for Health Innovation (Alliance) is a group of diverse cross-sector stakeholders that together represent patients, providers, caregivers, academia, biopharmaceutical innovators, and business communities.

Led by the Global Coalition on Aging (GCOA), the Alliance is committed to establishing the importance of innovation in achieving healthy aging and advocates for state policy solutions that support a thriving innovation sector that enables Marylanders and other communities to live longer – and healthier – lives.

We write to share our deep concerns about the possibility of Maryland's Prescription Drug Affordability Board (PDAB) establishing Upper Payment Limits (UPLs) on prescription drugs, as this would likely decrease reimbursements from payers to pharmacies and providers for certain drugs. While this may save payers in the short term, the Alliance believes pharmacies and providers will be forced to respond by limiting patient access to newer – and often more effective –medicines if not adequately reimbursed.

Such policies typically lead to significant access restrictions for patients, which disproportionally affect the disadvantaged populations these policies are meant to protect.

Many diseases that once burdened aging populations have evolved into manageable chronic conditions due to the development of safer, more effective treatments.

However, while there have been significant strides to discover new treatments in recent decades, there remains a vast unmet patient need for new solutions to complex, age-related health challenges, including Alzheimer's disease, HIV, heart disease, cancer, bone health, and more. Unfortunately, price limits will undercut the incentives to research and develop such innovations and derail progress toward achieving healthier, more productive societies.

Vulnerable populations – such as older adults living with HIV – are even more dependent on access to innovative medicines than others who suffer from chronic conditions. Thanks to

years of biomedical investment and innovation, a person with HIV who starts treatment soon after their diagnosis can expect to live the same lifespan as an HIV-negative person.

However, as people with HIV live longer, they can develop comorbidities that affect their health-related quality of life and are costly to treat. People living with HIV are more likely to develop additional health issues as they age and tend to develop them earlier than people who do not have HIV.

As a result of the proposed legislation, life-saving innovations could become inaccessible to Marylanders who depend on them to manage chronic and, in some cases, life-threatening conditions.

Thank you for allowing us to share our concerns and for your commitment to finding solutions to Maryland patients' affordability and access challenges. We would be happy to discuss these concerns further or answer any questions you might have.

Sincerely,

Michiel Peters, Senior Director, Global Coalition on Aging

PIPC Maryland Board bill comment Senate.pdf
Uploaded by: Sara van Geertruyden
Position: UNF

February 6, 2024

Senator Pamela Beidle
Chair
Finance Committee
Maryland Senate
3 East Wing
Miller Senate Office Building
Annapolis, Maryland 21401

Senator Cheryl Kagan
Vice Chair Katherine Klausmeier
Finance Committee
Maryland Senate
3 East Wing
Miller Senate Office Building
Annapolis, Maryland 21401

Dear Chair Beilde and Vice Chair Klausmeier:

The Partnership to Improve Patient Care (PIPC) is writing to respond to the comment opportunity provided by the Maryland Senate Committee on Finance as it advances legislation, SB 388, to be considered on February 8, 2024. We understand that the rising cost of healthcare is a concerning issue that requires real solutions. We agree that the affordability of health care is a significant priority and urge state policymakers to manage health costs in a manner centered on meeting the health care needs of people with disabilities and chronic conditions. In doing so, we urge the state to avoid policies that would potentially discriminate by relying on measures such as the Quality-Adjusted Life Year (QALY) that have detrimental implications for access to needed care and treatment. We also urge the state to meaningfully engage people with disabilities and serious chronic conditions in the legislative process and to require their engagement in the Prescription Drug Affordability Board's deliberations.

Ban QALYs and Similar Measures from Consideration

We are concerned that QALYs and similar measures have not been barred in state law from use in the considerations of the Prescription Drug Affordability Board. As background, referencing discriminatory metrics such as QALYs can potentially violate existing civil and disability rights laws. QALY-based assessments assign a financial value to health improvements provided by a treatment that do not account for outcomes that matter to people living with the relevant health condition and that attribute a lower value to life lived with a disability. When applied to health care decision-making, the results can mean that people with disabilities and chronic

illnesses, including older adults, are deemed not worth the cost to treat. We encourage you to review the report from the National Council on Disability, an independent federal agency, recommending that policymakers avoid referencing the QALY, clarifying that its use in public programs would be contrary to United States civil rights and disability policy.[1]

The United States has a thirty-year, bipartisan track record of opposing the use of the QALY and similar discriminatory metrics and establishing appropriate legal safeguards to mitigate their use. Section 504 of the Rehabilitation Act ensures that people with disabilities will not be "excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination," under any program offered by any Executive Agency, including Medicare.[2] Title II of the Americans with Disabilities Act (ADA) extended this protection to programs and services offered by state and local governments.[3] Following the ADA's passage in 1990, HHS rejected a state waiver application in 1992 because its reliance on QALYs and cost effectiveness standards would have violated the ADA and led to discrimination against people with disabilities in determining the state's prioritized list of services.[4]

In 2010, the Affordable Care Act (ACA) prohibited QALYs and similar metrics from being used by HHS as a threshold to establish what type of health care is cost effective or recommended, as well as prohibiting their use as a threshold in Medicare to determine what is covered, reimbursed or incentivized.[5] Therefore, we remain concerned that the legislation currently under consideration adds new authority to the state's Prescription Drug Affordability Board, again without consideration for its implications for discrimination. The bill does not ban the board from considering measures of clinical and cost effectiveness that may devalue the lives of people with disabilities, patients with chronic conditions or older adults.

It is essential for the legislature to learn from the experience of other states that have created Prescription Drug Affordability Boards. Even where legislatures have added language intended to restrict a board's consideration of QALYs and similar measures, these measures have proved insufficient. States like Colorado and Oregon are being advised by entities such as the Program on Regulation, Therapeutics, and Law (PORTAL),[6] which we know to have a subcontract with the Institute for Clinical and Economic Review (ICER) for its work with the Massachusetts Health Policy Commission. ICER is well known for its use of the QALY and the equal value of life year gained (evLYG), calling the QALY the "gold standard" for value assessment of health care. PORTAL's independent work also routinely references the QALY and evLYG in estimating cost effectiveness of treatments.

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[1] National Council on Disability. (November 16, 2019). Quality-Adjusted Life Years and the Devaluation of Life with Disability. https://ncd.gov/sites/default/files/NCD_Quality_Adjusted_Life_Report_508.pdf.
[2] 29 USC Sec 794, 2017. Accessed November 30, 2020.
[3] 42 USC Sec 12131, 2017. Accessed November 30, 2020.
[4] Sullivan, Louis. (September 1, 1992). Oregon Health Plan is Unfair to the Disabled. The New York Times.
[5] 42 USC Sec 1320e, 2017. Accessed November 30, 2020.
[6] https://www.linkedin.com/in/portal-research/

This current bill raises concerns that the proposed assessment for an Upper Payment Limit for these treatments may involve reference to ICER studies, potentially using their evLYG calculations, which have been widely critiqued for failing to account for quality-of-life improvements and for being calculated using the QALY's flawed health utilities.[7] We urge the committee to consider the implications of effectiveness measures that are known to disproportionately impact care access for subpopulations already experiencing substandard health care, especially for people that too often experience discrimination doubly by virtue of being Black, Indigenous, or people of color and having a disability or chronic condition.[8] The National Council on Disability, an independent federal agency, called for a blanket prohibition on QALYs, whether used directly or by reference to a third party, as part of its Health Equity Framework.[9] Therefore, we recommend consideration of the provisions outlined in the legislative template created for state legislatures, specifically subsection (d) barring QALYs and similar measures.[10]

Engage People with Disabilities and Serious Chronic Conditions

People with disabilities and serious chronic conditions have diligently called for a robust engagement process in state Prescription Drug Affordability Board deliberations and in the process to negotiate drug prices in Medicare. For example, 56 organizations sent a letter to the Centers for Medicare and Medicaid Services (CMS) related to their initial guidance for implementing the Medicare Drug Price Negotiation Program. Their comments centered on three pillars: 1) creating additional procedures to meaningfully engage with patients and ensure that the evidence CMS relies on is transparent; 2) establishing patient-centered standards and outcomes; and 3) more definitively rejecting the use of Quality-Adjusted Life Years (QALYs) and other discriminatory cost-effectiveness standards. Their recommendations to CMS may also be useful to your efforts to develop stronger evidentiary standards and engagement practices in statute that ensure patient benefits are central to decision-making. The letter is also attached as an appendix.[11] We hope that the committee will take into consideration each of its recommendations.

As states like Oregon implement their board, we share the concerns expressed by Oregon advocates about its process. First, patients and people with disabilities should be represented on the board. Board meeting agendas should formally involve expert advisors living with a condition treated by the selected drugs for review, and meetings should give priority to hearing their testimony. In light of the experience in other states with the lack of transparency of their

[7] https://ncd.gov/sites/default/files/NCD_Quality_Adjusted_Life_Report_508.pdf
[8] https://www.thevalueinitiative.org/wp-content/uploads/2022/10/IVI_Sick-Cells_Equity-in-Value_2022.pdf
[9] https://www.ncd.gov/sites/default/files/NCD_Health_Equity_Framework.pdf (Recommendation #8 on page 10)
[10] https://valueourhealth.org/wp-content/uploads/2020/05/Advancing-Health-Care-Research-and-Decision-Making-Centered-on-Patients-and-People-with-Disabilities.pdf
[11] http://www.pipcpatients.org/uploads/1/2/9/0/12902828/joint_comment_to_cms_on_negotiation.pdf

own board processes and their consideration of evidence that is discriminatory or biased from entities such as PORTAL, we would emphasize the importance of policies requiring the board to publicly disclose for comment the evidence under consideration from third parties related to clinical effectiveness, cost effectiveness, and any comparators used in judgements of therapeutic benefit. This step is essential in protecting the process from being undermined by considerations of evidence that is biased, discriminatory, or unlawful. It is essential that the board work closely with organizations representing patients and people with disabilities to ensure that their real-world affordability concerns are driving the board's determinations. Therefore, we strongly urge consideration of the provisions included in the template legislation for states developed by patients and people with disabilities.[12]

We strongly support standards for the research used to make judgements about therapeutic impacts of drugs, assuring it is centered on value to patients and people with disabilities and inclusive of real-world evidence.[13] The decision-making process, whether in the selection of drugs for an affordability review, the affordability review itself, or in establishing payment limits, should be publicly transparent and avoid discriminatory research using QALYs or similar methods steeped in stigma. Instead, the process should favor measures that encourage treatments valued by patients and people with disabilities. The legislature should begin by recognizing the historic discrimination from use of biased cost effectiveness measures such as QALYs to make decisions related to health care, instead focusing on outcomes that matter to patients and people with disabilities.[14]

It is disappointing that neither the legislation expanding the board nor the board itself outline a robust process for engaging patients and people with disabilities. Engagement should be required to happen early and often, including roundtables with affected patients and people with disabilities related to the treatments being considered by the board, and concerted efforts to engage with diverse communities, especially those not represented in the data, to capture outcomes that are valued by all people living with the condition.

We urge the committee to learn from the experience of other state boards and to include appropriate policies that ensure the board's activities do not discriminate or limit access to needed care and treatment. Please reach out to Sara van Geertruyden at sara@pipcpatients.org with any questions or concerns.

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[12] https://valueourhealth.org/wp-content/uploads/2020/05/Advancing-Health-Care-Research-and-Decision-Making-Centered-on-Patients-and-People-with-Disabilities.pdf

[13] https://www.healthaffairs.org/content/forefront/medicare-drug-price-negotiations-avoid-metrics-steeped-stigma

[14] https://www.ajmc.com/view/is-the-qaly-fit-for-purpose-

Sincerely,

Tony Coelho
Chairman
Partnership to Improve Patient Care

April 14, 2023

Meena Seshamani, M.D., Ph.D.
CMS Deputy Administrator and Director of the Center for Medicare
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Deputy Administrator Seshamani:

Thank you for this opportunity to comment on the Initial Memorandum for Implementation of the Medicare Drug Price Negotiation Program. Our organizations represent the public stakeholders referenced in the guidance – the patients and people with disabilities impacted by this negotiation process. Our comments will focus on the role that we hope to play in ensuring that the agency centers its considerations on outcomes that matter to patients and people with disabilities as it implements this important new program to ensure drug affordability for individuals under Medicare.

The Maximum Fair Price (MFP) provisions of the Inflation Reduction Act (IRA) provide the Centers for Medicare & Medicaid Services (CMS) with significant new authority to reduce drug prices for Medicare beneficiaries. As your guidance recognized, the MFP provisions of the law also include provisions to protect patients and support patient centered action. CMS has the opportunity to continue advancing this crucial goal throughout the implementation of the Medicare Drug Price Negotiation Program. As CMS makes decisions to improve drug affordability, it is vital for the agency to center its decisions around patients and people with disabilities.

Specifically, this important new program gives CMS an opportunity to advance patient-centeredness in health care decision making while improving medical affordability through lower drug prices. While we commend the agency for the steps it has already taken in this direction, such as soliciting stakeholder input at the beginning of the decision-making process, we urge the agency to include additional measures to ensure the program is truly centered on the needs of patients and people with disabilities.

Our recommendations below center on three pillars: 1) creating additional procedures to meaningfully engage with patients and ensure that the evidence CMS relies on is transparent; 2) establishing patient-centered standards and outcomes; and 3) more definitively rejecting the use of Quality-Adjusted Life Years (QALYs) and other discriminatory cost-effectiveness standards. We believe these recommendations will be useful to CMS in developing evidentiary standards and engagement practices that ensure patient benefits are central to decision-making.

We Urge Meaningful Engagement of Patients and People with Disabilities

Allowing members of the public to provide input into the decision-making process, particularly the Medicare beneficiaries directly impacted by this work, will best position CMS to identify all available unbiased and nondiscriminatory evidence for the factors described in section 1194(e)(2). We appreciate that CMS is inviting patients and other public stakeholders to provide input in an initial 30-day period for information collection. Further, we are aware that CMS also released an information collection request (ICR) on Negotiation Data Elements which describes how CMS intends to collect the data described, including information relevant to section 1194(e)(2). We are reviewing this and will provide additional comments as pertinent. As CMS considers the tactics that will be used to gather information, we provide the following recommendations:

- CMS should create an ***ombudsman*** for the Medicare Drug Price Negotiation Program to act as a central point of input for patients and people with disabilities, similar to the Food & Drug Administration's (FDA's) Patient Affairs Office or the Patient-Centered Outcomes Research Institute's (PCORI's) Director of Patient Engagement. The ombudsman should be an individual with significant experience in patient engagement, familiar with the organizations representing patients and people with disabilities and responsible for ensuring that input is disseminated to decision-makers at CMS and responses are given back to those providing said input.
- ***CMS should incorporate additional procedures to obtain and respond to input from patients and people with disabilities early*** in the drug price negotiation process, giving stakeholders time to collect and provide meaningful comments. CMS likely will need to begin seeking input from patients and caregivers very early in the process so that CMS can consider it along with other inputs before the agency makes an "initial offer" of a Maximum Fair Price. This should go beyond written comments provided through a single, open-ended Information Collection Request, and could include, for example, CMS convening ***public roundtables*** of disease or treatment-specific experts from the patient and disability communities, as well as their caregivers, for each drug selected for MFP negotiation.
    - This process should look similar to the process used by the FDA to engage patients as part of Patient-Focused Drug Development, both as part of externally led meetings[1] and FDA-led meetings.[2]
    - Another potential reference point is the engagement process used by PCORI to identify the outcomes that the organization values. CMS should similarly engage patients and people with disabilities to establish a predictable process for engagement related to its consideration of data elements about a selected drug, the

[1] "Externally-Led Patient-Focused Drug Development Meetings." U.S. Food and Drug Administration, FDA, 29 July 2022, https://www.fda.gov/industry/prescription-drug-user-fee-amendments/externally-led-patient-focused-drug-development-meetings
[2] "Externally-Led Patient-Focused Drug Development Meetings." U.S. Food and Drug Administration, FDA, 29 July 2022, https://www.fda.gov/industry/prescription-drug-user-fee-amendments/externally-led-patient-focused-drug-development-meetings

evidence used in consideration of factors in statute used to assess therapeutic value, and its alternative therapies.

- CMS should share the non-proprietary evidence that they are considering for unmet need, including comparative research and therapeutic advance. The agency should then solicit feedback about its relevance to the needs, and outcomes and preferences of patients. CMS should also solicit other patient sources from patients and people with disabilities that may have their own resources for collecting data.

- CMS should solicit input from ***diverse*** communities, in order to gain information about the differences among subpopulations and their needs, outcomes, and preferences.
- CMS should provide patients and people with disabilities the ***resources needed for effective engagement***.
    - Resources may include providing financial assistance to facilitate participation in meetings and roundtables, making meetings accessible to people with disabilities, providing informational materials in accessible formats, funding surveys and other forms of real-world evidence generation, and/or allowing an extended amount of time for input and comments.
    - This recommendation is consistent with best practices supporting engagement, particularly supporting the engagement of those historically not engaged, as consistently reflected in the work of PCORI.[3]
- CMS should ***seek input on topics that are relevant to people with disabilities, patients, and caregivers,*** and should clearly describe these topics to these stakeholders in advance. This engagement could include, for example, feedback on relevant treatment alternatives, outcomes that matter to patients, and the relative importance of these outcomes.
- CMS decisions should be ***sufficiently transparent*** so that people with disabilities, patients, and caregivers can see the extent to which their input was considered in the agency's decisions, ideally during the deliberation process before a final decision is made.
- CMS should ***ensure that information gathered during public comment periods and meetings is reflected in the final guidance*** that CMS publishes in advance of the first year of negotiations, advancing the principle of transparency that is supported across organizations.

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[3] PCORI, "Financial Compensation of Patients, Caregivers, And Patient/Caregiver Organizations Engaged in Pcori-Funded Research as Engaged Research Partners," Patient-Centered Outcomes Research Institute, published June 10, 2015, https://www.pcori.org/sites/default/files/PCORI-Compensation-Framework-for-Engaged-Research-Partners.pdf.

- CMS should engage patients and people with disabilities ***to assess any unintended consequences,*** including the impact on access to treatment, cost-sharing implications, or otherwise.
    - Organizations such as the Partnership to Improve Patient Care,[4] the National Council on Disability (NCD),[5] and the Disability Rights Education and Defense Fund (DREDF)[6] have identified restricted access implications experienced in countries relying on methods for assessing value that fail to capture the real-world value to patients.

We urge CMS to Explicitly Recognize, Without Exception, the Existing Statute Barring Use of QALYs and Similar Measures, Consistent with Current Law and Recommendations of the National Council on Disability Against Reliance on Cost-Effectiveness.

The initial CMS guidance recognized the agency's authorization to consider evidence about the selected drug, including whether the selected drug represents a therapeutic advance, its alternatives, comparative effectiveness and effects on specific subpopulations, and extent to which unmet medical needs are addressed. This reflects the IRA's focus on driving significant discounts in drug prices through the use of comparative clinical effectiveness research and cost data vs. one-size-fits-all cost-effectiveness analyses, consistent with the concerns of the NCD[7, 8] and other disability rights organizations.[9, 10]

CMS acknowledged that the agency may not use evidence from comparative clinical effectiveness research in a manner that treats extending the life of an individual who is elderly, disabled or terminally ill as of lower value than extending the life of an individual who is younger, nondisabled, or not terminally ill. However, the initial CMS guidance did not reference

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[4] Partnership to Improve Patient Care, PIPC, http://www.pipcpatients.org/international.html
[5] National Council on Disability. (November 16, 2019). Quality-Adjusted Life Years and the Devaluation of Life with Disability. https://ncd.gov/sites/default/files/NCD_Quality_Adjusted_Life_Report_508.pdf
[6] DREDF, ICER Analyses Based on the QALY Violate Disability Nondiscrimination Law , September 21, 2021 at https://dredf.org/wp-content/uploads/2021/09/ICER-Analyses-Based-on-the-QALY-Violate-Disability-Nondiscrimination-Law-9-17-2021.pd
[7] The NCD recommended that Congress, "Avoid creating provisions of any bill that would require the agency with management and oversight responsibilities (such as, for example, HHS) to cover only the most cost-effective drugs and treatments, or to require the agency to impose restrictions on less cost-effective treatments." https://ncd.gov/sites/default/files/NCD_Quality_Adjusted_Life_Report_508.pdf
[8] The NCD recommended Medicaid guidance, "The guidance should specifically discuss how these authorities apply to benefits and reimbursement decisions, and that payment decisions should not rely on cost-effectiveness research or reports that are developed using QALYs." https://ncd.gov/sites/default/files/NCD_Quality_Adjusted_Life_Report_508.pdf
[9] Joint letter from advocates to Oregon HERC, "Most cost-effectiveness analyses rely on data from randomized clinical trials (RCTs) and health utility preference weighting surveys, data sources that primarily rely on inputs from non-disabled, white, Caucasian populations. This systematically biases available therapies to favor covering those that are effective for white people to the detriment of covering treatments effective for people of color and people with disabilities." http://www.pipcpatients.org/uploads/1/2/9/0/12902828/herc_letter.pdf
[10] Joint letter to CMS, October 23, 2022, "More broadly, we also support the NCD recommendation that federal programs, including Medicaid, should not rely on cost-effectiveness research or reports that gather input from the public on health preferences that do not include the input of people with disabilities and chronic illnesses."

the Affordable Care Act (ACA) which specifically bars the use of the QALY and includes the language, “The Secretary shall not utilize such an adjusted life year (or such a similar measure) as a threshold to determine coverage, reimbursement, or incentive programs under title XVIII.”[11]

We deeply appreciate the statement made by Secretary Becerra on March 29, 2023, reaffirming that CMS will not use QALYs or similar measures, and look forward to the agency strengthening its guidance to reaffirm this.[12] We urge CMS to use language in its final guidance clarifying that existing law bars the use of QALYs and similar measures, not just QALYs as used in the context of life extension, and to state explicitly that, as directed in the IRA, it will rely on the factors of comparative clinical effectiveness outlined in section 1194(e)(2).

At a recent hearing in the House Energy and Commerce Committee, Ranking Member Frank Pallone, a primary author of the Inflation Reduction Act’s health care provisions, stated that the Congress had passed a landmark law allowing for Medicare Drug Price Negotiation “while also explicitly prohibiting the use of QALYs in this process.”[13] The ACA passed in 2010 and barred Medicare from using QALYs and similar metrics throughout Medicare, including the drug negotiation process. The IRA went a step further, ensuring that no evidence would be considered that valued life extension for older adults, people with disabilities, and people at the end of life as less than their counterparts, which Ranking Member Pallone and others have recognized to include QALYs.[14]

Therefore, we urge CMS to provide clarity that its drug negotiation process will be grounded in evaluation of comparative clinical effectiveness and patient-centered health outcomes and not use or consider QALYs or other cost-effectiveness standards that frequently discriminate against subgroups and devalue the needs and preferences of patients. This includes biased non-QALY measures such as the Equal Value of Life Years Gained (evLYG), a metric recently created by the Institute for Clinical and Economic Review (ICER) to supplement the QALY that similarly discriminates based on age and has shortcomings in accounting for quality-of-life improvements.[15] The NCD and DREDF have each analyzed the QALY and the evLYG to conclude neither are suitable measures for assessing treatments.

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[11] House of Representatives, Congress. 42 U.S.C. 1320e - Comparative clinical effectiveness research. U.S. Government Publishing Office, https://www.govinfo.gov/app/details/USCODE-2010-title42/USCODE-2010-title42-chap7-subchapXI-partD-sec1320e

[12] “Health Subcommittee Hearing: ‘Fiscal Year 2024 Department of Health and Human Services Budget.’” YouTube, 29 March 2023, https://youtu.be/OPMG5OU0I6c.

[13] “Health Subcommittee Legislative Hearing (Lives Worth Living).” YouTube, 1 Feb. 2023, https://www.youtube.com/watch?v=lZE_DVqg6dk.

[14] Ranking Member Anna Eshoo stated, “Democrats included a ban on QALYs in Medicare and the Affordable Care Act in 2010. Last year, Democrats further clarified that QALYs could not be used as part of Medicare's prescription drug price negotiations in the IRA.” “Full Committee Markup of 19 Bills (Part 2),” 24 March 2023.

[15] “Cost-Effectiveness, the QALY, and the Evlyg.” ICER, Institute for Clinical and Economic Review, 28 Mar. 2023, https://icer.org/our-approach/methods-process/cost-effectiveness-the-qaly-and-the-evlyg/

Recommendation:

- CMS should ***clarify in guidance and/or regulations that it will not use or consider QALYs or similar measures in any way***.
    - This recommendation is consistent with ACA's statutory ban on the use of QALYs and similar measures in coverage, reimbursement, and incentive programs in Medicare decisions.
    - This recommendation would also uphold the IRA's requirement that the comparative clinical effectiveness research factored into determinations of therapeutic benefit do not discriminate.
- With regard to CMS solicitation of information on other specific measures that discriminate, ***CMS should avoid consideration of any evidence that is informed by QALYs or similar measures such as the evLYG[16] [17] or Disability Adjusted Life Years (DALYs).[18,19]***

Consideration of Non-QALY Evidence in Reports Using QALYs

While we appreciate CMS's assurance that it will not consider QALYs, we are concerned that the guidance leaves the door open to submission of QALY-based analysis within other clinical or cost-effectiveness assessments. We urge transparency in how these assessments are ultimately used by the agency.

It is important to understand that most of the components that make up the calculation of QALY estimates may also be used in a particular study's assessment of comparative clinical

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[16] The NCD described the eLYG in its report as, "There are other challenges to the evLYG that indicate that it is not a suitable alternative to the QALY. First, as evidenced by the assessment of Spinraza, denial of coverage is possible under the QALY/evLYG system, even where a drug would provide significant clinical benefit, including life extension. Second, the QALY/evLYG system still relies on health utility weights to measure quality of life improvements, despite the fact that such measures are typically derived from survey data and do not account for the complexity of the preferences and experiences of people with disabilities. Third, the QALY/evLYG system affords no opportunity to account for clinical knowledge not reflected in the research literature, a significant concern articulated in Chapter 1. Finally, even within the narrow emphasis on life extension, ICER provides no guidance to payers as to which reimbursement level to prioritize—the one derived from the QALY or the one derived from the evLYG." https://ncd.gov/sites/default/files/NCD_Quality_Adjusted_Life_Report_508.pdf

[17] DREDF concluded the following about evLYG, "Thus, adding the evLYG is not a solution; it merely forces payers to choose between one measure that undervalues life extension (the QALY) and one that affords no value to quality of life improvements (the evLYG). Neither account for both the full value of life-extension and the value of quality-of-life improvement." https://dredf.org/wp-content/uploads/2021/09/ICER-Analyses-Based-on-the-QALY-Violate-Disability-Nondiscrimination-Law-9-17-2021.pdf

[18] Coelho, Tony. "PCORI Comments on Value Letter." Received by Dr. Nakela Cook, 3 Mar. 2023. http://www.pipcpatients.org/uploads/1/2/9/0/12902828/pcori_comments_on_value.pdf

[19] Grosse, Scott D et al. "Disability and disability-adjusted life years: not the same." Public health reports (Washington, D.C. : 1974) vol. 124,2 (2009): 197-202. doi:10.1177/003335490912400206

effectiveness and therefore could be subject to the same biases inherent in the QALY totals themselves. Simply cherry-picking the components of these QALY estimates that are included a study of comparative clinical effectiveness is not an effective route to avoiding their biases.

Instead, we urge CMS to identify with greater detail and transparency the acceptable input data variables to be taken from comparative clinical effectiveness research, in order to ensure that the methods used will not result in bias against older adults, people with disabilities, and people at the end of life. For example, CMS should recognize that the use of value or utility weights in comparative clinical effectiveness research may also be used in the QALY calculation and therefore also subject to bias and validity challenges.[20] These weights are often constructed by a very small subgroup of a country's population[21] despite purporting to represent all.[22] Yet, there is considerable empirical evidence that treatments impact people differently and that society strongly disagrees with treating all conditions, disease states, and patient types with the same priority.[23,24]

The QALY can introduce bias into a study of a treatment's effectiveness in several ways. For example, life expectancy estimates for the population being treated may be calculated from an older population or from a population that has co-existing conditions or disabilities, thereby creating weights for the potential life year gains that could accrue to a successfully treated individual that give a biased view of life-years gained. Another example is the quality of life (QOL) part of the equation - the source data for the weights that turn life years into quality-adjusted life years. We are concerned that the patient-reported outcome measures (PROs) in the commonly used EuroQoL instrument (EQ-5D) do not meet the FDA's definition:

> *PRO instrument item generation is incomplete without a range of patients with the condition of interest to represent appropriate variations in severity and in population characteristics such as age or sex.* [25]

The EQ-5D is the most commonly used PRO within QALY calculations, yet it relies upon weightings constructed by populations unfamiliar with the conditions being evaluated and therefore does not have the accuracy that is obtained by consulting with patients. Recent studies have provided strong evidence to suggest that there is a public bias against people with

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[20] Smith S, Cano S, Browne J. "Patient reported outcome measurement: drawbacks of existing methods". bmj. 2019 Feb 27;364:l844.
[21] McClimans L, Browne JP. "Quality of life is a process not an outcome. Theoretical medicine and bioethics". 2012 Aug 1;33(4):279-92.
[22] Broome J. "Fairness Versus Doing the Most Good". The Hastings Center Report. 1994 Jul 1;24(4):36-9.
[23] Weinstein MC. "A QALY is a QALY is a QALY—or is it?" Journal of Health Economics. July 1988 289-291.
[24] Whitehead SJ, Ali S. "Health outcomes in economic evaluation: the QALY and utilities". British medical bulletin. 2010 Dec 1;96(1):5-21.
[25] US Food and Drug Administration "*Guidance for Industry: Patient-Reported Outcome Measures: Use in Medical Product Development to Support Labeling Claims".* 2009. [2020-07-15].

disabilities.[26] Criticism of the inherent bias of the EQ-5D is widespread and growing.[27,28] It is also widely critiqued for failing to represent any consensus about the value of health states, as surveys of the general public reveal enormous heterogeneity (i.e., disagreement) within surveyed populations.[29]

Selective use of QALYs or selective use of the components of data inputs that make up QALY calculations in studies of comparative clinical effectiveness raise many of the same dangers as the blanket use of QALYs for measuring the therapeutic benefit or "value" of a drug to a patient or to society. The biases that CMS emphasizes that it needs to avoid are built into the methodological construction of QALYs at multiple levels. Attempts by CMS to pick their way around these biases by selectively choosing components of QALY estimates where convenient would have significant risks for bias and discrimination.

Recommendation:

- CMS should clarify in the final guidance that ***evidence relying on the same biased or discriminatory inputs, particularly the value sets or weights used to measure life extension or quality of life, will not be relied on*** as evidence for the factors of therapeutic benefit that CMS is authorized to consider in section 1194(e)(2).

Consideration of Comparative Clinical Effectiveness Research and Appropriate Comparators

We appreciate that CMS clearly states in its guidance its intent to consider "health outcomes, intermediate outcomes, surrogate endpoints, patient-reported outcomes, and patient experience when reviewing the clinical benefit of the selected drug and its therapeutic alternative(s)." As directed by current law, this includes a bar on any use of the QALY. We strongly urge CMS to directly engage affected stakeholders – the patients, people with disabilities and clinicians with practicing experience in the condition being treated – as the experts in determining the therapeutic benefit of treatments based on outcomes that are valued by patients.

Recommendations:

- ***CMS should clearly define comparative clinical effectiveness research*** in a manner consistent with the existing definition in the ACA.

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[26] HJ;, Chaudhry. "Expanding Licensure Portability and Access to Care: Lessons Learned during Covid-19." Health Affairs (Project Hope), U.S. National Library of Medicine, https://pubmed.ncbi.nlm.nih.gov/35914196/

[27] Cubi-Molla P, Shah K, Burström K. "Experience-Based Values: A Framework for Classifying Different Types of Experience in Health Valuation Research". *Patient.* 2018 Jun;11(3):253–270.

[28] Helgesson G, Ernstsson O, Åström M, Burström K. "Whom should we ask? A systematic literature review of the arguments regarding the most accurate source of information for valuation of health states". *Qual Life Res.* 2020 Jul;29(6):1465–1482

[29] Bansback N, Tsuchiya A, Brazier J, Anis A. "Canadian valuation of EQ-5D health states: preliminary value set and considerations for future valuation studies". *PLoS One*. 2012;7:e31115.

- The ACA stated, "The terms 'comparative clinical effectiveness research' and 'research' mean research evaluating and comparing health outcomes and the clinical effectiveness, risks, and benefits of 2 or more medical treatments, services, and items…" and makes it clear that such research does not involve cost comparisons or cost-effectiveness.
- In determining what comparative clinical effectiveness research to rely on, CMS should consider engaging patients and people with disabilities to understand their perspectives on the quality of the research available and whether it represents their preferred outcomes and experiences.
- The comparator matters and should reflect a clinically comparable treatment as indicated by patients and their clinicians as opposed to selecting a comparator based on its cost, a lesson learned from countries such as Germany and a key component of efforts to advance innovative methods.[30] We do not recommend that the initial offer rely solely on the price of a therapeutic alternative, but instead reflect the negotiated drug's therapeutic benefit.

Therapeutic Advance and Unmet Need

We appreciate that CMS specifically stated its intention to review real-world evidence. Data generated by registries and other sources of real-world data, particularly for subpopulations such as people with disabilities, should be treated as highly relevant to the factors listed in section 1194(e)(2) as they provide current evidence of the experience of patients that may not yet be reflected in other research literature or clinical trial data. When developing its offer for MFPs, CMS should ensure it is prioritizing feedback from patients, people with disabilities, and clinicians with practicing experience with the condition, as well as assessments of therapeutic benefit, thereby considering value through the lens of how patients and people with disabilities experience and value their health care. Doing so will require a strong commitment to engagement.[31]

<u>Recommendations:</u>

- CMS should determine whether a treatment reflects a ***therapeutic advance*** based not only on the clinical trial data but also on evidence that reflects what patients and people with disabilities value about their care and outcomes.
    - CMS will need to engage specific patient and disability communities with the condition treated by a selected drug to determine their specific priorities for

[30] PIPC, "The German Health Care System and its Impact on Patient Access – Lessons for the U.S., http://www.pipcpatients.org/uploads/1/2/9/0/12902828/germany_draft_2022_9-21_edited_clean.pdf
[31] Smith, Theo. "Real-World Evidence Classroom." National Health Council, 28 Feb. 2023, https://nationalhealthcouncil.org/additional-resources/real-world-evidence-classroom/

improving their quality of life with treatment, a theme consistent in calls for improved patient engagement in research and decision-making.[32,33]

  - CMS should specifically call for studies related to therapeutic advancements that reflect the diversity of the patients being treated.[34,35]

- CMS should define ***unmet need*** based on the patient perspective and whether a treatment meets their needs, outcomes, and preferences in a manner unmet by other treatments, consistent with the PCORI's statutory charge to address the "needs, outcomes and preferences" of patients.[36]
  - Unmet need should be defined in a manner that acknowledges the experiences of people living with a condition who may value a treatment with fewer side effects, modes of administration that do not require travel, frequency of administration, etc. The CMS definition should prioritize how a treatment advances adherence and improved quality-of-life as indicated by engaging patients and people with disabilities and by use of patient-level data.
  - Unmet need should not be defined by the averages, but instead take into consideration the subpopulations that may not benefit from existing therapies due to their unique characteristics or for whom those therapies are not accessible due to social determinants of health (SDOH).

CMS Should Set a High Bar for the Quality of Evidence to be Considered.

CMS stated its intent to consider the "source, rigor of the study methodology, current relevance to the selected drug and its therapeutic alternative(s), whether the study has been through peer review, study limitations, degree of certainty of conclusions, risk of bias, study time horizons, generalizability, study population, and relevance to the negotiation factors listed

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[32] PCORI, "Engagement Rubric for Applicants," *Patient-Centered Outcomes Research Institute*, last modified June 6, 2016, https://www.pcori.org/sites/default/files/Engagement-Rubric.pdf.

[33] NCD recommended, "HHS should consider including explicitly recruiting people with disabilities and chronic illnesses as members of committees and working groups formed to develop effective healthcare reform and strategies for lowering the cost of prescription drugs." https://ncd.gov/sites/default/files/NCD_Quality_Adjusted_Life_Report_508.pdf

[34] Wartman , Gretchen C, et al. Aligning Health Technology Assessment with Efforts to Advance Health Equity. Partnership to Improve Patient Care, http://www.pipcpatients.org/uploads/1/2/9/0/12902828/pipc_white_paper_-_measuring_value_in_medicine_-_uses_and_misuses_of_the_qaly.pdf

[35] Mark Linthicum, MPP, et al, "Finding Equity in Value: Racial and Health Equity Implications of U.S. HTA Processes," published 2022, https://sickcells.org/wp-content/uploads/2022/10/IVI_Sick-Cells_Equity-in-Value_2022.pdf

[36] House of Representatives, Congress. 42 U.S.C. 1320e - Comparative clinical effectiveness research. U.S. Government Publishing Office, , https://www.govinfo.gov/app/details/USCODE-2010-title42/USCODE-2010-title42-chap7-subchapXI-partD-sec1320e

in section 1194(e)(2) of the Act to ensure the integrity of the contributing data within the negotiation process." CMS has also stated its intent to incorporate real-world evidence into its considerations. We urge CMS to prioritize research that is rigorous, as well as real-world feedback from patients, people with disabilities, and practicing clinicians. Randomized clinical trials and studies relying on the existing literature to make conclusions about the effectiveness of drugs should themselves be peer reviewed and rigorous. It is also important to recognize that real-world evidence from the lived experience of patients, people with disabilities, and clinicians may be observational but is nonetheless also relevant to understanding the impact of treatments that may not have been subject to recent rigorous clinical trials. It will be important for CMS to have high standards that drive the rigorous study of therapeutic benefits in a manner that captures the diversity of people on treatment, the differences among subpopulations, and a focus on outcomes that are valued by patients as communicated to CMS by patients, people with disabilities, and practicing clinicians.

Recommendations:

- CMS should set standards for high-quality, patient-centered evidence that will drive investment in the development and testing of innovative methodologies that are inclusive and advance health equity.
  - Standards established by CMS should recognize and address the ***shortcomings of historic methods that are biased or discriminatory.***
  - CMS should rely on ***standards developed by leading patient and disability organizations*** to determine whether the evidence that it intends to rely on for the development of an initial MFP offer is centered on patients and people with disabilities.[37,38]
  - To determine what evidence meets standards for quality and patient-centeredness, the agency ***should look to the organizations representing affected patients and people with disabilities as well as the clinical experts*** among practicing physicians and providers, as they would be most familiar with the usefulness of the evidence base for making decisions and its potentially inherent biases.
  - As previously stated, CMS should ***prioritize evidence that is patient-centered*** and captures value for patients, caregivers, and persons with disabilities.

Conclusion

We appreciate CMS' consideration of our recommendations. CMS has an important task ahead in setting up a process to implement the negotiation provisions of the IRA. For CMS to meet its

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[37] The Patient Voice in Value - National Health Council. National Health Council, https://nationalhealthcouncil.org/wp-content/uploads/2020/11/20160328-NHC-Value-Model-Rubric-final.pdf

[38] "Landscape Review and Summary of Patient and Stakeholder Perspectives on Value in Health and Health Care." PCORI, Patient-Centered Outcomes Research Institute, 2 Sept. 2022, https://www.pcori.org/resources/landscape-review-and-summary-patient-and-stakeholder-perspectives-value-health-and-health-care

obligations to beneficiaries, it will be critically important for CMS to be thoughtful in how it assesses therapeutic benefit to affected patients. CMS must ensure that patients and people with disabilities are granted a seat at the table and a clear and robust path to engagement throughout the process.

Sincerely,

Access Ready
Alliance for Aging Research
Alliance for Patient Access
Allies for Independence
ALS Association
American Association of People with Disabilities
American Association on Health and Disability
American Behcet's Disease Association (ABDA)
Asthma and Allergy Foundation of America
Bazelon Center for Mental Health Law
Cancer Support Community
Cancer*Care*
Caring Ambassadors Program
Center for Autism and Related Disorders
Center for Independence of the Disabled, NY
Coalition of State Rheumatology Organizations
Coalition of Texans with Disabilities
Color of Crohn's and Chronic Illness (COCCI)
Cutaneous Lymphoma Foundation
Cystic Fibrosis Research Institute
Davis Phinney Foundation for Parkinson's
Derma Care Access Network
Disability Rights Education and Defense Fund
Disability Rights Oregon
Epilepsy Alliance America
Epilepsy Foundation
Global Liver Institute
Healthy Men Inc.
Hereditary Neuropathy Foundation
ICAN, International Cancer Advocacy Network
Independent Women's Forum
Infusion Access Foundation
Lakeshore Foundation
Lupus and Allied Diseases Association, Inc.
Lupus Foundation of America
MLD Foundation
Multiple Sclerosis Foundation

National Association of Councils on Developmental Disabilities
National Association of Nutrition and Aging Services Programs
National Disability Rights Network (NDRN)
National Down Syndrome Congress
National Down Syndrome Society
National Oncology State Network
New Jersey Association of Mental Health and Addiction Agencies, Inc.
Partnership to Advance Cardiovascular Health
Partnership to Improve Patient Care
Patients Rising Now
RetireSafe
Rosie Bartel
Spondylitis Association of America
The Bonnell Foundation: Living with Cystic Fibrosis
The Coelho Center for Disability Law, Policy and Innovation
The Headache & Migraine Policy Forum
The Hepatitis C Mentor and Support Group-HCMSG
TSC Alliance
United Spinal Association

2.7.24 AiArthritis MD Finance Committee Comments.d

Uploaded by: Tiffany Westrich-Robertson

Position: UNF

"We don't represent the patient voice, we *are* the patient voice."

February 7, 2024

Maryland Senate
Finance Committee
3 East
Miller Senate Office Building
Annapolis, Maryland 21401

Re: SB388

Dear Committee Chair Beidle, Vice Chair Klausmeier, and Committee Members:

The International Foundation for Autoimmune & Autoinflammatory Arthritis (AiArthritis), a patient organization led by people affected by AiArthritis diseases, has been actively engaged with the Maryland Prescription Drug Affordability Board (PDAB) and look forward to assisting as they explore the barriers patients with chronic disease face as they seek out treatments to maintain their health.

We have been impressed with the board's methodical approach to undertaking the work with which they have been tasked and integrating patients and stakeholders throughout the process. However, given the outsize impact policies implemented by the board can have on patients, we urge the committee to vote against efforts to broaden the board's oversight before the board has even completed their original undertaking.

AiArthritis has been actively involved in other states that have recently implemented local PDABs, including Colorado and Oregon, and have seen firsthand the limitations of the PDAB model in those states. Based on what we have seen, we believe that PDABs are an untested model and have so far been ineffective in identifying and solving the actual problems patients with chronic conditions are facing when attempting to access their medications. For example, in Colorado, testimonies from patients using Enbrel, Cosentyx, and Stelara repeatedly demonstrated access and affordability issues largely stem from the utilization management policies of insurers. In fact, many patients with chronic disease pay little to nothing for biologics due to manufacturer assistance programs.

Some of the risks that we have seen with the PDAB model in other states:

- Focusing solely on the price of drugs ignores the many complicated factors that ultimately drive costs up for patients and oversimplifies a very complex process.
- Reviewing only a handful of medications positions PDABs to create further inequities, picking winners and losers among patients and patient populations.
- Setting upper payment limits (UPLs) for drugs might endanger their accessibility in the state or limit appropriate reimbursement for the physicians that administer them. UPLs will not lower prescription drug costs for patients because they do not lower out of pocket costs.
- PDABs create another bureaucratic barrier and require chronic disease patients, who are often already overtaxed trying to maintain their own health and manage their care, to monitor additional government bodies and advocate to protect their healthcare.

Patients with complex and chronic conditions often spend years identifying treatments that work for them. Additionally, treatments can also work for years but then become less effective, forcing patients to change therapies. There is no "one size fits all" health solution; therefore, it is critical that health policies do not impede access to treatments or lead to fewer options for patients.

Proposals that come out of PDABs often target the most innovative medicines, disproportionately impacting patients with diseases where there is high unmet need and where low-cost treatment options are not available (e.g. rare diseases), running counter to the aims of personalized medicine and availability of new treatments.

To employ a healthcare analogy, some PDABs are seeking to address a symptom rather than the underlying condition. We are working with the Maryland PDAB to mitigate some of the shortfalls we have seen in other states. At the same time, we also urge you as legislators to pursue other reforms that would be more beneficial for patients including:

- Focus on the existing and pressing affordability and access issues that most impact patients, many of which originate from payers (insurance companies and pharmacy benefit managers (PBMs)).
- Address the broader healthcare industry when considering reforms and identify long-term solutions rather than short-term relief for a limited few.
- Ensure transparency and accountability to patients and citizens by keeping policymaking in the hands of legislators that are accountable to voters, not unelected boards.

In closing, we appreciate the committee's focus on issues that impact patient access to care and every opportunity given to patients that enables us to have a voice in the matters involving our healthcare. We hope you will give due consideration to the shortfalls that we have identified with the PDAB model and instead work to address the broader concerns of patients. Thank you for considering our input and do not hesitate to reach out to me at tiffany@aiarthritis.org with any questions.

Sincerely,

Tiffany Westrich-Robertson

Tiffany Westrich-Robertson
Chief Executive Officer
Person living with non-radiographic axial spondyloarthritis
International Foundation for Autoimmune & Autoinflammatory Arthritis

SB388.PDAB.pdf
Uploaded by: Aliyah Horton
Position: INFO

MPhA
MARYLAND PHARMACISTS ASSOCIATION

Date: February 7, 2024
To: The Honorable Pamela Beidle, Chair
From: Aliyah N. Horton, FASAE, CAE, Executive Director, MPhA, 240-688-7808
Cc: Members, Senate Finance Committee
Re: INFORMATION: SB 388 - Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding

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The Maryland Pharmacists Association (MPhA) is submitting this letter of information regarding **SB 388- Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding (The Lowering Prescription Drug Costs For All Marylanders Now Act)**.

Pharmacists are the healthcare providers facing patients who are challenged managing the costs of their medications. High out-of-pocket costs are often a barrier to medication access and adherence. We support efforts to address this issue.

However, we also have questions regarding whether fixing one problem will exacerbate others.

- Are there safeguards to ensure the proposed Upper Payment Limits (UPL) do not negatively impact pharmacies and pharmacists' ability to serve their communities?

- How will PDAB ensure that the cost-savings are not put on the backs of pharmacies, via even lower reimbursements by PBMs and other intermediaries? As the committee learned in the briefing from MDH in January, within the Medicaid MCO space, pharmacy reimbursements for medications are below cost and the dispensing fees are in the pennies. Clarity is needed to ensure that the situation is not worsened.

- What entity is intended to cover the difference between the UPL and the pharmacy's cost to acquire and dispense the targeted medications?

- Is it within PDAB's jurisdiction to ensure pharmacies are reimbursed for their drug acquisition costs and provided a dispensing fee at the Medicaid-fee-for-service rate for any medication subject to UPLs?

MARYLAND PHARMACISTS ASSOCIATION - Founded in 1882, MPhA is the only state-wide professional society representing all practicing pharmacists, pharmacy technicians and student pharmacists in Maryland. Our mission is to strengthen the profession of pharmacy, advocate for all Maryland pharmacists and promote excellence in pharmacy practice.

SB0388 LOI V 3.pdf
Uploaded by: Christina Shaklee
Position: INFO

MARYLAND
Prescription Drug Affordability Board

16900 Science Drive
Suite 112-114
Bowie, MD 20715
pdab.maryland.gov

February 7, 2024

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East Miller Office Building
Annapolis, MD 21401-1991

RE: SB0388 –Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs for All Marylanders Act of 2024) – Letter of Information

Dear Chair Beidle:

We want to first and foremost thank the Committee for your support of the Prescription Drug Affordability Board. The Board looks forward to conducting significant and important work to make prescription drugs affordable for Marylanders in 2024.

First, the Board continues to successfully conduct its Annual Fee Assessment to fund its work. The Board appreciated the $1,000,000 in General Funds in FY24, which allowed us to repay the Maryland Health Care Commission and put the Board on firm financial footing for the upcoming years. We appreciate that FY25 may be a lean fiscal year, and the Board is currently in a strong financial position.

Next, the Board has finalized its processes and regulations to conduct Cost Reviews at the end of 2023, and will be conducting its first set of Cost Reviews throughout 2024.

Additionally, the Board is working to publish its Upper Payment Limit Action Plan for setting upper payment limits for state and local government. The Board hopes to submit this plan to the Legislative Policy Committee for approval in 2024, and if approved, work through the process of setting upper payment limits for state and local government.

Finally, by December 1, 2026, the Board owes a report on setting upper payment limits on all purchases and payor reimbursements of prescription drug products in the state and recommendations on whether the General Assembly should pass legislation to expand the authority of the Board. The Board plans to learn from its experience in 2024 to make these recommendations.

Thank you for your consideration. If you have any questions, please contact Andrew York at (410)804-0251 or andrew.york@maryland.gov.

Sincerely,

Andrew York
Executive Director
Maryland Prescription Drug Affordability Board

2024 SB388 Opposition.pdf
Uploaded by: Deborah Brocato
Position: INFO

SB388
2024

Opposition Statement SB388
Prescription Drug Affordability Board -
Authority for Upper Payment Limits and Funding
(Lowering Prescription Drug Costs For All Marylanders Now Act)
Deborah Brocato, Legislative Consultant
Maryland Right to Life

On behalf of our over 200,000 followers, Maryland Right to Life opposes this legislation as written and respectfully requests an amendment to prohibit abortion purposes from this bill. Without the amendment, we request an unfavorable report for SB388.

NO MORE PUBLIC FUNDING. As written, the dangerous abortion drugs would be included in the administering of this bill. First, there is an appropriation of $1,000,000 for Fiscal Year 2025 and each Fiscal Year thereafter to be included in the annual budget (page 3). We object to any portion of this fund being used to further subsidize the abortion industry. The Abortion Care Access Act already provided that abortion be fully covered through Medicaid and private health insurance providers.

Maryland is one of only 4 states that forces taxpayers to fund abortions. There is bi-partisan unity on prohibiting the use of taxpayer funding for abortion. Year after year, the Marist poll shows that the majority of Americans oppose taxpayer funding of abortion.

PATIENTS BEFORE PROFITS. The case of *U.S. Food and Drug Administration (FDA) vs. Alliance for Hippocratic Medicine (AHM)* is a pending case before The United States Supreme Court. The case concerns the non-enforcement of The Comstock Act of 1873 and the validity of the 2016 FDA changes for use of abortion drugs. The Comstock Act prohibits sending abortion drugs through the mail. The following are the changes that are issues of grave concern for the safety of women and girls:

- Increasing the maximum gestational age from forty-nine days to seventy days;
- Allowing non-physicians to prescribe mifepristone;
- Removing the requirement that the administration of misoprostol and the subsequent follow-up appointment be conducted in person;
- Eliminating prescribers' obligation to report non-fatal adverse events;
- Switching the method of administration for misoprostol from oral to buccal;
- Changing the dose of mifepristone (600 mg to 200 mg) and misoprostol (400 mcg to 800 mcg).

For all of these safety concerns, we request an amendment to prohibit the use of this bill for abortion purposes.

D-I-Y Abortions Endanger Women: Public policy has failed to keep pace with the abortion industry's rapid deployment of chemical abortion pills. "D-I-Y" abortion is normalizing "back alley abortion" where women and girls self-administer and hemorrhage without medical supervision or assistance.

Chemical abortion is four times more likely to result in complications than surgical abortion. To date more than 6,000 complications have been reported and 26 women have been killed through chemical abortion since its approval by the FDA. Because half of all women experiencing complications is dramatically underreported.

ADOPT REASONABLE HEALTH AND SAFETY STANDARDS. The growing reliance on chemical abortions underscores the need for a state protocol for the use of abortion pills including informed consent specific to efficacy, complications and abortion pill reversal. Strong informed consent requirements manifest both a trust in women and a justified concern for their welfare. While we oppose abortion, we strongly recommend that the state of Maryland enact reasonable regulations to protect the health and safety of women and girls by **adopting the previous FDA Risk Evaluation and Mitigation Strategies (REMS) safeguards** that required that the distribution and use of mifepristone, the drug commonly used in chemical abortions, to be under the supervision of a licensed physician because of the drug's potential for serious complications including, but not limited to, uterine hemorrhage, viral infections, pelvic inflammatory disease, loss of fertility and death.

While the *FDA vs. AHM* case is pending, we strongly recommend that Maryland promote safety for women and girls of Maryland by adding an amendment prohibiting abortion from this legislation.

Without an amendment that excludes abortion purposes from this bill, Maryland Right to Life requests an unfavorable report on SB388.

420 Chinquapin Round Rd / Suite 2I Annapolis, MD 21401 / 410-269-6397 www.mdrtl.org

NIH Abortion Pill Adverse Events.pdf
Uploaded by: Deborah Brocato
Position: INFO

PubMed Nation Institue of Health

National Library of Medicine, National Center for Biotechnology information

https://pubmed.ncbi.nlm.nih.gov/33939340/

2021 Spring;36(1):3-26.

Deaths and Severe Adverse Events after the use of Mifepristone as an Abortifacient from September 2000 to February 2019

Kathi Aultman 1, Christina A Cirucci, Donna J Harrison 2, Benjamin D Beran 3, Michael D Lockwood 4, Sigmund Seiler 5

Affiliations expand

PMID: 33939340

Abstract

Objectives: Primary: Analyze the Adverse Events (AEs) reported to the Food and Drug Administration (FDA) after use of mifepristone as an abortifacient. Secondary: Analyze maternal intent after ongoing pregnancy and investigate hemorrhage after mifepristone alone.

Methods: Adverse Event Reports (AERs) for mifepristone used as an abortifacient, submitted to the FDA from September 2000 to February 2019, were analyzed using the National Cancer Institute's Common Terminology Criteria for Adverse Events (CTCAEv3).

Results: The FDA provided 6158 pages of AERs. Duplicates, non-US, or AERs previously published (Gary, 2006) were excluded. Of the remaining, there were 3197 unique, US-only AERs of which there were 537 (16.80%) with insufficient information to determine clinical severity, leaving 2660 (83.20%) Codable US AERs. (Figure 1). Of these, 20 were Deaths, 529 were Life-threatening, 1957 were Severe, 151 were Moderate, and 3 were Mild.

The deaths included: 9 (45.00%) sepsis, 4 (20.00%) drug toxicity/overdose, 1 (5.00%) ruptured ectopic pregnancy, 1 (5.00%) hemorrhage, 3 (15.00%) possible homicides, 1 (5.00%) suicide, 1 (5.00%) unknown. (Table 1).

Retained products of conception and hemorrhage caused most morbidity. There were 75 ectopic pregnancies, including 26 ruptured ectopics (includes one death).

There were 2243 surgeries including 2146 (95.68%) D&Cs of which only 853 (39.75%) were performed by abortion providers.

Of 452 patients with ongoing pregnancies, 102 (22.57%) chose to keep their baby, 148 (32.74%) had terminations, 1 (0.22%) miscarried, and 201 (44.47%) had unknown outcomes.

Hemorrhage occurred more often in those who took mifepristone and misoprostol (51.44%) than in those who took mifepristone alone (22.41%).

Conclusions: Significant morbidity and mortality have occurred following the use of mifepristone as an abortifacient. A pre-abortion ultrasound should be required to rule out ectopic pregnancy and confirm gestational age. The FDA AER system is inadequate and significantly underestimates the adverse events from mifepristone.

A mandatory registry of ongoing pregnancies is essential considering the number of ongoing pregnancies especially considering the known teratogenicity of misoprostol.

The decision to prevent the FDA from enforcing REMS during the COVID-19 pandemic needs to be reversed and REMS must be strengthened.

Keywords: Abortifacient; Abortion Pill; Adverse Event Reports; Adverse Events; DIY Abortion; Drug Safety; Emergency Medicine; FAERS; FDA; Medical Abortion; Medical Abortion Complications; Mifeprex; Mifepristone; Misoprostol; No touch abortion; Post-marketing Surveillance; REMS; RU-486; Risk Evaluation Mitigation Strategy; Self-Administered Abortion.

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Similar articles

Mifepristone Adverse Events Identified by Planned Parenthood in 2009 and 2010 Compared to Those in the FDA Adverse Event Reporting System and Those Obtained Through the Freedom of Information Act.

Cirucci CA, Aultman KA, Harrison DJ.Health Serv Res Manag Epidemiol. 2021 Dec 21;8:23333928211068919. doi: 10.1177/23333928211068919. eCollection 2021 Jan-Dec.PMID: 34993274 Free PMC article.

Analysis of severe adverse events related to the use of mifepristone as an abortifacient.

Gary MM, Harrison DJ.Ann Pharmacother. 2006 Feb;40(2):191-7. doi: 10.1345/aph.1G481. Epub 2005 Dec 27.PMID: 16380436

10a - SB 388 - FIN - MDH - LOI.docx.pdf
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Position: INFO

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

February 7, 2024

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401-1991

RE: Senate Bill 388 – Prescription Drug Affordability Board – Authority for Upper Payment Limits (The Lowering Prescription Drug Costs for All Marylanders Now Act) – Letter of Information

Dear Chair Beidle and Committee Members:

The Maryland Department of Health (Department) respectfully submits this letter of information for Senate Bill (SB) 388 – *Prescription Drug Affordability Board – Authority for Upper Payment Limits (The Lowering Prescription Drug Costs for All Marylanders Now Act)*. The bill requires $1 million in funding for the Prescription Drug Affordability Board to be included in the Governor's budget each year, and requires the Board to establish a process for setting upper payment limits for all purchasers and payor reimbursements of prescription drugs in the State that the Board determines have led or will lead to affordability challenges.

The Department supports initiatives by the Prescription Drug Affordability Board (PDAB) that result in cost-savings to the State and consumers. The Department notes that the Maryland Medical Assistance Program (Maryland's Medicaid program) may need certain flexibilities before adopting upper payment limits established by PDAB in order to maximize savings. The Department will continue to work with the PDAB on establishing flexibilities for our Medicaid program.

The Department looks forward to the PDAB's Upper Payment Limit Action Plan on setting upper payment limits for state and local governments, and its continued work on addressing prescription drug prices.

If you would like to discuss this further, please do not hesitate to contact Sarah Case-Herron at sarah.case-herron@maryland.gov or (410) 260-3190.

Sincerely,

Laura Herrera Scott, M.D., M.P.H.
Secretary

SB 388 2024 Written Statement 2.6.24.pdf
Uploaded by: Laura Vykol-Gray
Position: INFO

WES MOORE
Governor

ARUNA MILLER
Lieutenant Governor

HELENE GRADY
Secretary

MARC L. NICOLE
Deputy Secretary

SENATE BILL 388 Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding (The Lowering Prescription Drug Costs For All Marylanders Now Act)

STATEMENT OF INFORMATION

DATE: February 6, 2024

COMMITTEE: Health and Government Operations

SUMMARY OF BILL: Senate Bill 388 establishes an ongoing $1 million general fund mandate to the Prescription Drug Affordability Board (PDAB) beginning in fiscal 2025 for operation of the board. The bill also establishes a process for setting upper payment limits for purchases and payer reimbursement of prescription drug products.

EXPLANATION: PDAB is funded with special funds that come from annual fees from pharmacy benefit managers, health insurance carriers, and wholesale distributors and manufacturers. PDAB operations are intended to be funded by special fund revenues generated from these fees. In fiscal 2024, $1 million in general funds were added to PDAB's budget as a legislative priority. The Governor's fiscal 2025 allowance does not include general funds for PDAB with the assumption the board's operations will be funded by special funds. Currently, PDAB's annual expenditures exceed annual revenue; however, due to prior year fund balances and the general funds that were added to PDAB's budget in fiscal 2024, they are not projecting a negative fund balance. PDAB is assessing the current annual fee of $1,000 to support operations and may increase the annual fee in the future if necessary to better meet their operating expenditure needs. See a summary of PDAB's special fund below:

	Beginning Balance	Revenue	Expenditures	Closing Balance	Exp. as % of Rev.
FY 2023	$797,006	$993,093	$1,118,957	$671,142	113%
FY 2024	$671,142	$1,143,000	$1,424,862	$389,280	125%
FY 2025	$389,280	$971,000	$1,247,411	$112,869	128%
Average	**$619,143**	**$1,035,698**	**$1,263,743**	**$391,097**	**122%**

The Department of Budget and Management (DBM) is charged with submitting a balanced budget to the General Assembly annually and will be working with the General Assembly to achieve balance over the long-term. In light of current projected general fund deficits in fiscal 2026 and onward, the Department suggests that PDAB consider increasing its fee to cover expenses in future years rather than the General Assembly mandating general fund subsidy.

For additional information, contact Laura Vykol-Gray at (410) 260-6371 or laura.vykol@maryland.gov

10b - SB 388 - FIN - PHARM - LOI (1).pdf

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Position: INFO

The Board recommends expansion of the Prescription Drug Affordability Stakeholder Council to include one pharmacist representative of a statewide organization who can provide input on pharmacy reimbursement rates, patient access to treatments, and the cost of dispensing.

If you would like to discuss this further, please do not hesitate to contact Deena Speights-Napata, MA, Executive Director, at deena.speights-napata@maryland.gov or (410) 764-4753.

Sincerely,

Deena Speights-Napata, MA
Executive Director
Maryland Board of Pharmacy

The opinion of the Board expressed in this document does not necessarily reflect that of the Maryland Department of Health or the Administration.

DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

MARYLAND BOARD OF PHARMACY

February 7, 2024

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East, Miller Office Building
Annapolis, Maryland 21401

RE: Senate Bill 388 – Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding (The Lowering Prescription Drug Costs For All Marylanders Now Act)

Dear Chair Beidle and Committee Members:

The Maryland Board of Pharmacy (Board) respectfully submits this letter of information for House Bill (SB) 388 – Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding (The Lowering Prescription Drug Costs For All Marylanders Now Act).

The Board supports the provision of SB 388 in which the Prescription Drug Affordability Board, in consultation with, a Prescription Drug Affordability Stakeholder Council determines whether, in addition to setting upper payment limits in accordance with § 21-2C-14(A) of the Health General Article, it is in the best interest of the State for the Prescription Drug Affordability Board to establish a process for setting upper payment limits for all purchases and payor reimbursements of prescription drug products in the State that the Prescription Drug Affordability Board determines have led or will lead to an affordability challenge.

The opinion of the Board expressed in this document does not necessarily reflect that of the Maryland Department of Health or the Administration.