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.

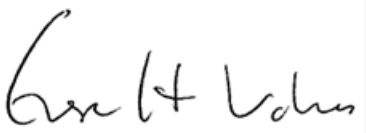
Oncologists do not set or control drug prices; they offer their patients the most appropriate, evidence-based treatment that will ensure the best outcome for an individual cancer patient and their specific disease. However, the landscape for acquiring and delivering cancer medications to patients is 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 **any** 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