SB0357 testimony 2.4.25.pdf
Uploaded by: Abigail Conrad
Position: FAV

Date of Hearing 2/6/2025

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Prescription Drug Affordability Board - Authority for Upper Payment Limits (**Lowering Prescription Drug Costs for All Marylanders Now Act)**

TESTIMONY ON SB#357- POSITION: FAVORABLE

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

FROM: Abigail Conrad

OPENING: **My name is Abigail Conrad. I am a resident of District 20. I am submitting this testimony in support of SB#357, (Lowering Prescription Drug Costs for All Marylanders Now Act)**

I am an active member of the Maryland Poor People's Campaign (MD PPC).

Overall, this bill will decrease drug costs on prescriptions that Marylanders desperately need- especially families with children, working adults, older citizens, and people with disabilities.

As a member of the MD PPC that bases its actions on poverty data. Maryland has one of the highest median household incomes in the country, yet 21% of Marylanders are poor and low-income. That means that they cannot afford high cost drugs.

My moral tradition emphasizes the importance of affordable health care to support the common good. High drug costs affect everyone and can unexpectedly hit anyone. I am someone with chronic illness and infertility. In the past two years, I have had to take multiple medications that are thousands of dollars per injection. I have had to pay hundreds of dollars in unexpected costs (e.g., $800) at the pharmacy to take extremely time critical medications for fertility treatments. You are left without a choice but to pay. I shouldn't have to spend thousands to build a family. I also have to take Xolair monthly, which is the only thing in over a decade that has worked to control my systematic allergy issues. The list price of Xolair is over $30,000 per year. If you don't have insurance or have poor coverage, there is no way someone can pay for that. Finally, we know that disparities in wealth make high drug costs a life and death question. My experience standing beside low-wealth and working Maryland residents, I learned how large the wealth gap is between Black and white people and know how disproportionately they are impacted by high drug costs. All Marylanders should have access to affordable medication.

To sum up, I support the SB#357 **Lowering Prescription Drug Costs for All Marylanders Now Act** because no one's access to medication should be limited by cost.

I respectfully urge this committee to return a favorable report on SB#357

Abigail Conrad

SB 354- PDAP, Support, UULM-MD, Betty McGarvie Cro
Uploaded by: Ashley Egan
Position: FAV

Support SB 357
Prescription Drug Affordability Board-authority for Upper Payment Limits
Senate Finance Committee, February 6, 2025

I am Betty McGarvie Crowley from Silver Spring, District 14, representing the Unitarian Universalist Legislative Ministry of Maryland (UULM-MD). We are an advocacy organization, with members in 23 UU congregations throughout the state and health care has been a major priority. We are an active member of the Prescription Drug Affordability Coalition.

UULM-MD supports **SB 357 - Prescription Drug Affordability Board (PDAB)-Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act)**. Despite a slow start because of the former Administration's opposition, this year the authority of the PDAB will allow it to place upper limits for what government entities pay for two high-cost drugs. The PDAB framework is established and, if granted expanded authority, is capable of going beyond its mandate to cover costs for state and local governments to ALL Marylanders. Elected officials support the PDAB as it will result in reduced premiums because 1/3 of insurance payments are for drugs. PDAB will help their budgets and those of employees.

Pharmaceutical companies have arbitrarily raised prices multiple times in the U.S. but the same drugs can be purchased for much less by our North American neighbors and other countries. The extra money is not going to research and development but profits, advertising, and lobbying with their allies. Unfortunately, Marylanders who cannot afford critically needed medications do not have the same resources to get public policies changed for them as seen in recent Federal actions.

The UULM-MD welcomes the opportunity to present our faith perspective as we have a reverence for the interdependent web of all existence which fosters justice, health, and equity in society. We appreciate the wonderful leadership on this legislation by Senators Gile and Feldman. We ask you to support SB 357 to help the 43% of Marylanders who struggle to afford the medications they need.

I recommend that you refer to a compelling testimony submitted by Ashley Egan who is an integral part of our organization. She experiences the challenges of paying for high-cost medications for her daughter and worries about what will happen when she is no longer under the family health insurance. Extending this legislation to All Marylanders would help this family.

Support HB 424
Prescription Drug Affordability Board-authority for Upper Payment Limits
House Health and Government Operations Committee, February 6, 2025

I am Ashley Egan, from District 26. As a Unitarian Universalist, I believe in bodily autonomy. I believe in the sacred bond between a patient and their doctor. I strongly believe that medical decisions should be made in the exam room, not the board room. That is why I am asking you to support **HB 424 - Prescription Drug Affordability Board - Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act)**

Yesterday, my daughter called me from college in a panic asking which insurance company we used, the relief in her voice when I told her UnitedHealthcare was palpable. She has epilepsy and is dependent on multiple thousands of dollars of medications ($2790.43 to be exact) a month to keep her alive. Imagine if there was a board that could do something about it.

That's why 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.

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 is basically the same drug, the 24-hour coating kept the amount of medicine in her system stable for longer. Plus, with less opportunity to miss a dose, she had less breakthrough seizures. In addition, due to the amount of medication she needed to be on she was having dizzy spells and eye spasms, being able to take her medicine at night allowed her to function in the morning and throughout the day.

In 2022, as my daughter was getting ready to leave for college, two things happened.

1. Her insurance decided that my daughter's medication was too expensive. They would cover other medications, but not Oxtellar. After two weeks of constant phone calls, from me and my daughter's neurologist, we were able to get a prior authorization, a process we have to re-visit yearly.

2. Her epilepsy got worse, which meant adjusting the dose and adding additional medications. At times, she needed both 600 mg and 300 mg tablets to make up her nightly dose. Unfortunately, instead of counting them as doses of the same medication, the insurance company counted these as two separate medications. So what should have been a simple manipulation in dosage, became a full-on negotiation. At one point, they would only cover the 300 mg, causing my daughter to have to take 7 pills nightly to make up her dose.

As you can see, 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 were 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 look at options 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.

SB357 Testimony MD.pdf
Uploaded by: Brian Jacobs
Position: FAV

TESTIMONY IN SUPPORT OF SENATE BILL 357
Prescription Drug Affordability Board - Authority for Upper Payment Limits
(Lowering Prescription Drug Costs for All Marylanders Now Act)
Before the Senate Finance Committee

By Brian R. Jacobs, MD, Pediatric Critical Care and Clinical Informatics, Annapolis, Maryland,
AND MEMBER OF THE COMMITTEE TO PROTECT HEALTH CARE
February 6, 2025

Chair Beidle, Vice-Chair Hayes, and Members of the Finance Committee;

Thank you for the opportunity to provide testimony in favor of **SB 357**, which would grant Maryland's Prescription Drug Affordability Board (PDAB) the expanded authority to set statewide upper payment limits to make high-cost drugs more affordable for my patients and all Marylanders. I'd also like to thank Senator Dawn Gile and Chair Brian Feldman for sponsoring these critical bills.

I've been a physician in Annapolis, Maryland for over 18 years. I know too well that drugs are not beneficial if patients cannot afford them. Time and time again, I've seen families grappling with very difficult decisions between buying groceries and putting gas in the car, or filling/refilling a prescription. No patient, young or old, should be forced to go without a beneficial or lifesaving prescription because of the cost. When, as too often happens, they're forced to split or skip pills, their otherwise manageable condition worsens, becoming more difficult to treat, resulting in an ER or inpatient visit and reducing their quality of life.

I am thankful for the work Maryland has already done to help alleviate these problems and lead the nation toward more affordable prescription drugs. Our first-in-the-nation PDAB has been a landmark initiative in addressing skyrocketing drug costs. The Board's approval of the Upper Payment Limit Action Plan will make a huge difference for state and local governments.
But more must be done, now more than ever. While patients across the state are struggling, pharmaceutical corporations continue to bring in record profits. In 2024, Merck, Pfizer, Johnson & Johnson, Roche, AstraZeneca, and Sanofi all profited in excess of $50 Billion. We cannot count on federal action to address these issues under the new administration.

At this critical point, I urge you to support SB 357 to address prescription drug costs statewide, beyond just state and local government plans. This legislation can provide meaningful relief for patients and families while helping to bring down health insurance premiums across the board. The PDAB has already demonstrated its effectiveness in tackling this issue, and expanding its authority would be a transformative step in making prescription drugs more affordable for all Marylanders.

I urge a favorable report of SB357 to give Maryland's Board the tools it needs to protect patients and ensure that cost is never a barrier to accessing life-saving medications.

Thank you for your consideration.

Sincerely,
Brian R. Jacobs, MD
1909 Carrollton Road
Annapolis, MD 21409

CBonacini testimony—Prescription Drug Affordabilit

Uploaded by: Cate Bonacini

Position: FAV

My name is Cate Bonacini and I am a 37 year old resident of Takoma Park, MD and a nonprofit professional. I am testifying in support of Maryland Senate Bill 357. In 2022, I developed long COVID, despite multiple vaccinations. Since then, I have experienced a cascading series of health impacts, including dysautonomia, a seizure disorder, and an arrhythmia. During my recovery, doctors discovered cancer and a new autoimmune disorder.

Managing my health has been a full time job and a wildly expensive one. In one plan year, even with insurance, I spent over $20,000. This figure includes premiums, my deductible, and co-pays for hospitalizations, prescriptions, ambulances, and doctor's visits. Additionally, I underwent testing, therapies, and visits with providers who did not accept insurance. My husband and I dipped into savings and put off desperately needed home repairs to shoulder the cost. Although doctors recommended I stop working, we could not financially afford to go down to one income. I often find myself struggling to juggle my health with the demands of my job.

I take nearly a dozen medications now, including levothyroxine, metoprolol, and pregabalin. Many of these have been subject to price increases over the last few years.[1] But for the purposes of today's testimony, I want to focus on one pharmaceutical — Skyrizi.

In November 2024, I learned that after nearly a decade in remission, my Crohn's disease has returned. Medications, including biologics, that weren't on the market when I was diagnosed are now the standard course of treatment. My doctor and I carefully weighed three options and decided on one — Skyrizi — precisely because it is the most effective at targeting the kind of Crohn's that I have. I received my first infusion last Thursday and I'm extremely hopeful that I will once again be in remission.

Over the next three months, I will receive two more infusions at an oncology suite at a local hospital. After these loading doses, I will switch to at-home injections every eight weeks. For this first year, that's just under $180,000. If there's one thing I've learned through my health care journey, it's that care is always more than the retail price. There will be additional out of pocket costs for the oncology center, bloodwork to check liver levels, doctors appointments, and endoscopies and colonoscopies to track disease progression.

I did not start Skyrizi without pause. It's a wildly expensive drug and I know full well that my family will continue to shoulder the costs both directly and indirectly, in addition to what we're already paying for my care. My husband works for an agency impacted by recent federal spending cuts and we don't know what will happen to his job. We're holding our breath, praying that we'll be able to shoulder whatever comes next.

In January 2025, the wholesale acquisition cost (WAC) for a single dose of Skyrizi was listed at $22,383.49.[2] When it was brought to market in 2019, the WAC was just under $15,000. This is a

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[1] https://patientsforaffordabledrugs.org/wp-content/uploads/2021/01/UPDATED-January-2021-Price-Hikes-Data-and-Methods.pdf

[2] https://www.skyrizi.com/crohns/cost-and-savings

nearly $7,500[3] price increase in a six year period. To be clear, the drug itself has not changed. Just what they're charging for it. As others will surely testify, we all pay for these price jumps in the form of higher premiums and greater cost sharing for our prescriptions.

Skyrizi comes with all of the bells and whistles one could ask for — manufacturer coupons; a dedicated nurse ambassador; an app on my phone with videos, push reminders, and symptom tracking; a branded sharps box; and fancy auto-inject pens. This is to say nothing of their aggressive marketing campaign. Friends on Skyrizi point to these perks as a tradeoff for the cost, but few make the connection between price increases and their rising premiums. A 2023 ICER report shows that Skyrizi is among the drugs with the highest net sales revenue.[4] Is my branded Skyrizi cooler worth next year's higher premiums or the burden on state and federal purchasing programs? If you ask me, absolutely not.

I ask that Maryland Senate take urgent action to lower prescription drug costs and reign in pharmaceutical profiteering by voting yes on Senate Bill 357.

[3] https://patientsforaffordabledrugs.org/2022/02/03/2022-price-hikes-report-round-2/
[4] https://icer.org/wp-content/uploads/2023/04/UPI_2023_Report_121123.pdf

SB0357_Prescription_Drug_Affordability_Board_MLC_F
Uploaded by: Cecilia Plante
Position: FAV

MARYLAND LEGISLATIVE COALITION

TESTIMONY FOR SB0357
Prescription Drug Affordability Board – Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act)

Bill Sponsor: Senator Gile
Committee: Finance
Organization Submitting: Maryland Legislative Coalition
Person Submitting: Cecilia Plante, co-chair
Position: FAVORABLE

I am submitting this testimony in strong support of SB0357 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.

Prescription drug prices are outrageous. There is no real point in making drugs that help people stay healthy if those same people cannot afford them. As many as 45% of Marylanders report struggling to afford the medicines they need, with one third of Marylanders skipping a dose, rationing medication, or leaving a prescription unfilled 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, prioritizing profits over patients. Marylanders should not have to choose between their prescription drugs and other necessities. With federal action on this issue uncertain under the new administration, it is critical that Maryland, under the guidance of this committee, continues to lead the nation on prescription drug affordability efforts.

This bill, if enacted, would grant Maryland's Prescription Drug Affordability Board the expanded authority to set statewide upper payment limits to make high-cost drugs more affordable for all Marylanders. The Board has already made progress, particularly the approval of its Upper Payment Limit Action Plan to make prescription drugs more affordable for state and local governments. However, the fact remains that we must do more to directly help Marylanders struggling to afford their medications. This legislation would provide meaningful relief to our families and neighbors at a time when so many Marylanders are forced to choose between filling their prescriptions and filling their fridges.

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

CE Ball 2025 - HoCo PDAB Testimony.pdf
Uploaded by: County Executive Calvin Ball
Position: FAV

HOWARD COUNTY OFFICE OF COUNTY EXECUTIVE
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February 6, 2025

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

Re: **TESTIMONY OF SUPPORT**: SB 357: Prescription Drug Affordability Board - Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act)

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

I commend Senator Gile for sponsoring Senate Bill 357 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 recent Open Enrollment seasons, we have 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. Prescription drug costs should not stand as a barrier to accessing the care they need to stay healthy.

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 357.

All the Best,

Calvin Ball
Howard County Executive

NAACP_FAV_SB357 (2).pdf
Uploaded by: Danita Tolson
Position: FAV

TESTIMONY IN FAVOR OF SENATE BILL 357
By Dr. Danita Tolson on behalf of the NAACP Maryland State Conference

Senate Finance Committee
February 6, 2025

Chair Beidle, Vice-Chair Hayes, and Members of the Senate Finance Committee;

Thank you for the opportunity to testify today in support of Senate Bill 357, which would expand the upper payment limit authority of Maryland's Prescription Drug Affordability Board. Since 2018, the NAACP Maryland State Conference has been working to create, support, and strengthen our state's Prescription Drug Affordability Board, recognizing the critical role prescription drug costs and accessibility play in the health and wellbeing of our members and communities. While we have been pleased to see the progress that the Board has made in the past year to address costs for state and local governments, we know that more needs to be done to help the average Marylander struggling to afford their prescriptions. Expanding the authority of our Prescription Drug Affordability Board equips our state with the tools it needs to address the runaway costs of medications.

While we are all hurt by the high cost of prescription drugs, Black Marylanders are faced with additional burdens due to persisting racial health inequities. One of the most prominent examples of this is diabetes and its care management, so the NAACP is appreciative of the Board's decision to review Farxiga and Jardiance—two drugs used to treat diabetes and heart disease—in its initial actions. Black Americans are 60% more likely to be diagnosed with diabetes than White Americans, and they are more than twice as likely to suffer from complications such as vision impairment or end-stage renal disease. Despite this, a recent report revealed that more than 70% of semaglutide prescriptions—like Ozempic—have gone to White patients.[i] Addressing the cost of products like this may in turn help to improve access for communities that have been excluded from these treatments due to economic and accessibility challenges, but in order to see true improvement, the Board needs statewide upper payment limit authority.

There are similarly discouraging disparities in medication utilization for several other products that were considered for review. A 2023 AJMC report revealed that Black patients diagnosed with psoriasis and other skin diseases are less likely to receive effective medications for their condition compared to White individuals.[ii] ADHD medications also have large disparities in usage, with Black, Hispanic, and Asian children having lower rates of access to medications like Vyvanse— likely due to inequities in health coverage and affordability challenges.[iii] We simply cannot wait to take meaningful action on this issue.

In addition to my role with the NAACP, I also am a Nurse Practitioner who has seen firsthand how patients are hurt by the high cost of prescription drugs. In my practice, I have witnessed clients forgo treatment because of an inability to pay. This can have devastating impacts on

health outcomes, while the alternative—purchasing excessively expensive medications—can leave them in financial ruin. No Marylander should be forced to choose between their medication and other necessities.

Thank you for the work this committee has done to improve health care access and affordability in this state, thus far, and thank you to the lead sponsors Senators Gile and Feldman. Maryland has been at the forefront of many issues and will need to continue to be a leader as we face unknown federal threats. We know that drugs don't work if people can't afford them, so we respectfully request a favorable report of Senate Bill 357.

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[i] https://www.cnn.com/2023/09/27/health/semaglutide-equitable-access/index.html

[ii] https://www.ajmc.com/view/examining-health-care-disparities-in-psoriasis-and-other-skin-diseases#

[iii] https://pubmed.ncbi.nlm.nih.gov/35959536/#:~:text=Results%3A%20In%20adjusted%20analyses%2C%20compare%20%20d,of%20having%20accessed%20ADHD%20medication

SB 357_AFSCME_FAV.pdf
Uploaded by: Denise Gilmore
Position: FAV

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Patrick Moran – President

SB 357 – Prescription Drug Affordability Board – Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act)
Finance Committee
February 6, 2025

Position: FAVORABLE

AFSCME Council 3 represents 45,000 public sector employees across the state, and we proudly support SB 357. This legislation expands the authority of the Prescription Drug Affordability Board to establish a process for setting upper payment limits for private plans, in addition to the state plans they have current authority over.

Since 1970, we have fought for the rights of our members on issues surrounding fair wages, working conditions, and health care coverage, including addressing prescription drug affordability. The skyrocketing cost of prescription drugs not only threatens the health and financial well-being of our members, but it puts considerable strain on our state and local government budgets and our health care system, as well.

We are pleased to see the progress that the Prescription Drug Affordability Board has made to date, particularly with the inclusion of anti-diabetics as the initial drugs chosen for consideration. Anti-diabetics represent the single biggest cost for the state employee health plan, with net spending increasing over 100% between 2020 and 2024 from $14.5 million to $29.3 million. The runaway costs of prescription drugs drive our premiums upwards and threaten to force patients to shoulder higher out-of-pocket responsibilities.

AFSCME is proud to support the Prescription Drug Affordability Board in its current work, and we are eager to see Senate Bill 357 pass so that *all* Marylanders can afford the prescription drugs they need. We urge the committee to provide a favorable report on SB 357. Thank you.

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Uploaded by: Erica Miller
Position: FAV

TESTIMONY IN SUPPORT OF SENATE BILL 357
Before the Senate Finance Committee
By Erica Miller
February 6, 2025

Madam Chair, Vice Chair Hayes, and Members of the Senate Finance Committee;

My name is Erica Miller, I am a Baltimore City resident who works in data management and runs a nonprofit organization dedicated to helping local nonprofits navigate the digital landscape effectively. I would like to thank this committee for the work it has done on prescription drug affordability so far, and to urge your support for Senate Bill 357, today. This is an issue that is of particular importance to me, because like so many of your constituents, I have been hurt by the skyrocketing costs of prescription drugs.

Several years ago, as I was working to get a diagnosis for my son, I learned well into my adulthood that I have ADHD. It explained so many of my struggles over the years, and while I initially tried to convince myself that this was something I should overcome on my own, I finally agreed to try medication. It took trial and error, but I cannot begin to express to you the relief I felt when I found the right dosage of Vyvanse. The static noise and racing thoughts disappeared, and for the first time in my life, I experienced a quiet mind.

It was life changing. My focus and performance at work improved, tasks felt manageable, and my anxiety quieted as I finally felt like I had things under control. With Vyvanse I no longer felt like I was constantly playing catch-up, and I was able to work with a therapist to develop additional tools to help me function in a world that often isn't built for people with neurodivergence.

From the start, Vyvanse was expensive, but I was fortunate enough to be able to afford the nearly $100 a month copay. That changed when I lost my health insurance. Suddenly I was facing a bill over $600 at the pharmacy counter, something I simply couldn't handle as a mother supporting two children. Drugs don't work if people can't afford them—and unfortunately, I am a living example of that motto. Forced to stop taking my medication, I felt the immediate negative impacts, and performing my corporate job duties became much more difficult. I know that the high cost of prescription drugs caused me to lose my job. It took losing my job to fully realize that the soaring cost of prescription drugs can impact middle class professionals, as well, it is just simply not something you expect to struggle with. It is my hope that with Senate Bill 357, we can help protect other Marylanders from the same hurt.

Even after I secured different employer-provided insurance, my struggles with Vyvanse continued. Each month it seemed my prescription would be a different cost, making it incredibly hard to plan for. Last year, after an unexplained jump to $388.40 a month, I finally had to switch medications. The generic version of Vyvanse is routinely out of stock, and I simply can't afford to skip taking this medicine. After some trial and error, I settled on Focalin, which isn't as effective for me as Vyvanse, but is better than nothing.

In 2023 the makers of Vyvanse made more than $3 billion in revenue from the drug. It simply feels wrong that a medicine that so many of us need to function is too expensive to actually help.[i] Drugs don't work if people can't afford them, and we can't afford to wait to take action in Maryland. We need a Prescription Drug Affordability Board with the authority to set statewide upper payment limits so that everyday Marylanders can see relief. For this reason, I ask you to please support Senate Bill 357.

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[i] https://www.biospace.com/fda-approves-generics-of-takeda-s-adhd-binge-eating-drug-vyvanse#:~:text=Takeda%20won%20ownership%20of%20the,from%20the%20previous%20fiscal%20year.

SB 357 - SUPP - FIN - Prescription Drug Affordabi
Uploaded by: Henry Bogdan
Position: FAV

MARYLAND NONPROFITS
marylandnonprofits.org

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February 6, 2025

Testimony on Senate Bill 357
Prescription Drug Affordability Board - Authority for Upper Payment Limits
(Lowering Prescription Drug Costs for All Marylanders Now Act)
Senate Finance Committee

Position: Favorable

Maryland Nonprofits is a statewide association of nonprofit organizations and institutions of all sizes serving Marylanders and communities across the entire state. Taken together nonprofits account for 13% of all private employment in Maryland and as employers strive to provide adequate health insurance coverage to their employees.

We urge you support Senate Bill 357, that would grant Maryland's Prescription Drug Affordability Board the expanded authority to set statewide upper payment limits to make high-cost drugs more affordable for *all* Marylanders. Skyrocketing drug costs are contributing to all of our health insurance premiums, making quality coverage less affordable for everyone. Nonprofits suffered along with the rest of the private sector throughout the pandemic, with disruption of operations, revenue losses, and workforce shortages. Many have also experienced declines in contributions in recent years and now face uncertain government funding in the future.

The Prescription Drug Affordability Board has made progress over the last year, particularly the approval of its Upper Payment Limit Action Plan to make prescription drugs more affordable for state and local governments. However, the fact remains that more must be done to directly help Marylanders and Maryland employers struggling to afford or provide adequate prescription coverage.

Polling shows as many as 45% of Marylanders report struggling to afford the medicines they need, with one third of Marylanders skipping a dose, rationing medication, or leaving a prescription unfilled due to cost. Meanwhile, the prescription drug industry spends far more on self-enrichment and advertising than they do on research and development, regularly prioritizing profits over patients. With federal action on this issue uncertain under the new administration, it is critical that Maryland continues to move forward on our prescription drug affordability efforts.

We thank you for your consideration of this issue and strongly urge a favorable report on Senate Bill 357.

SPONSOR OF STANDARDS FOR EXCELLENCE

SB357_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 357
Prescription Drug Affordability Board - Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act)
Before the Senate Finance Committee
By: Maryland Public Health Association (MdPHA)
February 6, 2025

Chair Beidle, Vice-Chair Klausmeier, and Members of the Finance Committee, thank you for this opportunity to testify in favor of SB 357, 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. The Prescription Drug Affordability Board has been making great progress in making high-cost drugs more affordable for state and local governments, and is ready to use expanded authority to make high-cost prescription drugs more affordable for ALL Marylanders. Marylanders have been waiting since 2019 for the Board to receive this authority, and with the cost of prescription drugs and other daily necessities rising every day, they should not have to wait any longer.

We strongly urge you to give a favorable report to SB 357.

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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SB357 - Prescription Drug Affordability Board - Au

Uploaded by: Jessica Morgan

Position: FAV

Bill No:	SB357
Title:	Prescription Drug Affordability Board - Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act)
Committee:	Finance
Hearing:	February 6, 2025
Position:	FAVORABLE

The Maryland Legislative Agenda for Women (MLAW) is a statewide coalition of women's groups and individuals formed to provide a non-partisan, independent voice for Maryland women and families. MLAW's purpose is to advocate for legislation affecting women and families. To accomplish this goal, MLAW creates an annual legislative agenda with issues voted on by MLAW members and endorsed by organizations and individuals from all over Maryland. **SB357 - Prescription Drug Affordability Board - Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act)** is a priority on the 2025 MLAW Agenda and we urge your support.

SB357 would grant Maryland's Prescription Drug Affordability Board the expanded authority to set statewide upper payment limits to make high-cost drugs more affordable for *all* Marylanders. We have been pleased to see the progress the Board has made over the last year, particularly the approval of its Upper Payment Limit Action Plan to make prescription drugs more affordable for state and local governments. However, the fact remains that we must do more to directly help Marylanders struggling to afford their medications. This legislation would provide meaningful relief to our families and neighbors at a time when so many Marylanders are forced to choose between filling their prescriptions and filling their fridges.

Polling shows as many as 45% of Marylanders report struggling to afford the medicines they need, with one third of Marylanders skipping a dose, rationing medication, or leaving a prescription unfilled 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, regularly prioritizing profits over patients. Marylanders should not have to choose between their prescription drugs and other necessities. With federal action on this issue uncertain under the new administration, it is critical that Maryland, under the guidance of this committee, continues to lead the nation on prescription drug affordability efforts

For these reasons, MLAW strongly urges the passage of SB357.

Maryland Legislative Agenda for Women
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mdlegagenda4women@yahoo.com ▪ www.mdlegagendaforwomen.org

MLAW 2025 Supporting Organizations

The following organizations have signed on in support of our 2025 Legislative Agenda:

1199 SEIU United Healthcare Workers East
AAUW Anne Arundel County
AAUW Garrett Branch
AAUW Howard County
AAUW Kensington-Rockville Branch
AAUW Maryland
Anne Arundel County NOW
Bound for Better, advocates for Domestic Violence
Calvert County Democratic Womens' Club
Charles County Commission for Womrn
Child Justice, Inc.
City of College Park MD
Court Watch Montgomery
Delta Sigma Theta Sorority North Arundel County Alumnae Chapter
FinnCORE, Inc.
Frederick County Commission for Women
Interfaith Action for Human Rights
Kids for Saving Earth
Maryland Chapter, National Organization for Women
Maryland Coalition Against Sexual Assault
Maryland Network Against Domestic Violence
Montgomery County, MD, NOW
National Coalition of 100 Black Women, Inc., Anne Arundel County Chapter
NCBWSOMD
ShareBaby, Inc.
Stella's Girls Incorporated
SUB&S LLC
The Rebuild, Overcome, and Rise (ROAR) Center of UMB
Trans Maryland
Unrooted Culture
Women of Honor International
Women's Equality Day Celebration across Maryland Coalition
Women's Equity Center and Action Network (WE CAN)
Women's Law Center of Maryland

*signed on as of 1/26/2025

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WDC Testimony 2025_SB357_Final.pdf
Uploaded by: JoAnne Koravos
Position: FAV

MONTGOMERY COUNTY, MARYLAND
WOMEN'S DEMOCRATIC CLUB
P.O. Box 34047, Bethesda, MD 20827 www.womensdemocraticclub.org

Senate Bill 357 – Prescription Drug Affordability Board - Authority for Upper Payment Limits
(Lowering Prescription Drug Costs for All Marylanders Now Act)
Finance Committee – February 6, 2025
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 2025 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 **SB 357,** a bill that expands the authority of Maryland's Prescription Drug Affordability Board (PDAB) to set upper payment limits for high-cost drugs purchased by all Marylanders.

The skyrocketing cost of prescription drugs hurts all Marylanders. Older adults, who are more likely to have chronic conditions requiring prescription drug treatment and be on fixed incomes, suffer disproportionately. 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).

Due to continued gender pay gaps, women also find it harder to afford prescription drugs they need. Polling routinely shows women are more likely than men to skip or ration their medication, causing poor health outcomes, according to the Maryland Health Care for All! Coalition.

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, especially older adults and women, will continue to face difficult decisions between paying for much-needed lifesaving medications and other necessities such as food, heat and housing.

We ask for your support for SB 357 and strongly urge a favorable Committee report.

Tazeen Ahmad
WDC President

Diana Rubin
WDC Aging Subcommittee

JoAnne Koravos
WDC Advocacy Co-Chair

SB 357_MD Center on Economic Policy_FAV.pdf
Uploaded by: Kali Schumitz
Position: FAV

MDCEP
MARYLAND CENTER ON ECONOMIC POLICY

FEBRUARY 6, 2025

Making Prescriptions More Affordable Would Improve Health, Quality of Life

Position Statement Supporting Senate Bill 357

Given before the Finance Committee

Being able to afford prescription medications is critical to Marylanders' health and quality of life. Senate Bill 357 will help more Marylanders access essential medications by giving the state's Prescription Drug Affordability Board (PDAB) the expanded authority to set statewide upper payment limits. Access to prescription medication should never be a privilege afforded only to those with financial means—it is a necessity for the health and well-being of individuals and families across our state. **The Maryland Center on Economic Policy supports Senate Bill 357, because Maryland has an opportunity to further its leadership in the fight for prescription drug affordability and ensure that no resident has to choose between filling their prescriptions and meeting their basic needs.**

At the Maryland Center on Economic Policy (MDCEP), our mission is to advance public policies that create an inclusive, equitable, and prosperous Maryland. We envision a state where all people—regardless of race, income, or background—have the opportunity to achieve economic security and thrive. We believe that economic opportunity is deeply connected to access to affordable healthcare, and prescription drug affordability is a key component of that equation. When individuals are forced to skip doses or forgo medications altogether due to cost, they are more likely to experience worsening health conditions, which can lead to costly emergency room visits, lost wages, and financial instability. These consequences disproportionately impact Maryland's low-income residents, seniors, and communities of color, further deepening health and economic inequities.

The high cost of prescription drugs is a crisis that affects every Marylander. According to polling, as many as 45% of Maryland residents report struggling to afford the medicines they need, with one-third skipping doses, rationing medication, or leaving prescriptions unfilled due to cost. At the same time, rising prescription drug costs contribute to higher health insurance premiums, putting additional strain on families, workers, and employers. Despite claims that high drug prices are necessary for innovation, pharmaceutical companies spend far more on advertising, executive compensation, and stock buybacks than on research and development. Instead of prioritizing patients, many of these companies prioritize profits, leaving Maryland families to bear the burden.

With federal action on this issue uncertain under the current administration, it is more important than ever that Maryland continues to lead the way in prescription drug affordability efforts. SB 357 represents a bold and necessary step toward ensuring that Marylanders are not left behind. By expanding the Board's authority, we can provide meaningful relief to families, seniors, and individuals with chronic conditions—people who are struggling with impossible choices between paying for medication, rent, groceries, or other essentials.

1800 North Charles Street, Suite 406 Baltimore MD 21201 | mdcep@mdeconomy.org | 410-412-9105

All Marylanders, regardless of income or insurance status, should be able to afford the medications they need to stay healthy and thrive. For these reasons, **The Maryland Center on Economic Policy urges the committee to make a favorable report on SB 357.**

Equity Impact Analysis: Senate Bill 357

Bill Summary

SB 357 grants Maryland's **Prescription Drug Affordability Board (PDAB)** the expanded authority to set statewide upper payment limits, making high-cost medications more affordable for all Marylanders.

Background

The high cost of prescription drugs is a crisis that affects every Marylander. According to polling, as many as 45% of Maryland residents report struggling to afford the medicines they need, with one-third skipping doses, rationing medication, or leaving prescriptions unfilled due to cost. At the same time, rising prescription drug costs contribute to higher health insurance premiums, putting additional strain on families, workers, and employers. Despite claims that high drug prices are necessary for innovation, pharmaceutical companies spend far more on advertising, executive compensation, and stock buybacks than on research and development. Instead of prioritizing patients, many of these companies prioritize profits, leaving Maryland families to bear the burden.

Maryland has already made progress in addressing this issue through the work of the Prescription Drug Affordability Board, which has developed and approved its Upper Payment Limit Action Plan for state and local governments. However, this progress must be expanded to include all Marylanders, not just those covered by public programs. SB 357 would provide the Board with the necessary authority to set payment limits statewide, giving all residents relief from excessive drug costs and ensuring that they can access the medications they need to maintain their health and quality of life.

Equity Implications

With federal action on this issue uncertain under the current administration, it is more important than ever that Maryland continues to lead the way in prescription drug affordability efforts. SB 357 represents a bold and necessary step toward ensuring that Marylanders are not left behind. By expanding the Board's authority, we can provide meaningful relief to families, seniors, and individuals with chronic conditions—people who are struggling with impossible choices between paying for medication, rent, groceries, or other essentials.

Impact

Senate Bill 357 will likely **improve the racial, health and economic equity** in Maryland.

2025 - SB 0357 - Prescription Drug Affordability B

Uploaded by: Ken Phelps Jr

Position: FAV

THE EPISCOPAL DIOCESE OF MARYLAND

The Maryland Episcopal Public Policy Network

TESTIMONY IN SUPPORT OF SB 357

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

Finance Committee

FAVORABLE

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

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

DATE: February 7, 2024

Thank you for the opportunity to testify in favor of SB 357, which would grant Maryland's Prescription Drug Affordability Board the expanded authority to set statewide upper payment limits to make high-cost drugs more affordable for *all* Marylanders. We have been pleased to see the progress the Board has made over the last year, particularly the approval of its Upper Payment Limit Action Plan to make prescription drugs more affordable for state and local governments. However, the fact remains that we must do more to directly help Marylanders struggling to afford their medications. This legislation would provide meaningful relief to our families and neighbors at a time when so many Marylanders are forced to choose between filling their prescriptions and filling their fridges. We thank Vice-Chair Bonnie Cullison and Delegate Jennifer White Holland for sponsoring this legislation.

The Episcopal Church teaches that access to quality and affordable health care is 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 vital mission of the Church. And we are proud to be working side by side in this effort with the Delaware-Maryland Synod, the Baltimore-Washington Conference of the United Methodist Church, The Baltimore Jewish Council and our many other faith partners.

Polling shows as many as 45% of Marylanders report struggling to afford the medicines they need, with one third of Marylanders skipping a dose, rationing medication, or leaving a prescription unfilled 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, regularly prioritizing profits over patients.

Marylanders should not have to choose between their prescription drugs and other necessities. With federal action on this issue uncertain under the new administration, it is critical that Maryland, under the guidance of this committee, continues to lead the nation on prescription drug affordability efforts.

The Diocese of Maryland thanks you for your consideration of this issue and **we strongly urge a favorable report of Senate Bill 357.**

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SB0357-FIN_MACo_SUP.pdf
Uploaded by: Kevin Kinnally
Position: FAV

Senate Bill 357

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

MACo Position: **SUPPORT**

To: Finance Committee

Date: February 6, 2025

From: Karrington Anderson and Kevin Kinnally

The Maryland Association of Counties (MACo) **SUPPORTS** SB 357, which enhances the authority of the Prescription Drug Affordability Board to establish a process for setting upper payment limits for prescription drug purchases and payor reimbursements in the state. This legislation strengthens efforts to address the financial burden of skyrocketing drug prices on local governments and their employees.

Counties, as public employers, bear the increasing costs of prescription drugs through the health insurance coverage they provide to employees and their dependents. While counties subsidize these health plans, employees also share the expense through premiums, co-payments, and deductibles. Unchecked prescription drug price increases make it more difficult for counties to offer comprehensive and affordable health benefits while straining local budgets.

SB 357 offers a targeted approach to controlling excessive prescription drug costs by allowing the Prescription Drug Affordability Board to establish upper payment limits. This ensures that payors such as local governments are not subject to unpredictable and unaffordable price spikes. By improving price predictability, this bill helps counties responsibly budget for employee healthcare expenses while ensuring that employees continue to receive the medications they need.

MACo supported the creation of the Prescription Drug Affordability Board in 2019 as a necessary step in addressing prescription drug affordability. SB 357 builds upon that foundation by strengthening the Board's ability to address affordability challenges.

For these reasons, MACo urges a **FAVORABLE** report on SB 357.

SB 357 PDABAuthorityUPL.FAV.pdf
Uploaded by: Larry Zarzecki
Position: FAV

Good afternoon, Chair Beidle and Members of the Senate Finance Committee. My name is Larry Zarzecki, and I am a retired Maryland State Police Officer and resident of Stevensville, Maryland. I am here today in full support of SB 357, Prescription Drug Affordability Board—Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act). I extend my gratitude to Senators Gile and Feldman for championing this critical legislation.

Over ten years ago, when I was diagnosed with Parkinson's due to tremors in my right hand, my life took an unexpected turn. That diagnosis fueled my second passion—advocating and lobbying for people struggling to afford their medications, a battle I know firsthand. I've fought to lift Maryland's pharmacy gag rule, ensuring pharmacists could inform patients about the most affordable prescription options, and supported allowing Medicare to negotiate prices directly with drug companies.

Despite being a retired law enforcement officer with health insurance through the state of Maryland, I was not shielded from exorbitant prescription costs. I take eight medications daily, but my insurance did not fully cover two of them. I was paying $3,200 a month out of pocket—without insurance, it would have been $8,000 a month. Like so many others, I found myself juggling credit card payments, borrowing funds, and tapping into my IRA just to afford life-saving medications.

Before finally qualifying for Medicare, I was prescribed additional medication to help with balance issues caused by Parkinson's, but I simply couldn't afford it. This is not an isolated experience—I personally know over 50 individuals, many of them retirees, who are struggling under similar financial strain, sacrificing their savings, retirement, and peace of mind just to afford prescriptions.

If I had the opportunity to speak directly to the leaders of major pharmaceutical companies, I would say:
"Thank you for the life-saving medications. But we're being crushed by the prices. We have to decide whether to heat, eat, or treat—no one should be put in that position."

My suggestion is simple but powerful: Reduce the advertising budget and pass those savings on to the consumers. Make the medications affordable for everyone who needs them. And give the Prescription Drug Affordability Board the power it needs to help Marylanders, just as we intended when the initial law passed in 2019.

Passing SB 357 is a vital step in ensuring that the people of Maryland—especially seniors, retirees, and those on fixed incomes—are not forced to choose between their health and their financial stability. I urge you to support this bill to help lower prescription costs and protect thousands of Marylanders from the overwhelming burden of medication expenses.

Thank you for your time and consideration.

TESTIMONY IN SUPPORT OF SENATE BILL 357.pdf
Uploaded by: Laura Packard
Position: FAV

TESTIMONY IN SUPPORT OF SENATE BILL 357
Prescription Drug Affordability Board - Authority for Upper Payment Limits
(Lowering Prescription Drug Costs for All Marylanders Now Act)
Before the Senate Finance Committee
By Laura Packard, Founder, Voices of Health Care Action
February 4, 2025

Chair Beidle, Vice-Chair Hayes, and Members of the Finance Committee;

We are testifying **in favor of SB 357**, which would grant Maryland's Prescription Drug Affordability Board the expanded authority to set statewide upper payment limits to make high-cost drugs more affordable for *all* Marylanders.

Voices of Health Care Action is a non-profit organizing adults with serious medical conditions and health care activists to make health care in America more affordable and available for all. I am representing 4,671 Marylanders, some of whom have reached out directly to their state legislators already in support of this bill. Patients, physicians, we all know that drugs don't work if people can't afford them.

Maryland's first-in-the-nation Prescription Drug Affordability Board (PDAB) serves as a watchdog for Maryland, examining high-cost prescription drugs and determining ways to make them more affordable.

Yet too many Marylanders are forced to skip doses, cut their pills in half, or leave a prescription at the pharmacy counter while pharmaceutical corporations make record-breaking profits. Maryland's PDAB is doing great work, but its current authority is limited to addressing costs for only state and local government entities.

Now we need to take action for everyone else.

At a time when one in three Marylanders reports having skipped a dose or rationed medication due to cost, it's critical to expand the PDAB.

We thank you for your consideration of this issue and strongly urge a yes vote on Senate Bill 357.

sb357 PDAB upper limits FIN 2-6-2025.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 357
February 6, 2025
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 advocates for access to appropriate, adequate, and affordable health care for all people in the United States (*Caring for Health*, ELCA, 2003) as the Committee knows well. We include medical treatment in "appropriate" and "adequate care", and therefore any calculation of "affordable". We supported SB202/HB279 of 2023 affirming the authority of PDAB to establish upper payment limits in its indicated circumstances.

Costly drugs can compromise medical treatment for anyone. As we've all learned by dreary repetition across the medical landscape, denial of treatment just builds up costs farther along the care continuum. That is a particular concern of our community's interest in those who are financially disadvantaged. Consigning them to suffering is a cruel way to manage care.

When pricing is chiefly influenced by demand, "most expensive" can mean "most needed." The PDAB policy expansion offered in **Senate Bill 357** would use its current authority to review prices on well-studied, commonly prescribed, expensive drugs sold in the State to establish upper payments across Maryland's medical marketplace.

Our community's experience in places we serve is that the cost of prescriptions is a common challenge people share. A list of charity solicitations for which folks enter church doors would include food, utilities, rent/housing, and *medicines*. Public assistance programs to which they may be directed only go so far. Medication can be a recurring treatment: filling a gap in one month won't suspend the need in the next.

Access to *adequate, appropriate care,* requires *affordable care.* Now that the context of *access* is changing nationally, Maryland has an available policy instrument to meet the moment. That policy's benefits will extend across the State to its residents, its medical marketplace—providers and financial actors—and its other health care programs beyond Medicaid and personnel insurances (*e.g.* MHBE).

Our community's position is that affordability *is* access to health care. We've joined our many Maryland religious community colleagues and endorsed the Health Care For All resolution to make drugs affordable with upper payment limits. We ask your favorable report for **Senate Bill 357**.

Lee Hudson

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SB357_LBCMD_FAV
Uploaded by: Legislative Black Caucus of Maryland
Position: FAV

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February 6, 2025

February 6, 2025

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

Dear Chair Beidle and Members of the Committee,

The Legislative Black Caucus of Maryland strongly supports Senate Bill 357 (SB0357) – Lowering Prescription Drug Costs for All Marylanders Now Act. This bill introduces essential reforms to Maryland's prescription drug pricing system, ensuring that all residents who are disproportionately impacted by high healthcare costs have access to affordable medications. **Senate Bill 357 is a 2025 Black Caucus legislative priority bill.**

The United States has witnessed alarming instances of pharmaceutical price gouging, which have severely impacted patient access to essential medications. A notable example occurred in 2015 when Turing Pharmaceuticals, under CEO Martin Shkreli, acquired the rights to Daraprim, an essential medication used to treat and prevent malaria and HIV among other uses. Within a month, the company increased the price from $13.50 to $750 per pill, an astronomical hike of over 5,000%. This exorbitant increase placed a life-saving medication out of reach for many patients.

In contrast, countries such as Australia and South Korea have implemented effective government oversight to regulate drug prices while maintaining pharmaceutical innovation. Australia's Pharmaceutical Benefits Scheme (PBS) uses an independent review board to assess drug prices and negotiate fair costs with manufacturers, ensuring affordability without restricting access. Similarly, South Korea's National Health Insurance system negotiates drug prices with pharmaceutical companies to keep medications affordable while ensuring quality care. These models demonstrate that strong regulatory frameworks can reduce drug prices without stifling medical advancements.

The issue of high prescription drug costs hits Black communities particularly hard, exacerbating existing health disparities. Black Marylanders are more likely to suffer from chronic conditions like hypertension, diabetes, and cardiovascular disease, all of which require ongoing medication. However, the high cost of these prescriptions creates treatment gaps that further deteriorate health outcomes. A Kaiser Family Foundation poll revealed that 61% of Black adults are concerned about affording prescription drugs, compared to 50% of White adults,

highlighting the urgency for legislative action. In addition, the CDC reported that over 9 million Americans aged 18-64 skip doses, take smaller amounts, or delay refills due to cost. This practice disproportionately affects lower-income Black families, leading to worsened health conditions and higher long-term healthcare costs.

Black Marylanders are also more likely to rely on state health programs than their White counterparts. As prescription costs rise, these programs face increased strain, leading to delays in care and formularies that may exclude critical medications. By reducing drug prices through regulatory oversight, SB0357 will provide direct benefits to Black Marylanders who depend on Medicaid and other public health programs to afford necessary treatments.

Rather than imposing a blanket price cap, SB0357 adopts an equitable approach by establishing a Prescription Drug Affordability Board. This board will thoroughly assess and evaluate drug costs before setting upper payment limits, ensuring that price regulations are based on real affordability challenges. Additionally, the board's structure allows for continuous oversight, meaning it can adjust pricing policies in response to market changes—avoiding the risks of a rigid, outdated price cap that could become ineffective over time.

By prioritizing affordability, healthcare equity, and economic relief for communities most affected by high drug prices, SB0357 advances the principles of justice and fairness. The bill reflects the Caucus' commitment to tackling systemic healthcare disparities and advocating for reforms that uplift Black Marylanders.

Senate Bill 357 represents a critical step in making prescription medications more affordable and accessible for all Marylanders. It balances public health needs with fiscal responsibility while ensuring that Maryland's most vulnerable populations receive the care they deserve. For these reasons, the Legislative Black Caucus of Maryland strongly supports Senate Bill 357 and urges this committee to make a favorable report.

Legislative Black Caucus of Maryland

SB357 - MoCo_Elrich_FAV (GA 25).pdf
Uploaded by: Leslie Frey
Position: FAV

OFFICE OF THE COUNTY EXECUTIVE

Marc Elrich
County Executive

February 6, 2025

TO: The Honorable Pamela Beidle
Chair, Finance Committee

FROM: Marc Elrich
County Executive

RE: Senate Bill 357, *Prescription Drug Affordability Board - Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act)*

Senate Bill 357 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 prohibits the setting of a payment limit of a drug that is in short supply in the State.

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 2025 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. Substantial savings on pharmaceutical expenses in our county budget have started to take shape since the Board's limits were put in place late last year. 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 357.

cc: Members of the Finance Committee

SB357 PDAB.pdf
Uploaded by: Loraine Arikat
Position: FAV

SB 357
Prescription Drug Affordability Board - Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act)
Position: Favorable

Dear Senator Beidle and members of the Senate Finance 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 SB 357 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 on SB 357.

Sincerely,

Ricarra Jones
Political Director
1199 SEIU United Healthcare Workers East

Ricarra.jones@1199.org

witness testimony.pdf
Uploaded by: Mariah Robertson
Position: FAV

My name is Dr. Mariah Robertson. I am double-boarded in Internal Medicine and Geriatric Medicine, and I work as a house call and hospital medicine doctor in the Baltimore and mid-Maryland region. The patients I serve often exist at the margins of healthcare, forgotten by the systems that are built for ambulatory patients who can get to the office for their care. My patients have significantly higher medical complexity than the average patient, and because of existing structural and systemic disparities in healthcare, my patients often fall into the donut hole of healthcare coverage. This translates to significant difficulty paying for basic necessities such as food, utilities, and housing. This also means that affording medications can be prohibitive. Of the medications most difficult to pay for, oral diabetes medications (specifically the GLP-1 agonists and SGLT2 inhibitors) and direct oral anticoagulants are some of the most cost-prohibitive. Given the medical complexity of my patients, these medications often serve multiple overlapping purposes and are often not able to be taken as prescribed because of exorbitant costs. In many cases I am forced to choose less expensive medications that carry higher risk profiles or are not first line for treatment. When I think about the rich and incredible lives my patients have lived and the challenges they have overcome, I hope deeply that we can do better by them and support legislation to make essential medications affordable.

SB 357 - MIA - FAV - CLEAN.pdf
Uploaded by: Marie Grant
Position: FAV

WES MOORE
Governor

ARUNA MILLER
Lt. Governor

MARIE GRANT
Acting Commissioner

JOY Y. HATCHETTE
Deputy Commissioner

DAVID COONEY
Associate Commissioner
Life and Health Unit

Maryland
INSURANCE ADMINISTRATION

200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202
Direct Dial: 410-468-2471 Fax: 410-468-2020
1-800-492-6116 TTY: 1-800-735-2258
www.insurance.maryland.gov

Date: **February 6, 2025**

Bill # / Title: **Senate Bill 357 - Prescription Drug Affordability Board - Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act)**

Committee: **Senate Finance Committee**

Position: **Support**

The Maryland Insurance Administration (MIA) appreciates the opportunity to share its support for Senate Bill 357.

Senate Bill 357 amends the Health General Article to require the Prescription Drug Affordability Board (PDAB or 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 affordability challenges. The bill also authorizes the Board to reconsider an upper payment limit for a drug that becomes a current shortage.

Under § 11-603(c)(2)(ii)(5) of the Maryland Insurance Article, the MIA can take into consideration "other relevant factors" when disapproving or modifying a proposed premium rate filing. Under that authority, if an upper payment limit is imposed, it would be a rating factor that the MIA could and would take into account when making determinations on proposed rates for the markets the Agency regulates.

Therefore, were the PDAB to set an upper payment limit for the commercial market, the MIA would be able to ensure it is incorporated in rate setting for the 34.5% of the market which it regulates (which includes Individual, Small Group, and Large Group fully insured plans). Last year, approximately 20% of overall change in claims cost in the MIA-regulated market was driven by the cost component of prescription drugs, so any upper payment limits set could help drive that component of spending down and lead to overall lower pricing trends for carriers and consumers.

For the reasons set forth above, the MIA urges a favorable committee report on Senate Bill 357 and thanks the Committee for the opportunity to share its support.

SBAF_ Testimony RX Cost MD Hearing.pdf
Uploaded by: Nia Gossett
Position: FAV

TESTIMONY IN SUPPORT OF SENATE BILL 357
Prescription Drug Affordability Board - Authority for Upper Payment Limits
(Lowering Prescription Drug Costs for All Marylanders Now Act)
Before the Senate Finance Committee
By Connie Mazur, Owner, CyberVillage Networkers Inc.
February 3, 2025

Chair Beidle, Vice-Chair Hayes, and Members of the Finance Committee,

Thank you for the opportunity to testify in favor of SB 357, which would grant Maryland's Prescription Drug Affordability Board the ability to set up a process to set statewide upper payment limits resulting in making high-cost drugs more affordable for all Marylanders. As a small business owner providing health coverage for my employees, I strongly support this legislation, which would help make medications more affordable for Maryland businesses, their employees, and families.

I am the owner of CyberVillage Networkers, Inc., where I employ six full-time staff and provide them with medical, dental, life insurance, and disability coverage. As someone who has navigated the challenges of offering health insurance, I've experienced how prescription drug costs directly impact both business operations and employee wellbeing. As a business owner, slowing the pace of insurance premium increases has saved our business. As an insured employee myself, I need insulin to manage my diabetes. Too often, I've received a cost estimate at the doctor's office only to face much higher costs at the pharmacy. This kind of price uncertainty and lack of transparency creates instability for small businesses trying to budget for healthcare costs and maintain consistent coverage for their employees.

The proposed improvements to the Prescription Drug Affordability Board would provide much-needed transparency, predictability, and relief for small businesses like mine. In fact, a Small Business for America's Future survey found that 94% of small business owners believe the current prescription drug pricing market needs to be changed. Setting upper payment limits for high-cost drugs would help control one of the main drivers of rising healthcare costs, making it easier for small businesses to continue providing quality health coverage—a significant expense that cuts into our bottom lines—to their employees.

When small businesses can accurately predict and manage healthcare costs, we can compete more effectively, create more jobs, and contribute more to Maryland's economy. I strongly urge a favorable report of Senate Bill 357. This legislation represents an important step toward making prescription drugs more affordable for all Marylanders and supporting the small businesses that are the backbone of our state's economy.

Thank you for your consideration of this important issue.

Connie Mazur Owner, CyberVillage Networkers, Inc.

SB 357_Horizon Foundation_FAV.pdf
Uploaded by: Nikki Highsmith Vernick
Position: FAV

HORIZON FOUNDATION

BOARD OF TRUSTEES

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Celián Valero-Colón, M.D.

David Wolf

Lanlan Xu, Ph.D

February 6, 2025

COMMITTEE: Senate Finance Committee
BILL: SB 357 - Prescription Drug Affordability Board – Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act)
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 357 – Prescription Drug Affordability Board – Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs for All Marylanders Now Act).

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 357 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, once the Board sets upper payment limits for state and local governments for at least two drugs.

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 357 would help ease the financial strain that prescription drugs can cause many families. For this reason, the Horizon Foundation **SUPPORTS SB 357 and urges a FAVORABLE report.**

Thank you for your consideration.

The Horizon Foundation of Howard County, Inc.
10221 Wincopin Circle, Suite 200, Columbia, MD 21044 **P** 410.715.0311 **F** 410.715.2973 · info@thehorizonfoundation.org

SB 357- LWVMD- FAV- Prescription Drug Affordabilit

Uploaded by: Nora Miller Smith

Position: FAV

LEAGUE OF WOMEN VOTERS® OF MARYLAND

TESTIMONY TO THE SENATE FINANCE COMMITTEE

SB 357: Prescription Drug Affordability Board- Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act)

POSITION: Support

BY: Linda Kohn, President

DATE: 2/6/2025

The League of Women Voters Maryland is a nonpartisan organization that works to influence public policy through education and advocacy. **The League believes that every resident should have access to affordable, equitable, quality health care, including essential medications.** The League supports **Senate Bill 357,** which would enable the Board to lower prescription drugs costs for ALL Marylanders, and not just those covered by state and local government health plans.

Per the NIH, "In 2023, overall pharmaceutical expenditures in the U.S. grew 13.6% compared to 2022, for a total of $722.5 billion."[1] Per JAMA,[2] [Prescription drug] **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**.

Maryland's Prescription Drug Affordability Board is in the process of implementing upper payment limits on high-cost drugs for Marylanders who are covered by state and local government health plans, which reduces financial pressure both on patients and those plan's budgets. **Senate Bill 357 would expand the authority of the Board to implement broader cost controls that would benefit ALL Marylanders**, 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 League of Women Voters Maryland, representing 1,500+ concerned members throughout Maryland, urges a favorable report on Senate Bill 357.

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[1]https://pubmed.ncbi.nlm.nih.gov/38656319/#:~:text=Results%3A%20In%202023%2C%20overall%20pharmaceutical,%25%20increase)%20drove%20this%20increase.

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

121 Cathedral Street, Suite 2B, Annapolis, MD 21401
410-269-0232 * info@lwvmd.org * www.lwvmd.org

PDAB Testimony SB357 2.4.2025.pdf
Uploaded by: Patty Snee
Position: FAV

Testimony: **Favorable** Report on SB 357

Feb. 4, 2025

Prescription Drug Affordability Board-Authority for Upper Payment Limits

Dear Chair Beidle, Vice-Chair Hayes, and Members of the Finance Committee,

Thank you for holding a hearing on this important legislation. It's critical for Maryland to expand the Board's authority, especially at this time. The Board has made headway using the UPL Action Plan to position state and local governments to see savings on drug costs. Now we need to make high-cost medicines affordable for ALL Maryland residents and the Board needs your support to make that happen.

Given the dangerous actions of the Trump Administration and the power grab by his key backer, the unelected and unaccountable Elon Musk, we don't know if Medicare will be able to continue negotiating drug prices. We fear drug company lobbyists (and there are hundreds in Congress) will have even more say in undermining policies that regulate the price gouging that everyday Americans are experiencing for a whole range of drugs.

Progressive Maryland is a statewide grassroots advocacy group working for a more robust, equitable and patient centered healthcare system. We're engaged with folks across the state and no matter where we are, we regularly hear from our supporters that they are struggling with the overall high cost of healthcare, particularly what they must pay for life sustaining and life saving medications. We've talked to parents who ration the medication they take in order to have the money they need to cover the prescription drugs their kids or their parents need. Our supporters have also asked us to focus on the crisis in health insurance denials. The two go hand in hand because, as you know, denials of care happen most frequently for doctor prescribed drugs in part because of the high cost.

Thank you for making this issue a priority. We urge a favorable report of Senate Bill 357 and ask that you urge your Senate colleagues to do the same when it comes up for a vote in the Senate.

Sincerely,

Patty Snee, Lead Organizer Healthcare Issue Campaigns

patty@progressivemaryland.org

301 655-5682

District 20 Resident

SB357 Testimony Paul Schwartz 020625.pdf
Uploaded by: Paul Schwartz
Position: FAV

Testimony of Paul Schwartz
February 6, 2025
Senate Finance Committee
SB357 – Prescription Drug Affordability Board – Authority for Upper Payment Limits and Funding
(Lowering Prescription Drug Costs For All Marylanders Now Act)

I am Paul Schwartz, National Region Vice President of the National Active & Retired Federal Employees – NARFE.

I testify today in support of SB357

As we pointed out during last year's hearing, "In 2022 for 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".

By the way, R&D costs can always be factored into the Board's pricing so that is a false concern.

Today over $1 Billion is spent monthly on pharmaceutical advertising.

"Jardiance is really swell, the little pill with the great big story to tell"

However, as you well know it wasn't the pharmaceutical industry that caused this bill to not pass last year; it was the Board's claim that they were not ready to take on the expanded authorities.

Accordingly, this time I want to shift focus to the rising cost of healthcare

The cost of healthcare, especially the price of pharmaceuticals, in America is simply unaffordable for many Americans including many Marylanders.

With the change in administration in Washington, we cannot rely on the federal government to address this ongoing threat to Marylanders.

There is even talk of removing the $35 cap on insulin (for those on Medicare) as well as Medicare's ability to negotiate pricing which had been sought for decades until it finally passed two years ago.

It is going to be up to you to help Marylanders afford their healthcare and their prescription drugs.

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.

If the Board isn't ready this time, get a new Board

I'll leave you with two words as I did last year: **MARTIN SKRELLI**

SB 357.HB424. Support Letter.pdf
Uploaded by: Reuben Collins
Position: FAV

Charles County Government

CHARLES COUNTY COMMISSIONERS
Reuben B. Collins, II, Esq., *President*
Ralph E. Patterson, II, M.A., *Vice President*
Gilbert O. Bowling, III
Thomasina O. Coates, M.S.
Amanda M. Stewart, M.Ed.

Mark Belton
County Administrator

February 6, 2025

Bill: SB 357/ HB 424 Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs for All Marylanders Act of 2024)
Committee: Senate – Finance; House – Health and Government Operations
Position: FAVORABLE

Dear Committee Members:

On behalf of the County Commissioners for Charles County, this letter is to express support for SB 357/ HB 424 Prescription Drug Affordability Board - Authority for Upper Payment Limits and Funding (Lowering Prescription Drug Costs for All Marylanders Act of 2024). This bill builds upon the Prescription Drug Affordability Board law you enacted in 2019 by expanding the Board's authority to make high cost drugs more affordable for all Marylanders.

According to a recent poll conducted by OpinionWorks, 45 percent of Maryland households have had trouble affording their necessary medications. This equates to our residents skipping necessary doses in order to ration their medication, or not even filling the needed prescription at all. Additionally, the cost of prescription drugs also means that public health workers are unable to afford the cost of medications, such as naloxone, EpiPen's and other needed medications, crippling our ability to respond during a medical crisis, despite the existence of these lifesaving drugs.

With passage of SB 357/HB424, the Board will have the authority it needs to use upper payment limits to make high cost drugs more affordable for all Marylanders. For the reasons stated herein, we encourage a FAVORABLE report. Thank you for the opportunity to provide our support.

Sincerely,

Reuben B. Collins, II, Esq., President
County Commissioners of Charles County

cc: Charles County Delegation

Testimony in support of SB0357 - Prescription Drug

Uploaded by: Richard KAP Kaplowitz

Position: FAV

SB0357_RichardKaplowitz_FAV
02/06/2025

Richard Keith Kaplowitz
Frederick, MD 21703

TESTIMONY ON SB#/0357 - FAVORABLE

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

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

FROM: Richard Keith Kaplowitz

My name is Richard K. Kaplowitz. I am a resident of District 3, Frederick County. I am submitting this testimony in support of SB#0357**,** Prescription Drug Affordability Board - Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act)

The Maryland General Assembly, recognizing the problems the increasing cost of medications has created for Marylanders, has begun the process of addressing prescription drug affordability for Marylanders. As a leader in the nation, Maryland's first-in-the-nation Prescription Drug Affordability Board (PDAB) is working hard at keeping Maryland patients' best interests at heart. They accomplish this by examining high-cost prescription drugs and determining ways to make them more affordable.

Yet, with inflation affecting multiple segments of society, the ability of people to afford the medications they need continues to be constrained. It is unfair that Marylanders are forced to skip doses, cut their pills in half, or leave a prescription at the pharmacy counter all while pharmaceutical corporations make record-breaking profits. Maryland's PDAB needs to be enabled to do more to help Marylanders afford their health care utilization of medicines. Unfortunately, its current authority is limited to addressing costs for only state and local government entities. This bill will support expanding this authority in 2025 so that the PDAB can set statewide upper payment limits. Doing so will faciliate an authority for the PDAB to implement upper payment limits making high-cost drugs more affordable for all Marylanders. It is critical that the PDAB is given this authority because we know that drugs don't work if people can't afford them.

We are all hurt by the high cost of prescription drugs, whether at the pharmacy counter, through our insurance premiums, or through government spending of our taxpayer dollars. At a time when one in three Marylanders reports having skipped a dose or rationed medication due to cost it is incumbent upon the General Assembly to be proactive in addressing this medical crisis.

This bill requires the Prescription Drug Affordability Board, under certain circumstances, to establish a process for setting upper payment limits for all purchases and payer reimbursements of prescription drug products in the State that the Board determines have led or will lead to affordability challenges. It decrees that the Board has the authority to reconsider an upper payment limit for a drug that becomes a current shortage. It alters the requirements related to the setting of upper payment limits by the Board.

I respectfully urge this committee to return a favorable report on SB#0357.

SB 0357 Support.pdf
Uploaded by: Ryan Coleman
Position: FAV

Randallstown

Po Box 731 Randallstown, MD 21133

February 4, 2025

Finance Committee
3 East Miller Senate Office Building
3 East Miller Senate Office Building
Annapolis, Maryland 21401

RE: SUPPORT SB 0357, Prescription Drug Affordability Board - Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act)

Dear Chair Beidle, Vice Chair Hayes and Members of the Finance Committee:

The Randallstown NAACP is a 500 member branch located in Baltimore County. Maryland. We have members in Baltimore County and Baltimore City. One of primary focuses is ensuring the quality of life for all residents especially black Marylanders free of discrimination.

The rising costs of prescription drugs is something most people are facing. Everything from the treatment of chronic conditions to one-time prescriptions are

getting more expensive. One of the leading causes for bankruptcy in any household is health care costs when you're trying to debate about $600 for medication or maybe $600 for maybe your utilities, a mortgage or rent or anything else. Many residents are reporting they have skipped a dose, rationed medication or left a prescription at the pharmacy counter due to cost. SB 0357 gives us another tool to lower the prescriptions for Marylanders.

The Randallstown NAACP supports SB 0357, Prescription Drug Affordability Board – Authority for Upper Payment Limits 3 (Lowering Prescription Drug Costs for All Marylanders Now Act) ***The Randallstown Branch of the NAACP urges a favorable report from the committee on SB 0357.***

.

yours

Ryan Coleman
Randallstown NAACP, President
https://randnaacp.org/
https://www.facebook.com/NAACPrandallstown
https://www.instagram.com/naacprandallstown

SB 357_FAV_BMNCBV_CONNER 2.pdf
Uploaded by: Sandra Conner
Position: FAV

Baptist Ministers' Night Conference of Baltimore *and* Vicinity (BMNCBV)

5405 York Road, Baltimore, Maryland 21212, (443) 386.4739

TESTIMONY IN SUPPORT OF SENATE BILL 357 BEFORE THE SENATE FINANCE COMMITTEE

BY REV. DR. SANDRA CONNER, PRESIDENT, BMNCBV
FEBRUARY 6, 2025

Chair Beidle, Vice Chair Hayes, and Members of the Senate Finance Committee, thank you for this opportunity to testify in favor of Senate Bill 357. The Baptist Ministers' Night Conference of Baltimore and Vicinity is an organization that strives to equip both community and faith leaders with resources to do effective health ministries for the members they serve. 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 congregants face having to make a decision on which bills they will pay and/or whether to 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 governments. The Prescription Drug Affordability Board has been making great progress, and is now ready to use expanded authority to make high-cost prescription drugs more affordable for ALL Marylanders. Our congregants have been waiting since 2019 for the Board to receive this authority. With the cost of prescription drugs and other daily necessities rising every day, it is urgent that the Board receive the expanded authority as soon as possible.

We thank your Committee for your leadership in creating the Prescription Drug Affordability Board, and thank Senators Gile and Feldman for sponsoring the legislation to expand its authority. We pray that our legislators will heed our call and give a favorable report for SB 357.

PGCex_Support_SB 357.pdf
Uploaded by: Sasha Desrouleaux
Position: FAV

THE PRINCE GEORGE'S COUNTY GOVERNMENT

OFFICE OF THE COUNTY EXECUTIVE

BILL:	**Senate Bill 357: Prescription Drug Affordability Board - Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act)**
SPONSOR:	**Senator Dawn Gile, Senator Brian Feldman**
HEARING DATE:	**February 6, 2025 at 1:00PM**
COMMITTEE:	**Finance**
CONTACT:	**Intergovernmental Affairs Office, 301-780-8411**
POSITION:	**SUPPORT**

The office of the Acting Prince George's County Executive urges **SUPPORT** of **Senate Bill 357: Prescription Drug Affordability Board - Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act)**, requiring the Prescription Drug Affordability 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; authorizing the Board to reconsider an upper payment limit for a drug that becomes a current shortage; altering requirements related to the setting of upper payment limits by the Board; prohibiting the Board from taking certain actions related to upper payment limits; and generally relating to the Prescription Drug Affordability Board.

Since 2019, Prince Georgians have worked diligently besides a State-wide coalition to pursue common sense regulations to make healthcare more accessible and reduce potential financial harm to patients. In 2022, Prince George's County again joined State leaders, caregivers, advocates and patients to demand further action to address the high cost of drugs to our constituents by urging this body to use its authority to enact rules that would place upper payment limits on what state and local governments pay for prescription drugs.

Today, once more, we join in a growing chorus to bring attention to this persistent concern which deserves the State's attention: the high cost of certain drugs is

making them unaffordable for many residents and action is needed today. The Prescription Drug Affordability Board should make use of its authority and help Marylanders everywhere by bringing the cost of life-saving medicine back within reach of not only the constituent, but also the government agencies which rely on those drugs to care for their constituents.

For the reasons stated above, the Office of the Acting Prince George's County Executive **SUPPORTS SB 357** and asks for a **FAVORABLE** report.

DG Written Testimony_SB0357.docx.pdf
Uploaded by: Senator Gile
Position: FAV

Dawn D. Gile
Legislative District 33
Anne Arundel County

Finance Committee

Chair

Anne Arundel County
Senate Delegation

THE SENATE OF MARYLAND
Annapolis, Maryland 21401

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Dawn.Gile@senate.state.md.us

Testimony in Support of Senate Bill 357 - Prescription Drug Affordability Board – Authority for Upper Payment Limits (*Lowering Prescription Drug Costs for All Marylanders Now Act)*

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

The skyrocketing cost of prescription drugs is a critical concern to the health and well-being of Marylanders across the state. These costs often serve as a barrier to essential care, forcing many of our families and neighbors to choose between filling their prescription or filling their fridge. Not only does this issue impact the economic stability of our state residents, but it threatens the efficacy of our broader health care system, as well. Senate Bill 357, which would expand the authority of our Prescription Drug Affordability Board to allow it to establish statewide upper payment limits, is an opportunity to provide direct relief to our residents and to ensure much-needed cost containment for our state.

The Growing Burden of Prescription Drug Costs

Despite an increase in state and federal scrutiny in past years, prescription drug prices remain unaffordable for many of our residents, meaning life-saving medications sit out of reach for patients and elevate costs across the health care system. Polling data already indicates that one in three Marylanders report that they have skipped a dose, rationed medication, or left a prescription at the pharmacy counter due to cost.[1] Medication adherence can significantly affect long-term outcomes, meaning these costs are keeping Marylanders from being their healthiest selves.[2] This has particularly devastating impacts on our most vulnerable populations, including the elderly, with it being estimated that as many as 1.1 million Medicare patients could die this decade due to being unable to pay for their prescriptions.[3]

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

2 https://www.cdc.gov/mmwr/volumes/66/wr/mm6645a2.htm

3 https://westhealth.org/news/new-study-predicts-more-than-1-1-million-deaths-among-medicare-recipients-due-to-the-inability-to-afford-their-medications/

Even those who are able to afford their medications are left shouldering 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. Unfortunately, over the last few years we've seen a concerning two-part trend of price hikes on existing drugs and new products being introduced at record-high prices. In January of 2025 alone, pharmaceutical corporations raised the list price on 575 brand name medications, many above the general rate of inflation.[4] While this year's median price hike is lower than in years past, the compounding increases have significant impacts to affordability. A prime example of this is with Pfizer's Paxlovid, a critical tool in reducing hospitalizations and serious illnesses of those who contract COVID-19. Despite seeing only a 3% increase in 2025, the fact remains that the price has more than doubled since 2021, jumping from approximately $500 per treatment to over $1400, threatening future access to a lifesaving medication as the U.S. shifts further from the pandemic phase.

The cost of new prescription drug products is also a growing concern. In 2023, the median annual price for a new drug was $300,000, and several products entered the market with a list price well over $1 million.[5][6] While it is true that this is not likely the price that an insured patient would see at a pharmacy counter, 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. In a supportive letter submitted by the Maryland Health Benefit Exchange during last year's hearing on similar legislation, it was reported that prescription drugs represented nearly thirty percent of the total spending for privately insured markets in Maryland in 2020.[7] 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 particular issue, accounting for nearly 50% of CareFirst's total drug spending, as reported in 2020.[8] This is significant, as specialty drugs represent a growing share of the newly approved medications coming to market, and an increasingly high percentage of total spending, while remaining a small portion of prescriptions overall.[9] 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.[10] 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.

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[4] https://www.npr.org/sections/shots-health-news/2025/01/14/nx-s1-5250174/drug-prices-rise-drugmakers

[5] https://www.reuters.com/business/healthcare-pharmaceuticals/prices-new-us-drugs-rose-35-2023-more-than-previous-year-2024-02-23/

[6] https://www.pharmaceutical-technology.com/features/the-most-expensive-drugs-in-the-us/

[7] https://mgaleg.maryland.gov/cmte_testimony/2024/fin/17eRTCOIBruK5mTQ1fbnocZVtGu_wC10a.pdf

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

[9] https://www.pewtrusts.org/~/media/assets/2016/12/specialty_drugs_and_health_care_costs.pdf

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

Maryland's Leadership & Renewed Need for State-Level Action

In 2019, under the direction of this committee, the Maryland General Assembly created the nation's first Prescription Drug Affordability Board.[11] Despite obstruction to funding and government slowdowns during the COVID-19 pandemic, the Board has done considerable work to build the necessary infrastructure for a novel state agency. In the past year, we have seen incredible progress, with our Prescription Drug Affordability Board securing the authority to establish upper payment limits for prescription drugs purchased by state and local governments. The Board is currently focused on establishing appropriate rates for two drugs, Jardiance and Farxiga, which treat diabetes and heart disease. Upper payment limits on these drugs promise to bring notable relief to strained government budgets, as anti-diabetics represent the single biggest cost for the state employee health plan, with net spending increasing over 100% between 2020 and 2024 from $14.5 million to $29.3 million.[12] In addition to shouldering the cost of coverage for these products, our country's taxpayers also contributed a combined $870 million towards basic and applied research for these two medications, which have generated over $45 billion in sales and are currently priced over ten times higher in the United States than other countries around the world.[13]

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. Additionally, three other states—Colorado, Minnesota, and Washington—now have Prescription Drug Affordability Boards with statewide upper payment limit authority, with Colorado being the furthest along in their processes.

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, and we feel confident that the Board is fully equipped to operate with this expanded scope of authority. When reviewing a prescription drug, the Board will consider a

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

[12] https://pdab.maryland.gov/Documents/comments/MD%20PDAB%20Selected%20Drugs%20Comments_AFSCME%20Maryland.pdf

[13] https://pdab.maryland.gov/Documents/comments/2025/Written%20Comment%20Packet%201.27%20Board%20Meeting%20%281%29.pdf

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 opaque rebate process and ensuring that lower costs benefit consumers.

The need for action on prescription drug affordability is more urgent than ever, particularly as we face budgetary pressures in Maryland and unknown federal threats. While we do not yet know what the Trump administration will do in terms of prescription drugs, early actions have not been promising. Executive orders have killed a Biden-era program that was to guarantee $2 generic drugs for seniors, limited the Affordable Care Act's open enrollment period for the uninsured, and have frozen critical grantmaking for health research—all of which contribute to a weaker health care system. Furthermore, while the Medicare negotiation provisions of former President Biden's Inflation Reduction Act have additional protections from repeal due to being established through legislation, there are no guarantees that the Trump administration will uphold these strong negotiation practices with manufacturers. Maryland must act to enshrine the authority it needs to make prescription drugs more affordable for our state residents.

Improvements to the Legislation

Following the introduction of similar legislation in the 2024 General Assembly Session, the lead sponsors have worked together with advocates and government entities to improve the mechanics of this bill and to assuage some of the opposition's concerns.

As mentioned previously, 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 July of 2025, the state should be able to see immediate projected savings from this first step. We heard from concerned parties that expansion should not occur until the Board has generated measurable cost savings to the state. To ensure these protections, we have added a provision that this expanded authority cannot be utilized until the Board has implemented upper payment limits for state and local governments on two prescription drug products that have been in effect for at least one year. By granting the Board this expanded authority now with this safety measure in place, 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.

We also heard from opposition their concern that cost savings from a statewide upper payment limit will not reach consumers, instead being absorbed by lower members of the supply chain. It is important to note that we also wholeheartedly share the intention that the savings generated reach the patients' pockets. We are confident that upper payment limits can accomplish this goal, both increasing transparency along the supply chain and eliminating the need for the opaque

rebate practices that are pervasive in our current system. In our ongoing work with the Maryland Health Benefit Exchange and the Maryland Insurance Administration, we feel confident that generated cost savings will reach the consumer through lowered pressure on premiums and out-of-pocket costs thanks to protections for Marylanders like the annual insurance rate review and Medical Loss Ratio constrains. The Medical Loss Ratio constraints imposed on health plans since the 2010 Affordable Care Act require that insurers spend 80-85% of premium dollars on medical coverage versus administrative or self-enriching expenditures. With comprehensive annual rate reviews that could include assessment of how upper payment limits have been implemented and used to benefit members, we are confident that the Maryland Insurance Administration has the authority it needs to ensure that savings reach consumers directly.

Opposition also regularly voices concerns about the unintended consequences of upper payment limits, with claims that state regulation could limit access to these medications, inhibit innovation, or threaten jobs in Maryland production facilities. Quite frankly, I am more concerned about the active consequences of egregiously priced medications and the harm these costs place on our state's residents. But it is also important to note that these claims are largely unfounded and used as a scare tactic. The fact of the matter is that while pharmaceutical corporations claim that these prices are needed to offset the costs of research and development, many of these companies routinely invest significantly more in self-enriching activities than on innovation.[14] A recent Gonzales poll shows that an overwhelming 83% of Marylanders believe that pharmaceutical companies could lower their costs to patients without harming innovation, simply by reducing spending on advertising.[15] This is something to remember for those who tune into the Super Bowl this weekend, where spots sold for an estimated average of $7 million per ad and viewers will notice an increase in appearances from the pharmaceutical industry.[16] Our state is further protected by consumer protection provisions of Maryland Commercial Law Code, which prohibits advertising consumers goods without the intent to sell—meaning, manufacturers that threaten to withhold prescription drugs with established upper payment limits would have to exit the mid-Atlantic media market. Finally, we must be clear that the Board's mission is not to restrict profits, but rather to ensure that the basic health needs of Marylanders are met without unnecessary financial hardship. The Board is able to carefully monitor economic situations and adjust practices based on changing market conditions, ensuring that it can protect consumers without dismantling the industry.

Finally, I anticipate that some Members may have questions regarding the outstanding Board report that is currently due to this Committee on or before December 1, 2026, which is set to outline the legality, obstacles, and benefits of setting statewide upper payment limits. When this

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

[15] https://healthcareforall.com/wp-content/uploads/2025/01/Gonzales-Report-Marylanders-Citizens-Health-Initiative-January-2025.pdf

[16] https://www.cnbc.com/2025/01/29/fox-super-bowl-ad-price.html

report was first required in 2019, the idea of an upper payment limit or rate-setting mechanism was truly a novel concept. In the years since, we collectively have considerably more information on this process, and it is a different landscape. Since the law's passage, three other states—Colorado, Minnesota, and Washington— have established Prescription Drug Affordability Boards with full statewide authority. While an upper payment limit has yet to be established, Colorado is considerably advanced in the process and is likely set to one this year. Additionally, the Medicare Maximum Fair Price negotiation practices of the Inflation Reduction Act provide a strong framework for how rate-setting could be completed. And, most importantly, our Board has spent the last several years establishing the processes for state and local government upper payment limits, shedding considerable light on how broader action could be accomplished in Maryland. It is also worth recognizing that we have seen alarming trends in drug spending since 2019. While industry partners will claim that out-of-pocket costs have remained relatively stagnant over the last few years, that is largely attributable to the growing number of available generic products. When we look more closely, we can see that drug spending is heavily driven by a small number of expensive products, with the cost of specialty drugs increasing 43% between 2016 and 2021.[17] We also know that these price increases on brand name drugs directly affect the out-of-pocket burdens to many patients with insurance plans that include deductibles or coinsurance.[18] The urgency of the moment is upon us; we should not let a report envisioned by the MGA seven years ago hold the PDAB back from bringing relief to more Marylanders as soon as possible. Logistically, we have enough learned experiences to move forward without this report, particularly considering the provision delaying implementation of expanded authority.

While I applaud our Prescription Drug Affordability Board for its work so far, the truth remains that without this legislation, it still can 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.

This session, we once again have an opportunity to help Marylanders struggling to afford the medications they need. In a time when household and state budgets are stretched thin, we must 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 357.

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[17] https://aspe.hhs.gov/sites/default/files/documents/88c547c976e915fc31fe2c6903ac0bc9/sdp-trends-prescription-drug-spending.pdf

[18] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2779442

Allen 2025 SB#357 Favorable.pdf
Uploaded by: Susan Allen
Position: FAV

Date of Hearing 2/6/2025
FR: Susan Allen
3463 Rockway Avenue, Annapolis, MD 21403
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Prescription Drug Affordability Board - Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act)

TESTIMONY ON SB#357- POSITION: FAVORABLE

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

FROM: Susan Allen

OPENING: **My name is Susan Allen. I am a resident of 30A Anne Arundel County. I am submitting this testimony in support of SB#357, (Lowering Prescription Drug Costs for All Marylanders Now Act)**

I am the Policy Lead of the Maryland Poor People's Campaign (MD PPC), as well as a member of Anne Arundel Connecting Together, the Episcopal Policy Network, and Jews United for Justice. I connect with many organizations who care about poor, low-wealth, disabled and working-class Marylanders.

I want to say upfront that my husband and I are struggling with prescription drug insurance coverage and are now paying 30% of prescription costs under Medicare Part D. The state threw us off the Retired State Employees prescription drug plan (SilverScript) and we now are forced into the open market for supplemental prescription drug plans.

If ordinary middle-class Marylanders like my husband and I are struggling, we can only imagine what the most vulnerable citizens face as they struggle to pay for expensive, life-sustaining prescriptions.

Overall, this bill will decrease drug costs on prescriptions that Marylanders desperately need- especially families with children, working adults, older citizens, and people with disabilities.

As a member of the MD PPC that bases its actions on poverty data, we know that this Board should have been implemented in 2019 so that Marylanders would have been paying lower costs for more than 5 years.

My moral tradition emphasizes the importance of **affordable health care** to support the common good and **PREVENT POVERTY AND BANKRUPTCY.** Poor and working Marylanders have testified about the large health care gap between vulnerable people and people with health care funded by employers. Most Americans use government-supported prescription drug payments, low- and moderate-income people of every ethnicity need them more.

To sum up, I support SB#357 **Lowering Prescription Drug Costs for All Act** because AFFORDABLE costs will protect many vulnerable Marylanders from harm and suffering.

I respectfully urge this committee to return a favorable report on SB#357

Susan Allen

SB 357 Prescription Drug Affordability Board Autho

Uploaded by: Tammy Bresnahan

Position: FAV

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SB 357 Prescription Drug Affordability Board – Authority for Upper Payment Limits
(Lowering Prescription Drug Costs for All Marylanders Now Act)
February 6, 2025
Senate Finance Committee
FAVORABLE

Good afternoon, Chair Beidle and Members of the Senate Finance Committee. I am Tammy Bresnahan; I am the Senior Director of Advocacy for AARP Maryland. I am submitting this testimony on behalf of AARP Maryland and its more than 850,000 members in Maryland, with an emphasis on the growing population of aging Marylanders who face significant challenges related to prescription drug affordability. We stand in strong support of SB 357, which authorizes the Prescription Drug Affordability Board to set upper payment limits for prescription drugs that pose an affordability challenge for consumers, employers, and the state. We thank Senator Gile for sponsoring this important piece of legislation.

The Burden of Prescription Drug Costs on Aging Marylanders
Maryland's aging population is rapidly increasing, and with it, the number of older adults who depend on life-saving and chronic condition management medications. According to recent reports, nearly nine in ten older adults take at least one prescription medication, and four in ten take five or more daily medications. For many older Marylanders living on fixed incomes or Social Security benefits, rising drug prices threaten their ability to maintain their health and financial stability.

- In 2022, more than 25% of Maryland seniors reported skipping doses or forgoing necessary medications due to cost.
- High drug prices disproportionately affect older individuals managing chronic diseases, such as diabetes, arthritis, heart disease, and cancer. These conditions often require long-term medication use, amplifying the financial strain.
- The Maryland Department of Aging projects that by 2030, nearly one in four Marylanders will be 60 years or older, further intensifying the need for systemic drug cost reforms as the population between 50 and 64 most often lack health insurance and prescription drug coverage as they are not Medicare eligible.

Why HB 424 Is Critical
The Prescription Drug Affordability Board was established to help address skyrocketing prescription drug prices for state and local government but its authority to set upper payment limits (UPLs) for all Marylanders is a key missing piece that HB 424 seeks to correct.

The Board's Comprehensive UPL Process
The Prescription Drug Affordability Board has demonstrated, with its knowledgeable staff and five appointed members, has worked diligently to develop a well-considered process for state and local governments. Their proposed upper payment limit process is among the most comprehensive to date, covering the entire supply chain and offering greater transparency. The Board's unanimous vote to adopt the UPL Action Plan is this past fall, especially considering federal developments, such as Medicare's new drug pricing negotiations under the Inflation Reduction Act.

Currently, two drugs under Medicare's Maximum Fair Price program are being reviewed by the Maryland Prescription Drug Affordability Board. With the approval of the UPL Action Plan, Maryland could align state upper payment limits with federal rates, potentially influencing prescription drug negotiations for state and local governments.

The UPL Action Plan, formed through a fair and thorough public discussion process, aims to efficiently establish upper payment limits while ensuring all stakeholders have ample opportunity to participate. Additionally, the plan includes safeguards to ensure that drugs under review for upper payment limits remain available to Maryland consumers.

Addressing the Opponents' Arguments
Some may argue that establishing UPLs could reduce drug availability or discourage pharmaceutical innovation. However, numerous studies show that responsible cost regulation has little to no impact on innovation and instead encourages pricing transparency. Furthermore, UPLs will be thoughtfully implemented under the Board's oversight, with considerations for potential shortages and public health needs.

Conclusion
For the thousands of aging Marylanders struggling under the weight of high prescription drug prices, SB 357 is not just a policy proposal—it is a lifeline. This legislation will provide immediate and long-term relief for seniors who have worked hard their entire lives and deserve to age with dignity, security, and access to affordable medications. We respectfully ask the Committee to support SB 357 and ensure that all Marylanders, especially older adults, have equitable access to the medications they need without sacrificing their financial well-being. Thank you for considering this testimony in support of this crucial legislation. If you have questions or follow up, please contact me at tbresnahan@aarp.org or by calling 410-302-8451.

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Uploaded by: Vincent DeMarco
Position: FAV

TESTIMONY IN SUPPORT OF SENATE BILL 357
Prescription Drug Affordability Board - Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act)
Before the Senate Finance Committee
By Vincent DeMarco, President, Maryland Health Care For All! Coalition
February 6, 2025

Madam Chair, Mr. 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 357. 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 (PDAB) 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 357 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.

On October 22, 2024, the Legislative Policy Committee approved the PDAB's plan to use upper payment limits to make high cost drugs more affordable for state and local governments. Now, after doing terrific work under the leadership of Chair Van Mitchell and Executive Director Dr. Andrew York, the PDAB is poised to use this authority to put upper payment limits on what state and local governments pay for at least two high cost prescription drugs, which will save these entities, and therefore Maryland taxpayers, millions of dollars. Though this is very important and landmark work, Marylanders need you to enact SB 357 so that those who cannot afford the life-saving drugs prescribed to them or have to give up other necessities in order to purchase them, or who are seeing high health insurance premiums due to the exorbitant cost of prescription drugs, also see the benefits of the PDAB's work.

As you know very well, drugs don't work if people can't afford them. As you can see from the attached poll 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.

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The drug corporations say that they charge these exorbitant prices in order to pay for necessary research. However, as the two attached reports and chart from Public Citizen make clear, the drug corporations spend many billions more on advertising and profits and other self-enriching expenditures than they do on research. And Marylanders understand this, as you can see in the attached poll by Gonzales Polls, Inc, showing that over 80 percent of Marylanders believe the drug corporations could make these high cost drugs more affordable if they spent less on advertising and profits.

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 Maryland's local leaders urge you to enact SB 357. Attached is a letter from our state's local leaders expressing support for giving the PDAB full authority to help all Marylanders and you can view a video compilation of the local leader's support linked here.

While we are pleased with the progress the PDAB has made so far, 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. We strongly urge a favorable report on SB 357.

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Maryland Prescription Drug Affordability Coalition

Profits Over Patients

We've long heard the argument that drug corporations need to charge excessive prices in order to fund research and development, but an examination of their spending shows what they truly prioritize: maximizing profits.

$22B more

82%

A majority of Americans think that drug costs are unreasonable

The manufacturers of the 10 drugs selected for Medicare negotiation spent $22 billion more on advertising and self-enriching expenditures than research & development

Executive pay for those manufacturers exceeded $560 million, with much coming from equity awards, which incentivizes inflated stock values

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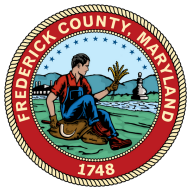
Maryland Health Care for All








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 Calvin 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.

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Farxiga

Maryland is working to support affordability through its Prescription Drug Affordability Board, while advocates press for the expansion of this authority to help more residents. Among the drugs up for review by the PDAB is Farxiga (dapagliflozin). Farxiga is manufactured by AstraZeneca and is used to treat diabetes, heart failure, and chronic kidney disease.

Farxiga has brought in more than $20 billion in revenue for AstraZeneca. As AstraZeneca reaped huge profits by charging Americans ten times more than it charges comparable countries, the company spent billions on self-enriching activities like executive compensation and dividends (a way publicly traded companies return cash to investors).

AstraZeneca has generated over $20.9 billion in sales revenue from Farxiga since its launch in 2014.

- Revenues obtained by AstraZeneca through Farxiga sales are nearly **30 times** the median cost for research and development of a new drug estimated by experts.

AstraZeneca charges Americans the highest price in the world for Farxiga.

- Farxiga's list price is $582 for a 30-day supply — this is 10.8 times higher than the average price across comparable countries ($54), according to a recent analysis.

AstraZeneca ripping us off is even more egregious considering significant taxpayer contributions to research prior to the approval of Farxiga, including $437.3 million[1] in NIH funding for basic and applied research.[2]

AstraZeneca uses predatory patenting tactics to expand monopoly protections over Farxiga. This staves off generic competition — a proven way to lower prices — keeping prices higher, longer.

- According to Public Citizen research, the patent protection for some of the more recent indications of Farxiga related to heart failure expires as late as 2040 — almost 14 years after the patent covering the drug substance expires and 26 years after the drug's initial approval.

AstraZeneca spends huge sums on payouts to executives and shareholders, rather than R&D.

- In 2023 alone, AstraZeneca spent $4.5 billion paying dividends and maintaining its exorbitant executive compensation.

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[1] Zhou et al. identified PubMed publications related to the drug target or the drug and subsequently identified NIH grants associated with the publications. Basic research funding was totaled through the date of approval of a first-in-class product associated with that target (in the case of Farxiga and Jardiance (which both target SGLT2), the first-in-class drug approval was Invokana (canagliflozin) in 2013). Thus, the funding total applies to multiple drugs.
See, https://www.ineteconomics.org/uploads/papers/WP_219-Federal-spending-on-drugs-Ledley-et-al-final.pdf

[2] NIH support for biomedical research is largely focused on basic research (the foundational research on biological targets for drug action that drug development is based upon). A smaller proportion goes toward applied research (research associated with later-stage development of a drug). See, https://www.bmj.com/content/367/bmj.l5766

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Jardiance

Maryland is working to support affordability through its Prescription Drug Affordability Board (PDAB), while advocates press for the expansion of this authority to help more residents. Among the drugs up for review by the PDAB is Jardiance (empagliflozin). Jardiance is sold by Boehringer Ingelheim and Eli Lilly and is used to treat diabetes and heart failure.

As Boehringer Ingelheim and Eli Lilly reaped huge profits by charging Americans over 11 times more than they charge comparable countries for Jardiance, Eli Lilly spent billions on self-enriching activities like executive compensation, stock buybacks (a practice where a company repurchases shares, thereby inflating stock prices and enriching shareholders—including executives often paid in stock), and dividends (another way publicly traded companies return cash to investors).

Boehringer Ingelheim and Eli Lilly have made billions from Jardiance.

- Jardiance has generated **over $26.8 billion in sales since its launch in 2014.**
- Revenues obtained through Jardiance sales are nearly **38 times** the median cost for research and development of a new drug estimated by experts.

Boehringer Ingelheim and Eli Lilly charge Americans the highest price in the world for Jardiance.

- Jardiance's list price is $611 for a 30-day supply — this is 11.7 times higher than the average price across comparable countries ($52), according to a recent analysis.

Boehringer Ingelheim and Eli Lilly ripping us off is even more egregious considering significant taxpayer contributions to research prior to the approval of Jardiance, including $434.2 million[3] in NIH funding for basic and applied research.[4]

Boehringer Ingelheim uses predatory patenting tactics to expand monopoly protections over Jardiance. This staves off generic competition — a proven way to lower prices — keeping prices higher, longer.

- According to Public Citizen research, Boehringer Ingelheim's patents covering methods for screening patients for use of empagliflozin can be exploited to exclude generics until as late as 2034 — an extra five years beyond the expiry of the drug compound patent and almost 20 years beyond the drug's initial approval.

Eli Lilly[5] spends huge sums on payouts to executives and shareholders, rather than R&D.

- In 2023 alone, Eli Lilly spent nearly $6 billion enriching shareholders through stock buybacks and dividends, maintaining its exorbitant executive compensation, and advertising its products.
- Since 2017, Eli Lilly has spent an average of over $1 billion on advertising each year. This is more than the total retail sales for prescription drugs covered by Medicaid in Maryland in 2019.

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[3] Zhou et al. identified PubMed publications related to the drug target or the drug and subsequently identified NIH grants associated with the publications. Basic research funding was totaled through the date of approval of a first-in-class product associated with that target (in the case of Farxiga and Jardiance (which both target SGLT2), the first-in-class drug approval was Invokana (canagliflozin) in 2013). Thus, the funding total applies to multiple drugs.
See, https://www.ineteconomics.org/uploads/papers/WP_219-Federal-spending-on-drugs-Ledley-et-al-final.pdf

[4] NIH support for biomedical research is largely focused on basic research (the foundational research on biological targets for drug action that drug development is based upon). A smaller proportion goes toward applied research (research associated with later-stage development of a drug). See, https://www.bmj.com/content/367/bmj.l5766

[5] Eli Lilly and Boehringer Ingelheim commercialized Jardiance together, but the latter company is privately held. Thus, data on self-enriching activities is only available for Eli Lilly.

PROFITS OVER PATIENTS

Jishian Ravinthiran

January 16, 2024

PROTECT OUR CARE

PUBLICCITIZEN

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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

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[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 $55 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.

[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.

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.

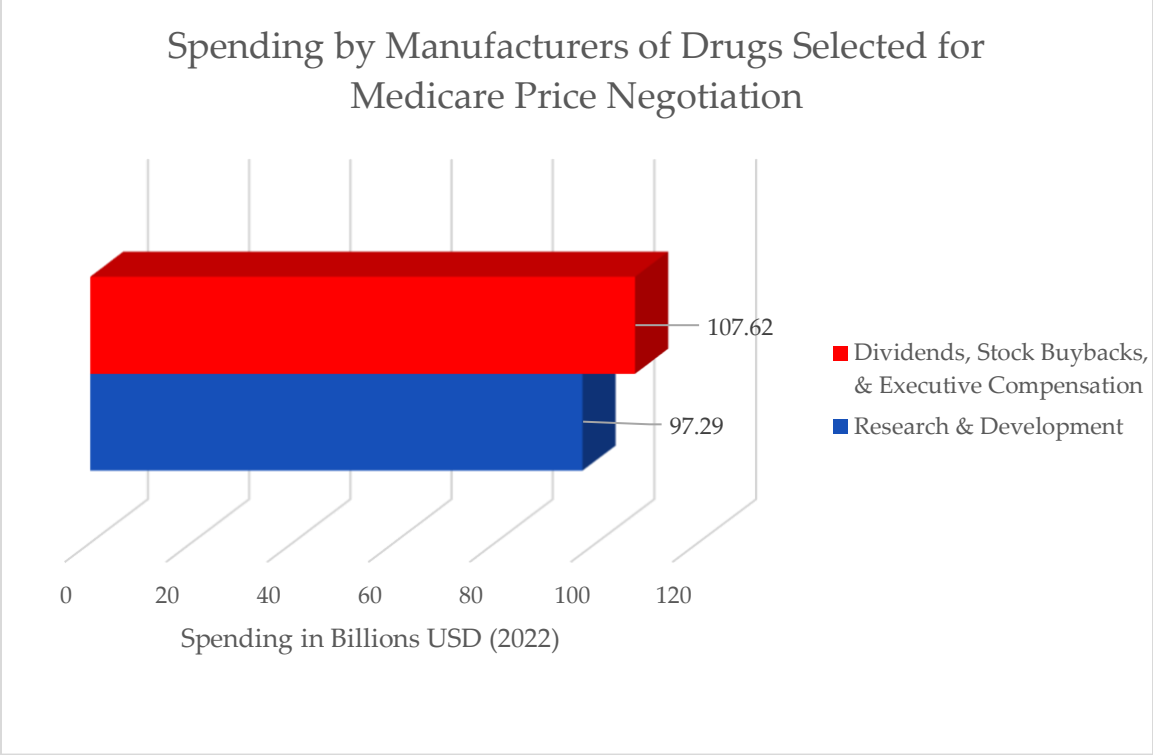
Table 2: Executive Compensation for the Manufacturers of Drugs Selected for Medicare Price Negotiation (in dollars)

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]

[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.

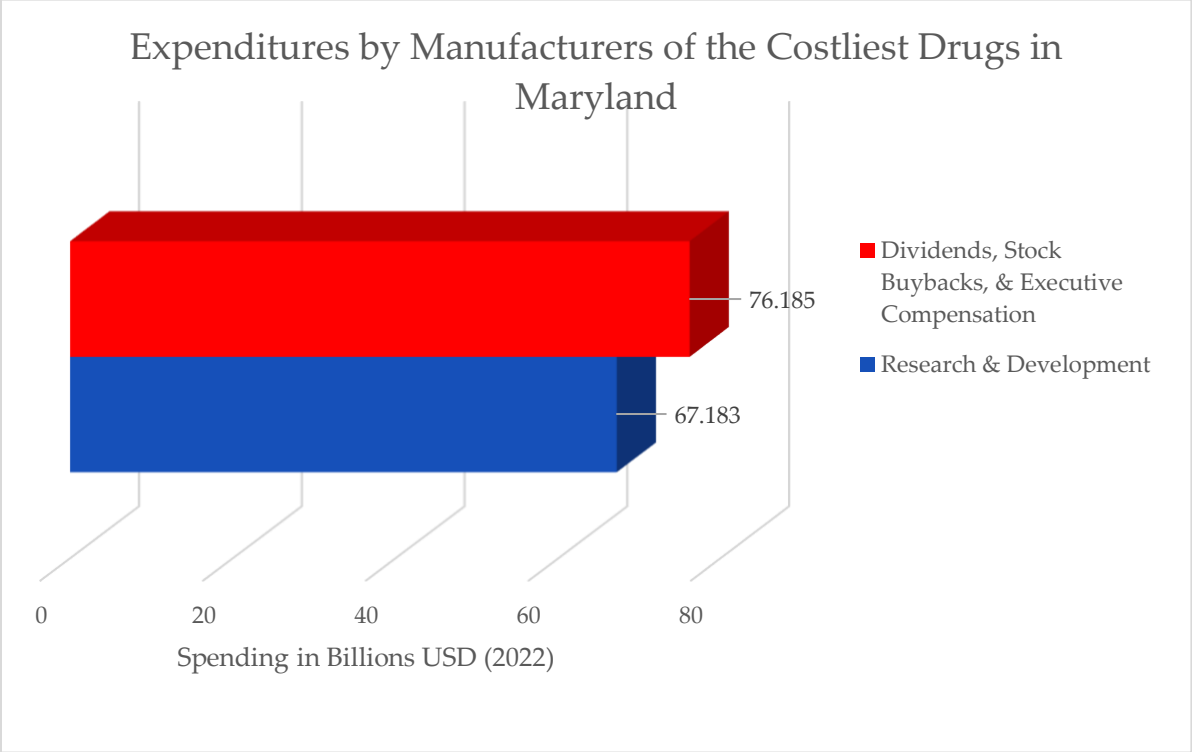
Like the manufacturers of the drugs selected for Medicare price negotiation, manufacturers of the ten costliest drugs in Maryland spent over half a billion dollars on executive compensation in just 2022 (see Table 4). For these companies, 60% of executive pay was based on equity awards, helping drive 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).

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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

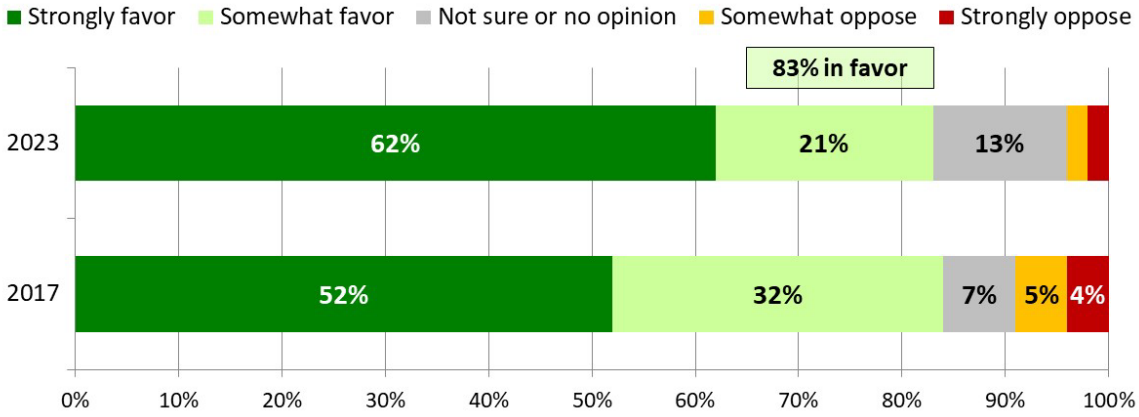
Prescription Drug Affordability Board: Strong and Growing Support among Maryland Voters

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.

Growing Support for Prescription Drug Affordability Board



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?

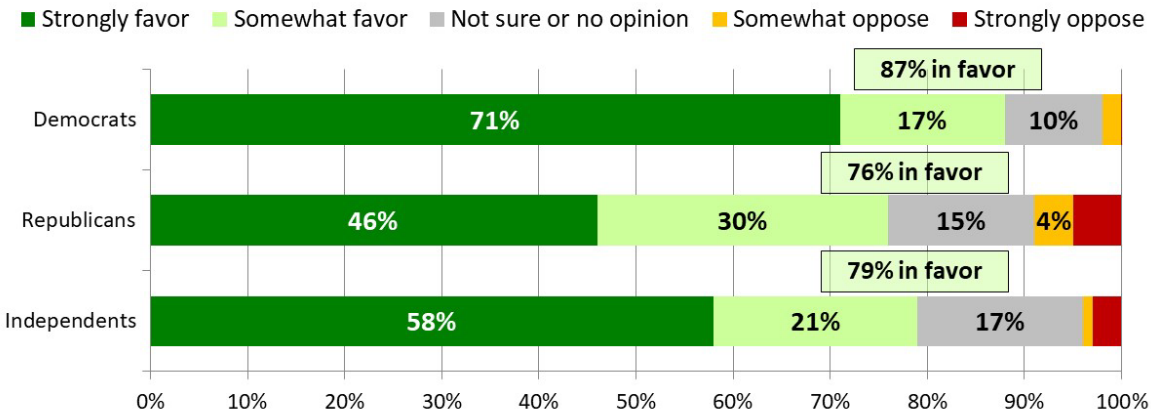
(Question asked with slightly different wording in 2017.)

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.

Prescription Drug Affordability Board

Support by Political Party

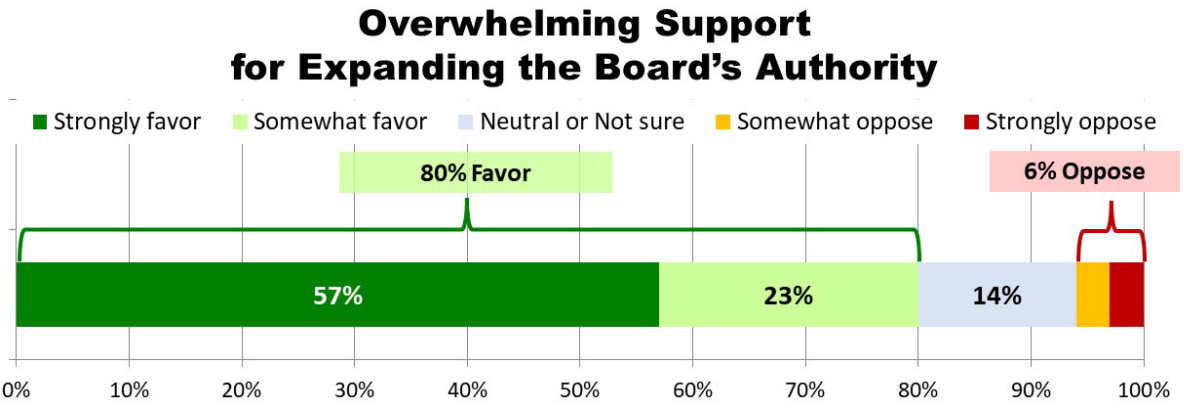


Based on this description, do you strongly favor, somewhat favor, somewhat oppose, or strongly oppose a Maryland Prescription Drug Affordability Board with the power to make high-cost drugs more affordable?

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

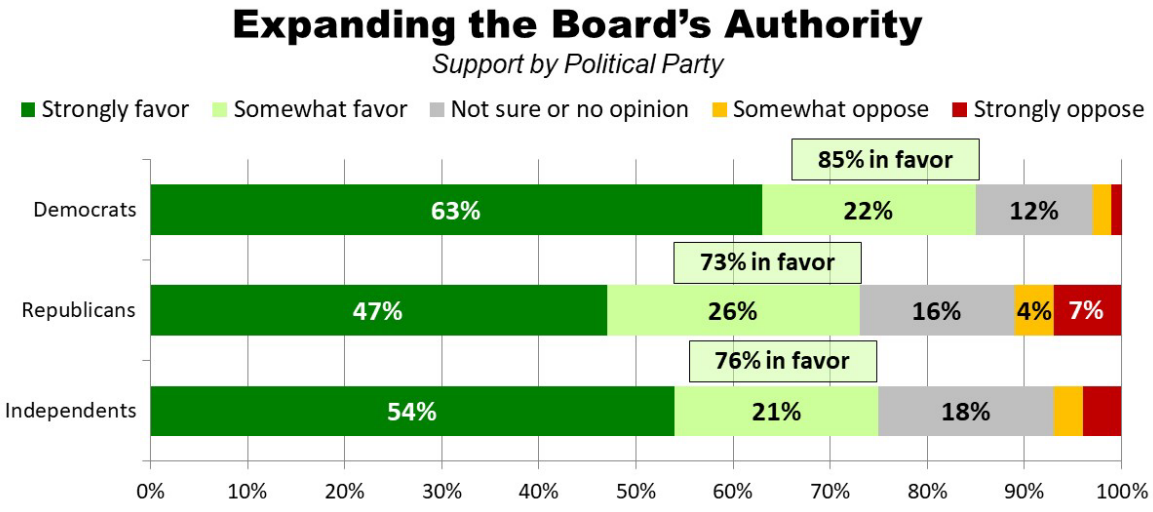
Currently, the Board only has the authority to limit high drug costs for state and local governments, not for most average Marylanders. Thinking forward, voters strongly favor expanding the Board's authority much further to limit high drug costs for all Marylanders.

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?"

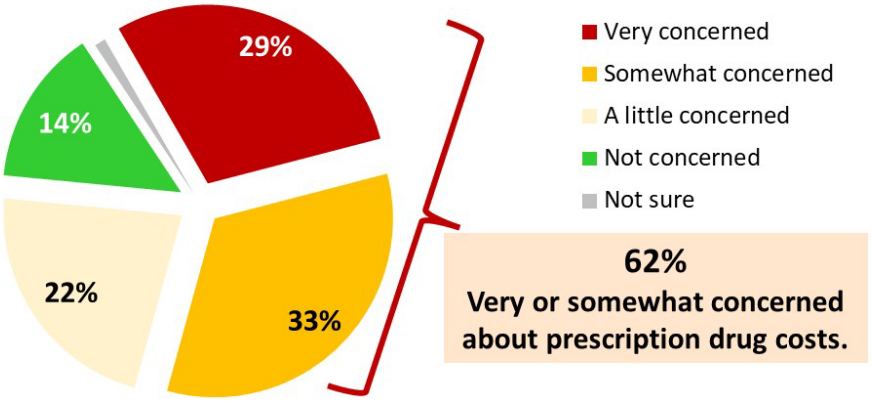
(Rotate order of next two questions):
"If you learned that the Democratic candidate in your legislative district supported expanding the authority of the Prescription Drug Affordability Board while the Republican candidate opposed it, who would you be more likely to vote for (rotate): the Democratic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

Personal Concern about Prescription Drug Costs

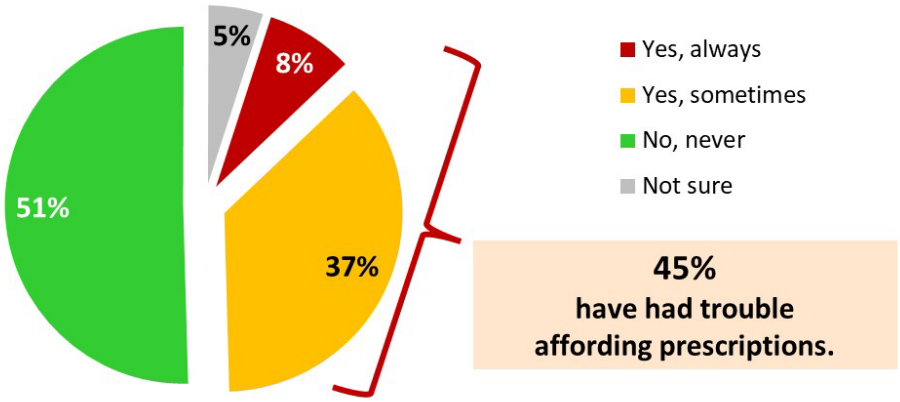


How much does the cost of prescription drugs concern you, personally? Would you say you are very concerned personally, somewhat concerned, a little concerned, or not personally concerned about it?

Trouble Affording Prescription Drugs

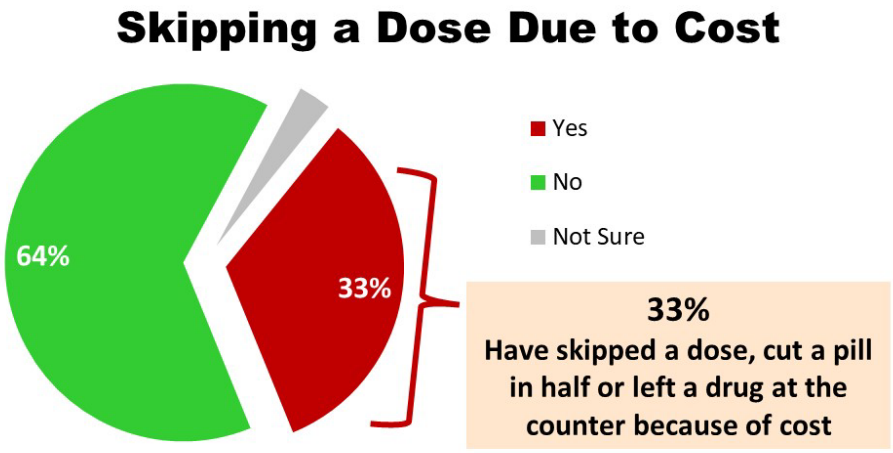
This concern about prescription drugs is often founded on personal experience. A sobering 45% of Marylanders – nearly half – indicated that they always or sometimes have had trouble affording prescription medications.

Trouble Affording Prescription Medications



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

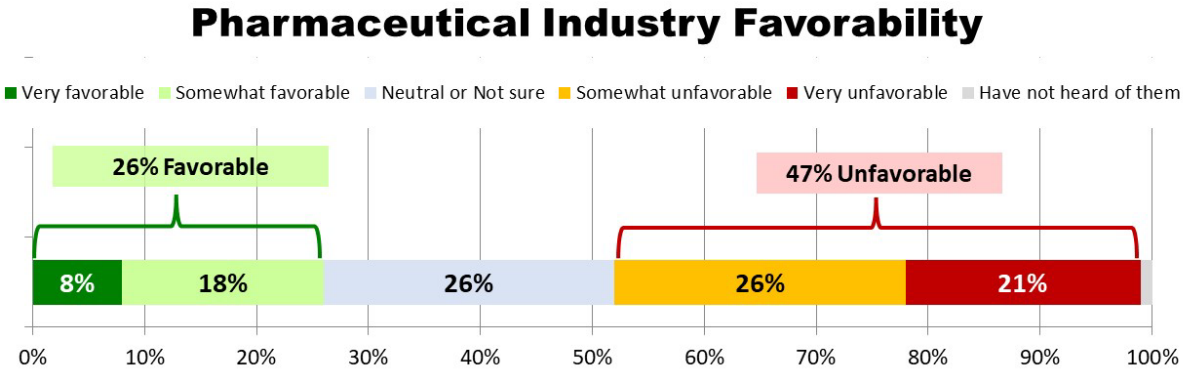
This is manifested in the real-life outcome that one-third (33%) of Marylanders said they have "skipped a dose, cut a pill in half, or left a drug at the counter" *because of cost*.



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.



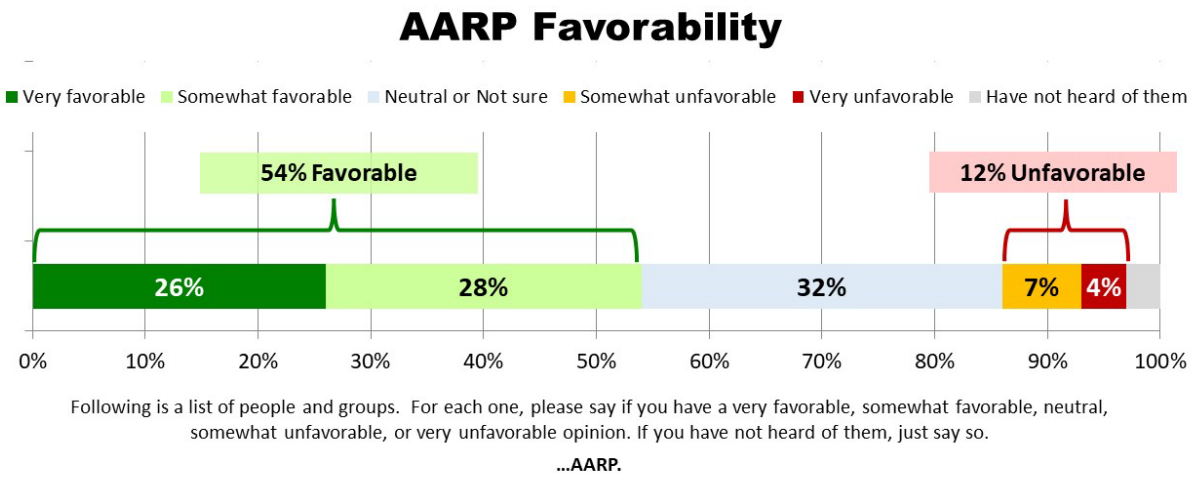
Following is a list of people and groups. For each one, please say if you have a very favorable, somewhat favorable, neutral, somewhat unfavorable, or very unfavorable opinion. If you have not heard of them, just say so.

...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.

GONZALES Polls, Inc.

MARYLAND POLL

January 2025

Table of Contents

Background and Methodology

Patrick E. Gonzales graduated magna cum laude from the University of Baltimore with a degree in political science.

His career in the field of public opinion research began in the mid-1980s as an analyst with *Mason-Dixon Opinion Research*. During this time, Mr. Gonzales helped develop, craft and implement election surveys and exit polls for television and radio in the Baltimore-Washington D.C. metro area.

Mr. Gonzales has polled and analyzed thousands of elections in Maryland and across the country over the past forty years. Further, he and his associates have conducted numerous market research projects, crafting message development plans and generating strategy blueprints for businesses and organizations throughout the state.

Over his decades of conducting public opinion polls, Patrick Gonzales has been widely recognized by his peers for his ability to conduct unbiased surveys, and analyze the results in an impartial, evenhanded manner.

Mr. Gonzales appears frequently on radio and television in the Baltimore-D.C. region as a guest commentator.

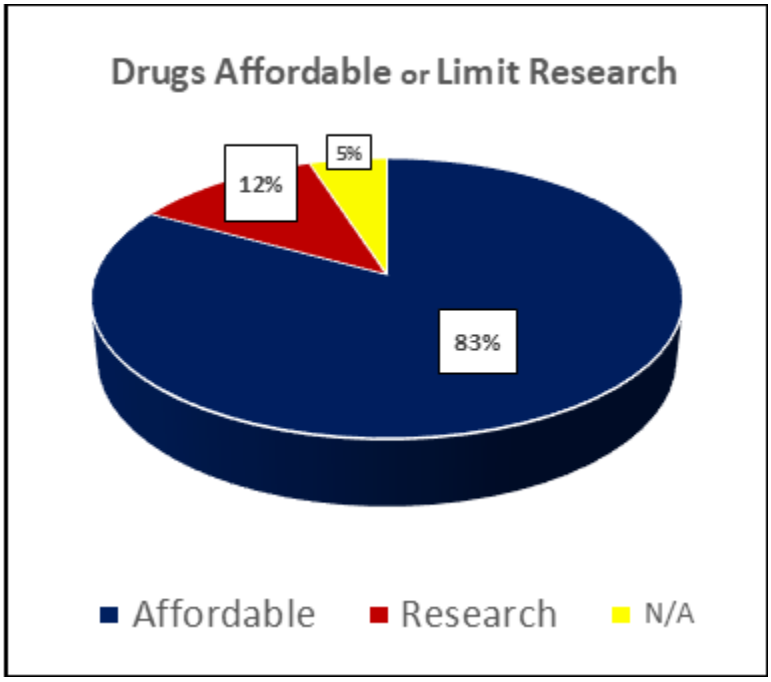
This poll was conducted by ***Gonzales Research & Media Services, Inc.*** from December 27th, 2024 through January 4th, 2025. A total of 811 registered voters in Maryland, who indicated they are likely to vote in the next election, were queried by live telephone interviews, utilizing both landline and cell phone numbers. A cross-section of interviews was conducted throughout the state, reflecting general election voting patterns.

The margin of error (MOE), per accepted statistical standards, is a range of plus or minus 3.5 percentage points. If the entire population was surveyed, there is a 95% probability that the true numbers would fall within this range.

Gonzales Maryland Poll – January 2025 Results

Maryland Citizens' Health Initiative – Drug Affordability

Among Maryland voters, a sweeping 83% align more closely with the belief that drug companies can afford to make their drugs less expensive, given their inflated profits and exorbitant spending on advertising; while only 12% think that capping the prices drug companies can charge for prescriptions would constrain their ability to finance research for new medications, with 5% providing no opinion.



Hefty majorities in every demographic subgroup side with the belief drug corporations can easily afford to make their drugs more affordable.

	Make Drugs Affordable	**Research**
Statewide	83%	12%
Democrat	90%	7%
Republican	76%	17%
Independent	73%	17%
White	83%	11%
African American	83%	13%
Other	82%	15%
Women	84%	10%
Men	81%	13%
18-34	92%	6%
35-49	78%	15%
50-64	82%	13%
65 and older	80%	12%
Rural Maryland	83%	12%
Baltimore City	90%	8%
Baltimore Suburbs	82%	12%
Washington Suburbs	82%	13%

Appendix A: Data Tables

QUESTION: Drug Affordability *Which of the following two statements comes closer to your belief?* **(ORDER ROTATED)**

1. Drug corporations make inflated profits and spend excessively on advertising. They can easily afford to make their drugs more affordable.

or

2. Limiting what drug corporations can be paid for expensive prescriptions would limit their ability to fund research for new drugs.

MAKE AFFORDABLE or NEW RESEARCH	Number	Percent
Make Drugs Affordable	670	82.6 %
Need New Research	97	12.0 %
No answer	44	5.4 %
Total	811	100.0 %

N=811	MAKE AFFORDABLE or NEW RESEARCH		
	Make Drugs Affordable	Need New Research	No answer
RESULTS			
Statewide	670 82.6%	97 12.0%	44 5.4%

N=811	MAKE AFFORDABLE or NEW RESEARCH		
	Make Drugs Affordable	Need New Research	No answer
PARTY REGISTRATION			
Democrat	386 89.6%	31 7.2%	14 3.2%
Republican	170 75.9%	39 17.4%	15 6.7%
Unaffiliated	114 73.1%	27 17.3%	15 9.6%

N=811	MAKE AFFORDABLE or NEW RESEARCH		
	Make Drugs Affordable	Need New Research	No answer
RACE/ETHNICITY			
White	393 82.6%	52 10.9%	31 6.5%
African American	202 82.8%	31 12.7%	11 4.5%
Other/No answer	75 82.4%	14 15.4%	2 2.2%

N=811	MAKE AFFORDABLE or NEW RESEARCH		
	Make Drugs Affordable	Need New Research	No answer
GENDER			
Female	367 84.0%	45 10.3%	25 5.7%
Male	303 81.0%	52 13.9%	19 5.1%

N=811	MAKE AFFORDABLE or NEW RESEARCH		
	Make Drugs Affordable	Need New Research	No answer
AGE			
18 to 34	134 92.4%	9 6.2%	2 1.4%
35 to 49	156 78.4%	30 15.1%	13 6.5%
50 to 64	197 82.4%	30 12.6%	12 5.0%
65 and older	183 80.3%	28 12.3%	17 7.5%

N=811	MAKE AFFORDABLE or NEW RESEARCH		
	Make Drugs Affordable	Need New Research	No answer
REGION			
Rural Maryland	104 82.5%	15 11.9%	7 5.6%
Baltimore City	56 90.3%	5 8.1%	1 1.6%
Baltimore Suburbs	261 82.1%	37 11.6%	20 6.3%
Washington Suburbs	249 81.6%	40 13.1%	16 5.2%

Appendix B: Maryland Poll Sample Demographics

AGE	Number	Percent
18 to 34	145	17.9 %
35 to 49	199	24.5 %
50 to 64	239	29.5 %
65 and older	228	28.1 %
Total	811	100.0 %

PARTY REGISTRATION	Number	Percent
Democrat	431	53.1 %
Republican	224	27.6 %
Unaffiliated	156	19.2 %
Total	811	100.0 %

RACE/ETHNICITY	Number	Percent
White	476	58.7 %
African American	244	30.1 %
Other/No answer	91	11.2 %
Total	811	100.0 %

GENDER	Number	Percent
Female	437	53.9 %
Male	374	46.1 %
Total	811	100.0 %

REGION	Number	Percent
Rural Maryland	126	15.5 %
Baltimore City	62	7.6 %
Baltimore Suburbs	318	39.2 %
Washington Suburbs	305	37.6 %
Total	811	100.0 %

Regional Groupings

Rural Maryland – includes Allegany, Calvert, Caroline, Cecil, Dorchester, Garrett, Kent, Queen Anne's, St. Mary's, Somerset, Talbot, Washington, Wicomico, and Worcester counties.

Baltimore City – includes Baltimore City.

Baltimore Suburbs – includes Anne Arundel, Baltimore, Carroll, Harford, and Howard counties.

Washington Suburbs – includes Charles, Frederick, Montgomery, and Prince George's counties.

SB357_Slide_VinnyDeMarco
Uploaded by: Vincent DeMarco
Position: FAV

Maryland Prescription Drug Affordability Coalition

Profits Over Patients

We've long heard the argument that drug corporations need to charge excessive prices in order to fund research and development, but an examination of their spending shows what they truly prioritize: maximizing profits.

$22B more

82%

A majority of Americans think that drug costs are unreasonable

The manufacturers of the 10 drugs selected for Medicare negotiation spent $22 billion more on advertising and self-enriching expenditures than research & development

Executive pay for those manufacturers exceeded $560 million, with much coming from equity awards, which incentivizes inflated stock values

PUBLICCITIZEN

PROTECT OUR CARE

Maryland Health Care for All

SB357.Rx.PDAB.25.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 Bill 357
In Support Of
Prescription Drug Affordability Board – Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act of 2025)
Finance Committee
Hearing: February 6, 2025 – 1:00 p.m.

Dear Honorable Senator Pamela Beidle, Chair, Senator Antonio Hayes, Vice Chair, and distinguished Finance Committee members,

The Maryland Retired School Personnel Association (MRSPA) supports SB357.

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 357 The Lowering Prescription Drug Costs For All Marylanders Now Act of 2025.

Sincerely,

Elizabeth H. Weller
President

Virginia G. Crespo
Legislative Aide

SB 357 - PDAB - FIN - LOSWA (2).pdf
Uploaded by: Meghan Lynch
Position: FWA

Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

February 6, 2025

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401-1991

RE: Senate Bill (SB) 357 – Prescription Drug Affordability Board – Authority for Upper Payment Limits (The Lowering Prescription Drug Costs for All Marylanders Now Act) - Letter of Support with Amendments

Dear Chair Beidle and Committee Members:

The Maryland Department of Health (Department) respectfully submits this letter of support with amendments for Senate Bill (SB) 357 - Prescription Drug Affordability Board – Authority for Upper Payment Limits (The Lowering Prescription Drug Costs for All Marylanders Now Act).

SB 357 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 drugs in the State that the Board determines have led or will lead to affordability challenges, and authorizes the Board to reconsider an upper payment limit for a drug that becomes a current shortage.

The Department supports initiatives by PDAB that result in cost-savings to the State and consumers. However, the Department notes that the Maryland Medical Assistance Program (Medicaid) may need certain flexibilities before adopting upper payment limits established by PDAB in order to maximize savings.

The Department would need approval from the federal government to implement State-established upper payment limits for drugs covered by the Medicaid. Setting upper payment limits may conflict with the Medicaid Drug Rebates Program as well as the Covered Outpatient Drug Rule (CMS-2345-FC). Furthermore, setting upper payment limits could prevent the Department from getting federal and supplemental rebates for those specific drugs with upper payment limits. Costs for any drugs purchased out of compliance with the federal requirements will need to be covered with 100% State general funds. There may also be a negative impact on managed care organizations' ability to negotiate rates with vendors, increasing costs paid by the State through capitation rates. These factors would result in an indeterminate, but substantial fiscal impact on the Medicaid.

To address these contingencies, the Department is offering an amendment to give Medicaid the authority to approve upper payment limits that would apply to Medicaid-covered drugs and avoid any adverse impacts from the setting of upper payment limits.

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, Director of Governmental Affairs at sarah.case-herron@maryland.gov.

Sincerely,

Laura Herrera Scott, M.D., M.P.H.
Secretary

Attachment included

In the House Health and Government Operations Committee

AMENDMENTS TO HOUSE BILL 424
(First Reading File Bill)

On Page 7, after line 12, insert the following:

"(3) ANY DETERMINATION MADE UNDER PARAGRAPH (1) OF THIS SUBSECTION TO IMPLEMENT UPPER PAYMENT LIMITS FOR DRUGS COVERED BY THE MEDICAL ASSISTANCE PROGRAM SHALL REQUIRE THE APPROVAL OF THE MEDICAL ASSISTANCE PROGRAM, TO ENSURE THAT

(I) THERE ARE NO CONFLICTS WITH THE MEDICAID DRUG REBATES PROGR AM, THE COVERED OUTPATIENT DRUG RULE (CMS-2345-FC) AND ANY OTHER FEDERAL REQUIREMENTS AS NECESSARY; AND

(II) THE PROPOSED UPPER PAYMENT LIMITS DO NOT REQUIRE ADDITIONAL FUNDING TO BE ALLOCATED TO THE MEDICAL ASSISTANCE BUDGET."

SB357.MPhA.PDAB-combined.pdf
Uploaded by: Aliyah Horton
Position: UNF

MPhA
MARYLAND PHARMACISTS ASSOCIATION

Date: February 6, 2025
To: The Honorable Pamela Beidle, Chair
From: Aliyah N. Horton, FASAE, CAE, Executive Director, MPhA, 240-688-7808
Cc: Members, Senate Finance Committee
Re: **UNFAVORABLE - SB 357 – Prescription Drug Affordability Board - Authority for Upper Payment Limits**

The Maryland Pharmacists Association (MPhA) urges an **UNFAVORABLE report on SB 357 Prescription Drug Affordability Board - Authority for Upper Payment Limits.**

When looking at the breadth of the pharmaceutical services pipeline at the absolute end are pharmacists and patients. Pharmacists are THE healthcare providers right with patients when barriers to access arise, whether from prior-authorization challenges to the shock of out-of-pocket cost of medications. When we look at this pipeline, there are entities making billions of dollars a year and others are in financial crises. It is the pharmacy community and patients that bear the painful brunt of all the successes and decisions of the other players. This community does its best to support patient access to medications and positive health outcomes, even at their own financial detriment. It is not sustainable.

The Prescription Drug Affordability Board's (PDAB) effort to expand its authority, has potential negative impacts on the pharmacy community and ultimately patients. I have attached with my testimony a document developed by the National Alliance of State Pharmacy Associations and the Partnership for Safe Medicines entitled, *Five Years of Prescription Drug Affordability Boards – Broken Promises, Rising Costs, and Risks to Access.* It identifies some of the pharmacy community's concerns for pharmacy sustainability and patient access to medication and pharmacy services.

We appreciate the language to protect dispensing fees. However, the bill lacks a process to ensure that Upper Payment Limits (UPLs) will not force pharmacies to dispense medications below their acquisition cost.

The General Assembly must fully and finally address the role of PBMs and mitigate the impact of pharmacy underpayments. Pharmacies must have protected reimbursement mechanisms for dispensing fees AND drug acquisition costs, full stop.

- Pharmacies must be reimbursed for medications at a minimum level of the National Average Drug Acquisition Cost and afforded professional dispensing fees based on the Medicaid Fee-for-Service rate (which is based on a cost of dispensing survey report from the Maryland Department of Health).

MPhA urges the committee to stop the proposed UPLs from further destabilizing our already fragile pharmacy ecosystem.

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.

Five Years of Prescription Drug Affordability Boards

Broken Promises, Rising Costs, and Risks to Access

Prescription Drug Affordability Boards (PDABs) have been created in several states with the goal to lower prescription drug costs for patients. One of the oldest, Maryland's, is five years old, but they have yet to fulfill their promise to lower medicine costs. Even worse, the implementation of Upper Payment Limits appears likely to impact patient access to lifesaving medicines and financially harm vulnerable community pharmacies. This is becoming a political liability rather than an admirable solution.

Here is what five years of PDAB work has revealed about the flaws in the PDAB and Upper Payment Limit approach

During affordability reviews, many patients testify they already receive copay assistance to alleviate financial burdens.

As PDABs have conducted affordability reviews over the past two years, patient advocates have often testified that they receive co-pay support from manufacturer-sponsored patient assistance programs. For many patients, that equates to no out-of-pocket cost. The things that they do struggle with, such as pharmacy benefit manager/health plan structure, formulary placement, prior authorization, step therapy, and premium costs, are not within the scope of most PDAB's powers.

> *"We pay about $15 a month for this drug and there's so many co-pay assistance programs."*
>
> -Hannah Pfeiffer, Colorado Cystic Fibrosis patient taking Trikafta, a medicine studied for affordability by the CO PDAB.
>
> Stat News

Upper Payment Limits cannot relieve insured patients' cost burdens.

While most PDABs are looking to establish Upper Payment Limits on medicines, these have nothing to do with insurance plan design, which determines how much a patient pays for their medicine. A PDAB could cut the amount a wholesaler can sell the medicine for in half, and a patient with a $250 per month copay would still have the same copay or more despite the PDAB spending years accomplishing this because that's a function of PBM/insurance company plan design, not the price of the medicine.

> Upper Payment Limits set a ceiling for what an insurance company can reimburse the pharmacy for a medicine, not a floor. Under-reimbursements below cost of medicine threaten pharmacy survival and patient access to care.

Upper Payment Limits may worsen pharmacy reimbursement.

PDAB powers do not include forcing Pharmacy Benefit Managers to reimburse pharmacies at least at-cost for medicine, and many pharmacies are currently losing money on these medicines and cannot stock them. Even a guaranteed dispensing fee is not sufficient to keep pharmacies from losing money. Patient access to these medicines will be impacted when pharmacies cannot afford to dispense them.

Independent economic analysis of Upper Payment Limits shows that stakeholders across the supply chain believe it will harm their access to medications, and there's a significant chance it could increase medicine costs to state health plans by as much as 1%.

A focus on rare and chronic diseases results in discrimination against these patients.

PDABs have focused on the cost of medicines that treat rare and chronic diseases, but that's quite dan-

gerous. Some rare diseases have only one treatment, so if an Upper Payment Limit experiment creates access issues, patients will have no alternative.

Analysis of drugs targeted by PDABs shows that they heavily focus on medicines for conditions that are protected disabilities by the ADA. This overlap makes it likely that any Upper Payment Limit implementation is likely to be tied up in ADA litigation, even after it takes years to implement for a small portion of the patient population of any state.

More than 86% of the medicines targeted by PDABs in MD, CO, WA, and OR **are used to treat conditions highly likely or likely to be classified as disabilities under the ADA**. Patients assert this is a form of **legally actionable disability discrimination**.

Pharmacies will bear an impossible burden: when to charge a UPL and when to charge the normal price.

Not all patients' health plans will be subject to Upper Payment Limits. For example, federally funded health plans and employer sponsored plans that are self-funded will be exempt from the state UPLs. As one board testified to, "the pharmacy, as the entity dispensing the drug [..] is the one responsible for knowing when the UPL applies, and that is it." [see Amgen v CO PDAB]. This level of mystery is impossible for a pharmacy to resolve at the counter with a patient waiting for a prescription. Pharmacies will not be able to dispense medicines if they have no way of knowing what they are allowed to charge. The most likely result of this situation is pharmacies will stop carrying medicines with an Upper Payment Limit, and patients will lose access.

Five years on, if PDABs aren't the answer, what is?

At five years and counting, legislators that pushed PDAB legislation have not seen relief for patients and may harm access and create political backlash. What other measures could legislators examine?

West Virginia saves over $50 million in under two years

In 2017 West Virginia's Medicaid program removed their PBM who was profiting from hidden spread-pricing and instead started managing the pharmacy benefit themselves. Their program now covers over 550,000 enrollees through a fee-for-service model. This change led to a savings of $54.5 million in 2018.

Ohio targets $223.7 million with a transparent pharmacy benefit

In January 2019, Ohio implemented a transparent pass-through pricing model whereby the managed care plan would pay the PBM the exact amount paid to the pharmacy for the prescription drug, a dispensing fee and in lieu of spread-based revenue, an administrative fee.

Resources on Prescription Drug Affordability Boards

- National Alliance of State Pharmacy Associations PDAB resource page (pharmacy-specific concerns)
- Partnership for Safe Medicines PDAB resource page (supply chain risks of Upper Payment Limits)
- Community Access National Network (explainers, infographics, and videos about the risk to patient access)
- HealthHIV PDAB resource page (risk to HIV patients and HIV service providers)
- AIMED Alliance PDAB resource page (explainers and nationwide survey of PDABs)

NASPA NATIONAL ALLIANCE OF STATE PHARMACY ASSOCIATIONS

The Partnership for SAFEMEDICINES®

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SB0357 PDAB - Maryland Statement.pdf
Uploaded by: Brandi Chane
Position: UNF

My name is Brandi Chane with Pharmacists United for Truth and Transparency writing in opposition to SB0357.

Thank you for the opportunity to speak today. While this bill aims to lower drug prices, it fails to address key issues that will have **devastating consequences for pharmacies and the patients they serve**. Without addressing **wholesaler pricing, administrative burdens, patient access, and reimbursement challenges**, this bill risks doing more harm than good.

This bill does not regulate **wholesaler pricing** nor does it regulate PBM reimbursement practices. There is no infrastructure in this bill to ensure a pharmacy can purchase these drugs under the UPL. T**his bill does nothing to ensure that pharmacies are reimbursed fairly by a PBM**, meaning many will be forced to fill prescriptions at a loss. When pharmacies cannot sustain these financial losses, **they are forced to reduce services, limit drug inventory, or close their doors altogether**.

Beyond financial strain, this bill adds **new administrative burdens on pharmacies**, including increased processing time and a longer drug procurement process if medications aren't available at the designated UPL. Community pharmacies already struggle with burdensome PBM complexities like prior authorizations and clawbacks. More red tape means **less time for pharmacists to care for patients**, further straining already overwhelmed healthcare providers.

For patients, this bill **does not directly lower out-of-pocket costs** and may **reduce access to essential medications**. It does not control insurance copays, deductible costs, or premiums.

If pharmacies close due to unsustainable pricing and reimbursement policies, patients—especially in rural and underserved areas—**will have to travel farther, wait longer, and may struggle to get the medications they need**. A law designed to make medications more affordable should not make them harder to access.

We all support efforts to lower drug prices, but **this bill ignores the full picture**. By failing to address **wholesaler pricing, reimbursement fairness, and administrative burdens**, it risks putting pharmacies out of business and **leaving patients with fewer options, not more**. We need real solutions that protect both affordability **and access**—because a lower price means nothing if the medication isn't there when a patient needs it.

Thank you.

Brandi Chane
PO Box 640
Weatherford, Tx 76086
817-594-3851 – office

Pharmacists United for
Truth & Transparency

SB0357_UNF_MDCSCO, ASCO_PDAB - Authority UPLs (Low

Uploaded by: Danna Kauffman
Position: UNF

MDCSCO
MARYLAND/DISTRICT OF COLUMBIA SOCIETY OF CLINICAL ONCOLOGY

ASCO®
ASSOCIATION FOR CLINICAL ONCOLOGY

February 6, 2025

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

RE: OPPOSE: Senate Bill 357*: Prescription Drug Affordability Board – Authority for Upper Payment Limits and Funding (The Lowering Prescription Drug Costs for All Marylanders Now Act)*

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 over 50,000 members, our core mission is to ensure that cancer patients have meaningful access to high quality care.

We are concerned that the expansion of authority in ***Senate Bill 357: Prescription Drug Affordability Board – Authority for Upper Payment Limits and Funding (The Lowering Prescription Drug Costs for All Marylanders Now Act)*** 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 during the 2023 Session. Currently, the Prescription Drug Advisory Board (PDAB) is charged with undertaking a process to set upper payment limits 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 upper payment limit, especially whether a shortage results. The second phase is then for the PDAB to study the legality, obstacles, and benefits of setting upper payment limits 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 upper payment limits 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 expand the program with no data.

As Maryland continues to examine the use of upper payment limits, 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 upper payment limits. 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 upper payment limit, 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) into the flow of dollars and rebates received. Too often, physicians face paying more to acquire drugs than they are reimbursed by pharmacy benefit managers (PBMs). This happens because payment amounts do not account for costs associated with special handling, storage and preparation required for administration of toxic drugs. Any setting of an upper payment limit 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 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 committee to vote on SB 357. This will then allow additional time for the State to fully understand the benefits and consequences of the use of an upper payment limit 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,

Mark Goldstein, MD
President
Maryland/DC Society of Clinical Oncology

Eric P. Winer, MD, FASCO
Chair of the Board
Association for Clinical Oncology

VCC Comment MD SB 357.pdf
Uploaded by: Derek Flowers
Position: UNF

Value of Care Coalition

February 6, 2025

The Honorable Pamela Beidle, Chair
The Honorable Antonio Hayes, Vice Chair
Members of the Senate Finance Committee
3 Miller East Senate Office Building
Annapolis, MD 21401

RE: Opposition to SB 357 Prescription Drug Affordability Board – Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act)

Chair Beidle, Vice Chair Hayes and Members of the Senate Finance Committee:

As a broad coalition of advocacy organizations including patients, caregivers and health care providers, we write to express **opposition** and concern with SB 357 – a bill to expand the reach of upper payment limits set by the Prescription Drug Affordability Board (PDAB). We recognize the importance of lowering health care costs. However, PDABs have no track record of achieving savings while upper payment limits pose a risk to patient access.

Currently, upper payment limits implemented by the PDAB apply only to government-sponsored health plans. SB 357 would expand the authority of the PDAB to impact commercial plans within the state.

As you consider this legislation, please also consider these concerns:

1) PDABs take a narrow view of a complex system
2) PDABs have not achieved savings, and patient savings remain unlikely
3) UPLs risk patient access to medications Marylanders rely on

---

PDABs TAKE A NARROW VIEW OF A COMPLEX SYSTEM

In addressing affordability, PDABs often take a narrow view of the true cost of care, ignoring the actual cost to patients after insurance and assistance programs.

PDABs' proposed solution to create savings – a cap on the topline price of prescription medications through the implementation of upper payment limits (UPLs) – fails to address other drivers of cost within the system, such as those added by pharmacy benefit managers, insurers and wholesalers. It also ignores the costs added to the health care system through delays or denials to treatment imposed by health plans. These delays allow disease progression, leading to additional doctor or hospital visits, and drive further negative economic impact through missed days at work for patients who are suffering.

Lawmakers seeking to lower the cost of care, and improve patient outcomes, should consider all parts of the health care system.

LACK OF PATIENT SAVINGS

SB 357 is named the "Lowering Prescription Drug Costs for All Marylanders Now Act". Evidence suggests the bill may never live up to its name.

Insured patients don't typically pay the list price of a drug – the price upper payment limits seek to impact. Rather, patients' out-of-pocket costs are determined by their health plan and its benefit design.

A 2024 survey of payers conducted by Avalere on behalf of the Partnership to Fight Chronic Disease shows health plans do not intend to pass savings, if any exist, on to patients. Payers stated:

- *"While well intentioned, state lawmakers did not place a ton of thought into the implementation of a UPL and how this will impact the supply chain."*
- *"Payers will not pass their savings (if any) onto individuals. It's not realistic and somebody will need to make up the differences."*
- *"UPLs will alter how formularies are determined by plans which will likely mean changes to patient copays and coinsurance amounts."* [1]

Now in its sixth year of operation, the Maryland PDAB has not produced any savings. In fact, no PDAB in any state has saved a single dollar for patients. The legislature should be skeptical of expanding a program with no history of positive results.

RISK TO PATIENT ACCESS

The implementation of upper payment limits poses a risk to patient access to the medications they rely on.

The same survey of payers referenced above shows that UPLs are likely to increase health plan utilization management, which can result in delays or denials for patients. Payers stated:

- *"Utilization management will undoubtedly go up with UPLs, whether for the drugs subjected to them or for competition. This is going to depend on how low or high the UPLs are set at and what changes this brings to classes and volume."*
- *"Anything that impacts product reimbursement over time will impact patient access. Providers will not want to take financial risks regarding inadequate reimbursement under UPL."*

[1] Partnership to Fight Chronic Disease. *Health Plans Predict: Implementing Upper Payment Limits May Alter Formularies And Benefit Design But Won't Reduce Patient Costs*. 2024 March. https://www.fightchronicdisease.org/sites/default/files/FINAL%20PFCD%20Avalere%20PDAB%20Insurer%20Research.pdf

While payers' comments are clear about the risk of decreased patient access resulting from UPLs, the PDAB has done nothing to ensure continued health plan coverage for drugs impacted by UPLs.

Pharmacists are also concerned about the impact of artificially capping prescription prices. At the Medicare level, The National Association of Community Pharmacists surveyed their members and reported that more than 50% of independent pharmacists are strongly considering not stocking drugs subjected to CMS payment limits due to concerns over reimbursements.

If upper payment limits prevent payers from providing coverage for a drug or pharmacies from stocking a drug, then Marylanders face a risk of reduced access to those drugs. Lawmakers should not expand a program that could diminish access to treatments Marylanders rely on.

With no proven model to follow and no track record of success, we remain concerned that upper payment limits present a broad threat to patient access while ensuring no patient savings.

Therefore, the Value of Care Coalition respectfully requests the Committee move forward an **unfavorable report** on SB 357.

Thank you,

Derek Flowers
Director, Value of Care Coalition

SB0357_UNF_MTC_PDAB - Authority UPLs (Lowering Pre

Uploaded by: Drew Vetter

Position: UNF

MARYLAND TECH COUNCIL
ADVANCING LIFE SCIENCES AND TECHNOLOGY

Senate Finance Committee
February 6, 2025
Senate Bill 357 – *Prescription Drug Affordability Board – Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act)*
POSTION: OPPOSE

The Maryland Tech Council (MTC), with over 800 members, is the State's largest association of technology companies. Our vision is to propel Maryland to be the country's number one innovation economy for life sciences and technology. MTC brings the State's life sciences and technology communities into a united organization that empowers members to achieve their goals through advocacy, networking, and education. On behalf of MTC, we submit this letter of opposition to Senate Bill 357.

This bill would create a process for the Maryland Prescription Drug Affordability Board (PDAB, or the Board) 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." The bill makes this new authority contingent on the PDAB enacting UPLs on two prescription drugs under the PBAB's current authority and for them to be in effect for one year.

The MTC has many life science companies among its members. 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 about whether the PDAB and UPLs are the best way to accomplish that goal.

The authority of the PDAB to set UPLs is limited to State and local government plans. As of this writing, the PDAB has yet to publish any cost reviews on any of the six drugs it has chosen to review to date. While the PDAB is close to publishing at least the first two reviews, the PDAB has yet to enact a UPL or other policy option. While we appreciate that this year's version of the bill is contingent on enacting UPL's for two prescription drugs that have been in place for a year, the MTC argues that expansion of the Board's authority remains premature until there is more information available for the General Assembly to evaluate about the effectiveness of UPL's.

The fact remains that the passage of this legislation would enable the expansion of the Board's authority to the full commercial insurance market. The MTC and our member companies in the life sciences still have concerns about the effectiveness of UPLs as a tool to lower the costs of prescription drugs for Maryland patients. For example, the MTC urges the Committee to closely examine the concern of some patient groups that UPLs could lead to access issues for specific medications, especially for specialty drugs for serious and rare diseases. This could happen when a UPL is lower than the wholesale acquisition price of a medication. In such circumstances, pharmacies may choose to stop stocking these medications rather than operate at a loss.

This legislation focuses solely on UPLs as the means to address the cost of drugs that are unaffordable. MTC encourages a more holistic look at the factors within the supply chain and healthcare systems contributing to affordability and patient access challenges. We would suggest that any policy aimed at getting to the bottom of the cost of medication in Maryland look at the role of pharmacy benefit managers (PBMs) and health insurance practices that contribute to high costs. While we appreciate that Maryland's PDAB is examining other cost drivers as part of its analysis, we think it is a mistake for new legislation to further expand UPLs without explicitly incorporating other entities involved in determining how much a patient pays for a given medication. For example, some practices and policies could directly impact what patients pay out-of-pocket for their medicines. For example, there are tools that insurance companies and 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. The committee will consider legislation on this topic this year and should seriously consider passing it.

The concerns about UPLs are not unique to stakeholders in Maryland. Although 11 other states have established PDABs of their own, none have yet implemented a UPL. The reason that states have had difficulty is related to many of the concerns raised above. One instructive example is the State of Oregon PDAB, established in 2021. Oregon PDAB decided this summer to postpone drug reviews until 2025 to address issues with its review process, including the need for better data. This same issue has been raised by stakeholders here in Maryland. As such, not only are there no Maryland UPLs for the General Assembly to evaluate, but there are no UPLs implemented in other states to base the rationale to expand authority in Maryland.

Additionally, we encourage the committee to consider the impact of policies such as the one proposed here on the life sciences community in Maryland. Maryland should be very proud of its life sciences ecosystem and all the investments and policies that have contributed to its growth. However, expanding upon a policy that has not yet demonstrated its effectiveness sends a message that is counter to Maryland being a welcoming state for life sciences. The possibility of expanded UPL authority in Maryland creates uncertainty for life sciences companies operating in Maryland, which could discourage investment and innovation in life sciences in Maryland. We believe that Maryland lawmakers should look for ways to support the life sciences industry and avoid creating uncertainty that makes the life sciences ecosystem question further investment in the State.

In conclusion, the MTC remains committed to participating in the conversation about reducing the cost of prescription drugs for Maryland patients. However, we believe the timing of this legislation is still pre-mature, given that no UPLs have been established under the PDAB's current authority. We also remain concerned that passing this bill would send the wrong message to Maryland's robust life sciences ecosystem. For these reasons, we respectfully request an unfavorable report.

For more information call:
Andrew G. Vetter
J. Steven Wise
Danna L. Kauffman
Christine K. Krone
410-244-7000

SB 357_MDCC_Lowering Prescription Drug Costs for A
Uploaded by: Hannah Allen
Position: UNF

MARYLAND
Chamber of Commerce

LEGISLATIVE POSITION:
Unfavorable
Senate Bill 357– Prescription Drug Affordability Board - Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act)
Finance Committee
Thursday, February 6, 2025

Dear Chairwoman Beidle and Members of the Committee:

Founded in 1968, the Maryland Chamber of Commerce is the leading voice for business in Maryland. We are a statewide coalition of more than 7,000 members and federated partners working to develop and promote strong public policy that ensures sustained economic health and growth for Maryland businesses, employees, and families.

Senate Bill 357 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.

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.

In 2019, Maryland became the first state to establish a Prescription Drug Affordability Board (PDAB). The law requires the board to review both state and commercial health plans' use of prescription drugs and make recommendations to state officials on ways to make them more affordable for residents. The board is required to submit a report to the General Assembly on legality, obstacles, and benefits of upper payment limits on purchases and payor reimbursements of prescription drugs by December 1, 2026, along with recommendations regarding whether legislation should be passed to expand the authority of the board to set upper payment limits to all purchases of prescription drugs in the state. SB 357 should not be considered until a final report has been submitted and reviewed.

The Chamber understands the intent of SB 357, 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.

The Maryland Chamber of Commerce respectfully requests an **unfavorable report** on **SB 357**.

NPF Comments to Maryland Senate Finance Committee
Uploaded by: Jason Harris
Position: UNF

February 4, 2025

Maryland Senate Finance Committee
3 East Miller Senate Office Building
3 East Miller Senate Office Building
Annapolis, Maryland 21401

RE: Prescription Drug Affordability Board – Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act)

Dear Chair Beidle, Vice Chair Klausmeier, and members of the Senate Finance Committee,

On behalf of the National Psoriasis Foundation, and the more than 8 million individuals living with psoriatic disease, we thank you for the opportunity to provide comment on the proposed reform to the Prescription Drug Affordability Board (PDAB). We write to convey our concerns about potential unintended consequences of the PDAB's intervention which might jeopardize patient access and to urge the Committee to allow the current process to unfold before evaluating any change to the board's authority.

Psoriasis is an immune-mediated disease that causes inflammation in the body. There may be visible signs of inflammation such as raised plaques and scales on the skin, which may look different for different skin types. The symptoms associated with psoriasis, including itch, pain, and flaking skin, can directly impact patient wellbeing, patient sleep, and ability to complete activities of daily living. Psoriasis is also well known to have systemic medical associations including metabolic syndrome, cardiovascular disease, metal health conditions like depression and anxiety, and psoriatic arthritis (PsA), a potentially debilitating inflammatory arthritis. In fact, one in three people with psoriasis may develop psoriatic arthritis.[1] Signs of PsA include swelling, stiffness, and pain in the joints and areas surrounding the joints. Scientific research on PsA progression has demonstrated that it is important for patients with PsA to begin treatment for PsA shortly after the onset of symptoms to avoid (or at least minimize) permanent joint damage.

The National Psoriasis Foundation (NPF) is a non-profit, 501 (c)(3) organization that works to drive efforts to cure psoriatic disease and improve the lives of the over 8 million Americans affected by psoriatic disease. As part of that second mission the NPF advocates for access to care reforms that will benefit people living with psoriasis, and it's in this capacity that we reach out to the committee today with our concerns about the consequences of implementing a UPL on drugs used to treat psoriatic disease.

The introduction of biologic products for the treatment of psoriasis and psoriatic arthritis has allowed many in our community to achieve a level of clearance never before possible. New systemic treatments, including biologics, have provided many patients with effective therapies for the first time in their lives. Biologics have also opened a new world of combination therapies, being used alongside other systemic

[1] Mease PJ, Gladman DD, Papp KA, et al. Prevalence of rheumatologist-diagnosed psoriatic arthritis in patients with psoriasis in European/North American dermatology clinics. J Am Acad Dermatol. 2013;69(5):729-735. doi:10.1016/j.jaad.2013.07.023

treatments, phototherapy, and/or topical treatments. Each patient is unique in the way they respond to various therapies, however, and there is no 'one size fits all' approach to managing psoriasis.

Although recent research has shed some light on the underlying factors that determine whether or not any given drug will effectively treat a patient's specific presentation of psoriatic disease (for instance, psoriatic arthritis patients with enthesitis seem to do better with IL-23 inhibitors, while those with axial involvement seem to do better with IL-17 inhibitors),[2] there is still no universal heuristic for matching a patient to the most effective treatment for their psoriatic disease. Physicians often prescribe one or more ineffective treatments for patients with psoriatic disease before identifying an approach that works, and the immunological nature of psoriatic disease means that patients may even have to cycle off previously effective treatments if they build up immune tolerance.

The extreme heterogeneity of both psoriatic disease and treatments for psoriatic disease make physician and patient access to the full range of therapies particularly important. Because of this unique set of considerations, we caution the committee to be on guard against creating scenarios in which the PDAB is called to make interventions which lead insurers to re-tier, restrict access to, or even eliminate certain drugs from their formularies. Given the diversity of drugs that could plausibly treat one patient's psoriatic disease but not another's, any incentive structure that makes it more difficult for psoriatic disease patients to access a full range of treatment options through Maryland's state-regulated plans would create major access barriers for people living with the condition.

UPLs are a new enough policy tool that our team has struggled to predict or model the potential impacts of a UPL on insurers, PBMs, hospitals, pharmacies, and providers. That said, we have seen some analyses of the likely impacts of a UPL that echo our concerns of increased utilization management. For instance, the health policy consulting firm Avalere came to many of these same conclusions after they were hired by the Partnership to Fight Chronic Disease to conduct double-blind interviews of 6 health plan representatives. Avalere summarized their findings into a March 2024 report that warned "All payers interviewed noted that UPL drugs and competitors in the therapeutic class are likely to see increased utilization management (e.g., step therapy, prior authorization) should the UPL restructure new benefit designs. Additionally, five of six payers cited in their interviews that UPL implementation would result in changes to formulary designs, such as movement up or down tiers for UPL drugs."[3]

Considering these concerns, we urge the Committee to allow the PDAB to complete its current work and affordability reviews before making any changes to its authority. NPF has commissioned a research analysis that explores how some of these specific dynamics might play out for the community we serve. We will continue to engage the PDAB and Maryland legislature to share these findings in March.

On behalf of National Psoriasis Foundation, thank you for your consideration of these comments. We invite you to call upon us, our Medical Board, and our patient community as you move forward. If you

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[2] Kamata M, Tada Y. Efficacy and Safety of Biologics for Psoriasis and Psoriatic Arthritis and Their Impact on Comorbidities: A Literature Review. Int J Mol Sci. 2020;21(5):1690. Published 2020 Mar 1. doi:10.3390/ijms21051690

[3] Avalere, Health Plans Predict: Implementing Upper Payment Limits May Alter Formularies And Benefit Design But Won't Reduce Patient Costs, https://www.fightchronicdisease.org/sites/default/files/FINAL%20PFCD%20Avalere%20PDAB%20Insurer%20Research.pdf.

have any questions, please reach out to Will Hubbert, NPFs State Government Relations Manager at Whubbert@psoriasis.org.

Sincerely,

Jason Harris
Vice President, Government Relations and Advocacy

MD PDAB draft letter.pdf
Uploaded by: Kari Lato
Position: UNF

RARE READY
A GENETIC CONDITION COALITION

February 4, 2025

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:

The Rare & Ready Coalition would like to express our opposition to SB 357, a bill to expand the scope of the Maryland Prescription Drug Affordability Board (PDAB). Rare & Ready is a coalition of 70 non-profit organizations working to ensure rare disease patients get timely access to the care they need and deserve. We are alarmed by the devastating impact the existing PDAB and its potential expansion will have on patient access to life-saving therapies.

We strongly urge the Committee to consider the unique circumstances of rare disease patients and therapies as it considers this legislation. You must protect access for patients living with a rare disease, who have no treatment alternatives. It's critical you consider the real-world experiences of those living with or caring for someone with a rare disease.

Patients living with rare and genetic disorders often have limited treatment options, with 95 percent of such conditions lacking any FDA-approved therapies. State efforts to create PDABs, while intended to make drugs more affordable for health plans, can deter access to critical medical innovations. The implications are most profound for patients living with a rare disease, many of whom are children.

PDABs are unelected boards set up by state legislators to cap prescription drug reimbursement for certain health plans in the state. Rather than fostering cost savings and enhancing patient affordability, the outcome of a PDAB is an environment where access to innovative therapies is restricted. This unfortunate reality will predominantly impact rare disease patients.

While we share the goal of reducing costs for patients, SB 357 raises significant concerns:

1. Potential Limitations on Access: The bill's "Upper Payment Limits" may prevent insurers and pharmacies from purchasing medications exceeding government-set prices, reducing treatment options for patients.

2. Crippling Innovation and Jeopardizing Patients' Health: When the government imposes mandates on the private sector, there are always unintended

RARE READY
A GENETIC CONDITION COALITION

consequences that only hurt consumers. In this case, price controls discourage innovation, making it impossible for companies to develop rare disease treatments. As a result, rare disease patients who depend on groundbreaking therapies will be the ones that suffer.

SB 357 will do nothing to lower prescription drug costs for Maryland residents. PDABs do not lower patient copayments, reduce premiums, create health system transparency, or increase access to care for rare patients. The reality is PDAB reimbursement caps result in less rare disease research, fewer new treatments for patients, and restricted patient access to medicines.

Additionally, the bill does not adequately address issues within the broader pharmaceutical supply chain, such as the role of pharmacy benefit managers (PBMs) and the application of significant rebates and discounts that fail to benefit patients directly.

For these reasons, we respectfully express our opposition to SB 357 in its current form and urge you and your colleagues in the Maryland Legislature to consider its dipropionate impact on people with rare and genetic disorders.

We urge the committee to hear directly from rare disease patients and the parents of children battling these conditions before making any decisions. This legislation is not just about dollars—it carries life-altering consequences for the most vulnerable among us. Please take the time to understand their stories before moving forward. We welcome the opportunity to connect you to those who are directly impacted—please reach out to the coalition administrator at kari.lato@rx4good.com to schedule a meeting with your constituents.

Sincerely,

Rare & Ready Coalition Members

MD SB 357 Supply Chain Coalition Opposition Letter

Uploaded by: Kelly Memphis

Position: UNF

February 6, 2025

Senator Pamela Beidle, Chair
Senator Antonio Hayes, Vice Chair
Maryland Senate Finance Committee
East Miller Seante Building, Room 3
Annapolis, Maryland 21401

Dear Chair Beidle, Vice Chair Hayes, and Honorable Members of the Committee:

On behalf of the undersigned organizations, representing diverse stakeholders in the healthcare supply chain, we would like to express our collective concerns regarding SB 357, a proposal to expand the UPL authority of the Maryland Prescription Drug Affordability Board (PDAB). While we recognize the importance of addressing the affordability of prescription drugs, we believe that the blanket use of state-level UPLs are not an effective or sustainable solution, but rather inadvertently create harmful disruptions to patient access to critical medications.

State-level UPLs overlooks the intricacies of the U.S. pharmaceutical supply chain, which operates on a national scale rather than being state-specific. Unfortunately, imposing a UPL on specific drug products can place in-state providers and healthcare entities in a precarious position, limiting both the purchase and notably the reimbursement price of these products to pharmacies and pharmacy providers without consideration for the critical access challenges that Marylanders may experience in consequence of the costs associated with purchasing, storage, compounding, monitoring, dispensing and administering these vital medications.

Policies like those proposed in SB 357, imposing stringent controls on drug pricing, have also proven to inadvertently diminish patient access to the pharmaceuticals they depend on for chronic and acute disease management. Consequently, patients in Maryland may face restricted access to cutting- edge treatments and medications. Furthermore, the establishment of a UPL by a PDAB, which often has little to no legislative oversight, at a price unsustainable to the pharmaceutical supply chain and care continuum could result in the unfortunate forced withdrawal of these products from the market and subsequent neighborhood pharmacies, leaving Marylanders without access to highly effective medications.

Given the concerns that state-level UPLS create, the undersigned organizations believe it is imperative for the Maryland patients who depend on timely access to critical medications that the Board's current work be completed, fully realized, and thoroughly evaluated before any legislation to expand the UPL authority or funding is passed. We ask that you do not advance SB 357 at this time.

Sincerely,

EPIC Pharmacies, Inc (EPIC)

Healthcare Distribution Alliance (HDA)

National Association of Chain Drug Stores (NACDS)

National Community Pharmacists Association (NCPA)

MD SB 357 Supply Chain Coalition Opposition Letter

Uploaded by: Leah Lindahl

Position: UNF

February 6, 2025

Senator Pamela Beidle, Chair
Senator Antonio Hayes, Vice Chair
Maryland Senate Finance Committee
East Miller Seante Building, Room 3
Annapolis, Maryland 21401

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Sincerely,

EPIC Pharmacies, Inc (EPIC)

Healthcare Distribution Alliance (HDA)

National Association of Chain Drug Stores (NACDS)

National Community Pharmacists Association (NCPA)

HCMA PDAB Letter Senate Committee.pdf
Uploaded by: Lisa Salberg
Position: UNF

Hypertrophic Cardiomyopathy Association

Serving the HCM Spectrum Disorder Community Since 1996

February 4, 2025

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:

I am the founder and CEO of the Hypertrophic Cardiomyopathy Association, a nonprofit dedicated to internationally supporting individuals and families affected by hypertrophic cardiomyopathy.

HCM impacts 1 in 250, and Maryland has an estimated 12,000 to 30,000 HCM warriors.

The Hypertrophic Cardiomyopathy Association would like to express our opposition to SB 357, a bill to expand the scope of the Maryland Prescription Drug Affordability Board (PDAB). We are alarmed by the devastating impact the existing PDAB, and its potential expansion will have on patient access to life-saving therapies.

We strongly urge the Committee to consider the unique circumstances of rare disease patients and therapies as it considers this legislation. You must protect access for patients living with rare diseases who have no treatment alternatives. It's critical that you consider the real-world experiences of those living with or caring for someone with a rare disease.

Patients living with rare and genetic disorders often have limited treatment options. State efforts to create PDABs, while intended to make drugs more affordable for health plans, can deter access to critical medical innovations. The implications are most profound for patients living with a rare disease.

PDABs are unelected boards set up by state legislators to cap prescription drug reimbursement for certain health plans in the state. Rather than fostering cost savings and enhancing patient affordability, the outcome of a PDAB is an environment where access to innovative therapies is restricted. This unfortunate reality will predominantly impact rare disease patients.

66 Ford Road, Suite 213B, Denville, NJ 07834 | P: 973-983-7429 | F: 973-983-7870 |
4hcm.org

While we share the goal of reducing costs for patients, SB 357 raises significant concerns:

1. Potential Limitations on Access: The bill's "Upper Payment Limits" may prevent insurers and pharmacies from purchasing medications exceeding government-set prices, reducing treatment options for patients.

2. Crippling Innovation and Jeopardizing Patients' Health: When the government imposes mandates on the private sector, there are always unintended consequences that only hurt consumers. In this case, price controls discourage innovation, making it impossible for companies to develop rare disease treatments. As a result, rare disease patients who depend on groundbreaking therapies will be the ones that suffer.

SB 357 will do nothing to lower prescription drug costs for Maryland residents. PDABs do not lower patient copayments, reduce premiums, create health system transparency, or increase access to care for rare patients. The reality is PDAB reimbursement caps result in less rare disease research, fewer new treatments for patients, and restricted patient access to medicines.

Additionally, the bill does not adequately address issues within the broader pharmaceutical supply chain, such as the role of pharmacy benefit managers (PBMs) and the application of significant rebates and discounts that fail to benefit patients directly.

For these reasons, we respectfully express our opposition to SB 357 in its current form and urge you and your colleagues in the Maryland Legislature to consider its disproportionate impact on people with rare and genetic disorders.

We urge the committee to hear directly from rare disease patients and the parents of children battling these conditions before making any decisions. This legislation is not just about dollars—it carries life-altering consequences for the most vulnerable among us. Please take the time to understand their stories before moving forward. We welcome the opportunity to connect you to those who are directly impacted—please reach out to our legislative lead julie@4hcm.org to schedule a meeting with your constituents.

Sincerely,

Lisa Salberg
Hypertrophic Cardiomyopathy Association
CEO and Founder

2.4.25 EACH_PIC Letter to MD Senate Finance.pdf

Uploaded by: Mark Hobraczk

Position: UNF

EACH PIC COALITION

February 4, 2025

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

RE: Opposition to Expanding PDAB Upper Payment Limit Authority (S.B. 357)

Dear Chair Beidle,

The Ensuring Access through Collaborative Health (EACH) and Patient Inclusion Council (PIC) submit the following comments in opposition to S.B. 357, which would expand the upper payment limit authority of the Prescription Drug Affordability Board (PDAB)

EACH/PIC is a two-part coalition that unites patient organizations and allied groups (EACH), as well as patients and caregivers (PIC), to advocate for drug affordability policies that benefit patients. The coalition has actively engaged with the Maryland PDAB since its creation, and while we respect the efforts and intentions of the board members and staff, we remain concerned with the impact the PDAB will have on patients in Maryland. We believe the PDAB approach is ineffective in lowering patient costs for prescription drugs and could ultimately cause more harm by creating added barriers between patients and their medically necessary treatment. Therefore, we urge you to oppose this legislation.

We respectfully urge committee members to consider the concerns of patient organizations outlined in this letter. We offer our organization as a resource to the committee as it seeks to connect with patient organizations and patients.

PDABs Are Unproven and Expensive

Despite laudable intentions, in its sixth year of operation the Maryland PDAB has yet to directly achieve cost savings for patients. The Maryland PDAB was projected in its authorizing legislation to cost $4 million and budget requests include another $1.28 million for 2026.

Other states have similar experiences with PDAB costs. The Oregon PDAB is projected to cost over $1 million per year. And the Colorado PDAB was projected to cost $800,000 for its first year, but already requested a supplement of $260,000.

We are concerned that the PDAB will continue to cost Marylanders in the ballpark of $1 million each year without the ability to realize savings for patients.

Cost Reviews and UPLs Could Compromise Patient Access to Medications

While we applaud the committee's commitment to supporting patients and lowering the costs of prescription medications, we are concerned that cost reviews and upper payment limits (UPLs) can further complicate an already complex healthcare marketplace and result in worse outcomes for patients.

EACH PIC COALITION

At their core, cost reviews necessitate selecting individual drugs for review and implementing market interventions for the selected drugs. This alone puts PDABs in a position of creating inequities between patient populations by selecting and reviewing individual drugs, rather than evaluating systemic health costs.

While UPLs are intended to lower costs for patients, the reality is that they will create a new incentive structure for payers that could compromise patient access to the selected medications due to increased utilization management or reshuffling of formularies. This eventuality was outlined by the Centers for Medicare and Medicaid Services in their May 3, 2024 Guidance on Medicare Drug Price Negotiation, "CMS is concerned that Part D sponsors may be incentivized in certain circumstances to disadvantage selected drugs by placing selected drugs on less favorable tiers compared to non-selected drugs, or by applying utilization management that is not based on medical appropriateness to steer Part D beneficiaries away from selected drugs in favor of non-selected drugs."

Additionally, many of the drugs under cost review are administered directly by physicians under a "buy and bill" model. Physician reimbursement rates are already being squeezed, and UPLs could additionally lower opportunities for treatment costs to be recouped. As a result, it is likely that physicians would adjust treatment recommendations to avoid facing financial deficits, leaving patients with fewer treatment options.

Finally, creating a unique pricing structure in Maryland will create state-specific conditions for coverage. We don't know yet how either insurers or manufacturers will react to state-by-state exceptions, but this has potential to cause either of these stakeholders to limit availability in the state and could cause confusion for patients and providers in the state.

Upper Payment Limits Don't Necessarily Translate to Patient Savings

Assuming that UPLs directly translate to lowered costs for patients ignores the complicated nature of our healthcare system. In our system, patients are not responsible for paying the full cost of their prescription medications nor are they allowed to freely select from the full range of treatments medically approved for their condition. Instead, these decisions are determined by their insurance company and pharmacy benefit manager (PBM). It is also these stakeholders that determine if cost-savings realized by the payer are subsequently shared with patients. Unfortunately, in most cases, they are not.

Payers in our health marketplace do not necessarily derive the most value from the lowest cost drugs. According to reporting on PBMs by the New York Times, "Even when an inexpensive generic version of a drug is available, PBMs sometimes have a financial reason to push patients to take a brand-name product that will cost them much more. For example, Express Scripts typically urges employers to cover brand-name versions of several hepatitis C drugs and not the cheaper generic versions. The higher the original sticker price, the larger the discounts the PBMs can finagle, the fatter their profits — even if the ultimate discounted price of the brand-name drug remains higher than the cost of the generic."

EACH PIC COALITION

Ultimately, this could mean insurers and PBMs place drugs subject to UPLs on higher tiers of the formulary. This could ultimately lead to higher out-of-pocket costs for patients who could face higher copay or coinsurance rates to retain access to that drug or alternatively be forced to switch to a more expensive drug that results in higher profits to their PBM. This is also supported by the concern raised by CMS above.

Additionally, non-medical switches in medication can cause unnecessary complications for patients. At a minimum, a switch in medication will require more doctor visits to monitor the efficacy of a new treatment. Further, if the switch results in side effects or worsened outcomes, patients could face more costly medical interventions or hospitalization.

Patient Access Cannot Be Compromised

Once diagnosed with a chronic condition, each patient starts an often life-long journey to identify the correct treatments to successfully manage their symptoms and improve their health. Many chronic disease patients will ultimately rely on multiple medications to their condition. Some will face multiple chronic conditions or even need additional medications to treat the side effects of either their condition or the medication that keeps their condition manageable.

For these reasons, patients with chronic conditions often rely on a complicated and personalized course of treatment that is not easily altered. Substituting or requiring patients to change drugs based on cost considerations instead of medical needs can disrupt continuity of care and result in complications and higher overall medical costs.

Identify and Resolve Patient-Reported Obstacles to Care

While our health system and the policies that impact it are complicated, one principle is simple: every change that we make and policy we implement should ultimately benefit patients. We urge the committee to keep this principle as a singular focus as it evaluates health reform proposals and new legislation.

As we have outlined, while well-intentioned, UPLs fail to address many of the underlying causes and complicated factors that result in higher prescription drug costs for patients. Therefore, we urge the committee to focus its time on identifying and addressing *patient-reported* obstacles to drug affordability.

Failing to resolve the underlying factors that lead to higher costs for patients can result in short-term relief and uneven benefits – aiding some but potentially leaving others with higher costs and drug accessibility challenges.

In closing, we hope you will forego an ineffective and expensive reform proposal and instead work with our coalition and others to pursue more productive patient-driven reforms. We appreciate an increased focus on issues that impact patient access to care and providing patients every opportunity to have a voice in matters involving our healthcare.

EACH/PIC COALITION

We look forward to working with you in the future on initiatives that can address the broader concerns of patients. Thank you for considering our input and do not hesitate to reach out to me at mark@aiarthritis.org with any questions.

Sincerely,

Mark Hobraczk, JD, MPA
Director of Public Policy, AiArthritis
Legislative Lead, EACH/PIC Coalition
Person living with Ankylosing Spondylitis

cc: Members of the Senate Finance Committee

COGI draft MD letter SB357 and HB424.docx.pdf
Uploaded by: Melodie Narain-Blackwell
Position: UNF

February 4, 2025

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

Delegate Joseline A. Pena-Melnyk
Chair
240 Taylor House Office Building
Annapolis, Maryland 21401

Senator Antonio Hayes
Vice Chair
3 East Miller Senate Office Building
Annapolis, Maryland 21401

Delegate Bonnie Cullison
Vice Chair
241 Taylor House Office Building
Annapolis, Maryland 21401

Dear Chair Beidle, Vice Chair Hayes, Chair Pena-Melnyk and Vice Chair Cullison:

I am writing on behalf of the Color of Gastrointestinal Illness (COGI) to share my concerns about SB357 and HB424 requiring 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 affordability challenges. As the founder and CEO of COGI, I can attest to my personal experience and the experiences of so many patients that we represent that access to affordable care is the most important challenge we face. We are very concerned that the PDAB has ignored concerns shared by patients, has no plans to meaningfully engage patients and has failed to communicate how patients will be protected from egregious utilization management strategies because of UPLs.

I founded COGI based on my own personal experience. I have been on 16 medications, from pills to injections to suppositories. I started having rectal bleeding at the age of 13, yet was not diagnosed with Crohn's disease until 2018 after a 30-year journey. And even with diagnosis, I did not get an advanced therapy prescribed, Skyrizi, until December, 2023. That medication changed my life. Yet, I also recognize that I have a progressive disease and my health has been forever impacted by a delayed diagnosis and delayed prescribing of the advanced therapy I needed.

Based on my experience and so many like me, it is imperative that the activities of the PDAB do not result in patients experiencing furthers delays in receiving the drugs needed to achieve the outcomes that matter most to them and that evidence demonstrates to be most effective for them based on their personal characteristics. These drugs do not have the same impact on different patients and we should be making sure patients and their physicians are not being steered by payers into prescribing decisions.

The Board has failed to provide any information on how patients will be protected from adverse formulary placement and utilization management strategies in response to an upper payment limit (UPL) that will make patient access to affordable care that much more challenging. In August, 2024, COGI sent a letter to the Board expressing concerns about its ongoing cost review activities, particularly as it

pertains to Skyrizi. COGI represents Black, indigenous and other people of color (BIPOC) who are affected by inflammatory bowel disease (IBD), digestive disorders, gastrointestinal cancer and associated chronic illnesses. Skyrizi is a highly effective and needed treatment for many in our community.

Our letter expressed serious concerns about health equity and access to care.[1,2] Yet, upon review of the Board's website, we noticed that our comment letter was not posted. It is not clear to me that it was ever shared with the Board or its advisory committee. And it was not mentioned in the Board or advisory committee proceedings. It was posted at a point long after consideration of Skyrizi.

Another letter from COGI and 37 other organizations to the Board specifically commented on the draft UPL Plan and also seems to have been ignored, as none of the concerns it raised were addressed in the revised plan nor was it posted on the website as a letter considered by the Board until long after the meeting.[3] For this process to be trusted and credible, the Board cannot simply hope to get this right and ignore the real-world experiences of patients that are the source of our legitimate questions and concerns.

To date, the Maryland Prescription Drug Affordability Board (PDAB) has ignored the pleas of so many in the patient and disability communities for reassurances that their affordability review process will not use discriminatory value assessments that devalue people with disabilities and serious chronic conditions. Instead, we are aware that the Board is being supported by entities that are on record supporting the use of value assessment measures that are barred by federal law under Section 504 of the Rehabilitation Act. The Board has explicitly invited and referenced input from the Institute for Clinical and Economic Review and the Program on Regulation, Therapeutics and Law (PORTAL), both entities supported by Arnold Ventures which has a long history of supporting the generation and use of value assessments that utilize discriminatory measures.[4,5] Federal law bars use of "any measure, assessment, or tool that discounts the value of life extension on the basis of disability" by an entity receiving federal financial assistance, including Medicaid.[6] It also bars denying care based on "bias or stereotypes about a patient's disability."[7] The final rule explains, "Methods of utility weight generation are subject to section 504 when they are used in a way that discriminates."[8] Therefore, any reference to measures such as quality-adjusted life years (QALYs) or equal value of life year gained (evLYG) are contrary to federal law.

To help meaningfully engage patients, we were pleased to work with the Ensuring Access through Collaborative Health (EACH) Coalition on a new survey for patients that elicits real-world information about their challenges accessing affordable medications. We do not have reassurances that the PDAB will meaningfully incorporate this data into its decisions.[9] For now, real-world information is not being

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[1] Borum ML. Racial and Ethnic Disparities in Inflammatory Bowel Disease. Gastroenterol Hepatol (N Y). 2023 May;19(5):281-283. PMID: 37799459; PMCID: PMC10548245.

[2] Liu JJ, Abraham BP, Adamson P, Barnes EL, Brister KA, Damas OM, Glover SC, Hooks K, Ingram A, Kaplan GG, Loftus EV, McGovern DPB, Narain-Blackwell M, Odufalu FD, Quezada S, Reeves V, Shen B, Stappenbeck TS, Ward L. The Current State of Care for Black and Hispanic Inflammatory Bowel Disease Patients. Inflamm Bowel Dis. 2023 Feb 1;29(2):297-307. doi: 10.1093/ibd/izac124. PMID: 35816130; PMCID: PMC10210746.

[3] http://www.pipcpatients.org/uploads/1/2/9/0/12902828/maryland_pdab_comments_final.pdf

[4] ICER submissions at https://pdab.maryland.gov/Pages/cost_review_process.aspx

[5] PORTAL presentation at https://pdab.maryland.gov/documents/stakeholders/2023/havard_med_brigm_prst.pdf

[6] Section 504 of the Rehabilitation Act, final regulations at 84.57.

[7] Section 504 of the Rehabilitation Act, final regulations at 84.56.

[8] 45 CFR Part 84 at 40102.

[9] https://eachpic.org/pic-launches-patient-created-survey-on-drug-affordability-and-access/

considered, and with it the real-world consequences for patients who consistently face barriers to care imposed by payer utilization management strategies.

We support the legislative intent to help patients afford and access the care they need. We do not support the activity of a PDAB to conduct affordability reviews that are discriminatory and that fails to address the tough questions being asked by patients. As it stands, the PDAB does not protect patients or advance health equity. Therefore, we urge the legislature to oppose this bill. Instead, the legislature should be restricting the impact of the PDAB until it provides reassurances that patients are meaningfully engaged and protected against discrimination, with safeguards in place against unintended consequences for patient access to care. In our experience, when payers do not cover the drugs we need, they do not become more affordable – only less.

Thank you for your consideration of our comments.

Sincerely,

Melodie Narain-Blackwell

Founder and CEO

Color of Gastrointestinal Illnesses (COGI)

20250203 Concerns Regarding the Impact of Expandin

Uploaded by: Michiel Peters

Position: UNF

Global Coalition on Aging

February 3, 2025

RE: Concerns Regarding the Impact of Expanding the State Drug Affordability Board on Marylanders & Innovation

Honorable Members of the Maryland General Assembly,

The Alliance for Health Innovation (Alliance) represents a diverse group of stakeholders including patients, providers, caregivers, biopharmaceutical innovators, and business communities, all committed to promoting healthy aging and fostering innovation in healthcare. Led by the Global Coalition on Aging (GCOA), the Alliance advocates for policies that support a thriving healthcare sector, enabling Marylanders and others to live longer and healthier lives.

On behalf of the Alliance, we write to you to share our concerns on the legislation (SB357/HB424) that seeks to expand the authority of the prescription drug affordability board (PDAB) in Maryland.

The Alliance is deeply concerned that SB357/HB424, which would enable the Maryland PDAB to set upper payment limits (UPLs) on prescription drugs that impact patients covered by commercial health plans, threatens to further increase costs for Maryland taxpayers and negatively impact the ability of patients to access medicines that help them manage complex conditions. Alarmingly, this bill to expand the board's work has been introduced despite the board failing to deliver the promised financial relief to patients in the form of lower out-of-pocket costs at the pharmacy and incurring significant costs to taxpayers since its enactment.

SB357/HB424 expands the PBAB's current authority to set UPLs on certain prescription medicines to include commercial health plans. It does so by giving the board, in consultation with the PDAB Stakeholder Council, the authority to set the price of selected medicines following a drug "affordability" review. All patients living with complex and chronic conditions, such as HIV, cancer, arthritis, and many more rely on timely access to the treatments their physician prescribes. UPLs could limit reimbursement to Maryland providers, hospitals, and clinics – threatening the ability of such entities to stock and store treatments and provide high-quality care to patients. If these entities can no longer provide patients with the necessary treatments, Marylanders may be forced to travel farther, incur greater costs to access their treatment, and suffer worse health outcomes.

While doing so, expanding the board's operations would also increase the burden on taxpayers who have already footed a costly bill for PDAB activities since the board was enacted. For 2024 alone, the Maryland PDAB's allowed operating expenses totaled over $1.4 million. In Maryland, and other states that currently have a PDAB, such as Colorado, PDAB startup costs have reached from $730,000-$750,000. A survey of key state healthcare stakeholders, including hospitals, pharmaceutical manufacturers, and retail pharmacies, conducted by the PDAB in Oregon, found that 47% of respondents believed that a UPL would have a negative financial impact on their organizations. Despite the significant resources needed to establish and manage these boards, the efforts of established PDABs have not resulted in any cost savings to patients to date.

Global Coalition on Aging

UPLs are likely to decrease reimbursements from payers to pharmacies and providers for certain drugs – leading to significant access challenges for older Marylanders and other patient populations. While this may save payers in the short term, we believe Maryland's pharmacies and providers will be forced to respond by limiting patient access to newer – and often more expensive – innovative medicines if not adequately reimbursed.

Many diseases that once burdened aging populations have evolved into manageable chronic conditions due to modern, safer, and more effective treatments, allowing many patients to live longer, healthier lives. 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 incentives to research and discover innovations critical to achieving healthier, more productive societies.

We strongly urge you to consider the harmful consequences that SB357/HB424, and any efforts to further expand the Maryland PDAB through additional authority to set UPLs, pose to patients, taxpayers, and the environment that supports the development of new medicines. Across the country, PDABs and UPLs have cost taxpayers millions in establishment and management costs and have yet to produce any savings for patients.

Expanding the board's authority prior to understanding the true impact on patients, Maryland's care delivery system, the supply chain, and taxpayers is disruptive and premature – and the funds dedicated to this effort would be better allocated to other efforts to support patients who are struggling to access treatments and care. Instead of relying on the failed experiment of PDABs, Maryland legislators should instead advance policies that would meaningfully lower costs for patients at the pharmacy counter while safeguarding access to medicines.

On behalf of the Alliance and the broader community, we thank you for your leadership and urgent attention to this issue. We are happy to discuss our concerns further or answer any questions you may have.

Thank you,

Michiel Peters
Head of Advocacy Initiatives, Global Coalition on Aging

PUTT Letter of Concer re_ SB0357.pdf
Uploaded by: Monique Whitney
Position: UNF

Pharmacists United for Truth & Transparency

February 4, 2025

The Honorable Senators Dawn Gile and Brian J. Feldman
Senate Finance Committee
State of Maryland
Annapolis, MD 21401

RE: Letter of Concern Regarding SB0357 and Possible Unintended Outcomes of Upper Payment Limit Implementation

Senators Gile and Feldman, and Members of the Senate Finance Committee,

I write on behalf of Maryland's independent pharmacies, who, along with their patients, will be greatly affected by the implementation of an upper payment limit on certain medications as determined by the state's Prescription Drug Affordability Board.

Perhaps no one better understands the good-hearted intention behind this initiative—to improve access to affordable medications for all citizens —than pharmacists. Pharmacists are often the ones breaking the bad news of high cost shares and copays to the patient, and want to see medication made more affordable. However, we believe the potential consequences of an Upper Payment Limit could lead to unintended negative outcomes that may undermine the objective of making expensive medication more affordable.

Our key concerns are as follows:

Viability of Pharmacy Operations if Reimbursements are Below Drug Acquisition Cost
One of the most well-documented and publicized threats to pharmacy is the pharmacy benefit manager (PBM) business model, which promises savings to consumers and plan sponsors but takes those "savings" in the form of low- and below-acquisition cost reimbursements back to pharmacies. This has resulted in an epidemic of pharmacy closures and the emergence of pharmacy deserts in urban and rural areas. When pharmacies cannot recoup their costs through fair reimbursement (i.e. recouping the full acquisition cost and a professional dispensing fee to cover costs of dispensing because patients cannot bring their own pill bottles to the pharmacy), they ultimately cannot stay in business. The impact of pharmacy closures on communities has yet to be fully realized, but who loses most when a pharmacy closes is the patient. For many patients in many communities, the pharmacy is the only available healthcare provider.

Administrative Burden
Implementing the Upper Payment Limit program would likely introduce increased administrative complexities at the pharmacy, which will be additionally burdened in 2026 by the undefined reimbursement process of the Inflation Reduction Act's Medicare Part D drug price negotiations. Beginning in 2026, under the IRA, **pharmacies are projected to need to "float" some $11,000**

per week in unpaid reimbursements from drug manufacturers of the first 10 negotiated medications, and are expected to absorb losses as much as $46,476 per year - the equivalent of a pharmacy tech FTE.[1] We are deeply concerned that SB 0357 may not have its repayment processes fully defined and may unintentionally create additional administrative burdens for pharmacies already struggling to work through reporting and repayment processes under the IRA.

Impact on Drug Innovation
As the medical professionals specifically trained on the efficacy and safety of medications, pharmacists cannot pretend there isn't a need for potentially better, safer medications that can transform a patient's illness from "sustained treatment" to "cured". We remain concerned that upper payment limits may disincentivize pharmaceutical companies from investing in research and development (R&D), and/or reduce the number of new drug discoveries.

Affordability and Accessibility in Underserved Areas
While the aim is to make medications more affordable, there is a risk that this program may disproportionately affect marginalized communities. Patients in underserved areas may face challenges in accessing medications if pharmacies cannot afford to stock certain drugs due to price restrictions. It is crucial that any affordability measures consider the diversity of patient needs and the ability of the patient to access medication.

In light of these concerns, we respectfully ask the Senate Finance Committee to carefully consider how the implementation of the Upper Payment Limit program in its current form could potentially undermine patient access to medication and their local pharmacies. It is essential that we seek a balanced approach that promotes both affordability and ease of program administration while keeping an eye on the factors that promote necessary innovation in medication research and development.

Thank you for your hard work on behalf of your constituents, and for your time and attention to our comments on this important matter. If we can be of assistance and/or a resource to work through the intricacies of administering drug-cost savings programs for patients at the pharmacy level, I hope you will not hesitate to contact us. We look forward to your response and hope to see a solution that benefits all stakeholders involved.

Yours in advocacy,

Monique Whitney
Executive Director
Pharmacists United for Truth and Transparency
Monique@Truthrx.org

[1] *Unpacking the Financial Impacts of Medicare Drug Price Negotiation Analysis on Pharmacy Cash Flows*, 3 Axis Advisors. January 2025. https://www.3axisadvisors.com/projects/tag/Inflation+Reduction+Act

Aimed Alliance Comment MD PDAB 2.4.25.pdf
Uploaded by: Olivia Backhaus
Position: UNF

AIMEDALLIANCE

February 4, 2025

Senator Dawn Gile
Maryland General Assembly
dawn.gile@senate.state.md.us

Delegate Bonnie Cullison
Maryland General Assembly
bonnie.cullison@house.state.md.us

Senator Brian Feldman
Maryland General Assembly
brian.feldman@senate.state.md.us

Delegate Jennifer White Holland
Maryland General Assembly
jennifer.white@house.state.md.us

Via Electronic Correspondence

Re: Prescription Drug Affordability Board – Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act) SB0357/HB0424

Dear Senator Dawn, Senator Feldman, Delegate Cullison, and Delegate White Holland:

Aimed Alliance is a non-profit health policy organization that seeks to protect and enhance the rights of health care consumers and providers. Aimed Alliance appreciates the efforts the Maryland General Assembly has taken to lower prescription drug costs for health care consumers.

SB0357/HB0424 would permit the Maryland Prescription Drug Affordability Board (PDAB) to establish a process for setting upper payment limits for certain eligible prescription drugs. Aimed Alliance encourages the Maryland General Assembly to consider alternatives that can directly impact consumer cost-sharing, such as a copay accumulator ban.[1] In addition, Aimed Alliance urges the Maryland General Assembly to modify the current PDAB law to ensure clearer opportunities for consumer engagement, representation, and direct impacts on consumer prescription drug affordability. Specifically, we urge the Maryland General Assembly to:

- **I. Appoint a member to the Board that has lived experience with chronic disease, disability, and/or health equity;**
- **II. Require the Board to explain how it considered feedback from the Stakeholder Advisory Council;**
- **III. Ensure monitoring of UPLs consider access and affordability challenges developed in relation to the UPL; and**
- **IV. Ensure PDAB savings are required to pass through directly to consumers in the form of lower prescription drug costs or lower premiums.**

I. Appoint a member to the Board that has lived experience with chronic disease, disability, and/or health equity.

Currently, Maryland's PDAB law requires Board Members to have expertise in health care economics or clinical medicine.[2] The Board does not require any representation from individuals with lived experience in disability or chronic disease. Individuals with lived experience have direct knowledge about

[1] All Copays Count Coalition, *State Legislation Against Copay Accumulators,* https://allcopayscount.org/state-legislation-against-copay-accumulators/.
[2] HB 0768, https://mgaleg.maryland.gov/2019RS/bills/hb/hb0768e.pdf

how public policy and health initiatives directly impact health care consumers access and affordability. Working with individuals with lived experience ensures decision makers have a deeper and more realistic understanding of how certain conditions and circumstances affect different populations and provides a clearer understanding of the most appropriate solutions for those problems.[3]

Recently, the federal government has recognized the value of ensuring a permanent position for the patient perspective by requiring all Pharmacy & Therapeutics (P&T) Committees to include at least one patient representative as a member of the P&T Committee. In making this decision, the government recognized that consumer representatives can provide "insights into real consumer experiences unknown to P&T committees."[4] Thus, a similar permanent position could be equally as valuable and beneficial for Maryland's PDAB.

While we recognize consumers have the opportunity to engage through the Stakeholder Advisory Council this is insufficient to meet consumers' needs. The Stakeholder Advisory Council does not have decision-making authority, as such without appropriate representation the Board could disregard consumer perspectives shared as part of the Stakeholder Advisory Council. As such, Aimed Alliance urges the Maryland General Assembly to modify the current statute to include a patient representative in the PDAB Membership.

II. Require the Board to explain how it considered feedback from the Stakeholder Advisory Council;

Maryland's PDAB statute requires the Board to consult the Stakeholder Advisory Council throughout the drug selection and UPL setting process. However, the statute fails to identify how the Board must weigh and reconcile stakeholder feedback with its ultimate decision. For instance, in the 2024 Annual Report, the Board recognized it received input from the Stakeholder Advisory Council when selecting drugs from negotiation.[5] Specifically, the Report states "The Board referred 8 drugs to the Stakeholder Council for input in March 2024 (Biktarvy, Dupixent, Farxiga, Jardiance, Ozempic, Skyrizi, Trulicity, and Vyvanse). The Board considered public and Stakeholder Council input and selected drugs for the Cost Review Study Process. The Board selected 6 drugs for the Cost Review Study Process in May 2024 (Dupixent, Farxiga, Jardiance, Ozempic, Skyrizi, and Trulicity)."[6] This statement does not explain the type of feedback that was received; how the information was used in the Board's decision-making process; or what additional information would have been helpful to the Board.

Therefore, Aimed Alliance urges the Maryland General Assembly to modify the current PDAB statute to ensure that the Board must reconcile the Stakeholder and consumer feedback it receives and its ultimate decision. Moreover, requiring the Board to disclose the additional types of information that could

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[3] ASPE, *Engaging People with Lived Experience to Improve Federal Research, Policy, and Practice,* https://aspe.hhs.gov/lived-experience.
[4] 2025 NBPP; See also, Lisa Baumann, et al., Public and patient involvement in health policy decision-making on the health system level – A scoping review, 126 HEALTH POL. 1023-38 (Oct. 2022), https://www.sciencedirect.com/science/article/pii/S0168851022001919
[5] MD PDAB 2024 Annual Report, https://pdab.maryland.gov/Documents/reports/2024.12.31.2024%20Annual%20Report%20%281%29.pdf
[6] *Id.*

have been helpful to the Board will ensure advocates and organizations are aware of the type of information the Board needs to make consumer-focused decisions.

III. Ensure monitoring of UPLs considers access and affordability challenges developed in relation to the UPL.

Both the original PDAB statute and SB0357/HB0424 recognize the importance of the Board monitoring the implementation of UPLs, and specifically how UPLs may be impacted during Food and Drug Administration (FDA) recognized drug shortages. However, neither the statute nor the proposed legislation recognizes the need to monitor UPL implementation more broadly to ensure it does not impact consumer access or affordability. UPLs are novel concepts within state health insurance markets, as such potential consequences of UPLs such as formulary restrictions are not completely known. Therefore, the Maryland PDAB should be required to monitor how UPLs impact consumer access and affordability to ensure UPLs do not impair access. Aimed Alliance urges the Maryland General Assembly to codify this obligation in SB0357/HB0424.

IV. Ensure PDAB savings are required to pass through directly to consumers in the form of lower prescription drug costs or lower premiums.

Maryland's PDAB law recognizes that prescription drugs are a high-cost expenditure for commercial health plans, Medicaid, and state employee health benefit programs.[7] As such, the PDAB is intended to protect these entities from the high-cost of prescription drugs.[8] In addition, PDABs allege they can lower prescription drug costs for consumers through the savings from UPLs. This requires that plans pass savings to consumers in the form of lower premiums or lower prescription drug prices. However, without a statutory mandate this may not occur.

Without a requirement to pass savings, state and local governments could elect to use plan savings toward other necessary expenditures such as road repairs or schools. Therefore, Aimed Alliance urges the Maryland General Assembly to modify the current PDAB statute to include specific language that requires UPL savings to be passed down to beneficiaries in the form of meaningful reductions to premiums or prescription drug costs.

V. Conclusion

We sincerely appreciate the opportunity to comment on this proposed legislation and look forward to continuing to engage with the Maryland General Assembly and Maryland PDAB to ensure consumers access and affordability are centered throughout these reforms. Please contact us at policy@aimedalliance.org if you have any questions regarding this comment.

Sincerely,
Ashira Vantrees
Director of Legal Strategy & Advocacy

[7] MD HB 0768, https://mgaleg.maryland.gov/2019RS/bills/hb/hb0768e.pdf.
[8] *Id.*

BIO Opposition HB 424 SB 537.pdf
Uploaded by: Russell Palk
Position: UNF

Biotechnology Innovation Organization
1201 New York Avenue NW
Suite 1300
Washington, DC, 20005
202-962-9200

Bill: SB 357 / HB 424- Prescription Drug Affordability Board - Authority for Upper Payment Limits

Position: OPPOSE

Dear Chair, Vice-Chair, and Members of the Committee:

The Biotechnology Innovation Organization (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 respectfully opposes HB 424/SB 357 as it does not address the root cause of the problems affecting patients, including lowering out-of-pocket costs. Prescription Drug Affordability Boards (PDAB) across the country have failed to determine whether patients will see any savings to out-of-pocket expenses. In fact, Maryland's own PDAB has said patients will not see savings at the counter. Imposing government price controls like those proposed in this legislation will jeopardize patient access to life saving and life-altering biopharmaceuticals and stymie innovation.

This bill does not address the root cause affecting patients' out-of-pocket costs.

Nearly 90% of patients[1] pay a given price based on what their health insurer determines. Out-of-pocket costs have been rising for patients because of decisions made by health insurers. Net of rebates and other price concessions, medicine spending grew by only 0.8% in 2020.[2] Despite this fact, many insurers require more and more patients to pay for their drug costs through deductibles and cost-sharing rather than an established copayment, increasing their out-of-pocket costs. A May 2021 Congressional Research Service report found that insurers are imposing higher levels of cost sharing and forcing some patients, i.e., the chronically ill, to pay a greater financial burden than others.[3] In fact, insurers require patients to pay proportionately almost 5 times more out of pocket for prescription drugs than for hospital care.[4]

Legislative proposals such as these 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.

The arbitrary nature of the PDAB process ignores the value that an innovative therapy can have

[1] Kaiser Family Foundation. https://www.kff.org/uninsured/state-indicator/nonelderly-uninsured-rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[2] "The Use of Medicines in the U.S.: Spending and Usage Trends and Outlook to 2025, IQVIA, June 2021.
[3] "Frequently Asked Questions About Prescription Drug Pricing and Policy," Congressional Research Service Report, Updated May 6, 2021.
[4] "BIO Analysis of Historical National Health Expenditure Data, Centers for Medicare & Medicaid Services. December 2020.

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to an individual patient—especially one who may have no other recourse—or the societal impact innovative technologies can have, including increased productivity and decreased overall healthcare costs (e.g., due to fewer hospitalizations, surgical interventions, and health provider office visits). "Affordability reviews" also create discriminatory effects on patients with rare diseases by prioritizing cost containment over patient value. Patients with rare and chronic diseases have complex treatment plans that must be tailored to individual needs, making access to treatments without interruptions absolutely critical. The affordability review's biased focus on cost containment could lead to restrictions on patient access to treatments for rare diseases, which would be especially devastating on these populations.

Price controls will dampen investment and will not allow companies to adequately establish prices that will provide a return on investment.

The cost to bring an average biopharmaceutical from research and development to market is $2.6 billion.[5] Small and mid-sized innovative, therapeutic biotechnology companies which make up most of BIO's membership are responsible for more than 72% of all "late-stage" pipeline activity.[6] They sacrifice millions of dollars, often for decades before ever turning a profit, if at all. In fact, 92% of publicly traded therapeutic biotechnology companies, and 97% of private firms, operate with no profit.[7] The overall probability that a drug or compound that enters clinical testing will be approved is estimated to be less than 12%.[8] Only five out of 5,000 compounds become viable marketed products. Pricing must also account for the 4,995 failures before the company discovers that successful drug compound.

PDABs fail to consider the significant and devastating unintended consequences of its policies on patient access.

Drugs deemed to be "unaffordable" may shift market-based access incentives and lead payers to reform their benefit designs with greater utilization management or adverse formulary adjustments.[9] This in turn may reduce patient access to those medications. Under PDAB laws, insurers can deny coverage on products with a UPL.[10] Since insurers already have wide discretion to deny coverage on drugs that are deemed to not be "medically necessary", it is problematic that UPLs may provide yet another incentive for insurers to deny coverage for critical drugs.

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[5] DiMasi, JA, et al., Innovation in the pharmaceutical industry: New estimates of R&D costs. Journal of Health Economics. February 12, 2016.
[6] "The Changing Landscape of Research and Development: Innovation, Drivers of Change, and Evolution of Clinical Trial Productivity," IQVIA Report, April 2019.
[7] Ibid.
[8] Biopharmaceutical Research and Development, The Process Behind New Medicines. PhRMA, 2015. http://phrma-docs.phrma.org/sites/default/files/pdf/rd_brochure_022307.pdf
[9] Upper Payment Limits on Drugs Could Alter Patient Access. Avalere. April 8, 2024. Retrieved: https://avalere.com/insights/upper-payment-limits-on-drugs-could-alter-patient-access
[10] "Stop the Minnesota Prescription Drug Affordability Board." Patients Rising Now. Retrieved: https://patientsrisingnow.org/stop-the-mn-pdab/

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In addition, patient access could be harmed as providers change prescribing patterns for drugs subject to price setting. Patients who visit small provider practices and specialty providers may be disproportionately harmed if those providers cannot, or will not, access these drugs anymore because reimbursement for associated services is limited. To circumvent drug shortages and limitations on patient access, patients may be forced to travel outside the state to access drugs not available under the UPL. This may exacerbate growing health inequities between those high-income patients with the means to travel outside the state, and low-income patients who have a more difficult time to take leave and travel across state lines.

For these reasons, BIO opposes HB 424/SB 357 requests an unfavorable report. Please do not hesitate to contact us for any further information.

Sincerely,

Russell Palk

NICA and IAF Comments in Opposition to SB 357.pdf
Uploaded by: Sam Miller
Position: UNF

NATIONAL INFUSION CENTER ASSOCIATION

The Nation's Advocacy Voice for In-Office Infusion

3307 Northland Dr, Ste 160 ▪ Austin, TX 78731
www.infusioncenter.org ▪ info@infusioncenter.org

Maryland Senate
Finance Committee
11 Bladen Street
Annapolis, MD 21401

February 6, 2025

Re: Support for SB 357

Dear Committee Members:

On behalf of the National Infusion Center Association (NICA), which represents infusion therapy providers across Maryland, we write to express our strong opposition to SB 357. This bill would expand the authority of the Maryland Prescription Drug Affordability Board (PDAB) to impose Upper Payment Limits (UPLs) on certain drugs across all state-regulated health plans. If enacted, this policy would jeopardize the financial stability of infusion therapy providers and, more importantly, restrict patient access to critical, life-sustaining treatments.

NICA is a nonprofit organization formed to support non-hospital, community-based infusion centers caring for patients in need of infused and injectable medications. To improve access to medical benefit drugs that treat complex, rare, and chronic diseases, we work to ensure that patients can access these drugs in high-quality, non-hospital care settings. NICA supports policies that improve drug affordability for beneficiaries, increase price transparency, reduce disparities in quality of care and safety across care settings, and enable care delivery in the highest-quality, lowest-cost setting.

Infusion therapy providers operate under a buy-and-bill model, meaning we must purchase medications upfront from manufacturers or wholesalers before seeking reimbursement from insurers. If UPLs are expanded and reimbursement rates fall below acquisition costs, providers will be forced to absorb financial losses on every treatment administered. This untenable situation would likely result in clinic closures, service reductions, and significant barriers to care for patients with chronic and complex conditions such as autoimmune disorders, neurological diseases, and rare genetic disorders.

NATIONAL INFUSION CENTER ASSOCIATION

The Nation's Advocacy Voice for In-Office Infusion

3307 Northland Dr, Ste 160 ▪ Austin, TX 78731
www.infusioncenter.org ▪ info@infusioncenter.org

Ensuring access to high-quality infusion therapy is essential to the health and well-being of Maryland patients. By voting no on SB 357, you will help protect the viability of provider practices and prevent unnecessary disruptions to care. We urge you to oppose this bill and preserve access to infusion therapy for the thousands of Marylanders who depend on it.

Thank you for your consideration. We appreciate your leadership on this important issue and welcome the opportunity to discuss this matter further.

Sincerely,

Brian Nyquist, MPH
President & CEO
National Infusion Center Association

Infusion Access Foundation

Maryland Senate Finance Committee
11 Bladen St
Annapolis, MD 21401

January 15th, 2025

Re: Support for SB 357

Dear Committee Members,

On behalf of the Infusion Access Foundation, which represents patients across Maryland who rely on infusion therapy to manage chronic and life-threatening conditions, we write to express our strong opposition to SB 357. This bill would expand the authority of the Maryland Prescription Drug Affordability Board (PDAB) to impose Upper Payment Limits (UPLs) on certain medications across all state-regulated health plans. If enacted, this policy would threaten access to essential treatments for thousands of vulnerable Maryland patients.

The Infusion Access Foundation is a nonprofit advocacy organization dedicated to protecting access to infusions and injections. We support patients across all disease states and advocate for expanding access to the therapies that help patients live their best, healthiest lives. In conjunction with our grassroots advocacy work, we advocate for individual patients who face significant barriers to care.

Many of the patients we represent live with complex autoimmune diseases, neurological conditions, genetic disorders, and other serious illnesses that require regular infusion therapy to maintain their health and quality of life. Infusion providers purchase these medications upfront before seeking reimbursement from insurers. If UPLs result in reimbursement rates below the actual cost of acquiring and administering these treatments, providers may be forced to reduce services or shut down, leaving patients with limited or no access to the care they need.

For many patients, infusion therapy is not optional—it is lifesaving. Restricting access to these medications could lead to disease progression, hospitalizations, disability, and significant declines in health outcomes. Maryland should be working to expand access

to high-quality, specialized care—not implementing policies that could force providers out of business and leave patients without viable treatment options.

We urge you to vote no on SB 357 to ensure that Maryland patients can continue receiving the care they depend on. Thank you for your time and commitment to protecting patient access to essential therapies. We welcome the opportunity to discuss this critical issue further.

Sincerely,

Alicia Barron, LGSW
Executive Director
Infusion Access Foundation

PIPC MD letter SB357 and HB424.pdf
Uploaded by: Sara van Geertruyden
Position: UNF

PIPC Partnership to Improve Patient Care

February 4, 2025

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

Delegate Joseline A. Pena-Melnyk
Chair
240 Taylor House Office Building
Annapolis, Maryland 21401

Senator Antonio Hayes
Vice Chair
3 East Miller Senate Office Building
Annapolis, Maryland 21401

Delegate Bonnie Cullison
Vice Chair
241 Taylor House Office Building
Annapolis, Maryland 21401

Dear Chair Beidle, Chair Pena-Melnyk, Vice Chair Hayes, and Vice Chair Cullison:

I am writing on behalf of the Partnership to Improve Patient Care (PIPC). The attached correspondence with the Legislative Policy Committee and the Maryland Prescription Drug Affordability Board (PDAB) demonstrates our continued efforts to share concerns about the implications for discrimination related to the PDAB's work. As the original author and sponsor of the Americans with Disabilities Act (ADA), I am concerned that the legislature is seeking to expand the PDAB's scope of work and influence over decisions that will impact how patients and people with disabilities access care and treatment. As you debate SB357 and HB424, I hope you will consider the strong concerns you are hearing from the patient and disability communities.

Thank you for reviewing and considering the attached in your deliberations.

Sincerely,

Tony Coelho

Tony Coelho
Chairman
Partnership to Improve Patient Care

PIPC Partnership to Improve Patient Care

October 15, 2024

Senator Bill Ferguson
Department of Legislative Services
Annapolis, Maryland 21401

Delegate Adrienne A. Jones
Department of Legislative Services
Annapolis, Maryland 21401

Dear Senator Ferguson and Delegate Jones:

Since its founding, the Partnership to Improve Patient Care (PIPC) has been at the forefront of applying principles of patient-centeredness to the nation's health care system – from the generation of comparative clinical effectiveness research at the Patient-Centered Outcomes Research Institute (PCORI), to the translation of evidence into patient care in a manner that achieves value to the patient. Having driven the concepts of patient-centeredness and patient engagement in the conduct of research, PIPC looks forward to bringing the voices of patients and people with disabilities to the discussion of how to advance patient-centered principles throughout an evolving health care system.

I am writing to share PIPC's serious concerns about the Upper Payment Limit Plan submitted to Maryland's General Assembly Legislative Policy Committee by the Prescription Drug Affordability Board (PDAB) for its review and approval. We share the goals of health care affordability and want to be engaged partners with you in addressing the challenges facing patients. For too long, patients and people with disabilities have been subjected to adverse utilization management strategies that force use of a treatment that fails patients before gaining access to a treatment that works – or outright coverage denials of prescribed treatments. Their real-world experiences are critical to allow policymakers to understand what is driving affordability challenges and develop policy solutions addressing their economic burdens.[1]

Unfortunately, the Maryland PDAB process was less focused on the perspectives of patients and people with disabilities and more focused on payer perspectives. For example, recent written comments on the draft UPL Plan were ignored by the Board. 38 organizations sent a letter to the Maryland PDAB suggesting changes to its draft UPL Plan.[2] That letter was not immediately posted to the PDAB website, it was not listed among letters considered by the Board, and it was not discussed at the PDAB meeting during which the revised UPL Plan was

[1] PCORI advanced a patient-engaged process to determine economic burdens. See https://www.pcori.org/sites/default/files/PCORI-Patient-Centered-Economic-Outcomes-Landscape-090524.pdf
[2] See http://www.pipcpatients.org/uploads/1/2/9/0/12902828/maryland_pdab_comments_final.pdf

approved to be sent to the Legislative Policy Committee.[3] Unsurprisingly, the revised UPL Plan did not address any of the concerns expressed in that letter.

Moreover, regulations were finalized in May, 2024 under Section 504 of the Rehabilitation Act barring disability discrimination that included provisions barring the use of discriminatory value assessments in decisions impacting access to care, including reimbursement and coverage.[4] PIPC and its partners have reiterated to the Maryland PDAB several times that federal law bars the use of cost effectiveness measures such as quality-adjusted life years (QALYs) and similar measures that devalue disabled lives.[5,6,7] That includes reference to international prices in countries that use such measures and do not prioritize care for people with disabilities and serious chronic conditions. Yet, the Maryland PDAB is relying on entities such as the Program on Regulation, Therapeutics and Law (PORTAL) and the Institute for Clinical and Economic Review (ICER) that favor use of discriminatory value assessments to inform its work.[8,9] Their advice is not centered on achieving access to affordable care for patients and people with disabilities yet seems to be taken most seriously. We are concerned about Board members' ties to entities that view the QALY and similar measures as the gold standard for assessing value in healthcare.[10] Those concerns were amplified by the PDAB's failure to provide answers to credible questions from the disability community as to how UPLs may impact the use of payer tools to restrict formularies and increase out-of-pocket costs for patients, whether for the drug under review or other drugs in its class.

Also, the Maryland PDAB process has not prioritized accessibility. Comment deadlines and meeting dates and times often change, leaving patients and people with disabilities unable to participate. Comments submitted by the public are difficult to find on the website and are not posted in a timely manner. Accessing the recorded PDAB meetings for older meetings is challenging and are difficult to navigate on the Maryland PDAB website. Public participation has clearly not been a priority for the PDAB, much less participation from the disability community or patients personally affected by decisions related to drugs under review. Recent federal regulations issued by the U.S. Department of Justice covering Title II of the ADA require the accessibility of web content and mobile applications (apps) for people with disabilities. To be compliant, state and local governments must make their websites and mobile applications

[3] See https://pdab.maryland.gov/Pages/2024-Board-Meeting.aspx
[4] 45 CFR § 84.56 and § 84.57
[5] See http://www.pipcpatients.org/uploads/1/2/9/0/12902828/pipc_maryland_pdab_2024.pdf
[6] See https://www.pipcpatients.org/uploads/1/2/9/0/12902828/pipc_maryland_pdab_050223.pdf
[7] See https://valueourhealth.org/wp-content/uploads/2021/08/MD-Letter-Final.pdf
[8] PORTAL Presentation to PDAB, https://pdab.maryland.gov/documents/meetings/2023/havard_med_sch_prst.pdf
[9] ICER Presentation to PDAB, https://pdab.maryland.gov/documents/presentations/Leveraging_ICER_Rpt_for_Prescription_Drug_Affordability.pdf
[10] Dr. Gerard Anderson has reported grants from Arnold Ventures, which is a primary funder of the Institute for Clinical and Economic Review and supporter of their QALY-based methodology, as well as funder of PORTAL Research and NASHP.

accessible. Beyond what is legally required, we had hoped that the PDAB would proactively want to make the process accessible for patients and people with disabilities and prioritize responding to their concerns and incorporating their input.

As the original author and sponsor of the Americans with Disabilities Act and a person with epilepsy, I have spent my adult life fighting for disability rights and against these types of policies that devalue us. I have had personal experience with non-medical switching imposed by my insurer, with adverse outcomes that were entirely unavoidable. As an older adult now, I am do not subscribe to the idea that my life is worth less, as most measures of cost effectiveness would have you believe. With recent federal regulations to more clearly guide us, the disability community is now fighting for enforcement of U.S. laws that protect patients and people with disabilities.

The Legislative Policy Committee should not approve a UPL Plan that does not protect against disability discrimination and adverse utilization management strategies by payers. The goal of the PDAB should be to improve patient access to the care they and their doctors determine to be most effective. By pausing this process, the Legislative Policy Committee could take the time to understand the implications of the PDAB's UPL Plan and engage with patients and people with disabilities on solutions that are meaningful for advancing affordable access to care and in compliance with disability rights laws.

Thank you for your consideration.

Sincerely,

Tony Coelho
Chairman
Partnership to Improve Patient Care

August 26, 2024

Mr. Van T. Mitchell
Chair
Maryland Prescription Drug Affordability Board
16900 Science Drive, Suite 112-114
Bowie, MD 20715

Dear Chair Mitchel and Board members:

As organizations representing patients and people with disabilities, we strongly urge the Maryland Prescription Drug Affordability Board (PDAB) to prioritize the perspectives of people whose care may be impacted by your decisions as it works to finalize a Plan of Action for Implementing the Process for Setting Upper Payment Limits. Therefore, we would like to provide the following recommendations:

- Develop a concrete plan to monitor and respond to potential increased use of utilization management strategies and adverse formulary placements for both selected drugs *and* their alternative treatments.
- Improve the Board's patient engagement practices and use of survey data.
- Avoid the use of discriminatory value assessments.
- Avoid reference to drug prices in other countries.

We are deeply concerned with recommendations from academia to states implementing PDABs that are not centered on helping patients gain affordable access to the drugs that patients and doctors determine to be the most effective treatment.[1,2] Patients and people with disabilities have consistently expressed opposition to policies advancing use of discriminatory value assessments, closed formularies, utilization management strategies in which a drug must fail before patients can access a drug that works, non-medical switching to "therapeutic alternatives" as determined by a payer based on cost considerations, and formulary exclusions. Ultimately, we urge the Board to advance policies that support high-quality shared decision-making between patients and providers, ensuring patients can access the care that will have the most optimal impact on their quality of life and health outcomes. Adopting the recommendations below will be a strong start to protecting people with disabilities and serious chronic conditions in Maryland.

Develop a concrete plan to monitor and respond to potential increased use of utilization management strategies and adverse formulary placements for both selected drugs *and* their alternative treatments.

[1] NASHP Toolkit to PDABs https://nashp.org/prescription-drug-affordability-board-toolkit/
[2] https://pdab.maryland.gov/documents/stakeholders/2023/havard_med_brigm_prst.pdf

We appreciate that the statute governing the Board's activities calls for cost reviews that determine whether a treatment "has led or will lead to affordability challenges for the State health care system or high out-of-pocket costs for patients." It is our hope that the Board is first and foremost seeking to protect patients and people with disabilities seeking to access the treatment that is recommended by their providers and most effective for the patient. By now, the Board is aware that affordability challenges are often associated with placement on formularies, utilization management strategies imposed by payers to restrict access to certain drugs, and outright denials that force patients to pay out-of-pocket for access to the drug on which they are most stable. It does patients and people with disabilities little good to lower the price of a drug if the outcome is to make it harder to access that drug or an alternative drug that may be more effective for the patient but is no longer on a preferred tier or is subject to a fail first policy.

The Board has significant latitude to determine whether an Upper Payment Limit (UPL) is the policy solution for an affordability challenge. What many patients know to be true is getting the drug they need is often difficult and burdensome. Meaningful policies to genuinely help patients address their out-of-pocket costs must mitigate the use of discriminatory value assessments by payers to justify restricting access to care for people with disabilities and serious chronic conditions, as well as older adults. Addressing affordability starts with policies that support shared decision-making between patients and providers and ensure affordable coverage of the treatment plan that patients and providers determine to be most effective.

Therefore, we urge the Board to develop a concrete plan to monitor and respond to potential increased use of utilization management strategies and adverse formulary placements for both selected drugs *and* their alternative treatments, which could increase patient costs and impede physicians' judgment about the best care for individual patients. The draft plan states the Board will set UPLs in a way to minimize adverse outcomes and minimize the risk of unintended consequences, as well as monitor availability of prescription drugs subject to a UPL to protect against shortages. We hope the Board will go further to ensure patients and people with disabilities are not losing access due to coverage denials, step therapy, prior authorization, etc. We appreciate that the Board proposes to reconsider or suspend UPL's where they find selected drugs to be unavailable and propose the Board adopt the same policy to respond to payers that restrict access to selected drugs or other alternatives.

Improve the Board's patient engagement practices and use of survey data.

The Board states in its draft UPL plan that its process is transparent and offers multiple opportunities for public engagement and input. Yet, it is not clear to stakeholders how information submitted by patients is used by the Board to make decisions. We would urge the Board to review the work of experts in patient engagement such as the patient-Centered Outcomes Research Institute (PCORI), National Health Council, the University of Maryland, AcademyHealth and the Innovation and Value Initiative on how to best engage the patient community in its work. For meaningful engagement on the factors listed for consideration by

the Board – including therapeutic alternatives, patient access, comparative clinical effectiveness research, cost sharing, clinical information and disease burden – we recommend the Board:

- Develop a formalized process to ensure continuous, robust engagement of patients and people with disabilities at multiple levels.
- Use patient insights to clearly communicate how it intends to use the input it receives, and how that input is reflected in the final negotiated prices.
- Solicit input from diverse communities to ensure representation of the diversity of the patients and communities affected by the topic.
- Ensure that opportunities for patient engagement are accessible.
- To gauge both successes and challenges, establish a structured process for continuous review and assessment of its engagement strategy.
- Avoid one-size fits all value metrics.[3]

The Board has received substantial comments about the factors that drive affordability challenges for patients and people with disabilities, yet the Board continues to focus its work on establishing UPLs without addressing the economic burdens that patients too often face, whether it be transportation, caregiving, utilization management strategies blocking coverage of prescribed care, etc. Entities such as the Patient-Centered Outcomes Research Institute (PCORI) have invested significant resources in engaging patients to identify the full range of clinical and patient-centered outcomes, including the potential burdens and economic impacts of health care services[4,5]. Additionally, a patient-developed survey is now available to help the Board determine the many factors that can lead to affordability and access challenges for patients, led by the Patient Inclusion Council, also known as the PIC.[6] We urge the Board to use these resources to better understand the burdens facing patients and to develop patient-centered strategies for improving access to care.

Avoid the use of discriminatory value assessments.

The Board highlights in the draft that it may consider many different factors part of a cost review, including cost effectiveness analyses. Yet, on May 9, 2024, the final new regulations governing Section 504 of the Rehabilitation Act were published, protecting the rights of people with disabilities in programs and activities receiving federal financial assistance against the use of discriminatory value assessments also known as cost effectiveness analyses.[7] The U.S. Department of Health and Human Services' rule represents a critical step forward to protecting

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[3] https://www.pipcpatients.org/uploads/1/2/9/0/12902828/pipc_recommendations_for_patient_engagement_final.pdf

[4] https://www.pcori.org/sites/default/files/PCORI-Out-of-Pocket-Cost-Taxonomy-Scoping-Review-Sept-2023.pdf

[5] https://www.pcori.org/sites/default/files/PCORI-Assigning-Costs-to-Healthcare-Utilization-Report-March-2023.pdf

[6] https://www.surveymonkey.com/r/PatientDrugAffordability

[7] https://www.govinfo.gov/content/pkg/FR-2024-05-09/pdf/2024-09237.pdf?utm_campaign=subscription+mailing+list&utm_medium=email&utm_source=federalregister.gov

patients and people with disabilities and sends a strong message that we need better solutions for U.S. decision-making that don't rely on the biased, outdated standards historically used by payers. As described in the final rule, the new regulations would bar health care decisions made using measures that discount gains in life expectancy, which would include measures such as the quality-adjusted life year (QALYs) and the combined use of QALYs and equal value of life years gained (evLYG) that are most common methodologies for calculating cost effectiveness. The agency broadly interpreted what constitutes the discriminatory use of value assessment in its description of the rule, stating recipient obligations under the rule are broader than section 1182 of the Affordable Care Act. Section 1182 of the ACA bars Medicare's use of QALYs and similar measures that that discount the value of a life because of an individual's disability. Therefore, it is important for the Board to avoid the use of cost effectiveness analyses to make decisions that affect reimbursement and coverage of prescription drugs to remain aligned with federal law and regulations barring discrimination.

It is now widely recognized that traditional methods and metrics of value assessment – even beyond the QALY – have significant shortcomings. Well-intentioned development of other measures and approaches that developers assert to be nondiscriminatory and more patient-centered come with tradeoffs, need for improvement, and inherent methodological flaws. We urge the Board to avoid the use of cost effectiveness analyses that at worst violate federal nondiscrimination laws and regulations and at best force tradeoffs such as whether to value life extension or quality of life improvement. No patient is average, and no measure of value should assume so.[8]

Avoid reference to drug prices in other countries.

The Board's draft plan also proposes use of an international reference upper payment limit using drug prices in other countries. Referencing other countries is similarly contrary to federal laws governing disability discrimination due to their reliance on discriminatory value assessments, including QALYs. The Board's proposed policy would import those discriminatory standards from other countries and lead directly to lack of access to needed treatments for many Americans.[9] While Germany is often raised, we encourage the Board to review the German system, including its limited use of evidence, inappropriate comparators and endpoints, exclusion of health outcomes that are important to patients, and failure to capture heterogeneity of patient populations.[10] In Canada, the current coverage and reimbursement process for new drugs impedes access to care due to its reliance on QALY-based assessments conducted by the Canadian Agency for Drugs and Technologies in Health (CADTH).[11] In the United Kingdom, medicines exceeding the National Institute for Health and Care Excellence (NICE) cost-per-QALY threshold are not deemed cost effective, leading to a high rate of

[8] https://www.pipcpatients.org/uploads/1/2/9/0/12902828/pipc_value_critique_updated.pdf
[9] https://www.pipcpatients.org/uploads/1/2/9/0/12902828/pipc_stakeholder_comment_on_importing_qalys.pdf
[10] https://www.pipcpatients.org/uploads/1/2/9/0/12902828/germany_draft_2022_9-21_edited_clean.pdf
[11] Guidelines for the Economic Evaluation of Health Technologies: Canada. July 2017

rejections denying patients access to new medicines.[12] Ireland similarly denies patients care based on QALY thresholds.[13]

We encourage the Board to reference the work of the National Council on Disability, an independent federal agency advising Congress and the administration on disability policy, which has consistently recommended against referencing foreign prices in comments related to a proposed international pricing index,[14] Most Favored Nation policy,[15] and federal legislation.[16] The NCD's recommendations against reliance on cost effectiveness are largely reflected in the new federal Section 504 regulations, providing increased clarity on the prohibited use of discriminatory value assessments.

Thank you for the opportunity to comment on the draft UPL plan. We look forward to revisions that prioritize policies centered on access to care for patients and people with disabilities. Please reach out to sara@pipcpatients.org with any questions.

Sincerely,

Alliance for Aging Research
Alliance for Patient Access
ALS Association
American Association of Kidney Patients (AAKP)
Asthma and Allergy Foundation of America
Biomarker Collaborative
Cancer*Care*
Caring Ambassadors Program
Coalition of State Rheumatology Organizations (CSRO)
Color of Gastrointestinal lllnesses
Cystic Fibrosis Research Institute
Derma Care Access Network
Diabetes Leadership Council
Diabetes Patient Advocacy Coalition
Disability Equity Collaborative
Epilepsy Foundation
Exon 20 Group
Familia Unida Living with MS
GO2 for Lung Cancer

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[12] Drummond, M. and Sorenson, C. Nasty or Nice? A Perspective on the Use of Health Technology Assessment in the United Kingdom. Value in
Health 2009; 12(S2).
[13] National Centre for Pharmacoenomics (NCPE). http://www.ncpe.ie/about/
[14] https://www.ncd.gov/2020/08/05/ncd-statement-on-harm-of-using-international-pricing-index-for-u-s-prescription-drug-pricing/
[15] https://www.ncd.gov/letters/2021-01-15-ncd-letter-to-cms-on-most-favored-nation-rule/
[16] https://www.ncd.gov/letters/2021-04-29-ncd-letter-to-house-committees-with-concerns-regarding-h-r-3/

Headache and Migraine Policy Forum
Health Hats
HealthHIV
HIV+Hepatitis Policy Institute
ICAN, International Cancer Advocacy Network
Infusion Access Foundation
Lupus and Allied Diseases Association, Inc.
MET Crusaders
MLD Foundation
Monica Weldon Consulting, LLC
National Infusion Center Association (NICA)
National Infusion Center Association (NICA)
Partnership to Fight Chronic Disease (PFCD)
Partnership to Improve Patient Care
Patients for Patient Safety - US
PD-L1 Amplifieds
The Bonnell Foundation: Living with cystic fibrosis
The Coelho Center for Disability Law, Policy and Innovation
The IMAGE Center for People with Disabilities

cc: Stakeholder Council

SB357_HealthHIV_UNF
Uploaded by: Scott Bertani
Position: UNF

HealthHIV

1630 Connecticut Avenue, NW, Suite 500
Washington, DC 20009

202.232.6749 | healthhiv.org

Senate Finance Committee

Miller Senate Office Building
11 Bladen St.
Annapolis, MD 21401

February 05, 2025

Regarding Senate Bill 357 – Prescription Drug Affordability Board (PDAB) Expansion

Dear Chair Beidle *and* Members of the Senate Finance Committee,

On behalf of HealthHIV, we appreciate the opportunity to provide comments on Senate Bill (SB 357). We also thank you for your leadership in advancing policies that promote prescription drug affordability for Marylanders.

As background, HealthHIV is a national non-profit organization dedicated to advancing HIV, HCV, STI, and LGBTQI+ healthcare, harm reduction, and health equity. We work with healthcare organizations, local and state health departments , communities, and providers (prescribing and supportive) to strengthen care through education, training, technical assistance, capacity building, advocacy, communications, and health services research and evaluation.

As SB 357 moves forward, we urge the Committee to carefully consider the implications of expanding the Prescription Drug Affordability Board's (PDAB) authority—particularly its impact on oversight, provider reimbursement, drug availability, and alignment with broader healthcare frameworks.

As proposed, SB 357 adds to these challenges by scaling back legislative oversight, reducing transparency, and eliminating key monitoring requirements. Without meaningful checks in place, affordability decisions could end up restricting patient access or making it harder for providers (as yet fully defined) to participate.

Oversight & Drug Availability Risks

One of the biggest worries (we feel) with SB 357 is that it removes existing legal requirements for PDAB to factor in supply risks when setting UPLs. Under current law, PDAB must assess affordability before imposing UPLs and cannot set them on drugs already on the FDA shortage list. SB 357 appears to eliminate the provision that automatically suspends a UPL if a drug goes into shortage. Instead, it gives the Board the option to revisit the UPL—but without any obligation to take action. This shift weakens protections for both patients and the broader healthcare system, increasing the risk of supply disruptions.

SB 357 removes critical statutory provisions requiring the PDAB to monitor drug availability for any medication under a UPL. Without a clear mandate to track and respond to shortages, access gaps could widen unchecked and disproportionately affect low-income patients on public programs.

Impact on MADAP and HIV Treatment Continuity

While UPLs could affect drug availability more broadly, their impact on the Maryland AIDS Drug Assistance Program (MADAP) is especially concerning.. As a program designed to increase access to HIV medications, support adherence, and improve viral suppression, MADAP ensures uninterrupted medication access for approximately 5,900 Marylanders

living with HIV. This is achieved through a structured provider network of 1,636 pharmacies statewide, enabling geographically accessible, predictable, and sustainable HIV care. However, SB 357 could destabilize this framework by introducing reimbursement shifts without clear safeguards—or, at minimum, conversations with MADAP and its QM Committee.

A stable pharmacy network is essential to MADAP's ability to help clients effectively monitor their medication regimens and ensure continuity of care. If UPL-driven reimbursement reductions make participation unsustainable for some pharmacies, network cohesion could weaken, creating access gaps, treatment delays, and increased administrative burdens for both providers and patients—especially in rural and underserved areas, exacerbating "pharmacy desert" (or more care) issues.

MADAP further relies on pharmacy reimbursement mechanisms and Ryan White rebate funds to sustain its operations. Unlike a traditional PBM, MADAP *does not profit* from price negotiations but instead reinvests drug rebates into healthcare coverage, including purchasing health insurance premiums for eligible clients to reduce out-of-pocket costs and expand access. This model ensures that nearly all MADAP clients pay less than $.1 for their medications, a key clinical quality measure reflecting the program's success in ensuring equitable treatment access.

If SB 357 leads to reimbursement changes without clear protections, pharmacies may leave the MADAP network, rebate-based funding could become unstable, and access to (truly) life-saving HIV medications could be disrupted. This would also increase the need for stronger medical case management to support adherence, especially for clients who may have to navigate adherence challenges , or regimen changes.

Medicare Part C and D Reimbursement

The impact of Medicare Part C and D reimbursement is particularly urgent as the population of people with HIV rapidly ages, with more individuals transitioning from Ryan White coverage to Medicare. As eligibility shifts, so do the financial structures that sustain HIV care—rebates that previously supported MADAP are reduced as individuals move into Medicare unless their income remains within the Federal Poverty Level (FPL) thresholds for Ryan White eligibility.

This transition thus places greater reliance on Medicare Part D, which comes with higher cost-sharing requirements and formulary restrictions, making stable pharmacy participation even more critical. If reimbursement instability forces pharmacies out of safety-net programs, older adults with HIV—who often manage multiple comorbidities—could face treatment disruptions, reduced access to specialized HIV care, and financial barriers to affording essential medications necessary for viral suppression. Without a structured state monitoring process, pharmacy exits and reimbursement shifts could go unchecked, leading to shortages and widening access gaps before intervention occurs.

While SB 357 prohibits the PDAB from applying UPLs to Medicare Part C and D reimbursement, *it does nothing* to address broader concerns about pharmacy viability. Excluding dispensing fees from UPLs is an insufficient safeguard, as overall reimbursement reductions may still drive independent and rural pharmacies out of safety-net programs—further restricting access to HIV medications.

Implications for 340B Providers

Pharmacies that dispense 340B-priced medications on behalf of covered entities—including Ryan White clinics, HRSA-covered entities, and Federally Qualified Health Centers (FQHCs)—do not purchase 340B drugs directly but serve as

critical distribution points, particularly in areas where in-house dispensing is limited. While covered entities retain 340B savings, these pharmacies play a key role in ensuring patient access to discounted medications, often bridging gaps in care.

MADAP is not a direct 340B entity but instead functions as a payer for prescriptions through Medicaid-participating pharmacies. Unlike Ryan White clinics and FQHCs, MADAP does not purchase drugs at 340B prices but relies on manufacturer rebates to sustain its operations. These rebates are reinvested into healthcare coverage for eligible clients, including insurance premium assistance and direct medication support.

However, many Ryan White-funded clinics that serve MADAP clients do rely on 340B revenue to sustain HIV care and support services. A UPL that disrupts 340B savings could disproportionately impact Ryan White-funded clinics, reducing their capacity to provide HIV treatment, medication adherence support, and case management services. Given the specialized and limited scope of Ryan White programs, any financial strain on their model risks undermining Maryland's HIV care infrastructure, particularly for populations who rely on both MADAP's rebate-supported funding and 340B-backed clinical services.

Governance & Future Expansion of the PDAB's Authority

Beyond its impact on drug pricing and reimbursement, SB 357 fundamentally alters how the PDAB operates—shifting authority away from direct legislative oversight. The bill eliminates key reporting requirements, further reducing transparency in how PDAB decisions are made.

Previously, the PDAB was required to report to the General Assembly on the feasibility of UPLs and whether further legislative expansion was warranted. SB 357 removes this requirement entirely, shifting key decision-making away from elected officials and placing it solely in the hands of the PDAB and the Stakeholder Council—without legislative approval or public accountability.

Additionally, the bill ties the full expansion of UPLs to the PDAB's implementation of at least two UPLs for one year but does not define the specific criteria for evaluating whether those UPLs are actually "successful." While coordination with federal drug pricing reforms like Medicare Maximum Fair Prices (MMFP) is important, the bill does not clarify how these savings interact with Medicaid reimbursement or other state-based payer structures, raising further questions about its long-term fiscal impact on safety-net programs.

Given these concerns, I strongly urge the Committee to consider amendments that restore critical oversight mechanisms and provide greater clarity on provider and pharmacy protections. Specifically:

1. Reinstate drug availability monitoring requirements to ensure the PDAB proactively assesses the impact of UPLs on access and shortages.
2. Clarify the definition of "providers of 340B drugs" to ensure it accurately reflects covered entities that rely on 340B savings, such as Ryan White clinics and FQHCs. Without a clear definition, UPLs may have unintended consequences for safety-net providers and their ability to deliver HIV care and services.
3. Require the PDAB to report back annually to the General Assembly before expanding UPLs statewide, ensuring elected officials retain direct oversight of affordability measures.

4. Assess pharmacy reimbursement impacts beyond dispensing fees, recognizing that UPLs may still create financial strain on pharmacies that serve vulnerable populations.

Without stronger oversight**,** UPL policies could destabilize Maryland's safety-net programs, limit access, and weaken provider participation in MADAP and 340B-supported HIV care**.** While these programs operate under separate funding structures, both serve as critical lifelines for people living with HIV—especially those with low incomes or complex healthcare needs. Protecting both manufacturer rebate funding and 340B reinvestment mechanisms is essential to maintaining HIV care access and continuity.

I urge the Committee to adopt these recommendations to ensure affordability measures do not unintentionally undermine Maryland's established HIV care framework.

I welcome further discussion on refining this bill to support prescription drug affordability while preserving patient access and provider sustainability.

Thank You (*all*) for your time and consideration. I welcome further discussion on refining this bill to achieve affordability without undermining Maryland's strong HIV medication access.

Md_Senate_Finance Testimony UPL.pdf
Uploaded by: Steven Newmark
Position: UNF

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February 6, 2025

Maryland Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, Maryland 21401
Sent via MyMGA

RE: Prescription Drug Affordability Board - Authority for Upper Payment Limits (SB-0357) [OPPOSE]

Dear Committee,

I am proud to say that I was born and raised in the great state of Maryland and that 25 years ago I co-founded an organization, the Global Healthy Living Foundation (GHLF), that today represents chronically ill patients across the country. I spend my days working tirelessly to educate patients and being a voice to patients at hearings such as this across the nation. The patients GHLF represents rely on various therapies to live the most fulfilling lives they can. As such, our organization has taken a keen interest in the work of Prescription Drug Affordability Boards (PDABs or Boards) in various states and the potential impact to our patients' accessibility to necessary drugs.

We write to comment on SB-0357, Prescription Drug Affordability Board – Authority for Upper Payment Limits. Specifically, **we write to oppose this legislation** as we believe this will harm patient access to important therapies without providing financial relief directly to patients.

While it is always commendable for a state to tighten belts and save taxpayer money, we implore you not to take such actions that are detrimental to the lives of chronically ill patients.

The treatment of chronically ill patients – who rely regularly on medications to live – should be of paramount importance to elected officials. While the title of the bill sounds laudable – it hints at making medicines more "affordable" for patients – the reality is setting upper payment limits on medications not directly save patients money but are aimed at setting price limits on certain products purchased by the state and local governments.

That is not just the opinion of GHLF. That was admitted in a briefing given to this committee on January 9, 2025, by Andrew York, the Executive Director of the Maryland Prescription Drug Affordability Board. Specifically, Mr. York said this to the Committee: "for state and local government it would likely be taxpayer savings … taxpayer expenditures [not individual savings for patients]."[1] Prior to those words, it was made clear that the specific savings *do not goto patients*.

[1] Available online at : https://www.youtube.com/watch?v=2Jz33THaV00&list=PLJ-XD0yRQ-kWtTdIla4wq5kodU04DzdEt (*See Minutes* 27:51 – 28:14).

Let's be clear: the effects of attempting to create savings of the type designed here could have deleterious effects for patients. Upper Payment Limits should be completely disallowed in the state of Maryland – not expanded as envisioned by this bill. This bill is particularly troublesome because it is seeking to expand the Board's powers with respect to upper payment limits to include limitations on all purchases, which presumably includes purchases made by private health insurers. Creating more barriers to entry in the marketplace could cause manufacturers simply to leave Maryland, leaving patients in the lurch. It could very likely cause health plans to switch patients onto different medications, which could have disastrous effects. Worse: the costs "saved" by local governments via an upper payment limit may save short term costs but lead to devasting costs down the road for local governments required to covered health care needs for patients requiring surgeries, hospitalizations, and more because they were denied access to medications that had kept these patients stabilized.

People in the United States pay more for medicine than people living in many other parts of the world simply because our system allows for secret negotiations between drug manufacturers, pharmacy benefit managers, and health insurers that artificially inflate drug prices through complex contracts that include rebates and discounts. Yet, these savings never trickle down to patients.

Patients often spend years trying different medications before they can find one that leads to stabilization of their condition. Disruptions in the marketplace could have devastating consequences for these patients. Just in terms of costs: the cost to an individual who ceases to be stable could include lost income, increased childcare costs associated with the inability to rear their children, and medical expenses not covered by existing plans. Beyond the fiscal costs are the human ones: to through chaos into the system can destabilize chronically ill patients leading to mental health ailments that can take years to remedy.

We thank you for your time, and again, hope that you will consider the patient voices as you deliberate on the costs of drugs.

Sincerely,

Louis Tharp
Executive Director

Maryland Senate PDAB Final.pdf
Uploaded by: Zach Lynkiewicz
Position: UNF

HIV+HEP
POLICY INSTITUTE

February 4, 2025

Senator Pamela G. Beidle, Chair
Senate Finance Committee
Maryland Senate
Miller Senate Office Building, 3 East Wing
11 Bladen Street
Annapolis, MD 21401

RE: Opposition to SB0357—Proposal to Expand the Authority of the Prescription Drug Affordability Board

Dear Chair Beidle,

The **HIV+Hepatitis Policy Institute** is a leading national HIV and hepatitis policy organization promoting quality and affordable healthcare for people living with or at risk of HIV, hepatitis, and other serious and chronic health conditions. While we share a commitment to addressing the high cost of prescription drugs, **we have significant concerns with SB0357 that expands the authority of the Prescription Drug Affordability Board (PDAB).** We believe it will not translate into lower drug costs for patients and may dampen future drug development.

Access to and affordability of the latest drugs are especially critical for patients living with HIV, hepatitis, cancer, and rare diseases. People with HIV and hepatitis B rely on drug treatments that they must take for the rest of their lives, while people with hepatitis C can be cured of their disease in as little as 8 to 12 weeks. We also now have medications that prevent HIV.

Not long ago, an HIV diagnosis was all but a death sentence. Today, thanks to decades of sustained progress and investment, people living with HIV can lead long and healthy lives. Instead of relying on multiple daily medications with severe side effects, patients now benefit from highly effective and well-tolerated single-tablet regimens. Looking ahead, advancements such as longer-acting treatments, vaccines, and even the potential for a cure are within reach.

There are now even drugs that prevent HIV, either as daily orals or an injection every two months. Later this year, a twice-yearly option is expected to be approved by the FDA, with additional long-acting prevention drugs in development.

Price-setting mechanisms like Upper Payment Limits (UPLs) imposed by a PDAB fail to account for the complexities of both drug pricing and the broader drug development ecosystem. This approach could discourage investments in new treatments and slow the development in advances we desperately need, and also risks creating significant barriers to patient access.

Patient Affordability of HIV, Hepatitis, & Other Drugs

We understand the need to address the affordability of prescription drugs, but it is important to recognize the existing substantial safety net programs that help people afford HIV and other essential medications. The AIDS Drug and Assistance Program (ADAP), part of the nationwide Ryan White HIV/AIDS Program, provides assistance to over 291,000 low-income people living with HIV. The program, currently funded with $900 million in federal funds, provides HIV and other medications at little or no cost, copay assistance, and helps patients purchase insurance coverage. In addition to government funding, drug manufacturers contribute over $1 billion in rebates to states, further offsetting the cost of HIV medications.

The 340B Drug Pricing Program plays a vital role in expanding healthcare access for underserved communities. Through this program, states and clinics associated with the Ryan White Program purchased $2.8 billion in prescription drugs, generating rebates that help people afford their medications and support other health services. Nationwide over $66.3 billion in prescription drugs were purchased through the 340B program.

In the private insurance market, drug manufacturers provide copay assistance to people to help them pay for their medications. In 2023, that totaled $23 billion nationwide. Additionally, as part of the Medicaid program, manufacturers contribute $42.5 billion in rebates to states, further reducing the financial burden of prescription drugs for low-income populations. For those who are uninsured, many manufacturers provide free medications through patient assistance programs.

Due to the preventive services requirements of the Affordable Care Act (ACA) and the “A” grade received by Pre-Exposure Prophylaxis (PrEP) from the U.S. Preventive Services Task Force (USPSTF), insurers are mandated to cover all PrEP drugs and associated services without cost-sharing, thereby removing financial barriers for PrEP users.

These existing safety nets and affordability programs demonstrate why a PDAB is unnecessary to address the cost of HIV and related drugs. Moreover, the imposition of UPLs through a PDAB will lower the rebates and disrupt funding that sustain these programs, jeopardizing access to life-saving medications and critical patient services.

State Limitations in Addressing the Complex Landscape of Drug Pricing

Drug pricing is shaped by a global ecosystem and involves extensive research and development, clinical trials, manufacturing, distribution, and regulatory frameworks. Pharmaceutical companies must not only fund future treatments and cures but also absorb the high costs of drug development failures—factors that cannot be accounted for in government-imposed price controls on a single drug. Companies that are involved in HIV provide drugs for PEPFAR, the Global Fund, other philanthropic endeavors, and voluntarily enter licensing agreements in which they donate and provide medications at a low cost or at a loss to low and middle-income countries. States do not have the knowledge and expertise to effectively navigate these complexities. Efforts to set drug prices at the state level risk oversimplifying this process, leading

to unintended consequences such as reduced availability of medications or delays in access to new treatments.

Alternative Solutions

Instead of expanding the authority of the PDAB, we urge lawmakers to pursue policies that directly tackle affordability barriers without threatening access or new drug development including:

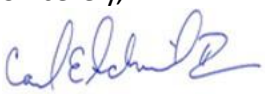
- Regulate Pharmacy Benefit Managers and Insurer Practices: Require transparency in PBM operations and mandate that rebates and discounts be passed directly to patients.
- Strengthen Patient Assistance Programs: Ensure that payments made through copay assistance programs count toward patients' deductibles and out-of-pocket maximums.
- Reduce Patient Costs Directly: Promote insurance plans with fixed, predictable copayments instead of high, unpredictable co-insurance rates, and eliminate prescription drug deductibles for certain plans.

These targeted solutions will meaningfully lower costs and improve access for patients, achieving tangible benefits without the harmful consequences or administrative complexities associated with PDABs.

The **HIV+Hepatitis Policy Institute** remains committed to advancing policies that ensure access to affordable medications while fostering the development needed to fight HIV and hepatitis. **We urge you to oppose SB0357 and recommend exploring alternative approaches that directly address affordability without risking access or undermining medical advancements.**

If you have any questions or need any additional information, please do not hesitate to reach out to our Government Affairs Manager, Zach Lynkiewicz, at zlynkiewicz@hivhep.org.

Sincerely,



Carl E. Schmid II
Executive Director

cc: Senate Finance Committee

Letter of Information-SB0357- Prescription Drug Af

Uploaded by: Andrew York

Position: INFO

MARYLAND
Prescription Drug Affordability Board

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February 6, 2025

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East Miller Office Building
Annapolis, MD 21401-1991

RE: Letter of Information – SB0357 - Prescription Drug Affordability Board - Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act)

Dear Chair Beidle and Members of the Senate Finance Committee,

Thank you to the Committee for the support of the Prescription Drug Affordability Board. The Board looks forward to conducting important work to make prescription drugs more affordable in 2025.

The Maryland Prescription Drug Affordability Board (Board) submits this letter of information on Senate Bill 357 - Prescription Drug Affordability Board - Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act) as it directly impacts the Board.

This bill expands the authority of the Prescription Drug Affordability Board to set upper payment limits. The statute would direct the Board to develop a process to implement upper payment limits ("UPLs") "for all purchases and payor reimbursements of prescription drug products" in Maryland, subject to the following: (1) the Board's determination that setting UPLs for all purchases and payor reimbursements is in the best interest of the State; and (2) the Board's consideration of certain factors, including savings to State and local governments resulting from implementation of UPLs under the Board's current authority.

Implementation of this statute will build on the Board's current work, but may require additional resources to: (1) revise the Board's existing regulations to account for the new requirements in this bill; and (2) establish and implement a process for setting UPLs "for all purchases and payor reimbursements" that may require more administration and oversight than the current process.

For questions, please contact Andrew York at (410) 804-0251 or andrew.york@maryland.gov. Thank you for your consideration.

Sincerely,

Andrew York
Executive Director
Maryland Prescription Drug Affordability Board

SB357_MCHS_INFO
Uploaded by: Robyn Elliott
Position: INFO

Maryland Community Health System

Committee: **Senate Finance Committee**

Bill Number: **Senate Bill 357 – Prescription Drug Affordability Board - Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act)**

Hearing Date: **February 6, 2025**

Position: **Letter of Information**

The Maryland Community Health System wants to provide informational comments in regards to *Senate Bill 357 - Prescription Drug Affordability Board - Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act)*. This bill would expand the scope of the Prescription Drug Affordability Board (PDAB) to allow upper payment limits to be set in the commercial insurance market. Additionally, the bill would require PDAB to consider the effect of upper payment limits on providers of 340B drugs. If a drug is under consideration by PDAB for an upper payment limit but then meets the requirements of becoming a drug with a current shortage, PDAB may not count a pharmacy dispensing fee toward an upper payment limit.

The Maryland Community Health System (MCHS) is a network of federally qualified health centers (FQHCs) providing primary, behavioral, and dental care to underserved communities throughout Maryland. While we recognize additional language has been added in the bill relating to 340B providers, the 340B program is still very complex. We wanted to provide background information on how the 340b program works for FQHCs. There still could be scenarios where PDAB could decrease our 340b pharmacy savings used by FQHCs to care for the complex needs of the underserved communities.

The 340b program was established 30 years ago by the federal government to provide access to discounted medications for low-income and underinsured patients and also to

provide additional resources in the form of savings to covered entities, including FQHCs, to sustain the mission of providing health care to underserved communities. The 340b program reduces acquisition costs for medications for covered entities enabling uninsured patients to obtain discounted medications. For insured patients, 340b discounted medications enable covered entities to bill insurance companies at allowable reimbursement rates which results in savings to be reinvested in patient care and to sustain the mission. Any reduction in allowable reimbursement rates or increases in the costs of discounted medications reduces the value of the 340b savings realized by these covered entities. An upper payment limit which reduces current reimbursement rates or increases the acquisition costs of 340b discounted medications reduces the realized savings and revenues which may be reinvested into patient care, caring for the uninsured and sustaining the mission. FQHCs invest all these savings back into supporting patient care and sustaining their missions. Imposing an upper payment limit could have negative health equity effects

FQHCs have a dedicated mission to serve impoverished communities "regardless of ability to pay." Our health centers are required to offer healthcare services with sliding fee scales for patients who have significant barriers to access health care. In addition, there are other programs that support access to care and medications so that no patients go without their medications. FQHCs utilize their 340B savings to provide the array of integrated care that includes adult and pediatric primary care, behavioral health, substance use, psychiatry, ob/gyn services, dental services, pharmacy, social services, food assistance, transportation, even housing in some situations.

We appreciate the very important goal of reducing patient cost burdens. We ask the Committee for special consideration of any statutory language that references the 340B program. If we can provide any further information, please contact Robyn Elliott at relliott@policypartners.net.

SB 357 - MHBE - FIN - LOI.pdf
Uploaded by: State of Maryland (MD)
Position: INFO

MARYLAND HEALTH BENEFIT EXCHANGE

750 E. Pratt St., 6th floor
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marylandhbe.com

February 6, 2025

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

Re: Senate Bill (SB) 357 – Prescription Drug Affordability Board - Authority for Upper Payment Limits (Lowering Prescription Drug Costs for All Marylanders Now Act) - Letter of Information

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) 357 – Prescription Drug Affordability Board - Authority for Upper Payment Limits. SB 357 would expand the authority of 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 an affordability challenge.

MHBE recognizes the importance of state-wide efforts to address high costs of prescription drug products and health care costs generally. We know that prescription drugs, in particular brand name drugs, are a significant driver of premium costs in the individual market and state costs via the state reinsurance program. A report from the Maryland Health Care Commission determined that **prescription drugs accounted for almost a third (30%) of total per capita spending** for privately insured markets in Maryland in 2020.[1] In an MHBE analysis of 2022 Maryland individual market claims, **brand name drugs accounted for** 21% ($343M) of all claims costs by all enrollees and **27% ($279M) of all claims costs by enrollees in the state reinsurance program**. Just a few drugs account for a significant portion of these costs: the top 10 drugs by total spend accounted for 10% ($105M) of all claims costs for reinsurance-eligible enrollees.

Our analysis indicates significant overlap between the top drugs by spending in the individual market and eight high-cost prescription drug products initially identified by PDAB in 2024 to consider for cost review.[2] In 2022, these eight drugs alone accounted for around $76 million in spending in the individual market in Maryland, equating to around 5% of spending on all services in the individual market.[3]

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[1] Maryland Health Care Commission: Spending and Use Among Maryland's Privately Insured Report, 2020 (2022).
[2] Prescription Drug Affordability Board: May 2024 Meeting.
[3] MHBE analysis of 2022 all-payer claims databases (APDC) individual market data.

MARYLAND HEALTH BENEFIT EXCHANGE

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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. 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.[4] Reduced out-of-pocket costs may improve

Lowering certain prescription drug costs would also potentially decrease costs associated with the 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 the threshold at which reinsurance payments made by the State to an individual's insurer kicks in ($21,000 for plan year 2025),[5] and, for those individuals who reach the threshold, reduce the claims costs that the reinsurance program reimburses.

For further discussions or questions on SB 357, please contact Johanna Fabian-Marks, Director of Policy and Plan Management at johanna.fabian-marks@maryland.gov.

Sincerely,

Michele Eberle

Michele Eberle
Executive Director

[4] Kaiser Family Foundation: Public Opinion on Prescription Drugs and Their Prices (August 2023).
[5] Maryland Health Benefit Exchange: 2025 Reinsurance Parameters (July 2024).