MPhA
MARYLAND PHARMACISTS ASSOCIATION

Date: February 6, 2025
To: The Honorable Joseline Pena-Melnyk, Chair
From: Aliyah N. Horton, FASAE, CAE, Executive Director, MPhA, 240-688-7808
Cc: Members, House Health and Government Operations Committee
Re: **UNFAVORABLE - HB 424 - Prescription Drug Affordability Board - Authority for Upper Payment Limits**

The Maryland Pharmacists Association (MPhA) urges an **UNFAVORABLE report on HB 424 - 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. The pharmacy 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 will not force pharmacies to dispense medications below their acquisition cost.

We strongly urge the General Assembly to fully and finally address the role of pharmacy benefit managers in this issue and fix 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 expanded UPL authority 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."*
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> -Hannah Pfeiffer, Colorado Cystic Fibrosis patient taking Trikafta, a medicine studied for affordability by the CO PDAB.
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> 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)

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