EACH PIC COALITION

February 4, 2025

The Honorable Joseline Pena-Melnyk, Chair
House Health and Government Operations Committee
Maryland House of Delegates
Lowe House Office Building, Room 240
Annapolis, MD 21401

RE: Opposition to Expanding PDAB Upper Payment Limit Authority (H.B. 424)

Dear Chair Pena-Melnyk,

The Ensuring Access through Collaborative Health (EACH) and Patient Inclusion Council (PIC) submit the following comments in opposition to H.B. 424, 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 and 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 roughly $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.

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 system 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."

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Ultimately, this could mean insurers and PBMs place drugs subject to UPLs on higher tiers of the formulary. This leads to higher out-of-pocket costs for patients as they 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, 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.

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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 House Health and Government Operations Committee