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Testimony in Support of House Bill 424
Prescription Drug Affordability Board – Authority for Upper Payment Limits
Lowering Prescription Drug Costs for All Marylanders Now Act

Madam Chair and fellow members of the House Health and Government Operations Committee, thank you for this opportunity to present **House Bill 424 Prescription Drug Affordability Board – Authority for Upper Payment Limits*, Lowering Prescription Drug Costs for All Marylanders Now Act.***

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. House Bill 488, 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 lifesaving 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.[i] Medication adherence can significantly affect long-term outcomes, meaning these costs are keeping Marylanders from being their healthiest selves.[ii]

Even those who can 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.[iii] While this year's median price hike is lower than in years past, the compounding increases have significant impacts to affordability.

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.[ivv] 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.[vi] 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.[vii] 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.[viii] 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.[ix] 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.

The Possibilities

The United States is the only first world country that is dealing with these out-of-control cost increases. We are told that the US is subsidizing the lower costs in other countries, but when one investigates how the costs are set in those countries, it raises some questions about that explanation.

In terms of the cost of research and development, it is important to understand that, at least historically, the U.S. government has subsidized research and development. Specifically, for the two drugs being currently assessed by PDAB, Farxiga and Jardience, the manufacturers received $437 million and $434 million of taxpayers' money respectively for their development. I am not opposed to those subsidies; I am just looking for reasonable consideration of that fact in pricing in the U.S.

In addition, one of the manufacturers has spent an average of over $1 billion on advertising each year for the last seven years.

Because of the differences between the US and other countries, I was curious about how the pricing chains works in those countries. I commission one of my interns to do a thorough investigation of the drug pricing chain in Germany, whose health system is strong and has better health outcomes than the US. We found that the infrastructure for determining what we consider to be "upper payment limits" is very similar to our Prescription Drug Affordability Board. The overall regulatory body is at the federal level, which would be analogous to our state government. In 2011, the Market for Medicinal Products (AMNOG) was established in Germany, which follows a five-step process, including a Health Technology Assessment (HTA), to evaluate the therapeutic value of a new drug compared to existing treatments. This part of the process incorporates two diverse groups that complete an independent analysis.
One group includes medical practitioners, insurance payers, hospitals and consumers; the other is a scientific body responsible for evaluating medical interventions. The results from these independent analyses are the bases of the negotiations with the manufacturers for pricing. This structured approach provides for checks and balances, ensuring that health care decisions reflect the interests of all stakeholders, from insurer to provider to patients and independent experts.

The result of this approach is clear in these charts:

Price Difference: Skyrizi (150 mg) Metric	U.S.	Germany	Difference	Difference (%)
List Price, VK	$22,383.00	$4,560.74 (€4,385.33)	$17,822.26	491.16% higher in U.S.
WAC, EK	$21,017.36	$3,711.04 (€3,569.31)	$17,306.32	566.35% higher in the U.S.

Price Difference: Dupixent (200 mg, 2 Syringes) Metric	U.S.	Germany	Difference	Difference (%)
List Price, VK	$6,412.20	$1,388.55 (€1,335.33)	$5,023.65	461.47% higher in U.S.
WAC, EK	$3,993.36	$1,123.58 (€1,080.94)	$2,869.78	355.41% higher in the U.S.

I would suggest to you that our PDAB has some similarities to the AMNOG process, but without the benefit of the transparency provided by defining the pricing chain.

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.[x] 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.[xi] 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.[xii]

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 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 premiums. In addition, Medical Loss Ratio constraints imposed on health plans since the 2010 Affordable Care Act that require insurers spend 80-85% of premium dollars on medical coverage versus administrative or self-enriching expenditures is considered in premium rate setting by the MIA. 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.

Finally, opposition 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.[xiii] 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.[xiv] 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.[xv] 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 can carefully monitor economic situations and adjust practices based on changing market conditions, ensuring that it can protect consumers without dismantling the industry.

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/House Bill 488.

[i] https://healthcareforall.com/wp-content/uploads/2023/09/Statewide-MD-Poll-on-Prescription-Drug-Affordability-PDAB-091123.pdf
[ii] https://www.cdc.gov/mmwr/volumes/66/wr/mm6645a2.htm
[iii] https://www.npr.org/sections/shots-health-news/2025/01/14/nx-s1-5250174/drug-prices-rise-drugmakers
[iv] https://www.reuters.com/business/healthcare-pharmaceuticals/prices-new-us-drugs-rose-35-2023-more-than-previous-year-2024-02-23/
[v] https://www.pharmaceutical-technology.com/features/the-most-expensive-drugs-in-the-us/
[vi] https://mgaleg.maryland.gov/cmte_testimony/2024/fin/17eRTCOIBruK5mTQ1fbnocZVtGu_wC10a.pdf
[vii] https://pdab.maryland.gov/documents/meetings/pdab_prst_carefirst_20201019.pdf
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