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Senate Finance Committee

Miller Senate Office Building
11 Bladen St.
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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.