COMMUNITY ACCESS NATIONAL NETWORK

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September 23, 2025

Maryland Prescription Drug Affordability Board
16900 Science Drive, Suite 112-114
Bowie, MD 20715

RE: Affordability Challenge Determinations

Dear Honorable Members of the Maryland Prescription Drug Affordability Board,

The **Community Access National Network (CANN)** is a 501(c)(3) national nonprofit organization focusing on public policy issues relating to HIV/AIDS and viral hepatitis. CANN's mission is to define, promote, and improve access to healthcare services and support for people living with HIV/AIDS and/or viral hepatitis through advocacy, education, and networking.

While CANN is primarily focused on policy matters affecting access to care for people living with and affected by HIV, we stand in firm support of all people living with chronic and rare diseases and recognize the very reality of those living with multiple health conditions and the necessity of timely, personalized care for every one of those health conditions. State Prescription Drug Affordability Boards are of profound importance to our community.

Affordability Goals Need Clarity

The purpose of the cost review studies is to determine whether the use of a medication "has led or will lead to affordability challenges for the state health care system or high out-of-pocket costs for patients." As such, the main reasons the Board deemed both Jardiance and Farxiga to both be determined as posing affordability challenges are due to WAC increase over time, the percentage of the drug spend compared to overall prescription drug spend, and the cost burden to patients compared to the amounts payers are paying after rebated amounts.

It is unclear how WAC increasing faster than the cost of inflation is something the Board can effectually change and how that relates to patient affordability. Before even considering the commercial market, deliberations on Jardiance, for example, pointed out that its spending represented over 1.8% of total overall prescription drug spend for state and local government. For Farxiga, the amount was greater than one percent. The data point of 1.8% of spend is being defined as an affordability challenge without defining what is and is not acceptable or what is plausible as a goal. Additionally, the cost burden to patients in comparison to

payer net spend is a function of plan design. It is unclear how a UPL could improve plan design and also what other actions the board plans to implement to mandate plan design changes that benefit patients directly.

Overall, the Board's paradigm of affordability appears nebulous, thus making it hard to envision how specific remedies can be created without well-defined concerns.

Missing Information is a Hindrance to Analysis

There is information needed that the Board currently does not have. For example, the Board did not receive input from state and local government entities for the cost review study of Farxiga. There was also an acknowledgement that out-of-pocket cost considerations associated with patient expenditures, such as transportation and childcare, were not readily available. Additionally, it was acknowledged that a detailed investigation into how plan design affects costs to patients and the system is needed. Moreover, the Board recognized that it would be beneficial to see an analysis showing the level of state spending for both drugs over time. There is also a paucity of data concerning copay programs and how Marylanders are utilizing them.

We are concerned, as there seems to be a significant amount of data gathering and analysis needed before things can effectively move forward in a manner that positively changes the current state of "affordability".

Potential Policy Suggestions

In terms of policies that would ensure patients with high deductibles and coinsurance rates are not paying a large proportion of the drug's cost, that is a plan design issue, which would be unaddressed by the implementation of a UPL, as discussed in more detail below. It would be helpful to set base levels of acceptable plan design by working with the state CMS coordinators for Medicaid and setting specific benchmarks for ACA plans (EHB, for example) of how and what should be covered.

Concerning how a UPL will affect formulary placement for a drug, ongoing research by Avalere Health indicates that there would be adverse effects. Avalere interviewed and surveyed health plans. Eighty percent of the respondents stated that patients would be the most impacted stakeholders of UPL implementation. Payers expect the impact to vary depending on the drugs selected for a UPL, but most respondents anticipated moderate to significant disruption to formulary design. This includes moving drugs to higher tiers, which would increase out-of-pocket costs through increased copays and coinsurance.

Half of the survey respondents also foresee increased utilization management on UPL drugs, which would create delays and barriers to necessary treatment and increase administrative burden on physicians. For clarity, Avalere only interviewed payers in states that passed legislation for PDABs that are required to conduct affordability reviews. Also, regarding formularies, it would be beneficial to have legislation in place to guarantee plans cannot remove drugs from formularies once a UPL is applied. If a drug is covered now, then that should not change. Whether or not a patient can afford a drug is not even a question if it isn't on the formulary to start with.

We also understand that Maryland legislation requires the carve-out of 340B claims from a UPL. We encourage the Board and staff to consider ways to guarantee a UPL is not applied to any 340B claims before the implementation of any UPL. Thus far, no such functional guarantee has been discussed - "trust us" is not sufficient.

We appreciate that the Board acknowledges it does not want to do anything to adversely affect access to medications, especially ones that have already been proven to be effective and widely used. However, a significant level of analysis needs to occur before any 'solutions' are implemented.

Respectfully submitted,

Ranier Simons
Director of State Policy, PDABs
Community Access National Network (CANN)

On behalf of
Jen Laws
President & CEO
Community Access National Network

DIABETES PATIENT ADVOCACY COALITION

September 29, 2025

Maryland Prescription Drug Affordability Board
16900 Science Drive, Suite 112-114
Bowie, MD 20715

RE: PDAB September 29, 2025 Meeting – Policy Review Process: Drivers and Policy Recommendations for Farxiga and Jardiance

Dear Members of the Maryland Prescription Drug Affordability Board,

On behalf of the Diabetes Patient Advocacy Coalition (DPAC), thank you for the opportunity to provide public comment regarding Farxiga and Jardiance. We recognize the Board's important responsibility to evaluate prescription drug affordability. As you continue your policy review process and begin to consider potential policy recommendations, we urge you to ensure that access to essential diabetes treatments is not compromised in the pursuit of cost containment.

Risks of Upper Payment Limits (UPLs)

While DPAC respects the Board's duty to consider all affordability tools, we strongly caution against the use of UPLs for Farxiga and Jardiance. These therapies are not optional treatments for people with type 2 diabetes, they are clinically proven to reduce the risk of heart failure and kidney disease. Restricting access would undermine years of progress in diabetes care and lead to more hospitalizations and long-term costs.[1]

We are also concerned that Maryland's planned UPL framework remains rebate-driven, relying on supplemental rebates from manufacturers. As Andy York acknowledged during the September 2025 informational hearing, the Board's plan is to layer additional rebates on top of existing flows.[2] However, it is unclear how such a requirement would work across the state's diverse coverage landscape which includes state employee plans, ACA marketplace plans, and commercial plans, each of which contract with different PBMs under different terms.

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[1] PDAB Jardiance Dossier, July 2025.

[2] Transcript of PDAB Informational Hearing, Sept. 2025 (Andy York comments).

This is where the real risk lies: **carriers and PBMs control how drugs are covered, and their incentives are tied to rebates rather than patient affordability.** A change in the rebate flow without protecting patients could lead to unintended consequences reducing access to care. For example:

- **Formulary Exclusions:** If PBM rebates are reduced under a UPL, PBMs may respond by excluding Jardiance or Farxiga from their formularies entirely, steering patients to higher-priced alternatives that generate larger rebates.[3]
- **Tier Manipulation:** PBMs often place higher-rebate drugs on preferred formulary tiers while keeping lower-cost alternatives on higher tiers or completely off formulary. Ironically, lowering the cost of a drug could result in its being placed on a more expensive tier raising the cost for patients.
- **Cost-Sharing Shell Games:** Carriers design patient cost-sharing around inflated list prices (WAC), not net prices. Patients pay coinsurance on the $600 list price, while PBMs and carriers pocket the $300 rebate difference.[4] A UPL does not automatically change this dynamic unless rebates are passed directly to patients at the point of sale. This is especially true if the UPL is implemented as an additional rebate.
- **Prior Authorization and Utilization Hurdles:** When rebate revenue shrinks, carriers and PBMs frequently impose stricter prior authorization rules, step therapy, or other utilization controls to shift patients toward drugs with higher rebate flows.[5]

In other words, disrupting rebate flows without reforming benefit design simply creates opportunities for PBMs and carriers to play shell games. They will adjust formularies, tiers, and utilization rules to protect their rebate revenue — leaving patients no better off. Unless rebates and other concessions are directly passed through to patients at the point of sale, a UPL will not have its intended effect, and Marylanders will see no real relief at the pharmacy counter and could easily pay even more.

Patient Access and Continuity of Care

Farxiga and Jardiance have transformed the standard of care for people with type 2 diabetes, particularly those at heightened risk of heart failure and kidney disease. The Board's own dossiers confirm that these therapies are guideline-recommended for patients with T2D, CKD, and HF, and consistently demonstrate significant reductions in cardiovascular death, hospitalizations, and disease progression.[6]

The July 2025 dossiers highlight the scale of this need: in Maryland, the age-adjusted prevalence of diagnosed diabetes among adults is approximately 10.5%, with CKD and HF as

[3] Ibid.; Farxiga Dossier, July 2025.

[4] Ibid., Section 3.4.

[5] PDAB Farxiga Dossier, July 2025, Section 5.1.

[6] ADA Standards of Care in Diabetes, 2025.

common comorbidities.[7] For patients with these conditions, access to Jardiance and Farxiga is not optional — it is lifesaving. Moreover, Jardiance currently has no therapeutically equivalent generic alternatives, making it indispensable for those prescribed it.[8]

Affordability, however, remains a barrier. Both dossiers document that out-of-pocket costs can exceed $600 per month, as cost-sharing is tied to inflated list prices rather than net prices.[9] Net costs, after rebates, are closer to $250–$300 per month, but patients rarely see these savings.[10] This disconnect is not primarily about the drug's intrinsic price but about benefit design: patients pay based on WAC list price, while PBMs and insurers capture rebates.[11] The Jardiance dossier further shows that variations in patient cost-sharing directly affect utilization, underscoring the risk that high costs drive therapy abandonment.[12]

Policy Recommendations

As a coalition dedicated to protecting patient access to diabetes treatments, we respectfully urge the Board to:

- **Prioritize patient access and continuity of care in all affordability decisions.**
- **Evaluate how affordability actions impact access to therapies specifically for people with diabetes.**

We recommend the Board to consider non-UPL solutions that reform benefit design directly:

1. **Point-of-Sale Rebate Pass-Through**
   Require insurers and PBMs to pass negotiated savings, rebates, discounts, or other concessions, directly to patients at the pharmacy counter when cost-sharing is based on drug price. With rebates for branded drugs averaging 48%, this reform can cut patient costs nearly in half while remaining essentially cost-neutral for health plans.[13]
2. **PBM Contract Reform**
   Require that PBM compensation is de-linked from list prices. This removes the incentive to inflate list prices in exchange for higher rebates and ensures patients benefit from lower net prices. Insulin pricing data show how net prices fell between 2012 and 2021 even as list prices soared, leaving patients to shoulder inflated costs.[14]

[7] Maryland Department of Health, Diabetes Data & Statistics, 2024.

[8] PDAB Jardiance Dossier, July 2025, Section 2.3.

[9] Ibid., Section 3.1.

[10] PDAB Farxiga Dossier, July 2025, Section 3.4.

[11] PDAB Farxiga Dossier, July 2025, Section 3.4.

[12] PDAB Jardiance Dossier, July 2025, Section 5.2.

[13] Congressional Budget Office, Report on Drug Rebates, 2023.

[14] USC Schaeffer Center, "Insulin Pricing Trends 2012–2021."

3. **Out-of-Pocket Protections**
   Caps on monthly spending and expanded deductible smoothing would provide predictable, sustainable affordability for patients. For Marylanders living with chronic conditions such as diabetes, heart disease, and kidney disease, the ability to budget reliably for medications is critical.[15]

Conclusion

Any reduction in the price of a drug is meaningless unless it is passed directly through to patients. Without this, so-called affordability measures like UPLs will have no effect at all on what Marylanders actually pay at the pharmacy counter and it could actually cause them to pay more. The only effective solutions are non-UPL reforms such as requiring point-of-sale rebate pass-through, de-linking PBM compensation from list prices, and enacting out-of-pocket protections that directly lower patient costs while preserving access to life-saving therapies.

Thank you for your commitment to Maryland patients and for the opportunity to comment.

Sincerely,

George Huntley

George Huntley
Chief Executive Officer
Diabetes Patient Advocacy Coalition

[15] Kaiser Family Foundation, “Patient Cost-Sharing and Medication Adherence,” 2024.

EACH PIC COALITION

September 24, 2025

Maryland Prescription Drug Affordability Board
16900 Science Drive, Suite 112-114
Bowie, MD 20715

RE: Public Comments on Policies to Address Affordability Challenges

Dear Members and Staff of the Maryland Prescription Drug Affordability Board:

The Ensuring Access through Collaborative Health (EACH) and Patient Inclusion Council (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.

We appreciated the recent opportunity to participate in the informational hearing to assist the board in developing policy to address the affordability challenges created by the use of Farxiga and Jardiance. Our comments in this letter build on the testimony provided during that hearing.

First, we respectfully request additional clarification regarding the proposed supplemental rebate structure tied to Maryland's upper payment limit (UPL) process. While we were advised that information on supplemental rebates would be found in the UPL Action Plan, the document contains no mention or explanation of such rebates. Given the importance of transparency and the potential impact on patient access, we urge the board to provide further detail on the design, function, and intent of this rebate structure so that all stakeholders, including patients, can provide meaningful input.

Prioritize Patient-Driven Solutions

Our coalition strongly believes that policies should begin with patient-identified challenges and focus on solutions that improve real-world affordability. Findings from our Patient Experience Survey: Prescription Drug Affordability and Unaffordability underscore that affordability is not defined solely by list price. Many patients paying $0–$10 per month for their prescriptions still reported them as unaffordable, citing insurance barriers, copay accumulator policies, or the cumulative costs of disease management. These realities highlight why reforms must be centered on patient experience, not just system-level costs.

UPLs Alone May Be Ineffective or Harmful

While intended to reduce costs, UPLs can create new incentives for insurers and pharmacy benefit managers (PBMs) that may ultimately restrict patient access to needed medications. These include increased utilization management, formulary reshuffling, and adverse tiering, all of which can delay or disrupt treatment. As our survey results highlight, access delays and insurance rules, not cost alone, are often the true barriers behind "affordability" labels. Implementing a UPL without complementary protections risks worsening these challenges.

Advance PBM Reforms to Address Real Patient Challenges

EACH PIC COALITION

The recent informational hearing highlighted that PBM reforms could more effectively address patient concerns and lower both system and patient costs. We encourage the board to prioritize reforms that would:

- Eliminate spread pricing and delink PBM compensation from drug costs to ensure that incentives align with patient access and affordability.
- Require greater PBM transparency so policymakers and patients alike can understand how drug pricing decisions affect coverage and cost-sharing.
- Mandate that rebates and negotiated savings are shared with patients, directly lowering their out-of-pocket costs.
- Cap patient out-of-pocket costs and establish programs that allow patients to smooth out-of-pocket costs over time.

These reforms align with both the patient experiences captured in our survey and with the calls for accountability voiced at the hearing. By targeting the systemic practices that patients consistently identify as affordability barriers, the board can achieve meaningful improvements without risking access.

Conclusion

We commend the Maryland PDAB for its commitment to lowering costs for prescription medications. We respectfully ask the board to clarify the supplemental rebate structure, to prioritize patient-driven reforms, and to pursue PBM accountability measures that directly address the causes of unaffordability. EACH and PIC stand ready to collaborate and share additional patient data to support these efforts.

Thank you for your consideration and for your commitment to ensuring patients' needs remain at the center of this process.

Sincerely,

Tiffany Westrich-Robertson
tiffany@aiarthritis.org
Ensuring Access through Collaborative Health (EACH) Coalition Lead

Vanessa Lathan
vanessa@aiarthritis.org
Patient Inclusion Council (PIC) Coalition Lead

September 24, 2025

Maryland Prescription Drug Affordability Board
16900 Science Drive, Suite 112-114
Bowie, MD 20715

TO: Members of the Maryland Prescription Drug Affordability Board

As a physician with decades of experience caring for patients whose families often struggle to access and afford necessary medications, I am deeply concerned that the Board's process for selecting medications and conducting affordability reviews will leave Maryland patients without access to necessary medications.

I am a board-certified pediatrician and pediatric rheumatologist and spent my career caring for young people with chronic or disabling conditions with specialized, innovative and, unfortunately, expensive therapies. My primary focus is always ensuring the well-being of my patients, but as a result of your legislative charges, I fear that the Board's analyses and decisions cannot reflect this same mandate. The prime directives for the Board, as stated by your enabling legislation, are that "… the [cost] review shall determine whether use of the prescription drug product … led or will lead to affordability challenges for the State health care system or high out–of–pocket costs for patients."

Clinicians view the Board's search for "therapeutic alternatives" as inherently misguided and potentially dangerous to patients for whom substitution is not clinically appropriate due to their unique medical situations, genetics and/or treatment needs. The complexities of personalized patient care cannot be considered as these so-called "alternatives" may not be able to address the patient's individual circumstances. Further, unilaterally designating certain medications as "therapeutic alternatives" fundamentally disrupts the clinician's ability to exercise their medical expertise in concert with their patient.

While the dossiers provided for this meeting of Empaglifozin (Jardiance) and Dapagliflozin (Farxiga) are extensive and more transparent than many other PDAB's analyses, they still fail to present clinically relevant alternatives. These drugs are compared to other "treatments," but the analyses do not adequately consider interventions that directly address the full range of approved FDA indications and conditions impacted by these medications. Instead, the comparisons are primarily focused on other diabetes medications with different mechanisms of action and

incomplete, if any overlap in therapeutic indications. An easily foreseeable result of your actions could be patients now requiring 2 or 3 drugs to potentially control the multiple medical issues that were previously successfully controlled by one. Will you be tracking these potential financial increases in the State's health care system?

Notably, even the dossiers themselves acknowledge that no true therapeutic equivalents exist for either drug, making any proposed substitution clinically inappropriate and potentially harmful. Throughout the over 80 pages of data analyses, calculations, and other technical details, I did not see meaningful input from the clinicians who prescribe these medications and/or the patients who rely upon them. This disconnects between the data presentation and clinical reality raises significant concerns about the validity and utility of your admittedly extensive review process.

Another area of concern is the treatment comparisons presented alternatives within the dossiers. Different potential treatment options are presented without consideration of the direct and indirect costs of untreated or under-treated diabetes, kidney or cardiovascular disease. While these costs may at times considered be "medical" and not "pharmacological" and therefore considered within different budgets, the reality is that they will cost the State health system and its residents more than any potential short-term drug "savings" might occur from a UPL. These predictable "complications" of being switched to different treatment(s) need to be followed, measured and reported; does the Board have plans and funding to track and report the health and financial outcomes of their decisions? If not, shouldn't it?

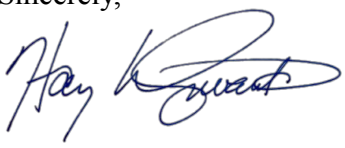
While I have also submitted comments in August regarding the next medications (Ozempic and Trulicity) selected for upcoming cost review studies, the current notification process provides insufficient opportunity for meaningful stakeholder input. Healthcare providers, patient advocacy groups, and other clinical stakeholders require more comprehensive information about the Board's selection criteria, analytical methodology, and timeline for these reviews. Simply announcing which drugs will undergo cost analysis without providing detailed context about the review scope, comparative frameworks, or opportunities for clinical input severely limits the quality and relevance of stakeholder feedback.

Everyone shares your goal to lower prescription drug costs, but the current myopic process that only focuses on the drug list prices and not the total cost to patients risks limiting access to essential medications while creating longer term negative health outcomes. Since the Board is unable to address the roles of all participants within the drug pricing and supply ecosystem, I fear your many efforts will be for naught. All clinicians and patients are eager to collaborate with the Board to ensure affordability decisions reflect real-world patient needs on a more thoughtful, patient-centered approach. As it stands, however, the Board's actions could inadvertently restrict access to effective cost-saving medications for those Maryland residents who need them the most. We encourage the Board to address the multiple deficiencies and restrictions placed upon it

by asking the legislature to consider expanding your ability to develop methods of lowering actual drug costs, not just the list prices of drugs purchased by the State and Marylanders.

Thank you for your attention to this critical issue.

Sincerely,



Harry L. Gewanter, MD, FAAP, MACR
Board Member, Let My Doctors Decide Action Network

MARYLAND TECH COUNCIL
ADVANCING LIFE SCIENCES AND TECHNOLOGY

September 24, 2025

Maryland Prescription Drug Affordability Board
16900 Science Drive, Suite 112-114
Bowie, MD 20715

Submitted via email: comments.pdab@maryland.gov

Re: September 2025 Board Comments

Dear Members of the Prescription Drug Affordability Board,

On behalf of the Maryland Tech Council and our members, particularly those in the life sciences industry, we are pleased to submit the following comments regarding the "Policy Review Process – Drivers and Policy Recommendations" for Farxiga and Jardiance, which the Prescription Drug Affordability Board ("PDAB" or the "Board") will consider at the September 29, 2025 meeting of the Board.

We want to begin by highlighting the strength of the life sciences ecosystem in the State of Maryland and its overall importance to the Maryland economy. Maryland's life sciences ecosystem includes 2,700 companies and 54,000 workers. These innovative companies and workers develop therapies, cures, and treatments that millions of patients depend on. According to the 2024 annual rankings from *Business Facilities*, Maryland ranks as the third-best State in the country for life sciences, behind only Massachusetts and California. Assets such as proximity to the National Institutes of Health ("NIH") and other federal Research and Development funding agencies, strong academic and medical institutions, and a highly skilled workforce all combine to make Maryland a competitive state for life sciences. These are some of the reasons why Governor Moore has rightly highlighted life sciences as one of three "lighthouse industries of the future," and stated that his Administration wants Maryland to be the capital of biotech.

Despite Maryland's life sciences advantages, recent actions by the Federal government have put the industry under an unprecedented level of threat and strain. Cuts to NIH grant funding, delays, freezes, and terminations of other grant and research activities, as well as other reductions, have put the Maryland life sciences ecosystem at significant risk. Maryland policymakers, therefore, must be intentional about supporting this industry and the economic, job, and tax benefits that accompany it. As the MTC has consistently stated, this means we must seek opportunities to build upon the strengths of the life sciences industry. All too often, however, the industry feels as if decisions being made at the State-level create a higher tax burden, uncertainty, and foster an overall environment that feels more hostile than welcoming to the industry.

To that end, the life sciences and drug manufacturing industries have consistently expressed deep skepticism that Upper Payment Limits ("UPLs"), the only tool the PDAB is expressly authorized to implement, will be effective in accomplishing the goal of making prescription drugs affordable to patients. In fact, both the drug manufacturing industry and patient advocacy groups have warned that UPLs are not only ineffective in lowering out-of-pocket costs for patients, but may actually compromise access to life-saving therapies and medication that patients rely on. Losing access or having to navigate new complexities in obtaining necessary medications can result in delays in care and adverse outcomes that can have life-threatening consequences. To that end, we urge the Board to seriously consider the comments from patient

advocacy organizations such as the Diabetes Patient Access Coalition ("DPAC"). In their July 23, 2025 written comments submitted to the Board, DPAC stated

> *"Farxiga and Jardiance have transformed the standard of care for people with type 2 diabetes, particularly those at risk of heart failure or kidney disease. For many patients, these therapies are critical for preventing complications, reducing hospitalizations, and improving quality of life. Any action that affects how these medications are priced, covered, or accessed could have unintended harmful effects on diabetes management by restricting formulary access managed through Pharmacy Benefit Managers."*

Lawmakers in New Hampshire recognized these pitfalls and affirmatively repealed their PDAB last month after it had been in existence since 2020. Other states, such as the State of Oregon, have delayed the proceedings of their PDAB as they continue to debate the effectiveness of UPLs. New Hampshire lawmakers recognized that UPLs would not only fail to lower the cost of prescription drugs for patients, but would also compromise access to treatments by potentially squeezing pharmacies and providers by limiting the reimbursements they would receive when stocking and dispensing medications subject to a UPL. Maryland should follow New Hampshire's lead and, at a minimum, focus on strategies other than UPLs for lowering the cost of prescription drugs.

The PDAB could be poised at its September 29th meeting to potentially recommend a UPL for either or both Farxiga and Jardiance when it considers "drivers and policy recommendations" for these two medications. For the reasons stated above, we encourage the PDAB to focus on non-UPL policy solutions. The MTC has highlighted several alternative approaches that would be more effective in lowering patient out-of-pocket costs throughout the proceedings of the PDAB. For example, the PDAB should consider "share the savings" solutions that would ensure that discounts and rebates on the price of medications would be passed directly to patients, rather than allowing them to be retained by Pharmacy Benefit Managers ("PBMs") or insurers, which effectively serve as middlemen in the transaction when patients pay for medications at the pharmacy counter. We have encouraged greater transparency in PBM practices, including the requirement for more transparency around PBM contracts. We have also supported efforts to reform PBM practices so that cost-sharing assistance, such as copay coupons and other manufacturer-provided assistance, counts toward patient deductibles and out-of-pocket maximums.

In addition to the serious concerns about the effectiveness of UPLs, we continue to urge the PDAB to consider the message being sent to Maryland's life sciences ecosystem by the PDAB's proceedings. As CEO of the MTC, I interact with our members in the life sciences industry on a daily basis. As stated above, there is a palpable sense of concern about the viability of the industry in Maryland due to recent federal-level pullbacks and attacks on research and development. As a result, the Maryland life sciences industry expects its State leadership to do everything in its power to bolster this industry, which is so critical to the State's economy. While these companies have been encouraged that the Moore Administration has elevated life sciences as a "lighthouse industry of the future," the feedback I have received is that the proceedings of the PDAB and the possibility of UPLs send the opposite message. Rather than creating an environment where the state signals openness to investment by the industry, the movement of the PDAB toward implementing UPLs is being perceived as creating an environment that is not welcoming to the life sciences industry.

As leaders in the State, we have a choice – we can either continue to embrace innovation and build an environment open to research and development, economic growth, and job creation, or we can take actions that drive investment to our competitors. The pursuit of unproven and potentially ineffective strategies such as UPLs is consistent with the latter. For these reasons, we urge the PDAB to reconsider using UPLs as a strategy to achieve our shared goal of making prescription drugs more affordable for Maryland patients. Thank you for the opportunity to comment and for considering our comments.

MARYLAND TECH COUNCIL
ADVANCING LIFE SCIENCES AND TECHNOLOGY

Sincerely,

Kelly Schulz
CEO, Maryland Technology Council

cc: The Honorable Governor Wes Moore
The Honorable Lieutenant Governor Aruna Miller
The Honorable Dr. Meena Seshamani, Secretary of the Department of Health
Mr. Jonny Dorsey, Deputy Chief of Staff
Mr. Jeremy Baker, Chief Legislative Officer
The Honorable Bill Ferguson, Senate President
The Honorable Adrienne A. Jones, Speaker of the House of Delegates
The Honorable Pam Beidle, Chair of the Senate Finance Committee
The Honorable Antonio Hayes, Vice Chair of the Senate Finance Committee
The Honorable Joseline A. Pena-Melnyk, Chair of the House Health and Government Operations Committee
The Honorable Bonnie Cullison, Vice Chair of the House Health and Government Operations Committee

Value of Care Coalition

September 3, 2025

Maryland Prescription Drug Affordability Board
16900 Science Drive, Suite 112-114
Bowie, MD 20715

Re: INFORMATIONAL HEARING REGARDING POLICY OPTIONS TO ADDRESS AFFORDABILITY CHALLENGES WITH FARXIGA AND JARDIANCE

Dear Director York,

Thank you for the opportunity to provide input regarding the drivers of patient costs, concerns with policy options currently under consideration, and other potential policy solutions to address affordability challenges for prescription drugs.

The Value of Care Coalition is a network of patient, health care provider, and caregiver organizations engaged in policy discussions about cost and value in health care. These hearings on Farxiga and Jardiance are not just about addressing their list price. Rather, they are about value, access, and ultimately, patient lives.

Value of Treatment

Farxiga and Jardiance are not niche products. They are frontline therapies for diabetes, heart failure, and chronic kidney disease. Physicians consistently tell us these drugs are essential because each plays a distinct role in their treatment toolbox:

- Farxiga has been shown to reduce cardiovascular death for patients with certain kinds of heart failure.
- Jardiance is often prescribed for people with both diabetes and cardiovascular disease or stroke.
- Both treat chronic kidney disease and heart failure independent of diabetes but are commonly used for patients living with multiple complex conditions at once.

Patients, in turn, describe the value in personal terms: better controlled diabetes, less weight gain, reduced risk of eye disease, neuropathy, foot complications, kidney failure, stroke, or even amputation – all possible outcomes of uncontrolled conditions.[1]

[1] American Diabetes Association, *Diabetes Complications, https://diabetes.org/about-diabetes/complications*

Every 40 seconds, someone in America has a heart attack. Every three minutes and 17 seconds, someone dies of stroke. These drugs help reduce those numbers. The American Heart Association estimated indirect costs of cardiovascular disease at $155 billion annually in 2019.[2]

Medicines that lower that burden are not just clinically valuable - they are economically valuable too.

Threat to Access

Yet, despite their importance, patients continue to face affordability barriers - not simply because of drug list prices, but because of insurance design and supply chain practices. Formularies, coinsurance, deductibles, and utilization management ultimately decide whether a patient can walk out of the pharmacy with the medicine their doctor prescribed.

That's why a central truth has emerged in every forum where upper payment limits (UPLs) have been discussed:

There is no guarantee patients will see savings, but there is overwhelming evidence that UPLs will diminish access.

- **Health plans themselves** - the very entities that determine patient cost and patient access - have warned in surveys that UPLs will mean higher deductibles, more coinsurance, and more prior authorizations. They cite complex negotiation and contracting dynamics as changes that could increase patient costs.[3] [4]
- **Medicare is also showing us what's coming**: Drugs subjected to its price controls are already seeing, on average, a 32% increase in out-of-pocket costs for patients[5], paired with sharp increases in deductibles and plans demanding coinsurance rather than copayments[6] - further shifting costs to patients.

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[2] American Heart Association, *2023 Heart Disease and Stroke Statistics Updated Fact Sheet, https://professional.heart.org/en/science-news/-/media/453448D7D79948B39D5851D1FF2A0CFE.ashx*

[3] Partnership to Fight Chronic Disease / Avalere Health, *Health Plans Predict: Implementing Upper Payment Limits May Alter Formularies And Benefit Design But Won't Reduce Patient Costs,* March 2024, https://www.fightchronicdisease.org/_files/ugd/b11210_20c7d158bf93452395d6b4e2b0056bb0.pdf

[4] Partnership to Fight Chronic Disease / Avalere Health, *Payer Perspectives Confirm UPL Will Likely raise Costs and Hinder Patient Access to Medicines,* March 2025, https://b11210f4-9a71-4e4c-a08f-cf43a83bc1df.usrfiles.com/ugd/b11210_1e92735a49744639ac37321c6320e8c8.pdf

[5] Pioneer Institute. *Key Findings to Date: The Inflation Reduction Act (IRA).* May 2025. https://pioneerinstitute.org/the-inflation-reduction-act-ira-key-findings-to-%20date/

[6] USC Leonard D. Schaeffer institute for Public Policy & Government Service. *Most Medicare Beneficiaries May Pay More for Drugs Under the IRA*. June 2025. https://schaeffer.usc.edu/research/medicare-part-d-drug-costs-ira/

- **Doctors warn** of greater administrative burden and non-medical switching when insurers shift patients to other therapies based on UPL implementation, which can result in negative health outcomes.[7]
- **Independent pharmacies report** that a third won't stock price-controlled drugs at all, creating new access deserts.[8]
- **Policy expert and PDAB Board Member, Gerard Anderson** has been clear about the supply chain dynamics, saying in an NBC news interview this summer: *PBMs "are looking for the drug that makes them the most money"…The deals are "a negotiation between the drug companies and the PBM. The drug company wants their drug on the formulary in a favorable position. The PBM wants to get the largest possible rebate."*[9]

With that in mind, our concerns become plainly understandable. If UPLs restrict the ability for reasonable negotiations between PBMs and manufacturers, coverage is likely to be reduced or eliminated. If pharmacies can't stock medications, patients can't access medications. And if UPLs lead to increased out of pocket costs, they're costing patients more - not less.

Therefore, when patients ask, "Will this policy help me afford my medicine?" the honest answer is that UPLs may make it harder, not easier.

Alternative Solutions

We are encouraged that Maryland's PDAB has already shown an understanding of this dynamic. You know affordability isn't just about list price - it's also about benefit design. When we hear stories from patients about their cost for a drug jumping from $70 to $500 seemingly overnight (as was the case in the NBC News article referenced previously), it's a change in formulary construction and benefit design that's driving that increased patient cost. Without reforming benefit design, patients will continue to be squeezed even if list prices are capped.

That is why we urge the Board to:

- **Acknowledge the limitations of UPLs and move beyond them as the presumed solution.** They are not a fix for complex supply chain dynamics.
- **Bring transparency to benefit design.** Formularies, PBM rebates, and cost-sharing mechanisms are what delay care and drive patient pain at the counter.

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[7] Value of Care Coalition, *State Prescription Drug Affordability Boards (PDABs) and Analysis of Patient Impact: A US Physician Survey Study*, July 2025, https://valueofcarecoalition.org/doctor-survey-study

[8] National Community Pharmacists Association. *NCPA to CMS: A Third of Independent Pharmacies Won't Carry Drugs in the Negotiated Price Program, and 60 Percent More are Considering Dropping Out.* January 2025. https://ncpa.org/newsroom/news-releases/2025/01/27/ncpa-cms-third-independent-pharmacies-wont-carry-drugs-negotiated

[9] NBC News, *Parents sue over son's asthma death days after inhaler price soared without warning,* June 2025, https://www.nbcnews.com/health/health-care/asthma-death-prescription-price-pharmacy-lawsuit-rcna210075

- **Center policy discussions on direct relief for patients**, considering the entirety of their health care needs.
- **Work with lawmakers.** Recommend legislative reforms that allow patients access to the drugs their doctors prescribe without delay or denial. This will stabilize patients' chronic conditions, generate better health outcomes, bring down the cost of care and increase quality of life.

Conclusion

Marylanders who depend on Farxiga and Jardiance need real solutions. Doctors, health plans, pharmacies and researchers have all said that UPLs threaten access. And when access is diminished, patients suffer.

This Board should take a broader view: to recognize the true value of these treatments, to call out the benefit design flaws at the root of patient affordability challenges, and to pursue reforms that bring direct, lasting relief to patients.

Sincerely,

Derek Flowers
Executive Director
Value of Care Coalition