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Prescription Drug Affordability Board
Informational Hearing Oral Testimony
January 26, 2026

Good afternoon, Chair Mitchell and members of the Prescription Drug Affordability Board (PDAB). I am Sara Westrick, Advocacy Director for AARP Maryland, representing our 850,000 members in the state.

On behalf of AARP Maryland, I want to commend the members of the PDAB for all your outstanding work, including your efforts to make Ozempic and Trulicity more affordable.

We are, however, disappointed that you are not also using your authority today to impose upper payment limits on what state and local governments pay for Jardiance and Farxiga. Based on your work over the last few months, we expected the decision to be made at this meeting. It is critical that you take such action as soon as possible, both to help state and local governments afford high-cost drugs and to allow you to help all Marylanders.

The 2025 PDAB authority expansion law authorizes you to help all Marylanders one year after upper payment limits are set on what state and local governments pay for at least two drugs. We need this life-saving clock to start ticking down now.

AARP Maryland and many other tireless advocates have been working on this issue since before the original PDAB law was enacted in 2019. While we commend you for your great work and thorough analyses, we need to see action.

We have heard it so many times, but it remains true: drugs don't work if people can't afford them. And behind every statistic is a real person whose life and dignity depend on affordable access to medication.

Please use the authority you have to set upper payment limits at your March 16th meeting so that all Marylanders can afford the drugs they so urgently need.

COMMUNITY ACCESS NATIONAL NETWORK

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January 20, 2026

Maryland Prescription Drug Affordability Board
169000 Science Drive, Suite 112-114
Bowie, MD 20715

RE: Ongoing Affordability Discussions

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.

Affordability Challenge Remains Unclear

Just like Farxiga and Jardiance, Ozempic and Trulicity have been preliminarily found to pose "affordability challenges" because staff research indicated their Wholesale Acquisition Costs (WAC) increased faster than inflation. Additionally, it was found that total gross prescription drug spend for state and local governments exceeds 2.27% of gross prescription drug spend for Trulicity and 4.87% of gross prescription drug spend for Ozempic.

However, these data points do not define "affordability challenge". They simply state the status quo of spending. There has been **no** identification of what an acceptable percentage of gross spend is, nor an analysis of how something like a UPL will achieve that percentage once it is identified, ***if*** it is identified. Moreover, in this vein, the focus on affordability is through the lens of "system" costs and prices, and it remains unclear how patients or even government payors would directly benefit.

WAC does not directly translate into affordability for patients or government payors, despite it being one of the metrics statutorily used for potential drug selection. **Patient out-of-pocket costs, such as co-payments, are directly determined by plan design.** While it has been implied that a percentage of WAC is how plan co-insurance payments are determined, it is not a simplistic direct causal relationship. As staff has explained in the past, transparency on

pricing mechanisms based on the relationship between PBMs and plans is opaque. Thus, pursuing a policy to disincentivize WAC increases requires much more informed data to prove that it is a worthwhile endeavor.

Essential Baseline Data is Lacking

Staff reporting indicates that important data is missing, which raises questions about how effectively patient and system affordability can be reliably analyzed using the presented metrics. Repeatedly, staff have indicated that they have not been able to obtain data to assess cost impacts on public budgets for state and local governments. Additionally, a specific amount of spending cannot be deemed "too high" if it's simply a result of high utilization of an effective drug, because a large swath of Marylanders gain significant benefits from it. There has been no data presented describing the implications of contrasting differences between the specific drug utilization of Marylanders and the national population utilization.

Without a thorough background analysis, such as, but not limited to, addressing the aforementioned missing data, it is unclear how the analysis can conclude that a UPL is the remedy to a heretofore non-specific "affordability challenge". It is further unclear how using the "maximum fair price" as a benchmark for UPL is a bona fide solution, given the lack of clarity about public budget impacts or market adjustment in benefit design by PBMs upon imposition of a UPL.

Solution Development Efforts Appear Skewed

It has been presented that the development of non-UPL affordability solutions would run "in parallel" with UPL development. However, based upon Board and staff discussion, that intent does not appear to be represented as a meaningful consideration. Several non-UPL affordability solutions, without the potential for patient harm, appear to be more timely in terms of patient and system cost relief, but also less expensive for state budgets. Various aspects of PBM reform, including prohibitions on predatory plan tiering and copay caps, for example, are a means to directly regulate within the current abilities of the legislature and the way insurance is regulated without imposing a UPL, and more directly, addressing patient affordability needs.

Moreover, there hasn't been a discussion of a suggested policy for issues such as how to protect patients from readily foreseeable unintended consequences and ensure that a drug with an applied UPL cannot be removed from a formulary as a result of the UPL being set. "Monitoring" has been hinted at; however, it is unclear what is being done *now* and what will be done in the future, along with the actions to be taken based on information gleaned from said monitoring. The basic principles of program and policy monitoring require both a "baseline" and specified plans for evaluating the same data across change implementation. Thus far, neither the Board nor staff have committed to or sought out establishment of "baseline" benefit designs, pharmacy acquisition and availability of named medications, or even impact on the state's Medicaid Drug Rebate Program revenues of named medications. No meaningful effort to assess the current state of access has been made.

Furthermore, Director York has made repeated mention of imposition of a UPL "on the backend". What he means by this is entirely unclear and should be defined in explicit detail to the public and the Board so as to understand the impact of a UPL on any variety of supply chain actors and what patients should be expecting in the instance of imposing a UPL. If the Director is suggesting a post-reimbursement fee capture, similarly

structured to direct and indirect remuneration fees, that needs to be explained, as implementing this design would be particularly harmful to pharmacies.

Additionally, no effort has been made to explain how 340B claims will be identified and excluded from the imposition of a UPL, as mandated by Maryland law. This process needs to be explained and properly understood, with information from the public as to anticipated impacts, for the Board to make an informed decision.

With the present mandate to help patients and the state regarding public health plans, and the desire to further affect the commercial market, it appears there is too much left unanswered, unexamined, and unarticulated to continue on the present path. **Moving forward without the above information betrays the public trust and the stated legislative intent of the very law enacting this very Board.**

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.

Respectfully submitted,

Ranier Simons
Director of Patient-Centered Drug Pricing and Healthcare Access Policy
Community Access National Network (CANN)

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

DIABETES PATIENT ADVOCACY COALITION

January 21, 2026

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

RE: PDAB January 26, 2026 Meeting - Preliminary Policy Recommendations for Ozempic and Trulicity

Dear Members of the Maryland Prescription Drug Affordability Board,

DPAC appreciates the opportunity to comment on the Board's staff preliminary policy recommendations for Ozempic and Trulicity, specifically with respect to the proposed non–Upper Payment Limit (non-UPL) policy solutions. Set forth below are DPAC's comments on two of the proposed non-UPL policy approaches:

State Participation in CMMI models (Both Ozempic and Trulicity)

DPAC applauded the announcement by CMS to test a new approach to reduce prices of and improve access to GLP-1 drugs through the BALANCE model. However, significant uncertainty remains regarding how the model will operate in practice and what it will mean for Medicare and Medicaid beneficiary access. Key coverage details, including which beneficiaries and which drugs will be included, depend on participation by drug manufacturers, states, and Part D sponsors. Patients may also be subject to coverage qualifications determined through negotiations. In addition, it is unclear what types of lifestyle interventions will be required or offered under the model. We encourage the state to consider participating in the model, provided that its design and implementation would meaningfully expand access to GLP-1 medications.

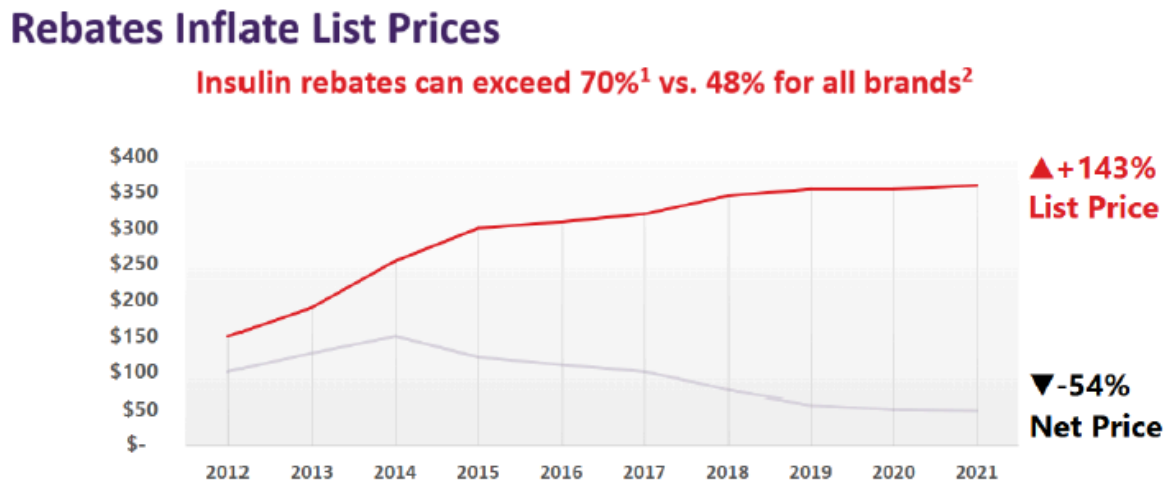
With respect to the GENEROUS model, we note that drug prices used for comparison in many foreign countries are derived from explicit cost-effectiveness frameworks that frequently rely on Quality-Adjusted Life Years (QALYs). QALYs set out guidelines about whose health gains are "worth" public investment, raising longstanding concerns in the United States regarding equity for people with disabilities, chronic conditions, and complex health needs. Before adopting an MFN approach, the state should carefully consider whether anchoring prices to systems that

rely on QALY-based thresholds aligns with its own policy goals, nondiscrimination principles, and commitment to ensuring access to medically necessary treatments for all patients.

Plan Design and PBM Reform Study and Recommendations (Both Ozempic and Trulicity)

While we welcome the Board's increased interest in pharmacy benefit manager (PBM) reform, we are concerned that a recommendation for a study will delay policies for which there is already substantial evidence to support action. This includes the Board's prior recommendation to support legislation delinking PBM compensation from rebates.

Delinking PBM compensation from drug list prices will limit future increases in list price, as it will remove incentives to inflate list prices and provide higher rebates to PBMs. It will ensure that patients benefit from the lowered list prices. The chart[1] below demonstrates the incentive to inflate list price by showing how insulin list prices increased from 2012 to 2021 while the net price decreased because of negotiated savings. The Board already noted that there is evidence that delinking compensation from the list price of a drug could lower overall drug spending by about 15%.[2]



There is strong evidence supporting rebate pass-through policies that require insurers and PBMs to pass negotiated savings directly to patients at the point-of-sale. West Virginia, Indiana, and Arkansas passed such legislation in 2021, 2023 and 2024, respectively. Following implementation, rate filings for plans in Indiana and Arkansas saw no increase in premiums

[1] U.S. Senate Finance Committee on Finance. Insulin: examining the factors driving the rising cost of a century old drug. January 14, 2021. https://www.finance.senate.gov/imo/media/doc/Grassley-Wyden%20Insulin%20Report%20(FINAL%201).pdf; Kakani P, Chernew M, Chandra A. Rebates in the pharmaceutical industry: evidence from medicines sold in retail pharmacies in the U.S. March 2020. NBER Working Paper 26846. https://www.nber.org/papers/w26846; Sanofi 2021 Pricing Principles Report. March 3, 2021 https://www.sanofi.us/en/pricing-principles-report. Sanofi is a member of the DLC Industry Advisory Board.

[2] Joyce G. The cost of misaligned incentives in the pharmaceutical supply chain. Health Aff Sch. 2025;3(7):qxaf126. Published 2025 Jun 25. doi:10.1093/haschl/qxaf126

attributable to these policy reforms.[3] In West Virginia, the Office of the Insurance Commissioner has recently released data demonstrating that rebate pass-through has in fact reduced rate increases for plans by 0.7% to 14%.[4]

Finally, we respectfully reiterate our request that the Board prioritize the evaluation and advancement of non–Upper Payment Limit (non-UPL) policy options as it continues to work through its processes. Non-UPL approaches offer evidence-based pathways to improve affordability while minimizing the risk of unintended access disruptions. Advancing these strategies should be central to the Board's efforts to protect patient access and affordability.

Sincerely,

George Huntley
Chief Executive Officer
Diabetes Patient Advocacy Coalition

[3] Klein, M., & Holzer, H. (January 2024). Premium Impacts of POS Rebate Implementation in the ACA Market in the State of Arkansas. Milliman. Available at https://dfr.oregon.gov/pdab/Documents/Constituent-testimony-2.pdf; Robb, M., & Holzer, H. (January 2025). Premium Impacts of POS Rebate Implementation in the ACA Market in the State of Indiana. Milliman. Available at https://edge.sitecorecloud.io/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2025-Articles/1-29-25_POS-Filing-Impacts.pdf.

[4] West Virginia Insurance Bulletin No. 25-01 (February 13, 2025). Available at https://www.wvinsurance.gov/Portals/0/pdf/pol_leg/IB_25-01_Prescription_Drug_Rebate_Impact_to_Commercial_Health_Insurance.pdf?ver=2025-02-13-125517-883.

EACH PIC COALITION

January 21, 2026

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

RE: Public Comments on Policy Reviews for Ozempic and Trulicity

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 appreciate the opportunity to submit comments as the board considers policy recommendations following its affordability review of Ozempic and Trulicity. We share the board's goal of improving affordability for Maryland patients; however, for both Ozempic and Trulicity, the criteria that led to the board to deem these drugs as causing affordability challenges were related to system challenges, not patient costs. We respectfully urge the board to oppose the implementation of an Upper Payment Limit (UPL) for these therapies and instead prioritize alternative policy approaches that more directly address the drivers of patient affordability challenges.

UPLs Do Not Guarantee Savings for Patients

While a UPL may alter what insurers or the state pay for a medication, it does not cap or guarantee reductions in patient out-of-pocket costs. As our coalition has consistently emphasized, patient affordability is shaped by many factors, including insurance design, not solely by a drug's price. According to data from the Pioneer Institute, early evidence shows that patient out-of-pocket costs for drugs subject to Maximum Fair Price (MFP) have actually increased. This outcome underscores a critical reality: price controls alone do not ensure savings reach patients.

UPLs risk creating new incentives for insurers to shift costs or restrict access through adverse tiering, formulary reshuffling, or expanded utilization management. For patients, these actions can result in treatment disruptions or forced switches to less effective options, with potentially serious health consequences. Our Patient Experience Survey found that insurance-related barriers are already significant contributors to patient unaffordability. Policies that focus narrowly on price, without addressing these structural barriers, risk missing the root causes of the challenges patients face every day.

Delinking PBM Compensation Is a More Effective Path Forward

We strongly support the board's consideration of non-UPL alternatives and endorse the proposal to delink PBM compensation from drug prices. The current rebate-driven PBM model creates perverse incentives to favor higher-priced drugs, as PBMs profit from larger rebates tied to inflated list prices. Delinking PBM compensation from drug prices and rebates is critical to realigning incentives toward lower costs and improved access for patients.

This approach offers a more targeted and sustainable solution to affordability challenges and addresses the mechanics of the drug supply chain rather than imposing blunt payment caps that may shift costs and restrict access. States such as Colorado have already taken steps in this direction, and similar reforms are being actively considered at both the state and federal levels.

As the board continues its deliberations, we urge it to establish a clear and transparent framework for evaluating non-UPL policy options and to ensure these alternatives are given equal weight alongside UPL proposals. Based on available evidence and lived patient experience, PBM delinking and related insurance reforms are far more likely to reduce patient costs without introducing new access barriers or disrupting care.

Conclusion

We appreciate the board's willingness to consider alternatives to UPLs and its ongoing engagement with patient stakeholders. We stand ready to work collaboratively with the board to advance policies that address the real drivers of patient affordability while preserving timely access to the treatments patients rely on.

Sincerely,

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January 21, 2026

By Electronic Submission

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

Dear Members of the Maryland Prescription Drug Affordability Board ("Board" or "PDAB"):

Eli Lilly and Company ("Lilly") appreciates the opportunity to offer comments on materials for the Board Meeting to be held on January 26, 2026, including the Cost Review Study Process Preliminary Policy Recommendations presentation slides (the "Policy Presentation") and the initial upper payment limit ("UPL") framework for Trulicity® (the "Trulicity® UPL Framework").[1]

Lilly is proud to make Trulicity®, a once-weekly injectable prescription medicine for certain patients with type 2 diabetes to improve blood sugar (glucose) or to reduce the risk of major cardiovascular ("CV") events. Trulicity® is affordable and widely accessible, including for patients and health care entities in Maryland. Lilly shares the Board's goal of improving patient outcomes by making effective treatments accessible, but Lilly continues to have serious concerns that the Board's cost review activities threaten to jeopardize patients' access to vital medicines, including Trulicity®.[2] To that end, Lilly urges the Board to take into consideration the concerns and recommendations outlined below particularly regarding factors determining affordability and identified policy options to address affordability.

I. A UPL Is Not a Reasonable Policy Recommendation for Trulicity

The Board should not pursue a UPL policy for Trulicity® because it lacks authority under the governing legal standards and it will do nothing to make Trulicity® more affordable for patients. The Board itself acknowledges that gross spending, one of its two affordability findings, does not support a UPL recommendation; and, for the reasons outlined below, a UPL would not address the purported affordability challenges tied to Trulicity®'s WAC either.

Patient Experience and Affordability

[1] *See* Board, Cost Review Study Process Preliminary Policy Recommendations Presentation (Jan. 16, 2026), available here; Board, Trulicity® UPL Framework (Jan. 16, 2026), available here; Board, Trulicity® UPL Framework Presentation (Jan. 16, 2026), available here.

[2] In filing this letter, Lilly expressly reserves all available arguments regarding the legality of the PDAB statute and its implementation, and reasserts and incorporates by reference its prior comment letters.

Lilly reiterates the position that the primary focus of any cost review by the Board should be on patients, and Trulicity® is broadly affordable for Maryland patients. As addressed in our prior letters and as acknowledged by the Board, Trulicity® does not present an affordability challenge to patients in Maryland.[3] If it did, the Board would have made an affordability finding on that basis rather than focusing on WAC and gross spending, neither of which measures patient costs. The Policy Presentation itself recognizes that the GLP-1 class has experienced marked price reductions as a natural product of market competition in recent years, and these therapies already "are subject to multiple national and state efforts to promote affordability and access."[4]

Assessing Affordability and Policy Drivers

Lilly reiterates our concern with the underlying methodology and metrics the Board is using to determine affordability. The Board must base Trulicity®'s affordability on more reliable and accurate metrics of the cost of our medicine to the state and its residents. These determinations should be derived from a complete and holistic picture of the costs that purchasers and patients in the state actually incur when they interact with the healthcare system. Furthermore, aggregate spending metrics disconnected from per-patient data will consistently and disproportionately identify medications for common chronic diseases for "affordability reviews" – without regard for the obvious fact that the size of the eligible treatment population is often responsible for the utilization observed.

Trulicity®'s WAC is not a meaningful measure of affordability.[5] Although the Board may consider WAC in the cost review process, its ultimate statutory directive is to identify whether a drug "has led or will lead to affordability challenges," a determination which cannot reasonably rest on WAC.[6] The Board itself has acknowledged that WAC does not "represent the final net cost of the drug" because rebates and other price concessions "can dramatically impact the final 'net cost'" incurred by payors (including state payors).[7] It is unclear how WAC increasing faster than inflation could "lead to affordability challenges for the State health care system"

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[3] *See* Eli Lilly Comments on Stakeholder Informational Hearing, December 16, 2025; Letter from Lilly to Board (Nov. 12, 2025); Letter from Lilly to Board (Sept. 4, 2025).

[4] Policy Presentation at 14–15, 83. As noted in prior comments, Lilly recently announced direct-to-patient purchasing options making Trulicity widely available at a 50-60% discount off of the list price. Letter from Lilly to Board at 3 (Nov. 12, 2025).

[5] *See* Board, Notice of Informational Hearing 2 (Dec. 16, 2025) ["Notice of Informational Hearing"], available here.

[6] Md. Code, Health-Gen. § 21-2C-09(b)(1), (b)(2)(i); *see Md. Off. of People's Couns. v. Md. Pub. Serv. Comm'n*, 461 Md. 380, 399–40 (2018) (explaining that an agency may not exercise discretion "unreasonably or without a rational basis" and reviewing courts "may look for consistency with the policy goals stated in the pertinent statutes or regulations").

[7] Supply Chain Report – Health General Article § 21-2C-07 at 11 (Sept. 10, 2024) ["Supply Chain Report"], available here.

when WAC does not measure the cost to the system[8] (and given that list price growth in excess of inflation is offset by the net prices offered by manufacturers to state purchasers).

The Board has noted that an increasing WAC "*may* directly impact patients by influencing patient cost sharing" but has not presented any evidence of such an impact for Trulicity®, much less an impact that rises to the level of "affordability challenges for the State health care system or high out-of-pocket costs for patients."[9] In fact, the Board reviewed patient cost information for Trulicity® and, unlike in the case of Farxiga and Jardiance, did not identify patient costs as a circumstance reflecting an affordability challenge—only WAC and percentage of gross prescription drug spending, neither of which measures Trulicity®'s costs to patients. It is unclear how Trulicity®'s WAC has led to an affordability challenge simply because it "may" influence patient cost sharing when patient costs have not been deemed to present an affordability challenge.[10] Lilly urges the Board to make affordability determinations based not on assumptions but on a holistic and reasoned review of reliable data.

The stated basis for the UPL recommendation is "[e]nsur[ing] that affected entities' net costs are protected from WAC increases . . . by establishing a ceiling net price that is not contingent on WAC increases."[11] Board staff advance this recommendation despite acknowledging its mechanism has more weaknesses than strengths.[12] Specifically, the Policy Presentation acknowledges that (1) the "[i]mpact of the savings to the state is based on the net price that the entity is currently paying," *not* the list price; (2) "Trulicity may have biosimilar competition as soon as 2027," further driving down costs over the natural course of the pharmaceutical lifecycle; and (3) GLP-1s in particular are subject to additional affordability measures.[13] Thus, the Board's own analysis suggests that a UPL for Trulicity® will not generate savings or otherwise improve affordability.

The Policy Presentation reports that the WAC finding is driven by underlying market dynamics; as detailed below, Lilly urges the Board to focus on policy solutions that address those underlying drivers rather than wasting time and resources on UPLs which ultimately will not benefit patients or payors.[14] A UPL would not reduce the

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[8] Md. Code, Health-Gen. § 21-2C-09(b)(1); *see generally, e.g.*, *Harvey v. Marshall*, 389 Md. 243, 302 (2005) ("[A]n agency action nonetheless may be 'arbitrary or capricious' if it is irrationally inconsistent with previous agency decisions."). Lilly continues to urge the Board to focus on net costs to assess affordability in accordance with its statutory purpose. *See* Letter from Lilly to Board 7 (Jan. 10, 2025); Letter from Lilly to Board 6, 12 (Aug. 26, 2024).

[9] Policy Presentation at 31; Md. Code, Health-Gen. § 21-2C-09(b)(1).

[10] *See generally Md. Dep't of the Env't v. Cnty. Comm'rs*, 465 Md. 169, 201–02 (2019) (explaining that a reviewing court defers to an agency "when the record supports [its] findings and inferences").

[11] Policy Presentation at 83–85.

[12] *Id.* at 83.

[13] *Id.*

[14] *See id.* at 31–32.

prices paid by State health care entities, reduce patient cost sharing, nor otherwise meaningfully make prescription drugs more affordable.

Similarly, Trulicity®'s percentage of gross prescription drug spending is not a meaningful measure of affordability.[15] Gross spending, like WAC, does not reflect the underlying costs incurred by commercial and government payers. Both plan premiums and medical loss ratio ("MLR") calculations are derived from net drug spending.[16] Cost analyses that omit or overlook this information by focusing on gross spending provide an insufficient basis for finding an affordability challenge.[17]

Furthermore, as stated above, high aggregate spending on a drug could be the simple outgrowth of it being highly effective at treating a widespread chronic condition. Such treatments cannot plausibly represent an affordability challenge unless the proportion of total spending attributable to a given drug is inappropriate for its utilization and value. Affordability determinations cannot be fairly ascertained without consideration of the estimated net spending impact per patient – inclusive of medical cost offsets attributable to the drug that ultimately accrue to state purchasers. Although the Board *may* consider a variety of individual factors for its the cost review process, its ultimate statutory directive is to identify whether a drug "has led or will lead to affordability challenges". Such a determination should rest on a more accurate and holistic picture of financial impact, rather than a short-sighted focus on gross spending in aggregate. The Board should instead re-assess its determination with a focus on net expenditures per patient – inclusive of treatment costs offsets derived from clinical value to the system – while factoring in a broader range of metrics that includes patient out of pocket experience, manufacturer assistance provided, and a recognition that health plan costs (as reflected in premiums) are calculated based on net drug costs after manufacturer rebates.

The Policy Presentation itself attributes Trulicity®'s gross spending to high utilization, recognizing the medicine's "special place in therapy for treating patients with comorbidities, which represents a large portion of patients with diabetes."[18] The Policy Presentation adds that, in this case, "the price is high on both a list and net basis, so

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[15] *See* Notice of Informational Hearing 2.

[16] CMCS Informational Bulletin. Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors. May 15, 2019. Available here.

[17] *See Md. Off of People's Couns.*, 461 Md. at 399. Board members commented that 1% or more represents a "significant" portion of drug spend but did not explain how it determined that threshold nor make any attempt to contextualize that spending. July 2025 Meeting Recording 2:42:19. It is not clear that the Board even cross-referenced these percentages to patient counts much less weighed the data against the burden of disease, reductions in health care expenditures, or other relevant factors. One Board member noted the drugs' effectiveness, but there was no meaningful discussion of how the data combine to impact affordability. *See* July 2025 Meeting Recording 2:50:25. Presumably, the threshold at which the portion of total spending indicates an affordability challenge differs based on the particular medicine under review, but it is not evident how the Board is taking these considerations into account, if at all.

[18] Policy Presentation at 33.

high gross spend is associated with a high net spend."[19] But the Board never made an affordability finding based on net price or net spending, suggesting the data did not support such finding. The Board should not circumvent due process by resting policy recommendations on affordability concerns that the Board did not substantiate in the first instance.[20] Lilly asks the Board decline to find affordability challenges based on gross spending or other metrics that do not measure affordability.

Identified Policy Options

UPLs Do Not Address Underlying System Incentives

Aside from the fact that a decision to set a UPL on Trulicity® would flow from a flawed and misguided methodology, such a policy would not meaningfully improve patient affordability or access. On the contrary, UPLs are more likely to *harm* patient access in the long run, given underlying incentives within the pharmaceutical supply chain in need of reform.

Plan formulary designs continue to be driven by rebates and fees often calculated as a percentage of a drug's list price. To the extent that a UPL leads to a reduction in such price concessions to PBMs, formulary access to such products may be disfavored for alternative treatments that continue to offer rebates. This is not simply a theoretical concern.[21] A survey of large regional and national payers found most (83%) anticipated moderate or major disruption to formulary design due to state price controls and 50% expected increased copays or coinsurance on a drug subject to state price setting.[22] Additionally, a recent survey of independent pharmacies indicates most are considering not stocking drugs subject to MFPs, and about one-fifth have already decided not to stock such drugs, signaling a further risk to access if a UPL is set at the MFP.[23] These very real risks underscore that state policy efforts should be aimed at addressing underlying system incentives.

The Board Should Consider Alternative Policies to UPLs

As noted above, any actions to meaningfully address affordability will require targeting underlying incentives in the pharmaceutical supply chain in need of reform, rather than misguided policies like UPLs. Lilly is encouraged that the Board is considering non-UPL policy options and voted to pursue some of those options with respect to other drugs under review, but the Board subsequently has focused on developing only

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[19] *Id.*

[20] *See, e.g.*, COMAR 14.01.05.03.B ("The purpose of the policy review process is to: (1) Based on the best available information, confirm the drivers and market conditions causing the affordability challenge phenomena; and (2) Identify the policies that may *address those drivers and redress the affordability challenges*." (emphasis added)).

[21] *See generally, e.g.*, Magnolia Market Access, IRA Payer Insights Survey (Summer 2024), available here (reporting that more than half of surveyed payors anticipate adding utilization management or other coverage restrictions for drugs subject to Medicare MFPs in favor of non-negotiated drugs).

[22] Update: Health Plans' Perceptions of PDABs and UPLs, Avalere Health. Available here.

[23] National Community Pharmacists Association. Report for Medicare Drug Price Negotiation Program and Financial Health of Pharmacy, available here.

the UPL recommendations. The robust list of non-UPL policy options recommended for Trulicity® underscores the complexity of the drug pricing supply chain and the need for broad-based reforms. We urge the Board to prioritize policy options in accordance with each policy's ability to address the root drivers of any affordability challenges, as supported by reliable evidence.

Lilly believes certain policy alternative recommendations would meaningfully address issues in the pharmaceutical payment system without inviting the unintended consequences inherent with UPLs. The Board should move forward with policy reforms that address warped supply chain incentives and preferences for higher list prices that expose patients to higher cost-sharing obligations. Addressing such issues would enable lower costs for patients at the point of sale and create the conditions for downward pressure on drug prices. These policies would create the structural reform necessary to reduce the divergence between list and net prices.

In addition, Lilly is encouraged to see the Board considering participating in voluntary CMMI demonstrations that are designed to reduce pharmaceutical costs for state Medicaid programs. Rather than spending significant state resources on designing and implementing a UPL, the Board should further analyze the opportunities these demonstrations provide to potentially generate savings across a broad portfolio of medicines.

II. The Board Must Vote on Policy Recommendations and UPL Frameworks in Separate Meetings

Lilly continues to have serious concerns about the Board's processes in general and, in particular, the Board's apparent intent to vote on policy recommendations and consider a specific UPL framework for Trulicity® during the same Board meeting.[24] Although the meeting agenda notes that the framework discussion is contingent on the Board deciding to pursue a UPL, this clarification is not an adequate safeguard to facilitate sound agency decision-making.

The contemplated concurrent decision-making means that Board staff have already considered and developed UPL frameworks before the Board weighs available policy options and determines that a UPL is an appropriate policy solution for the identified affordability challenges. This process not only diverges from the Board's treatment of other drugs under review, for which these steps were performed at separate meetings with separate comment opportunities, but also contravenes the Board's own regulations. If the Board chooses to "pursue development of a UPL as a policy option," it may "direct Board staff to provide recommendations concerning the frameworks and contextual information that may be used to set a UPL."[25] Thus, unless and until

[24] Board, Meeting Agenda (Jan. 26, 2026), available here; *see* Letter from Lilly to Board at 2–3 (Aug. 26, 2024); Letter from Lilly to Board at 2–4 (Feb. 10, 2025).
[25] COMAR 14.01.05.05.C(4).

Board decides to pursue development of a UPL policy for Trulicity®, Board staff lack authority to develop a UPL framework.

Sequential decision making is essential to provide meaningful opportunities for public comment, including sharing "free-flowing information from a broad range of interests" to facilitate a "genuine interchange" of "information, concerns, and criticisms" to the Board.[26] Stakeholders should have the opportunity to comment on and engage in each of these processes separately, and the Board must meaningfully respond to those comments before proceeding onto the next step. Combining these steps would impair the integrity of the Board's decision-making, encouraging conclusory decisions that do not fully account for the full range of stakeholder feedback and perspectives relevant to each distinct decision.

Furthermore, such concurrent decision-making suggests that the Board will pre-judge the outcome of its policy review before considering all the information and public input provided during the review process. Ultimately, this creates undue risk that the Board would impose a UPL without fully evaluating the appropriateness of such a price control, which risks significant consequences for patients by resulting in rushed conclusion that may fail to fully consider the potential negative outcomes of a UPL on patient access across Maryland.

III. The Board Must Provide Meaningful Opportunities for Comment

The Board must also allow sufficient time for meaningful public and stakeholder participation in the affordability review process before rendering decisions.[27] The Board's practice of setting unreasonably short comment periods for stakeholders raises significant concerns about the ability for stakeholders to meaningfully review materials and provide comment. As noted above, the Board released a UPL framework as well as policy options for consideration with fewer than five business days for stakeholders to review the documents and submit public comment – including fewer than three business days for the UPL frameworks posted the Friday before a federal holiday weekend. This window is wholly inadequate for stakeholders to review over one hundred pages of complex policy analysis and develop thoughtful insights to aid the Board's decision-making. Unfortunately, this is not the first time the Board has opted for a highly abbreviated timeline for public comment, seriously inhibiting the

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[26] *Adventist Healthcare Midatlantic, Inc. v. Suburban Hosp., Inc.*, 350 Md. 104, 123 (1998); *Conn. Light and Power Co. v. Nuclear Reg. Com'n*, 673 F. 2d 525, 530 (D.C. Cir. 1982).

[27] *Adventist Healthcare Midatlantic, Inc. v. Suburban Hosp., Inc.*, 350 Md. 104, 123 (1998) (noting that the Maryland APA notice-and-comment procedures are designed "to afford fair notice and a *meaningful* opportunity comment to all persons who may be affected by the proposed regulation" (emphasis added)); *Fogle v. H & G Restaurant, Inc.*, 337 Md. 441, 462–63 (Md. Ct. App. 1995) (finding comment opportunity was meaningful and compliance with Maryland APA because "[s]everal public hearings were held," "[a] multitude of documentary evidence was submitted," and the published decision "set[] forth [the Commissioner's] explanation for the choices that he made in promulgating [the regulation] in light of the evidence presented to him throughout the rule-making process").

ability of patients, manufacturers, and other stakeholders to meaningfully comment on the Board's proposals.[28]

Lilly appreciates the opportunity to comment on the Board meeting and looks forward to continued engagement with the Board on these topics. Please do not hesitate to reach out if you have any questions or need clarifications.

Sincerely,

Senior Director, Government Pricing & Payer

Lilly USA, LLC

[28] For example, the cost review dossier for discussion at the Board's May 19, 2025, meeting was posted on May 12, 2025, just *two days* before the May 14 comment deadline. *See* 2025 Board Meetings, available here. A previous policy review presentation for the Board's September 2025 meeting similarly was posted less than four business days before the comment deadline. *Id.*

January 21, 2026

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 board-certified pediatrician and pediatric rheumatologist with decades of experience caring for patients whose families often struggle to access and afford necessary medications for their children with chronic or disabling conditions. 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.

Maryland is unique in that you are legislatively focused on primarily saving the state's health systems money. However, by only considering list drug prices without considering the total healthcare expenses creates an incomplete health care picture that can lead to poor outcomes and greater overall state costs. For instance, the anti-diabetic medications you are considering potentially deeming unaffordable, treat or prevent multiple serious and potentially expensive health conditions. Limiting access to life-altering medications based only on list prices ignores the potential additional health care costs the state will face when patients may require multiple separate medications for each condition and/or when their diseases worsen and require potentially preventable care.

Everyone shares your goal of lowering prescription drug costs for Maryland residents. However, as we look toward the year ahead, the current myopic process that only focuses on the drug list prices and not the total cost to patients not only risks decreased access to essential medications but also could create longer term negative health outcomes and costs. 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 ineffective.

All clinicians and patients are eager to collaborate with the Board to ensure affordability decisions reflect real-world patient needs based upon a 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

NATIONAL INFUSION CENTER ASSOCIATION

The Nation's Advocacy Voice for In-Office Infusion

3307 Northland Dr, Ste 160 ▪ Austin, TX 78731
www.infusioncenter.org ▪ info@infusioncenter.org

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

January 21, 2026

Re: Concerns with Upper Payment Limits (UPLs)

Dear Members of the Prescription Drug Affordability Board,

On behalf of the infusion providers we represent in your state, thank you for your service and commitment to the people of Maryland. As a nonprofit trade association that provides a national voice for non-hospital, community-based infusion providers, we ask you to please consider the potential consequences of establishing upper payment limits (UPL) for certain infusion drugs that require provider administration.

The National Infusion Center Association (NICA) is a nonprofit organization formed to support non-hospital, community-based infusion centers caring for patients in need of infused and injectable medications. To improve access to medical benefit drugs that treat complex, rare, and chronic diseases, we work to ensure that patients can access these drugs in high-quality, non-hospital care settings. NICA supports policies that improve drug affordability for beneficiaries, increase price transparency, reduce disparities in quality of care and safety across care settings, and enable care delivery in the highest-quality, lowest-cost setting.

Our organization writes to express our continued concerns with the MD PDAB, specifically its ability to establish an Upper Payment Limit (UPL) for drugs that the board believes will cause affordability challenges for Maryland patients and the healthcare system. We applaud Maryland lawmakers for attempting to address drug costs for patients. However, we believe that not only would UPLs for infusion drugs fail to achieve this goal, it would also harm the very vulnerable groups it intends to serve, unless certain measures are taken.

In practice, we believe the current process to establish UPLs would hinder patient access to life-saving medications by disrupting the delicate economics of medical benefit drug delivery and putting smaller, community providers, that represent the lowest-cost care setting for these

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expensive medications, out of business. Infusion providers typically acquire, administer, and bill for drugs through a buy-and-bill model. Providers are reimbursed for the drug and provided a small payment for professional services that does not begin to cover the overhead of their business. To remain in business, infusion centers must rely on their drug payments to offset the incredible cost-reimbursement disparity on the professional services side. Drug payments are the economic lynchpin to offset practice expenses, including inventory management, staff salaries, and office space. Unchecked implementation of UPLs would disrupt drug reimbursement for infusion providers and force most of the state's community-based infusion centers to shutter their doors, forcing patients into more expensive hospital care settings or potentially ending their treatments.

In conclusion, an upper payment limit would only limit how much insurers in the state pay for a drug, but it would not change the actual cost of drug acquisition and administration for Maryland providers. Though well-intended, UPLs would harm infusion providers and their patients.

NICA continues to reaffirm our request that Maryland lawmakers explore other options or a policy that would exempt infusion providers from the impact of this bill, essentially a provider carve-out. This would avoid disruptions to community-based care delivery and keep Maryland infusion centers in business. Thank you for your consideration. If I can provide any additional information, please do not hesitate to contact me.

Sincerely,

Brian Nyquist, MPH
President and CEO
National Infusion Center Association

Infusion Access Foundation

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

January 21, 2026

Re: Concerns with Upper Payment Limits (UPLs)

Dear Members of the Prescription Drug Affordability Board,

On behalf of the Infusion Access Foundation, which represents patients across Maryland who rely on infusion therapy to manage chronic and life-threatening conditions, we write to express our concerns with the Maryland Prescription Drug Affordability Board's (PDAB) imposition of Upper Payment Limits (UPLs) on certain medications, as this policy would threaten access to essential treatments for thousands of vulnerable Maryland patients.

The Infusion Access Foundation is a nonprofit advocacy organization dedicated to protecting access to infusions and injections. We support patients across all disease states and advocate for expanding access to the therapies that help patients live their best, healthiest lives. In conjunction with our grassroots advocacy work, we advocate for individual patients who face significant barriers to care.

Many of the patients we represent live with complex autoimmune diseases, neurological conditions, genetic disorders, and other serious illnesses that require regular infusion therapy to maintain their health and quality of life. Infusion providers purchase these medications upfront before seeking reimbursement from insurers. If UPLs result in reimbursement rates below the actual cost of acquiring and administering these treatments, providers may be forced to reduce services or shut down, leaving patients with limited or no access to the care they need.

For many patients, infusion therapy is not optional, it is lifesaving. Restricting access to these medications could lead to disease progression, hospitalizations, disability, and significant declines in health outcomes. Maryland should be working to expand access to high-quality, specialized care, not implementing policies that could force providers out of business and leave patients without viable treatment options. For example,

addressing the practices of pharmacy benefit managers (PBMs) that increase costs for patients without meaningful improvements in quality of care may be more effective in achieving the PDAB's stated goals than imposing UPLs.

We urge you to reconsider the PDAB's current UPL-centered strategy to ensure that Maryland patients can continue receiving the care they depend on. Thank you for your time and commitment to protecting patient access to essential therapies. We welcome the opportunity to discuss this critical issue further.

Sincerely,

Alicia Barron, LGSW
Executive Director
Infusion Access Foundation

NATIONAL INFUSION CENTER ASSOCIATION

Impact of Government Payment Limits on Providers, Infusion Centers and Patients

7 Seven states* have Prescription Drug Affordability Boards (PDABs), which were created by the legislature to review prescription drug costs.

4 Four of these PDABs** can set upper payment limits (UPLs), which cap the price of selected drugs for most entities in the supply chain, including infusion centers.

i Insurance companies and their pharmacy benefit managers (PBMs) are not restricted by the UPL.

This analysis examines how a UPL would influence an infusion center's ability to administer medications, and ultimately how this impacts patient access to care.

Access to Provider Administered Medications

Current State

Providers

Providers purchase medications slightly below list price. Providers administer medications to patients, possibly at an infusion center.

$2,000 Purchase Price

Patients

Patients are responsible for either a copay (flat fee) or coinsurance (percentage of the list price of the drug).

$30 Patient Copay

Providers

Providers submit reimbursement claims to a patient's insurance based on the cost of acquiring the drug, plus a small fee for administering the drug.

$2,000 + fee — Insurance Claim → Health Plan

Health Plan → Provider Reimbursement $2,086

+$86 Provider Profit Margin

This margin covers the cost of equipment, storage, staff and liability for the infusion center.

Under an Upper Payment Limit (UPL)

The PDAB sets a UPL on the drug. ~~$2,000~~ **$600**

Providers

The provider purchases the medication at the UPL and administers it to the patient.

$600 Purchase Price

Patients

Patient copay will remain the same regardless of the UPL.

Payments for patients with coinsurance will change based on the new list price of the drug.

$30 Patient Copay

UPL does not impact copays

Providers

PDAB caps reimbursement at the UPL, which means providers may not be able to bill for their administration fee. This will result in financial losses for the provider.

$600, No fee — Insurance Claim → Health Plan

Health Plan → Reimbursement with UPL $600

–$86 Provider Loss per Infusion

Provider Financial Losses

PDABs can **set UPLs below acquisition costs.**

When reimbursement doesn't cover purchase price, **providers and infusion centers cannot offer these treatments.**

Providers/infusion centers may **stop administering** drugs with UPLs.

Risks Patient Access

When providers and infusion centers cannot administer medications with UPLs, patients lose access in their communities.

Resulting in:

- Potential **therapy disruptions and delays in care**.
- Patients **traveling long distances (out-of-state) for access.**

No Patient Savings

- UPLs limit what health plans pay to providers/infusion centers.
- For patients with copays, UPLs **do not reduce** the patient's out-of-pocket cost.
- Patients are **unlikely to see affordability improvements** from UPLs.

*As of January 2026, Active PDABs: CO, ME, MD, MN, NJ, OR, WA. Past Studies: OH. Defunct PDABs: NH **PDABs with UPL Authority: CO, MD, MN, WA

Methodology: Model assumes no changes to the pharmaceutical supply chain, including manufacturer price and patient cost, other than the reimbursement rate being set at the UPL. UPL is hypothetical but similar to the first UPL set by the Colorado PDAB for Enbrel (e.g., a $600 UPL for a $2,000 drug).

Infusion Access Foundation

Impact of Government Payment Limits on Patient Access & Affordability

7 Seven states* have Prescription Drug Affordability Boards (PDABs), which were created by the legislature to review prescription drug costs.

4 Four of these PDABs** can set upper payment limits (UPLs), which cap the price of selected drugs for most entities in the supply chain, including pharmacists.

→ Insurance companies and their pharmacy benefit managers (PBMs) are <u>not restricted</u> by the UPL.

While patient affordability is at the heart of this legislation, **do these PDABs really make medications more affordable for patients?** ↓

Access to Pharmacy Medications

Health Plans with Copays

01	The PDAB sets a UPL on the drug	~~$2,000~~ → **$600**
02	Pharmacy purchases the medication at the UPL and dispenses the medication to the patients	**$600**
03	The patient pays a flat copayment, regardless of the price of the drug or the UPL	**$30 copay**
04	The health plan pays less for the drug based on the UPL	**Saves $1,400**

Health Plans with Coinsurance

01	The PDAB sets a UPL on the drug	~~$2,000~~ → **$600**
02	Pharmacy purchases the medication at the UPL and dispenses the medication to the patients	**$600**
03	The patient pays coinsurance, a percentage based payment that is typically based on the list price of the drug	**$150 payment** *Based on 25% coinsurance for brand drugs*
04	The health plan pays less for the drug based on the UPL	**Saves $1,400**

What does the health plan do with these savings? ?

Nothing in the PDAB requires these savings to be passed through to the patient

Is this really addressing affordability? ?

Health plans that require patients to pay coinsurance may still keep medications out of reach for most patients

*As of January 2026, Active PDABs: CO, ME, MD, MN, NJ, OR, WA. Past Studies: OH. Defunct PDABs: NH **PDABs with UPL Authority: CO, MD, MN, WA

Methodology: Model assumes no changes to the pharmaceutical supply chain, including manufacturer price and patient cost, other than the reimbursement rate being set at the UPL. UPL is hypothetical but similar to the first UPL set by the Colorado PDAB for Enbrel (e.g., a $600 UPL for a $2,000 drug).

Value of Care Coalition

January 21, 2026

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

Re: Policy Considerations for Ozempic and Trulicity

Dear Members of the Maryland Prescription Drug Affordability Board:

On behalf of the Value of Care Coalition (VCC) – a broad network of patient, caregiver, and health care provider advocacy organizations – we appreciate the Maryland Prescription Drug Affordability Board's (PDAB) mission to reduce health care costs and the dedication you have shown in pursuing that goal.

For our members, and for the patients and providers they serve, policy decisions affecting medications like Ozempic and Trulicity are not solely about list prices. They are about value, access, and ultimately, patient health and lives.

Cost Effective Drugs With Growing Utilization

Ozempic and Trulicity are essential frontline therapies. They play a critical role in the treatment of diabetes, cardiovascular disease, and chronic kidney disease — conditions that affect a substantial and growing number of Marylanders

Clinicians tell us they value these medications because each serves a distinct role in their treatment toolbox. Patients, in turn, report significant, life-altering benefits, including improved glycemic control, less weight gain, reduced risk of complications such as eye disease, neuropathy, foot complications, kidney failure, stroke, or amputation.

The evidence supports these lived experiences. Cost-effectiveness research reflects the strong value of these therapies. The Institute for Clinical and Economic Review (ICER) recently found Ozempic to be "highly cost effective" and noted that net prices have declined significantly. The Board's own meeting materials for Trulicity indicate that "some literature supports finding the drug cost effective at existing net prices." In addition, the federal government has announced reduced prices for both Ozempic and Trulicity, and lower-cost direct-to-consumer options have entered the market.

As utilization increases – driven by positive patient outcomes – it is critical that policymakers ensure continued access to these high-value treatments for common and serious conditions. Policies that restrict or destabilize access risk undermining both patient health and long-term system value.

Upper Payment Limits Threaten Patient Access

As the Value of Care Coalition has noted in previous comments, upper payment limits (UPLs) raise significant concerns for patient access:

- One-fifth of community pharmacies reported in September that they will not stock drugs subject to upper payment limits in Medicare — known as the Medicare maximum fair price — due to reimbursement concerns, and another two-thirds say they may not participate. This raises the risk of new pharmacy access deserts for patients.[1]
- Health plans indicated that they will increase premiums and out-of-pocket costs for patients and that access to impacted drugs may be restricted if UPLs are implemented.[2]
- Doctors warn of increased administrative burdens that reduce time available for patient care, as well as coverage disruptions that can force patients off stable therapies – often resulting in worse health outcomes.[3]
- A 2025 study found that Medicare patients experienced an average 32 percent increase in out-of-pocket costs for drugs subject to federal payment limits.[4] Early reviews of 2026 plans suggest this trend is continuing.[5]

These risks should be carefully weighed when considering policies that may unintentionally shift costs or restrict access for patients who rely on these medications.

Consider Patient-Centered Solutions

Affordability is not determined by list price alone. Benefit design and supply chain dynamics play a central role in what patients ultimately pay at the pharmacy counter. Health plan design is often the single largest determinant of patient out-of-pocket costs. When patients see their monthly costs suddenly increase from $70 to $500, it is most likely due to formulary changes, coinsurance requirements, or deductible design—not sudden increases in a drug's list price.

We are encouraged by the Board's consideration of non-UPL policy options that recognize these realities. We look forward to discussions around PBM delinking, as well as a study on plan design and PBM reforms. These approaches have the potential to address supply chain complexities that are not resolved through upper payment limits.

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[1] NCPA, *Independents may opt not to stock MDPNP drugs, NCPA warns CMS*, September 2025, https://ncpa.org/newsroom/qam/2025/09/08/independents-may-opt-not-stock-mdpnp-drugs-ncpa-warns-cms

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

[3] Value of Care Coalition, June 2025, https://valueofcarecoalition.org/doctor-survey-study/

[4] Pioneer Institute, *Pioneer Institute Launches Tracker Showing Drug Price Controls Are Raising Out-of-Pocket Costs for Medicare Patients,* May 2025, https://www.businesswire.com/news/home/20250509167994/en/Pioneer-Institute-Launches-Tracker-Showing-Drug-Price-Controls-Are-Raising-Out-of-Pocket-Costs-for-Medicare-Patients

[5] Avalere Health, *Part D Formulary Management Tightens in 2026,* November 2025, https://advisory.avalerehealth.com/insights/part-d-formulary-management-tightens-in-2026

Additionally, given declining prices and increasing utilization of GLP-1 therapies, we welcome further discussion of a GLP-1-focused study that could help support access for the growing number of Marylanders who may benefit from these treatments in the years ahead.

Thank you for your continued leadership and service, and for considering the patient and provider perspectives as you evaluate these important policy decisions.

Thank you for your continued leadership and service.

Sincerely,

Derek Flowers
Executive Director
Value of Care Coalition