AARP Maryland

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Maryland Prescription Drug Affordability Board
Written Public Comments
For Meeting May 18, 2026

Thank you for the opportunity to submit comments on behalf of AARP Maryland, which has about 850,000 members, in advance of the May 18 PDAB board meeting. The submitter is Jim Gutman, a member of the PDAB's Stakeholder Council representing the public, as well as a health care advocacy lead volunteer for AARP Maryland. AARP urges you to approve the proposed Upper Payment Limit (UPL) for Ozempic at the May 18 meeting.

This important drug hits all the key markers for needing a UPL starting at the beginning of 2027. For one thing, it already accounts for about 4.87 percent of state and local governments' gross drug spend in Maryland, according to the PDAB's own research. That figure is significantly higher than the percentage for Jardiance, for which you correctly already approved a UPL. It also means that government entities and their beneficiaries in Maryland stand to save millions of dollars per year when a UPL is in effect for Ozempic.

Moreover, the use of Ozempic is likely to continue rising strongly, especially since it is increasingly being prescribed "off label" by physicians for weight loss. That is in addition to its FDA-approved uses for type 2 diabetes, for which it is considered a preferred drug, as well as for cardiovascular disease and chronic kidney disease. The weight-loss use could rise even faster under the terms of SB 496, which passed in the Maryland General Assembly this year. That bill, if signed into law, authorizes Maryland Medicaid to begin covering obesity treatment as soon as next January 1 if the FDA approves the drug in question for chronic weight loss in patients with obesity. Should this occur, the potential costs to the state for Ozempic are likely to soar even higher.

There are also other major reasons why Ozempic is an ideal candidate for a UPL starting next January 1. These include that the drug is no longer in a shortage situation and that the last of its patents don't expire until December 2031 and June 2033, as the PDAB itself has noted. That means there is no competitive U.S. market for more than the next five years to help get its price down! Since the PDAB can't extend application of a UPL to the general public in Maryland until a year after it is applied to state and local government, it's doubly important to start the clock going now.

In addition, there is a federally negotiated price of this drug for Medicare, and the PDAB staff wisely recommends using that for the initial UPL. Furthermore, the Maryland price for government users starting in 2028 is appropriately tied to the federal Consumer Price Index for the 18 months preceding the initial Maryland UPL.

In summary, placing the recommended UPL on Ozempic is greatly needed, totally appropriate, and would be greatly appreciated by AARP Maryland and its members. We urge you to adopt this UPL at the May 18 meeting. And thanks very much for your wonderful work to help make important prescription drugs affordable for Maryland government entities and residents.

COMMUNITY ACCESS NATIONAL NETWORK

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May 12, 2026

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

RE: Ongoing Board Developments

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.

Patient Outreach Remains A Concern

A recurring issue in Board deliberations is the desire to increase patient engagement. This is imperative for multiple reasons, including to enable the board to operate with a patient-centered paradigm of affordability with regard to prescription drug spending. Ongoing polling shows that only a small share of Marylanders are aware of the PDAB and its work. Additionally, few fully understand the details of Board actions, such as the fact that the first wave only affects eligible governmental entities.

Moreover, at the March 23, 2026, meeting, Chair Mitchell supported obtaining broader stakeholder input, in addition to the handful of stakeholders who regularly engage. That is why it is confusing and concerning that Chair Mitchell spoke unfavorably regarding the idea of the Board marketing itself in order to drive more awareness. Roughly forty minutes into the meeting, he stated, “For us to be expected to put a marketing campaign on for our board and what we do, when we

are limited in employees and dollars and have been since we began, is really not at the top of our priority." He went on to say that after five years of board work, it was more important to get a 'win' across the line because a 'win' would then sell itself to the public.

Without the Board's desired broad swath of stakeholder engagement and greatly increased awareness by the public, how is a 'win' defined, and who is the win for? This is especially pertinent given the narrow scope of initial UPL implementation, which mainly affects the state and employees on state health plans. Moreover, it is concerning that public awareness has been a recognized challenge for the duration of the Board's existence, yet it has not been addressed.

Public awareness does not require a multimillion-dollar marketing campaign, nor is it a matter of public disinterest in civic engagement. Public awareness merely requires concerted effort and a truly deliberative process. Anything less is a betrayal of this Board's obligation to serve the very public its Chair is bemoaning engagement with. Public awareness is particularly pertinent, as the Board seeks to expand the reach of its decisions to cover the entire state. Discounting the importance of public awareness does not lend itself to a reasonable expectation of public buy-in and creates a perception of paternalism. Moreover, a lack of emphasis on public awareness raises questions about how much consideration will be given to monitoring potential adverse patient outcomes from implemented actions.

Mixed Response to Farxiga and Jardiance Decisions

We are encouraged that the Board decided not to put forth any UPL or non-UPL recommendations for Farxiga due to acknowledging recent developments regarding the plethora of generics slated to enter the market this year. Waiting to see how market changes unfold acknowledges the need to analyze current, Maryland-specific real-world data rather than broad-based historical data analysis.

Regarding Jardiance, we are concerned about the Board's decision to simultaneously move forward with several non-UPL policy developments as well as a proposed UPL. The non-UPL policies are noteworthy but will require a much longer timeline of development and legislative buy-in than the UPL, with the likelihood of never reaching implementation. Given the current concern about bandwidth for improving public awareness of the Board, the effective development and implementation of the non-UPL Farxiga recommendations would appear to be an even more taxing endeavor in terms of staff and Board resources.

Regarding whether UPLs are an appropriate tool to address affordability issues for Jardiance or other medications, such as Ozempic, the Board's current scope of allowed action still raises concerns. The potential negative impacts of setting a UPL in Maryland health settings are compounded by the unique moral and ethical dilemma posed by the PDAB's proposed implementation plan. The current statute only allows UPLs to be applied to state and local government, including employees, governmental health plans, and purchasers. This essentially seeks to 'test' a UPL on entities such as state hospitals and state university students. **The only state-owned hospitals are residential mental health facilities for which court-ordered residency and treatment are the near-exclusive population, meaning these resident-patients cannot legally consent to their own care, much less advocate for ensuring high-quality care**. The potential to adversely affect persons

who might otherwise be considered disabled due to mental health conditions does not present itself as a 'win', it does, however, present a moral and ethical failure.

We recognize the hard work the Board and staff have done and continue to do. We encourage the Board to continue with the mindset of carefully making decisions that are truly beneficial for Marylanders and of establishing documented, evidence-based positive outcomes within the current purview before expanding actions to the entire state.

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

EACH PIC COALITION

May 13, 2026

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

RE: Comments on Cost Review Rulemaking Procedure

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 board's decision to extend the public comment period for the proposed rulemaking on changes to the cost review process. However, this extended timeline remains an exception rather than the standard.

The board has too often advanced rulemakings with only a 14-day comment period, which effectively provides stakeholders with 10 business days or fewer to review complex proposals and develop meaningful feedback. We have long urged the board to adopt a minimum 30-day comment period for all rulemakings and continue to encourage the board to establish that standard moving forward.

We also appreciate the opportunity to learn more about the proposed changes during the upcoming meeting. Additional discussion of the proposed rule, the rationale behind the changes, and staff recommendations will help stakeholders and board members alike engage more meaningfully in the process and provide more informed feedback.

We encourage the board to use this process as a model for a more consistent and transparent approach to future rulemakings. Specifically, we urge the board to establish a standard process that includes:

- Initial presentation by board staff of a proposed rule during a regularly scheduled board meeting;
- A minimum 30-day public comment period;
- Formal review and discussion of submitted comments during a public board meeting; and
- Final board deliberation and vote.

A process structured in this manner would promote stronger deliberations, more constructive stakeholder engagement, and greater transparency into board decision-making. We thank the board for its consideration of our comments.

Sincerely,

Tiffany Westrick-Robertson

Tiffany Westrich-Robertson
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Ensuring Access through Collaborative Health (EACH) Coalition Lead

Vanessa Lathan
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Patient Inclusion Council (PIC) Coalition Lead

May 13, 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 physician with decades of experience caring for patients whose families often struggle to access and afford necessary medications, I remain concerned that the Board's process for selecting medications and conducting affordability reviews will leave Maryland patients without access to necessary medications.

As a board-certified pediatrician and pediatric rheumatologist who spent my career caring for young people 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.

On April 13, the Maryland PDAB voted to move forward with a cost review and Upper Payment Limit for Jardiance, thereby becoming the second state PDAB to take this action. Rather than treating this as a validation of the as yet unproven process, I urge the Board to consider it as an urgent call to answer some of questions it has thus far avoided: What exactly are you measuring? How will you prove it works? And who will be accountable if it doesn't? What predictable health consequences may arise from the state-imposed non-medical switching? And how will these health impacts be measured?

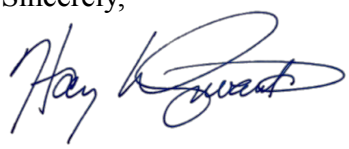
Jardiance is not simply a diabetes medication. This family of medicines has demonstrated clinically significant benefits in reducing the risk of at least heart failure and kidney disease progression. When a single medication impacts multiple serious conditions simultaneously, potentially restricting access solely on today's list price ignores what inevitably follows: patients may require multiple separate medications for each condition, as well as the substantially greater costs of treating complications when diseases progress unchecked. These are not unintended costs and consequences; they are predictable ones. They may just show up on a different spreadsheet or budget.

The Board's approach to measuring "cost savings" raises fundamental concerns that threaten the entire initiative. Before implementing Upper Payment Limits, the Board must establish clear, transparent metrics for comparing list price reductions against total downstream healthcare expenditures. Creating policy without meaningfully incorporating the ability to fully assess its systemic impact is ill-advised. Before instituting additional UPLs, the Board needs to demonstrate that their interventions actually deliver the promised patient and systemic savings.

Everyone shares your goal to lower prescription drug costs, but a process fixated on list prices, without measuring total patient costs, learning from other states, or addressing supply chain actors risks restricting access to essential medications while driving worse long-term 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 the legislature to consider expanding your ability to develop methods of lowering actual drug costs and improving long-term health impacts, 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