DIABETES PATIENT ADVOCACY COALITION

April 6, 2026

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

RE: Jardiance: Calculations and Analyses Comments

Dear Chair Mitchell and Members of the Maryland Prescription Drug Affordability Board,

On behalf of the Diabetes Patient Advocacy Coalition, we appreciate the opportunity to comment on the March 31, 2026 staff analysis, *"Upper Payment Limit (UPL) Calculations and Analyses Underpinning Potential UPL Values for Jardiance" (v.2.0).*

Jardiance (empagliflozin) is a foundational therapy in type 2 diabetes management, with demonstrated benefits in reducing cardiovascular and kidney complications. Given its clinical importance, we offer the following detailed comments on specific analytic provisions and assumptions underlying the proposed UPL framework.

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1. Reliance on Medicare Maximum Fair Price as Primary Benchmark

The analysis appears to anchor potential UPL values to the Medicare Maximum Fair Price (MFP), adjusted through state-specific assumptions. However:

- The document does not clarify how MFP-derived benchmarks—constructed for Medicare Part D—translate to Maryland's mixed payer environment (commercial, Medicaid, and uninsured populations).
- There is no modeling of how payer-specific benefit designs (e.g., high-deductible plans, coinsurance structures) would interact with a UPL derived from MFP.
- The analysis assumes price compression at the system level will translate into patient savings, but does not test this assumption.

Recommendation: Include scenario modeling that explicitly maps UPL benchmarks to expected patient out-of-pocket obligations across payer types and benefit designs.

2. Treatment of Gross-to-Net Adjustments and Rebates

The methodology appears to incorporate estimated gross-to-net discounts to approximate net prices. However:

- The analysis does not specify how manufacturer rebates, PBM spread pricing, or 340B dynamics are treated in the calculation of effective transaction prices.
- It is unclear whether the UPL is intended to bind at the pharmacy acquisition level, payer reimbursement level, or net-of-rebate level.
- The omission of rebate pass-through assumptions limits the ability to assess whether savings will accrue to payers, intermediaries, or patients.

Recommendation: Provide transparency on gross-to-net assumptions and include sensitivity analyses showing how different rebate pass-through scenarios affect both system savings and patient cost-sharing.

3. Assumptions Regarding Utilization Management and Formulary Behavior

The analysis appears to hold utilization patterns constant under the proposed UPL scenarios. This is a strong assumption that may not hold in practice:

- Plans may respond to a UPL by adjusting formulary placement, step therapy requirements, or prior authorization criteria.
- The document does not model potential therapeutic substitution effects (e.g., shifting to other SGLT2 inhibitors or GLP-1 receptor agonists) or the clinical implications of such shifts.
- There is no discussion of how a UPL could affect coverage decisions in Medicaid managed care versus commercial plans.

Recommendation: Incorporate behavioral response modeling, including potential formulary tightening and class substitution effects, and assess implications for clinical outcomes.

4. Pharmacy Reimbursement Methodology

The document does not clearly specify how the proposed UPL would interact with pharmacy reimbursement formulas (e.g., NADAC + dispensing fee, or other acquisition cost benchmarks):

- It is unclear whether the UPL would be set below, at, or above typical pharmacy acquisition costs.
- The analysis does not assess margin compression risks for community pharmacies, particularly independents and rural providers.
- There is no evaluation of potential dispensing disincentives if reimbursement falls below acquisition plus reasonable dispensing costs.

Recommendation: Include an explicit comparison of proposed UPL values to pharmacy acquisition cost benchmarks and model impacts on pharmacy margins and network adequacy.

5. Lack of Patient Cost-Sharing Modeling

While the analysis focuses on system-level pricing benchmarks, it does not model downstream effects on patient cost-sharing:

- No estimates are provided for changes in copays, coinsurance, or deductible exposure under different plan designs.
- The analysis does not address accumulator or maximizer program interactions, which can significantly affect patient affordability.
- There is no distributional analysis showing which patient populations (e.g., high-deductible enrollees, Medicare beneficiaries, Medicaid populations) would benefit or not.

Recommendation: Conduct patient-level affordability modeling, including distributional impacts across insurance types and income levels.

6. Absence of Clinical Differentiation in Therapeutic Class Analysis

The document appears to treat Jardiance within a broader therapeutic or pricing context without fully incorporating its clinical differentiation:

- There is no discussion of its specific indications (e.g., heart failure, chronic kidney disease) that may limit substitutability.
- The analysis does not consider guideline-driven use or outcomes data that may justify differential access considerations.
- A uniform pricing constraint across therapies may not align with individualized treatment pathways.

Recommendation: Integrate clinical guideline considerations and real-world evidence into the assessment of therapeutic alternatives and access implications.

7. Limited Consideration of Patient Experience and Access Barriers

The analysis does not incorporate qualitative or quantitative data on patient experience:

- No data are presented on adherence, abandonment rates, or cost-related nonadherence tied to current pricing structures.
- The document does not assess administrative burdens (e.g., prior authorization delays) that may be exacerbated under new reimbursement constraints.
- There is no engagement with patient-reported outcomes or advocacy input in shaping assumptions.

Recommendation: Incorporate patient experience data and stakeholder input to validate assumptions about access and affordability.

Conclusion

While the analysis provides a detailed framework for deriving potential UPL values, it remains incomplete without a corresponding evaluation of patient-level impacts, provider behavior, and clinical context.

We urge the Board to supplement the current analysis with:

- Patient out-of-pocket impact modeling
- Pharmacy reimbursement and access analysis
- Behavioral response modeling by payers and PBMs
- Clinical context and guideline integration
- Patient experience data

These elements are essential to ensuring that any adopted UPL do not inadvertently restrict access to appropriate care for Maryland patients living with diabetes.

We appreciate the Board's consideration of these recommendations to strengthen the analytic framework.

George Huntley
Chief Executive Officer
Diabetes Patient Advocacy Coalition

Maryland

Comments PDAB <comments.pdab@maryland.gov>

Jardiance: Calculations and Analyses/Farxiga & Calculations and Analyses Underpinning Potential UPL Values

1 message

Mike Eging <mike@rareaccessactionproject.com> Mon, Apr 6, 2026 at 2:58 PM
To: comments.pdab@maryland.gov
Cc: Kelsey Haddow <kelsey@rareaccessactionproject.com>

Thank you for the opportunity to comment on the Maryland PDAB's efforts to address prescription drug affordability. We share the Board's goal of lowering costs for patients. However, we do not believe that using Medicare Part D prices established under the Inflation Reduction Act as an Upper Payment Limit is an appropriate or sustainable way to achieve that goal.

The Rare Access Action Project recently released a white paper examining why Medicare's Maximum Fair Price is not a transferable model for state drug pricing. That analysis is available here: https://www.rareaccessactionproject.org/news/raap-policy-study-medicares-maximum-fair-price-is-not-a-transferable-model-for-state-drug-pricing/

As the Board considers whether to use a federal program's pricing framework to set a state-based UPL, we urge you to keep four points in mind.

First, there is a mismatch between the problem the Board is trying to solve and the tool it is proposing to use. Patient affordability is often driven less by the underlying list or net price of a drug than by benefit design, cost-sharing structure, and out-of-pocket exposure at the pharmacy counter. If a policy does not materially change what a patient pays when they fill a prescription, it does not solve the affordability problem patients actually experience.

Second, the methodology is flawed. The MFP is not a market price. It is a federally constructed price that depends on statutory leverage, program participation requirements, and federal authority that a state does not have. Using that price as the basis for a state UPL assumes a comparability that does not exist. Similarly, we have serious concerns about data inputs. The Board's own review documents already raise questions about transparency, assumptions, and underlying data inputs. Those questions should be resolved before Maryland moves forward with an approach that relies so heavily on a federal pricing construct that was never designed to be portable.

Third, the risk of unintended consequences is significant. If reimbursement falls below acquisition cost, or margins are compressed too far, pharmacies and providers will change behavior. That can affect stocking decisions, dispensing, and ultimately patient access. Plans have already indicated that a UPL is a non-starter for them, regardless of whether the number is state-generated or borrowed from Medicare's MFP. That should be taken seriously, particularly given the Board's obligation to minimize patient disruption.

Fourth, the early warning signs are already visible elsewhere. As we are hearing anecdotally in Colorado, patients may already be experiencing non-therapeutic switching in advance of implementation of an MFP-based UPL in 2027. Given what we know from the existing literature on Medicare MFP implementation and state UPL models, that risk should not come as a surprise.

The full white paper is available here:
https://b11210f4-9a71-4e4c-a08f-cf43a83bc1df.usrfiles.com/ugd/b11210_

1e92735a49744639ac37321c6320e8c8.pdf

We agree that affordability is a legitimate and urgent concern for patients. But if the goal is to reduce what patients pay, policymakers should pursue tools that directly address patient cost exposure rather than attempting to replicate a federal pricing tool that depends on federal leverage and programmatic authority.

Recommended alternatives include:

- targeted caps on patient out-of-pocket costs and cost-sharing smoothing mechanisms
- enhanced PBM transparency and pass-through requirements
- risk pooling and reinsurance models for high-cost, low-volume therapies
- guardrails and exemptions, where PDAB authority is used, to protect vulnerable access points

If the Board's goal is to protect patients, reforms should reduce what patients pay at the pharmacy counter, not create reimbursement distortions that may limit where and how patients can access care.

Thank you again for the opportunity to comment. If we can be of assistance, please do not hesitate to reach out.

Regards,
Michael Eging

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PDAB

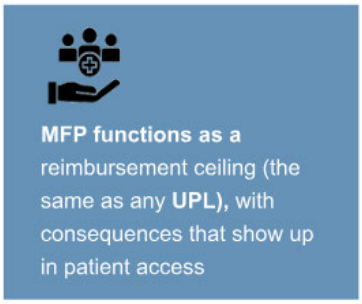
WHY MEDICARE'S MAXIMUM FAIR PRICE IS NOT A MODEL FOR STATE DRUG PRICING

Feb 17, 2026

States are under increasing pressure to respond to concerns about prescription drug affordability. In that search for solutions, Medicare's Maximum Fair Price (MFP) has begun to surface as an attractive model for state efforts. MFP is highly visible and branded as "negotiation," giving it the appearance of a tested and defensible pricing tool.

That appeal is understandable. But it is also misleading. Medicare's MFP does not function as a standalone benchmark. It works only because it is embedded in a federal program with national scope, statutory carve-outs, and the ability to redesign coverage and payment rules

around the negotiated price. Those features are not transferable to state markets and MFP has the same problems as any other upper payment limit (UPL) benchmark.



This issue brief builds off the Rare Access Action Project's (RAAP's) 2025 paper, "Solving for Access and Affordability: PDABs are Not the Answer" and explains why borrowing the MFP benchmark price for state prescription drug affordability boards (PDABs) would recreate the same legal, operational, and access problems already observed with any use of upper payment limits (UPLs). When removed from Medicare's statutory framework, MFP functions as a reimbursement ceiling (the same as any UPL), with consequences that show up in patient access and care delivery.

Where MFP Comes from and What It Is Designed to Do

Medicare's MFP is not a common "fair price" that can be lifted and dropped into any market. It is a federal program tool. It works because Medicare can attach a price to Medicare payment, and because the Centers for Medicare & Medicaid Services (CMS) can redesign coverage and payment rules around that price.

Under the Inflation Reduction Act (IRA), CMS selects a limited number of drugs and sets an MFP for Medicare. That number is intended to function as an acquisition price for beneficiaries and pharmacists. The leverage point is the part state policymakers tend to miss. MFP is not "negotiation" in the abstract. It is negotiation with the single largest purchaser in the country, and with real consequences attached. Manufacturers are not simply choosing whether to accept a lower price for a product in one corner of the market. They are deciding whether they are going to participate in Medicare at all. In practice, they either participate under Medicare's rules, or all their drugs are not covered by Medicare and there are severe financial penalties.

Why States Cannot Replicate MFP

Medicare's ability to negotiate an MFP rests on leverage that states simply do not have. States regulate only portions of the prescription drug market, and often only indirectly.

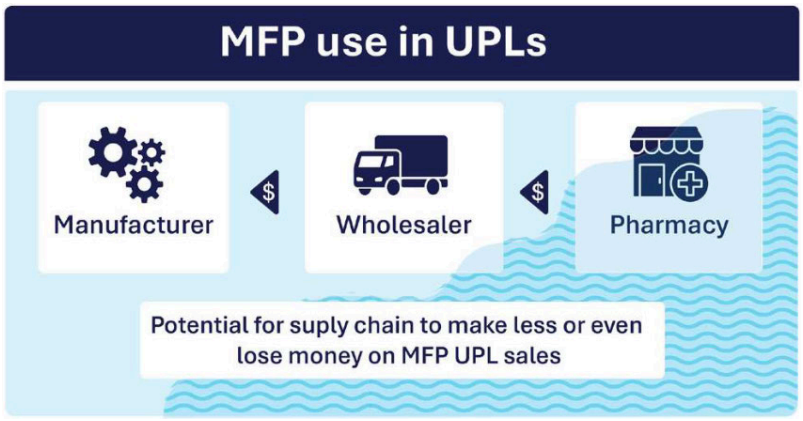
ERISA preemption alone removes large segments of the commercial market from state authority. Even within fully insured plans, state reach is fragmented across payers, benefit designs, and employer arrangements. Manufacturers can decline a state imposed pricing requirement without exiting the national market or jeopardizing coverage across an entire federal program. They are still likely able to sell to most of their patients in the state, just not those subject to a PDAB-imposed-imposed limit.

When one party can walk away with limited consequence, the interaction begins to resemble rate-setting rather than bargaining. The leverage that makes MFP function at the federal level does not scale down to individual states.

States Cannot Set Acquisition Prices, Only Reimbursement Ceilings

There is a second, more fundamental mismatch between Medicare's MFP and state drug pricing authority. Medicare negotiation changes the acquisition price of the product for pharmacies and beneficiaries. Manufacturers can choose to go below that price, but that Medicare negotiated price sets the bar for the system. State PDABs do not have that authority; they cannot require manufacturers to sell their product at the MFP price to wholesalers and pharmacies. This is the same problem PDABs face with any UPL benchmark; states can say they will only reimburse at that price, but it does not mean that supply chain stakeholders will be able to acquire the drug at a price that enables that reimbursement level to be viable.

Under Medicare, MFP operates as an acquisition price for supply chain stakeholders tied to manufacturer participation. The price is enforced upstream, at the manufacturer level, and integrated into how plans, pharmacies, and providers are paid.



When statutes allow PDABs to establish UPLs like using MFP as a benchmark UPL price, those limits apply to what plans or payers may reimburse. They do not

change the price at which manufacturers sell drugs into the distribution MFP reimbursement and hoping the rest of the system absorbs the difference.

Medicaid Best Price Ties with MFP

Medicaid Best Price also shows why Medicare negotiation is not a price benchmark states can simply copy. For drugs selected for Medicare negotiation, federal law ties the MFP into Medicaid rebate calculations by treating Best Price as inclusive of the Maximum Fair Price. That is a reminder that MFP is not just a "deal price." It is part of a larger federal legal structure that coordinates how a low price flows across programs.

States cannot recreate that structure, and they cannot control the ripple effects of trying to pull an MFP-level number into state markets. Manufacturers price and report nationally, not state by state. So, extending MFP-like pricing outside Medicare is not a clean, local decision. It is the kind of low price that can create broader obligations and consequences.

The practical result is that "borrowing MFP" is unlikely to produce a manufacturer price concession in the state market.

Patient Access and Care Delivery Impacts

The structural mismatches described above show up in how patients access care and how providers decide whether they can continue to offer certain treatments.

When pricing policies operate as reimbursement ceilings rather than acquisition prices, financial pressure moves downstream. Access effects often emerge first in settings where care delivery is already complex. Treatments requiring buy-and-bill arrangements, specialized handling, or site-based administration leave providers exposed to upfront costs. If reimbursement does not reliably cover acquisition and overhead, providers may limit stocking, restrict scheduling, or stop offering a therapy altogether. Patients then experience delays, referrals, or changes in where and how care is delivered.

Geography compounds the issue. Many patients receive care at regional centers or specialty clinics that serve multiple states. When reimbursement rules differ by state, providers face uneven financial exposure for the same treatment delivered at the same site. Over time, that misalignment can influence referral patterns, network participation, and willingness to accept patients from certain states, even when clinical need is identical.

Administrative responses also play a role. Plans facing reimbursement caps may rely more heavily on utilization management, prior authorization, or network design to manage exposure.

These tools do not reduce the underlying cost of treatment. **They manage access.** For patients, this means additional steps, longer timelines, and greater uncertainty about whether prescribed therapies will be covered and where they can be received. These dynamics are not limited to any single category of drugs. They arise whenever reimbursement constraints are imposed without corresponding changes to acquisition pricing and payment mechanics. The result is a system that manages affordability by shifting risk and friction onto patients and providers rather than resolving cost at the source.

What States Should Do Instead

States are right to focus on affordability. The mistake is trying to borrow a federal pricing tool that depends on federal leverage. There are practical state options that reduce patient cost exposure without creating downstream access risk.

- Target patient out-of-pocket costs directly. States can use benefit design levers that address affordability where patients feel it, including caps on cost sharing, smoothing mechanisms, and limits on coinsurance for high-cost therapies.
- Improve PBM and plan transparency and pass- through. States can focus on whether negotiated savings and fees are flowing to patients or are being retained elsewhere through pass-through requirements, standardized reporting, and point- of-sale transparency.
- Use risk pooling and reinsurance for high-cost, low-volume therapies. These approaches treat budget volatility as a financing challenge rather than a reimbursement-cap problem.

States have real options to address affordability, especially when the focus is patient cost exposure and system transparency rather than upstream price controls. The key is discipline. Medicare’s MFP works inside a closed federal system, and outside that system it turns into a reimbursement ceiling with predictable access consequences.

Sources

Inflation Reduction Act of 2022, Pub. L. No. 117-169, §§ 11001-11004.

Inflation Reduction Act of 2022. “Medicare Drug Price Negotiation Program.” Centers for Medicare & Medicaid Services.

https://www.cms.gov/inflation-reduction-act-and-medicare/medicare-drug-price-negotiation-program. Inflation Reduction Act enforcement and participation provisions, 26 U.S.C. §5000D.

Inflation Reduction Act of 2022. Medicaid Best Price exclusion for Maximum Fair Price, amending42 U.S.C. § 1396r-8.

Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1144.

(This study was commissioned by RAAP and researched and written by Jennifer Snow of Apteka Policy).

March 2025

Payer Perspectives Confirm UPLs Will Likely Raise Costs and Hinder Patient Access to Medicines

This report is based on research conducted by Avalere under contract to the Partnership to Fight Chronic Disease.

Key Findings

Prescription Drug Affordability Boards (PDABs) aim to improve affordability for prescription drugs, but payers believe that PDABs setting upper payment limits (UPLs) would likely raise patient out-of-pocket medicine and premium costs while disrupting medicine access for patients and the state healthcare system overall.

- 77% of health plan payers surveyed believe that UPLs would disrupt patient access to prescription drugs due to changes in coverage, tiering, cost sharing, or broader supply chain issues, such as pharmacies not stocking products with UPLs.
- 67% of health plan payers anticipate that patient cost sharing for UPL drugs will increase (50%) or stay the same (17%). Similarly, most payers (70%) anticipate that out-of-pocket (OOP) costs for drugs in the same class as a UPL drug will increase (53%) or stay the same (17%).
- 57% of payers surveyed anticipated changing premiums if a UPL is implemented.
- 50% of payers surveyed indicated their plan would increase utilization management on the UPL drug.

In addition, plans anticipate disruption affecting pharmacy and provider reimbursement, further exacerbating harms to patient access.

- 60% of respondents believe that pharmacies may not stock UPL drugs; Even more respondents (73%) expressed concerns that UPLs could lead to shortages of critical medicines, all of which leading to access challenges for patients.
- 57% of respondents agreed that if a UPL were to be implemented on a provider-administered product, a provider would be reimbursed less for a drug with a UPL than what the provider would otherwise be paid for that product.

Overview of PDABs and UPLs

State policymakers are touting PDABs and UPLs as ways to control state spending and lower patient costs on prescription drugs. As of March 2025, eight states (Colorado, Maine, Maryland, Minnesota, New Hampshire, New Jersey, Oregon, and Washington) had enacted PDAB laws, with four of those (Colorado, Maryland, Minnesota, and Washington) also authorized to set UPLs on drugs determined to be "unaffordable".[1] Concepts of "unaffordable" vary by state, with at least one PDAB noting they have been unable to define unaffordability.

PDABs may identify products to target for "affordability" review or a UPL based on pricing thresholds or other more subjective criteria. UPLs would impose a limit on how much purchasers (such as health plans, pharmacy benefit managers (PBMs), or public payers) within a state may pay or reimburse for drugs found to be "unaffordable" after review by the PDAB. The laws limit "payment" or reimbursement as opposed to drug prices. As a result, they raise several challenges and unanswered questions, which may lead to unanticipated impacts on plan benefit design, patient OOP costs, pharmacy reimbursement, and a pharmacy's ability to stock medicines.

[1] This analysis only included states that have passed legislation that establish PDABs that are required to conduct affordability reviews. For example, VT's Green Mountain Care Board has the option to conduct an affordability review of a set selection of drugs, but it is not a requirement.

State lawmakers supporting PDABs and UPLs intend to reduce what patients pay for prescription drugs but may see the opposite happen if OOP costs rise or fail to decline and new access restrictions, product exclusions, or shortages appear in markets with UPLs in place.

Research Background & Methodology

Health plans have a unique perspective to inform the possible implications of a UPL on coverage decisions and consequences for other stakeholders that may affect patient costs and access. To understand the implications, PFCD commissioned Avalere to gather insight into plan perceptions and preparedness for PDABs and UPLs.

Avalere updated and built on previous payer interviews done in 2023, released by PFCD in 2024. The previous research revealed doubts among payers that UPLs would be implemented, but this update shows that payers are now paying closer attention to PDABs and UPLs. Issues raised in the previous payer interviews prompted concern that patients would not benefit from UPLs, and those issues remain unresolved today. Payers were more focused on system-wide impacts this year, including concern that administrative burdens related to UPL implementation would raise costs. Clearly, Boards need to do more work and research to address unintended consequences of PDABs.

As payers refer to the cost of the drug throughout the responses described in this paper, it is important to note that they may be referring to their organization's cost – not the cost to the patient. Considering those plan costs, some interviewees implied that they believe PDABs could deem a drug unaffordable but simultaneously set a UPL higher than what payers already negotiate, negating the impact of the UPL and highlighting the savings in the system without UPLs that do not reach the patient or plan sponsor.

Interviews

Between January and February 2025, Avalere conducted six, in-depth, 30-to-45-minute interviews with current and recent representatives from national and regional plans who 1) had experience with plan decision-making on formularies and prescription drug benefit design and 2) were able to speak to their plan's perceptions of UPLs. Cumulatively, interviewees represented health plans with 115.2 million covered lives. The interviews were double-blinded and did not include interviewees from the 2023 project. Interview questions were asked consistently across interviewees and covered benefit design, patient costs and access, contracting, pharmacy access, reimbursement, and UPL implementation.

Surveys

In February 2025, Avalere conducted a survey with a different pool of 30 representatives from national and regional plans who 1) had experience with plan decision-making on formularies and 2) were able to speak to their plan's perceptions of UPLs. Cumulatively, survey respondents represented health plans with 476.3 million total enrollees.[2] The survey was double-blinded and did not include individuals who were interviewed in 2023 or 2025. The 37 survey questions focused on benefit design, patient access and costs, contracting, pharmacy access, reimbursement, appeals process, and UPL implementation.

[2] Surveyed payers did not identify their organization, thus there may be overlap of covered lives.

Detailed Findings

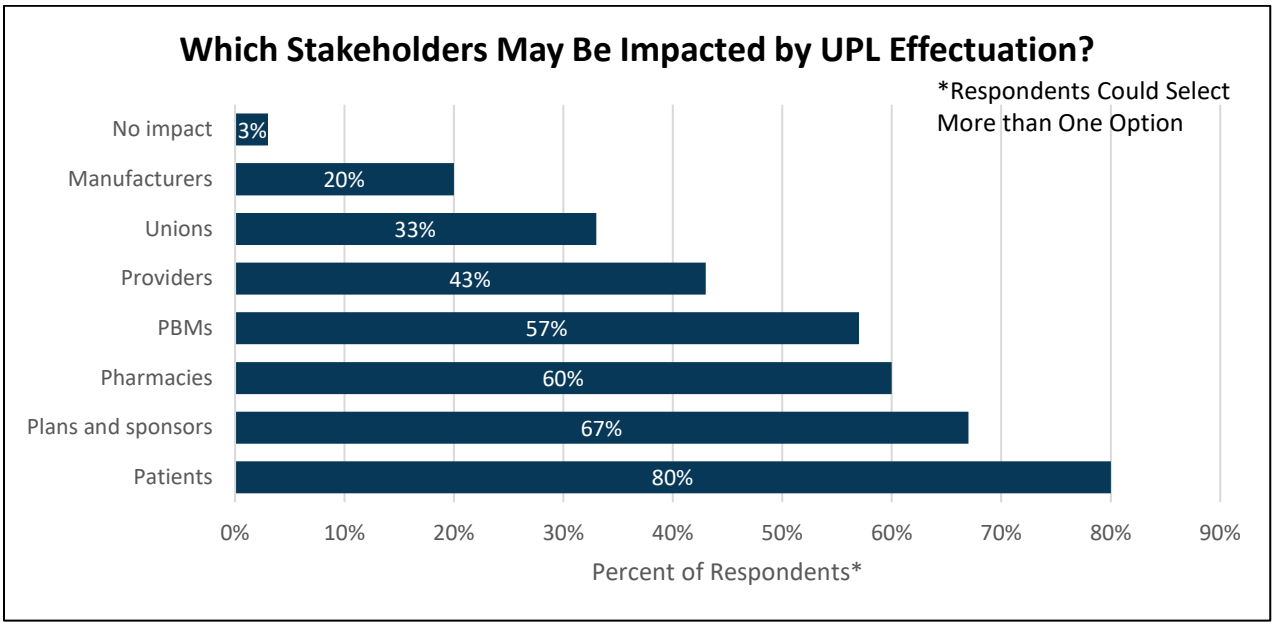
Disruption to Prescription Drug Ecosystem

Payers suggested that PDABs have "noble" goals but also raised concerns about unintended consequences of UPLs. For example, 77% of payers surveyed believe that effectuation of a UPL would disrupt patient access to prescription drugs. This disruption could come in the form of plan changes, such as adjustments to coverage, tiering, or cost sharing, or broader supply chain issues, such as pharmacies not stocking products with UPLs. The Analytics Lead at a national plan illustrated this idea, saying:

> ***"If a drug is out of stock or low stock in a specific state, depending on the formulary design, patients may not be able to get their preferred drugs, and the other alternative drugs may have higher out of pocket costs and require a prior authorization."***

When provided with a list of stakeholders susceptible to disruption due to UPLs, patients were identified most often by surveyed payers (80%) – higher than any other stakeholder group. Specifically, patients could see higher OOP costs, disruption to access, increased premiums, and added utilization management (UM).

Figure 1. Stakeholders That May be Impacted by UPL Effectuation



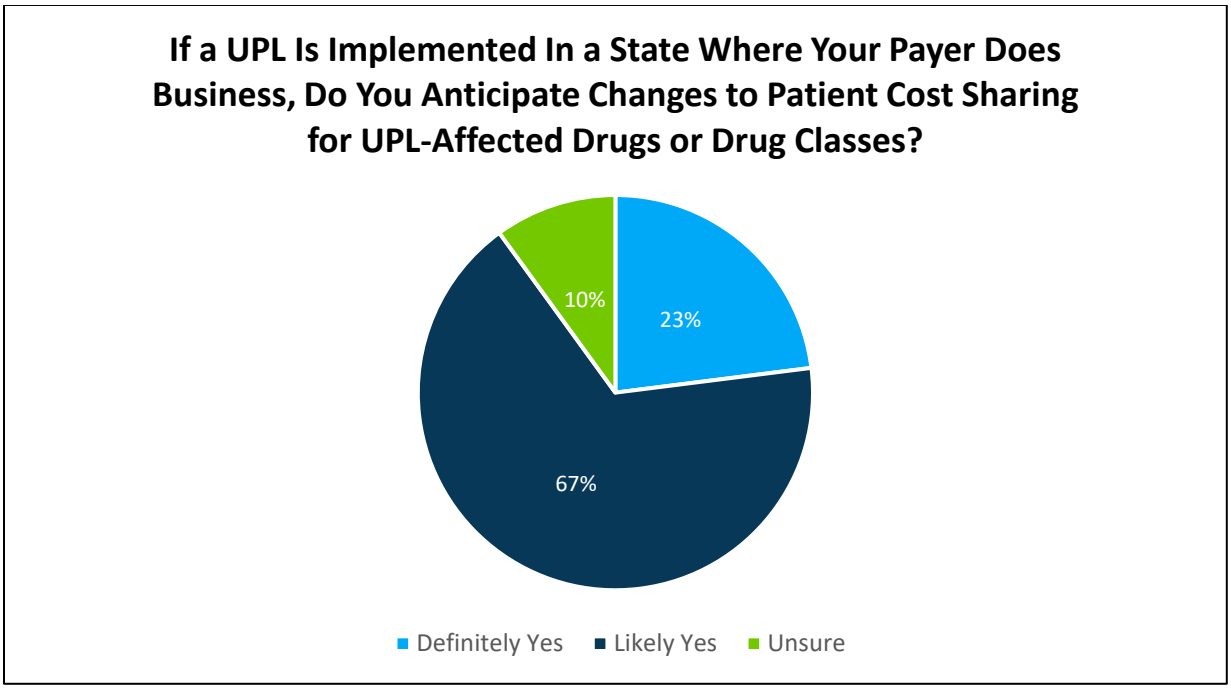
Considering plan and PBM impacts, payers highlighted that UPLs would necessitate changes to PBM contracts and that UPLs would impact plan profits—both of which could contribute to patient impact. The Senior Product Director of Consumer Experience at a national plan noted, "[*Setting a UPL lower than current price] would have an impact on access for sure, just because of the trickle effect it's going to have on plans and PBMs needing to remain sustainable.*"

Payers noted that plans will not absorb additional costs generated by UPLs but will instead pass those costs along to others in the system including enrollees. In the words of the Vice President of Operations at a regional plan, "*that cost has to be absorbed by somebody, and … the carrier is not going to absorb it because we might reduce our profitability*."

Respondents anticipate these additional costs will be driven by changes to claims systems and reimbursement practices, timing of implementation, and changes to cost sharing or formularies which were all identified as the primary challenges resulting from effectuation. More broadly, 63% of payers believe that a UPL would lead to disruption in the state's health insurance market. Respondents identified changes in reimbursements to pharmacies or providers, higher administrative burden, and changes to rebating as the primary disruptions.

Surveyed and interviewed payers both discussed the administrative burden likely to be incurred from UPL implementation. 40% of survey respondents agreed that UPL implementation would result in higher administrative burden on plans, provider, pharmacies, or even patients.

Figure 2: Changes to Patient Cost Sharing



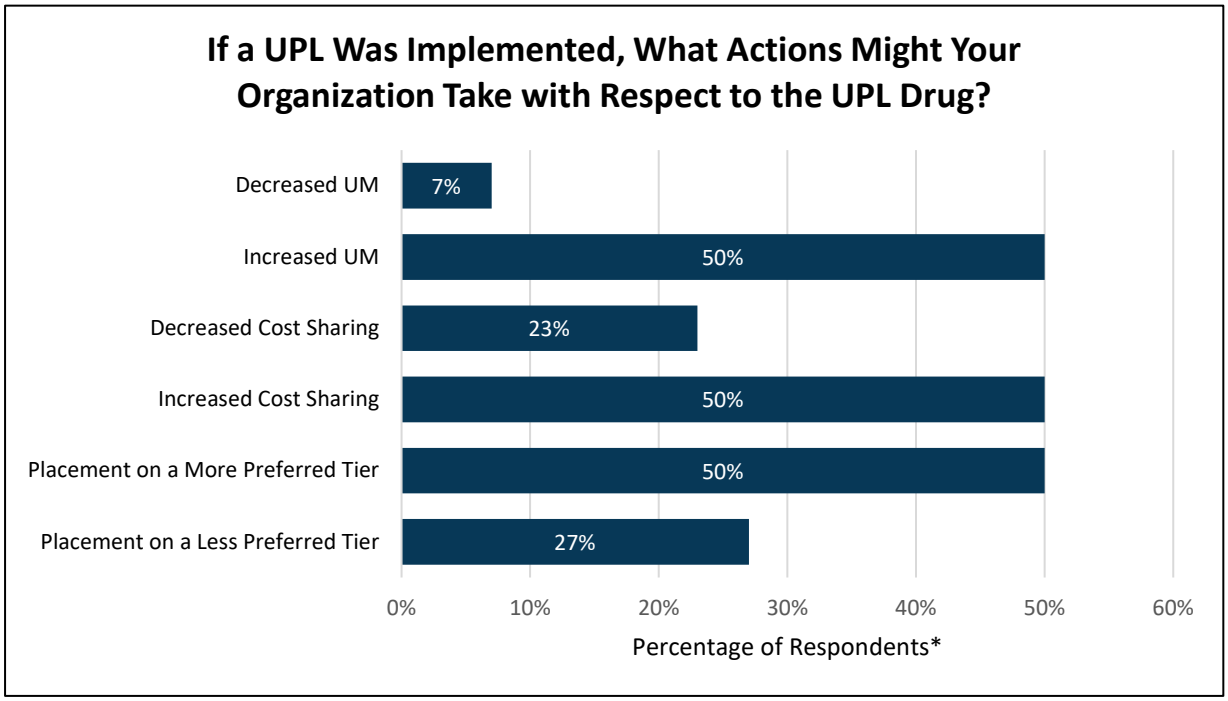
Benefit Design

Benefit design could change significantly in the face of UPLs. As shown in Figure 2, plans expect that patients will face changes to their costs as a result of UPL implementation, such as increased premiums or cost sharing. 90% of respondents said that there would "definitely" or "likely" be changes to patient cost sharing for UPL-affected drugs or drug classes, with interviewees noting complex negotiation and contracting dynamics as changes that could increase patient costs. Overall, payers (60%) expected changes to OOP costs, with 50% of all surveyed payers expecting increased copays or coinsurance on the UPL drug. Specifically with regard to premiums, 57%

anticipated increasing premiums if a UPL is implemented, and only 10% said they would decrease premiums for enrollees.

Payers also noted increased use of prior authorization (PA) and other UM techniques in the event of UPL effectuation. 50% of respondents indicated their plan would increase UM on the UPL drug. Increased UM could extend even to provider-administered products if PDABs place UPLs on those types of drugs. A Technical Product Director at a National Plan, referring to physician-administered products, noted that "stricter utilization management criteria and medical necessity criteria and possible site of care restrictions [would be needed]" in the case of a UPL.

Figure 3: Plan Responses to UPL Implementation



Pharmacy Access and Provider Payment

Payers expressed concerns that setting UPLs below current prices* could disrupt pharmacy contracts. Since PDAB legislation establishes a reimbursement cap on drugs with UPLs, PBMs would likely only be able to reimburse pharmacies up to the UPL while pharmacies' acquisition costs could exceed UPL. In line with this, 70% of respondents agreed that pharmacy reimbursement would decrease due to UPL effectuation. This could lead to strain on pharmacy operations. 60% of respondents thought that negative impacts to pharmacy reimbursement would decrease the likelihood that the pharmacy keeps the UPL drug in stock, leading to access challenges for patients. An even greater number of respondents (73%) believe that lower stock of UPL drugs

*Participants considered the impact of a UPL compared to the price the plan is currently paying for a drug. Because the amount paid by a plan varies widely, it is likely that some UPLs could be below the current cost to some payers but above other payers' current cost for a drug.

could lead to shortages in states with a UPL. When asked to elaborate on the impact of UPLs on pharmacies, payers responded:

> ***"If reimbursement is impacted, pharmacies will be less likely to stock the medication as they cannot afford to lose money on every fill."*** **– Mail Order Pharmacy Lead, National Plan**
>
> ***"I think there could be pharmacies that say that they don't want to participate because they can't do it at a loss because they're the last transaction in the supply chain."*** **– Vice President of Pharmacy Operations, Regional Plan**

The survey also asked specifically about physician-administered drugs. 57% of respondents agreed that if a UPL were to be implemented on a provider-administered product, a provider would be reimbursed less for a drug with a UPL than what the provider would otherwise be paid for that product. When asked who would make up the difference to the provider, 47% indicated that patients would be responsible for making up the difference, and 6% noted that providers would be responsible, i.e. that providers would not be made whole.

> **A Vice President of Operations at a regional plan emphasized this idea, saying,**
>
> ***"That cost has to be absorbed by somebody, and … the carrier is not going to absorb it because we might reduce our profitability."***

Conclusion

While PDABs have a goal of improving patient affordability and overall financial sustainability for the state and larger healthcare system, these interviews and surveys demonstrate that UPLs would not achieve that goal, but rather could result in higher premiums, increased UM, and decreased patient access.

Payers agreed that PDABs often simplify or fail to understand the complexities of the prescription drug supply chain, and that has led to proposed UPL effectuation plans that threaten to push a new administrative burden and cost onto various players in the system, including patients.

Value of Care Coalition

April 6, 2026

Maryland Prescription Drug Affordability Board
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Bowie, MD 20715

RE: Upper Payment Limit (UPL) Calculations and Analyses Underpinning Potential UPL Values for Jardiance

Dear Chair Mitchell and Members of the Maryland Prescription Drug Affordability Board,

On behalf of the Value of Care Coalition, we appreciate the opportunity to comment on the March 30, 2026 staff analysis, "Upper Payment Limit (UPL) Calculations and Analyses Underpinning Potential UPL Values for Jardiance" (v.2.0).

The Coalition's comments are focused on the analytical framework and conclusions presented in this document. As written, the analysis raises several substantive concerns regarding the adequacy, completeness, and policy relevance of the proposed UPL approach.

First, the proposed UPL is primarily derived from the federal Medicare Maximum Fair Price (MFP), rather than a Maryland-specific assessment of affordability. The document does not present an independent methodology grounded in state-level data, nor does it demonstrate how the selected benchmark reflects the costs, utilization patterns, or payer dynamics specific to Maryland. As a result, the analysis does not establish that the proposed UPL represents an appropriate or evidence-based price for this market.

Second, the document acknowledges that a UPL set at the MFP does not reflect all discounts, rebates, and price concessions. This is notable because the Board's own cost review process compiles net price data for the drugs it examines. Yet the chosen framework sets that data aside in favor of a Medicare-specific benchmark designed for a different market and a different population. Anchoring a state UPL to a figure that the document itself acknowledges is incomplete is not a sound basis for a policy with significant consequences for plan design, pharmacy access, and patient care.

Third, the document raises but does not resolve a fundamental implementation question: whether a single UPL is appropriate across the different entities it would govern. The analysis notes that payors and purchasers occupy different positions in the supply chain, and that pharmacy markups may or may not be appropriate depending on how a given entity acquires the drug — yet it does not recommend differentiated UPL values or analyze how a uniform MFP-derived figure would function equitably across these contexts. These questions warrant resolution before a UPL determination is made.

Fourth, the document does not assess the potential impact of the proposed UPL on patient affordability or access. The analysis does not model changes in patient out-of-pocket costs, nor does it evaluate how implementation could affect formulary design, utilization management, or pharmacy participation. Without these considerations, the document does not demonstrate that the proposed UPL would achieve its intended policy goals.

Taken together, these gaps suggest that the current analysis does not provide a sufficiently robust or comprehensive foundation for establishing a UPL for Jardiance. The Coalition encourages the Board to address these limitations to ensure that any future determinations are supported by complete data, Maryland-specific evidence, and a clear connection to patient affordability and access.

We appreciate the opportunity to provide comments and look forward to continued engagement on this important issue.

Sincerely,

Derek Flowers
Value of Care Coalition