DIABETES PATIENT ADVOCACY COALITION

February 17, 2026

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

RE: Public Comment on Revised Upper Payment Limit Framework Documents for Ozempic and Trulicity

Dear Members of the Maryland Prescription Drug Affordability Board,

Thank you for the opportunity to comment on the Board's revised Upper Payment Limit (UPL) framework documents for Ozempic and Trulicity.

DPAC notes that the proposed UPL approach focuses primarily on system-level reimbursement and does not consider a clear analysis of patient affordability. A policy adopted in the name of affordability should demonstrate evidence of meaningful patient benefit, including reductions in out-of-pocket costs or improvements in access rather than rely on assumptions that system-level savings will be passed on to patients.

Patient costs at the pharmacy counter are determined by deductibles, coinsurance, formulary placement, and utilization management. Two drugs with identical net prices to a payer can produce dramatically different patient out-of-pocket obligations depending on coverage design. Without an explicit assessment of how a proposed UPL would affect patient costs and access under common benefit designs, UPL policies risk generating savings for payers or intermediaries while leaving patient costs unchanged or reducing access through formulary tier changes, prior authorization, or other utilization controls.

An impact analysis should evaluate whether unaffordability is driven by list price, benefit design, or a combination of both. Absent this analysis, the Board risks misidentifying the source of patient harm and applying policy tools that reduce overall system spending without improving patient affordability. Below is a real world scenario of what could happen with a UPL on a drug.

UPL Example:

- Manufacturer list price: $1,349
- GoodRx price: $349
- Direct to consumer price from manufacturer: $349

The state sets a UPL at $349 to cap the amount the state plan will pay but doesn't pass the savings to plan participants. (Few plans pass these savings onto participants though it is required in WV, IN, AK, NM and NC).

A plan participant in their deductible will pay the list price of $1,349 until their deductible is met. After their deductible is met, they may pay a fixed copay or a coshare percentage of the cost of the drug (typically 20-30%). If they are paying a coshare, the percentage is based on the list price of the drug which in this case would be $270-$405. In this very likely scenario, the drug is no more affordable than it was before the UPL was set. The patient is likely to access the drug direct from the manufacturer at $349; however, this cost will not go towards their deductible because they are purchasing it outside of their health plan.

Now let's look at it from a pharmacy perspective. The community pharmacy pays roughly list price ~$1,349. If the UPL impacts the amount the pharmacy is reimbursed, which is highly possible if not probable, then the pharmacy loses money on the drug and refuses to stock it or refuses to sell it to a participant of a Maryland health plan. This is happening in jurisdictions across the country.

Incorporating a patient out-of-pocket impact assessment and requiring affirmative written finding of patient benefit would help ensure that any adopted policy improves access or affordability. DPAC respectfully urges the Board to integrate these patient-centered safeguards into its UPL framework and to ensure that any final methodology clearly demonstrates measurable patient benefit.

Sincerely,

George Huntley

George Huntley
Chief Executive Officer
Diabetes Patient Advocacy Coalition

EACH PIC COALITION

February 17, 2026

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

RE: Public Comments on Ozempic and Trulicity UPL Frameworks

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 comment on the board's upcoming review of the proposed upper payment limit (UPL) frameworks for Ozempic and Trulicity.

UPLs Do Not Guarantee Savings for Patients

We continue to underscore the limitations of a UPL in addressing patient affordability. UPLs may change what insurers or the state pay for a medication, but they do not cap or guarantee reductions in patient out-of-pocket costs. As our coalition has cautioned before, these policies can introduce new incentives for insurers and pharmacy benefit managers (PBMs) that may ultimately restrict access to needed treatments through greater utilization management, formulary reshuffling, or adverse tiering. These shifts risk delaying or disrupting care, and as our Patient Experience Study has demonstrated, insurance barriers, not price alone, are often the real drivers of patient hardship and perceived "unaffordability."

Furthermore, patients reported that treatments are not interchangeable and accessing the correct medication is critically important for patients with chronic conditions. Therefore, while intended to reduce costs, implementing a UPL without complementary patient protections could worsen the very challenges patients already face.

We urge the board to establish clear safeguards before advancing any UPL frameworks and to continue exploring its policy alternatives, including reforms that directly address PBM and insurance practices that most influence patient costs.

Limitations of Applying Medicare MFP

Maryland's proposal to apply the "maximum fair price" (MFP) established by the Medicare Drug Price Negotiation Program (MDPNP) to state programs is concerning because those prices were negotiated specifically for the Medicare population and benefit design. Those rates reflect the structure and cost-sharing rules of Medicare, which are not the same as those that apply in state-regulated coverage. Applying those prices outside of Medicare assumes the markets function the same way, and they do not.

Further, the establishment of UPLs at MFP rates does not guarantee any savings for patients. Patients could instead face higher copay or coinsurance rates to retain access to that drug or

alternatively be forced to switch to a more expensive drug which results in higher profits for their PBM. Recent research from the Pioneer Institute has shown that patient OOP costs have increased by an average of 32 percent under the MDPNP even before the maximum fair price caps for the first round of drugs went into effect on January 1st.

Simply importing Medicare pricing may create disruption without meaningfully improving what patients actually pay or experience.

Therapeutic Class Framework and Patient Value Assessments

Setting prices based on class-wide comparisons may unintentionally encourage insurers and PBMs to treat distinct therapies as substitutes, when patients' lived experience shows they are not. We urge the MD PDAB not to inadvertently promote policies that do not emphasize the importance of maintaining patient access to preferred and effective therapies.

Our recent Patient Experience Study revealed that among respondents who had tried multiple treatments, more than 80% described their current medication as valuable, often "exceptionally valuable," emphasizing its unique value to them personally rather than general effectiveness. For the same drug, one patient described it as life-changing while another found it ineffective, underscoring that treatment value cannot be generalized.

Patients cited fewer side effects, better control of comorbidities, easier administration, or success after other therapies failed as reasons their medication worked for them. For complex conditions like rheumatoid arthritis, most patients reported cycling through multiple medications, and nearly half had comorbidities shaping which treatments were appropriate. When non-medical switching occurred, patients reported disease recurrence, side effects, and worsened outcomes.

These experiences reinforce that drugs within the same class cannot be evaluated as interchangeable without risking harm to the patients who rely on them. Pricing approaches that flatten those differences risk reinforcing coverage policies that overlook patient value and could unintentionally disrupt access to the therapies that work best for them.

Conclusion

In closing, we respectfully urge the Maryland PDAB to reconsider pursuing UPLs and instead focus on policy remedies that directly address the obstacles patients themselves identify as driving affordability challenges.

Our updated Patient Experience Study reinforces again that insurance rules, cost-sharing volatility, access to financial assistance, and the ability to stay on a treatment that works all shape whether patients can maintain access over time. Approaches that focus too narrowly on price and do not address these underlying barriers risk producing limited or uneven benefit for patients.

We would welcome the opportunity to present our updated survey findings to the board in full and to discuss how patient-reported data can better inform Maryland's affordability framework. We stand ready to partner with the board to advance thoughtful, patient-centered reforms that improve access and affordability without compromising continuity of care.

EACH PIC COALITION

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

Sincerely,

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Patient Inclusion Council (PIC) Coalition Lead

February 17, 2026

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

VIA ELECTRONIC MAIL TO COMMENTS.PDAB@MARYLAND.GOV

RE: Revised Ozempic® Upper Payment Limit Framework

Dear Members of the Maryland Prescription Drug Affordability Board,

Novo Nordisk appreciates the opportunity to submit written comments to the Maryland Prescription Drug Affordability Board (Board) regarding staff's revised Upper Payment Limited Framework for Ozempic®. As we have expressed in previous comments, we share the Board's interest in making prescription medications affordable and accessible to all Marylanders. However, we are deeply concerned by staff's recommendation that the Board—if it wishes to set an upper payment limit (UPL) for Ozempic®—rely on the Maximum Fair Price (MFP) established as part of the Medicare Drug Price Negotiation Program. **We believe that deriving the UPL from the MFP will harm Marylanders' ability to access prescribed medicines and disrupt their care. Moreover, we maintain that the Board's approach to evaluating affordability is flawed.**

The Board's narrow evaluation of an "affordability challenge" based on gross spending unfairly targets treatments for common diseases—even if those treatments are cost-effective and save money over the long term for patients, the healthcare system, or both.

At its November 17, 2025, meeting, the Board made a preliminary determination that use of Ozempic® has created an affordability challenge for Maryland's health care system. As reflected in the preparatory materials for the Board's February 23, 2026, meeting, this determination was based solely on the total gross spend for state and local governments, which was reported as "exceeding 4.87%"[1] (a number that ignores important context), and not on any patient-related out-of-pocket metrics. This is likely because, as noted in previous comment letters to the Board, 80% of US patients with insurance coverage—and 82.5% of Maryland patients, specifically—are paying $25 or less per prescription for Ozempic®, and 90% are paying $50 or less.[2]

The Board's proceedings recognize that the driver of Ozempic® spend is primarily related to high levels of utilization "consistent with FDA label indications (e.g., diabetes) rather than off-label uses" (as confirmed by Board staff).[3] High utilization in Maryland does not reflect improper

[1] February 23, 2026 PDAB - Policy Review Recommendations
[2] NNI internal analysis
[3] February 23, 2026 PDAB - Policy Review Recommendations

use but rather the high prevalence and burden of diabetes in Maryland, along with clinicians' recognition of the drug's clinical value. Nonetheless, the Board has preliminarily determined that Ozempic® has created an affordability challenge based on a flawed and one-dimensional metric of gross spend. Evaluating affordability only by aggregate gross spending penalizes treatments for chronic disease and subjects them to continual scrutiny, even when they deliver strong clinical value for patients and generate long-term cost offsets and savings. For people living with type 2 diabetes—particularly those at higher risk of complications—Ozempic® offers a highly-effective treatment option and is frequently found to be cost-effective as compared to other glucose lowering agents in published models that consider long-term benefits and cost offsets.[4] Rather than targeting broadly used chronic disease therapies that provide good value for money, the Board should adopt a more holistic view of affordability and, for example, pinpoint low-value drivers of spending. Under its current narrow assessment of affordability, the Board risks setting a UPL that could undermine access to clinically effective treatments for patients who need them.

The net price of Ozempic® across channels continues to fall, but the Board's assessment continues to focus on list price and outdated data.

A further flaw in the Board's use of gross spend as an affordability metric is its reliance on list price rather than net price., Net price reflects rebates, discounts, and other concessions and better represents actual payer costs. As has been widely reported in the media[5] as well as in scholarly publications[6], market-based competition has led to significant net price reductions for GLP-1 therapies in recent years. For example, reporting by *The New York Times* in 2023 highlighted an almost 70% difference between list and net price for Ozempic®.[7]

Recently, Novo Nordisk announced significant changes to provide cost savings to patients without insurance coverage or those who choose to self-pay without using their insurance. In mid-2025, Novo Nordisk announced that Ozempic® would be made available to self-paying patients with type 2 diabetes with a prescription through NovoCare® Pharmacy.[8] Ozempic® is now available for as low as $199 per month from NovoCare® Pharmacy and other partner direct-to-patient platforms.[9] Novo Nordisk will also lower prices and expand patient access and affordability for Ozempic® in Medicaid as part of an agreement with the White House, announced in November 2025.[10] Assessments of the affordability of Ozempic® that fail to account for substantial net price reductions and other recent actions to expand access ignore

[4] See, for example, results of a systematic review and meta-analysis: Cost-effectiveness of Semaglutide Compared With Other Glucose-Lowering Medications in Treating Type 2 Diabetes: A Comprehensive Systematic Review and Meta-analysis - PubMed

[5] How Much Do Ozempic and Wegovy Cost? Not What You Think. - The New York Times

[6] Estimating the Cost of New Treatments for Diabetes and Obesity | American Enterprise Institute - AEI

[7] How Much Do Ozempic and Wegovy Cost? Not What You Think. - The New York Times

[8] Novo Nordisk lowers cost of Ozempic® to $499 per month for self-paying patients, in support of patient access to authentic, FDA-approved semaglutide medicines

[9] Novo Nordisk launches introductory self-pay offer for Wegovy® and Ozempic® for $199 per month

[10] News Details. This agreement also encompasses Medicare Part D. Ibid.

the complete picture and are constrained by stale data, rather than reflecting current market conditions. The Board's decision-making then risks prompting restrictive policies—like UPLs—that may have negative unintended consequences.

Setting a UPL based on the MFP risks unintended consequences for patients.

Novo Nordisk is deeply concerned by Board staff's recommendation that the Board set a UPL for Ozempic® based on the Medicare MFP. Implementation of the Medicare Drug Price Negotiation Program remains in its early stages, and the full effects cannot yet be fully known or understood. The market, however, has already started shifting. CMS announced the prices for the first round of drugs in August 2024—approximately a year and a half ago. Yet, emerging evidence suggests that payers began responding even before the lower prices were implemented in January 2026, taking steps to offset anticipated revenue reductions (due to decreasing rebates from manufacturers) by shifting costs to patients or otherwise mitigating financial impact. For example, one study found that seven out of nine[11] Initial Price Applicability Year 2026 drugs showed increases in patient out-of-pocket costs upon analysis.[12]

This dynamic reflects the flawed structural features of the existing system of pharmaceutical payment and reimbursement. Manufacturers typically provide substantial rebates to pharmacy benefit managers (PBMs), which lower a drug's net price. When price controls reduce a drug's list price, manufacturers' rebates to payers based on list prices decline accordingly. In response, PBMs seek to recoup lost revenue by increasing copayments or coinsurance, adjusting benefit design, or otherwise transferring costs to patients.

There is also concern that PBMs could remove drugs subject to an MFP from formularies or disadvantage them by placing them on less favorable tiers. The Inflation Reduction Act includes some safeguards requiring Medicare plans to cover MFP-subjected drugs. In addition, CMS has committed to monitoring plan behavior to discourage inappropriate tiering or unjustified expansion of utilization management. While these protections are imperfect, they may help to mitigate some of the negative patient impact within Medicare. By contrast, it is unclear whether comparable safeguards would apply in markets subject to a state-imposed UPL. Absent similar protections, patients could face formulary exclusions, non-medical switching, or additional utilization management restrictions that could disrupt continuity of care and negatively affect health outcomes.

Finally, imposing a UPL based on a disruptively low-price risks destabilizing the pharmaceutical supply chain. Independent and smaller community pharmacies in particular operate on thin margins and may struggle with reduced reimbursement rates from plans and PBMs. Lower

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[11] *Please note insulin aspart products were not part of this analysis because the copay for all insulins in Medicare was capped at $35 as part of a separate provision of the IRA*

[12] Pioneer Institute Launches Tracker Showing Drug Price Controls Are Raising Out-of-Pocket Costs for Medicare Patients

reimbursement can create cash-flow challenges and revenue losses, potentially leading pharmacies to limit or cease stocking impacted products (and possibly other treatments, as their revenues decline). Pharmacists are already preparing to make these difficult decisions in the wake of MFPs. In a recent National Community Pharmacists Association (NCPA) survey of more than 10,000 community pharmacists, nearly 20% reported they would not stock MFP drugs and an additional 67% indicated they were considering that step.[13] More than half also reported considering exiting one or more Medicare Part D pharmacy networks.[14] These findings raise serious concerns about patient access and the potential for significant disruptions in care.

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In sum, while Novo Nordisk supports the Board's goal of improving affordability and access, setting a UPL for Ozempic® based on the Medicare MFP would be misguided and risk unintended harm to patients. The Board's preliminary finding that Ozempic® has created affordability challenges fails to consider key contextual information, and relies on outdated data and a surface-level focus on list price that does not reflect the net prices paid by payers or patient out-of-pocket costs. Using the MFP to dictate a UPL will likely replicate the unintended effects already observed following MFP introduction—higher patient cost-sharing, more restrictive utilization management, formulary exclusions, and stress on the supply chain—all of which only serve to reduce patient access. **We urge the Board to adopt a more comprehensive assessment of affordability that fully accounts for patient impact and clinical value, and to abandon potential implementation of a price control measure that could ultimately reduce access and treatment options for Marylanders living with type 2 diabetes.**

Thank you for the opportunity to provide comments and for your consideration of the issues raised in this letter. Should you have any questions or concerns, please contact Stephanie Kutler, Head of Policy, at NSTK@novonordisk.com for additional information.

[13] Sept-2025-NCPAsurvey-MDPNPandFinancialHealth.pdf
[14] Ibid.