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Boehringer Ingelheim

July 21, 2026

Boehringer Ingelheim Pharmaceuticals, Inc.
900 Ridgebury Road
Ridgefield, CT 06877

Re: Prescription Drug Affordability Board Meeting, July 27th, 2026

Boehringer Ingelheim appreciates the opportunity to provide written comments in advance of the July 27th Board meeting. We respectfully resubmit the comments shared on July 13th regarding the implementation and monitoring of upper payment limits.

At Boehringer Ingelheim, we recognize the challenges within the U.S. healthcare system—particularly the burden patients face when confronted with high out-of-pocket costs at the pharmacy counter. While we agree that action is needed to make medicines more affordable, we believe that government-imposed price controls are not the most effective path forward. Instead, we advocate for solutions that improve patient access, affordability, and support medical innovation.

The Maryland Prescription Drug Affordability Board (PDAB) released final regulations, COMAR 14.01.06 (Implementation and Monitoring of Upper Payment Limits). These regulations outline how UPL will apply in practice, the contracting requirements imposed on payers, and the reporting obligations for state entities.

Boehringer Ingelheim respectfully disagrees with the Board's implementation and monitoring regulations. We are committed to ensuring that Jardiance® is affordable for all Maryland patients, but we have significant concerns about applying a UPL benchmarked to Medicare's Maximum Fair Price (MFP) across Maryland's markets. MFP was developed solely for the Medicare population; it does not reflect Maryland specific formulary structures, reimbursement, or utilization. Additionally, COMAR 14.01.06 does not account for the effectuation of the UPL. Medicare's MFP is based upon detailed guidance and has a dedicated Medicare transaction facilitator, to effectuate the MFP through plans and pharmacies. Under current draft regulations, the Maryland UPL framework lacks the operational infrastructure or direction for efficient implementation of UPL. Without a proper framework, UPL implementation and application will be difficult for stakeholders to operationalize which could increase the risk of improper payment and potential disruption to patient access.

Additionally, Boehringer is concerned about the reporting requirements included in the draft regulation, COMAR 14.01.06, as they raise significant confidentiality concerns. Because the regulations require detailed disclosure of gross spending, net costs, utilization, and formulary placement, the PDAB may receive competitively sensitive pricing information that reveals effective rebate levels and proprietary contracting strategies. Also, Pharmacy Benefit Managers (PBM) control most of the reported data; the reporting regime may amplify the PBM negotiation leverage and create perverse incentives to shift costs or tighten access to Jardiance®. Boehringer asks that the data reported by government entities to the Maryland PDAB be in aggregate form and not publicly disseminated.

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Patients face access and affordability barriers driven in part by PBM business practices. Manufacturers are only one part of the broader drug pricing and reimbursement system. A UPL tied to manufacturer list price does not address the role of plans and PBMs, which largely determine the out-of-pocket costs patients face at the pharmacy counter. PBMs may retain rebates and fees tied to higher list prices rather than passing savings through to patients, creating incentives that may discourage adequate coverage and increased utilization management for Jardiance® if reimbursement is capped below current rates.

Recent litigation in Colorado underscores the legal and operational uncertainty associated with state UPL frameworks. On July 1, 2026, a federal judge granted Amgen a preliminary injunction blocking Colorado's Prescription Drug Affordability Board from enforcing its UPL for Enbrel®[1]. This decision underscores the need for Maryland's PDAB to carefully assess whether a UPL could raise similar legal and operational challenges and, in turn, create risks to patient access.

Boehringer supports the Board's mission to improve affordability for Maryland patients. We urge the Board to consider non-UPL approaches that address cost drivers holistically, improve transparency across the supply chain, and maintain continuity of coverage for patients who benefit from Jardiance®. We remain committed to working collaboratively on solutions that sustain patient access while supporting continued medical innovation.

Regards,

Signed by:
Candice Finnegan
F5069C0EFC26442...

Candie Finnegan, ED State Government Affairs

[1] *Amgen Inc. v. Mizner et al.*, No. 1:25-cv-03452-DDD-STV, slip op. at 10 (D. Colo. July 1, 2026) (granting preliminary injunction)

COMMUNITY ACCESS NATIONAL NETWORK

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Industry Advisory Group (IAG)

National ADAP Working Group (NAWG)

July 22, 2026

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

RE: UPL Developments and 340B Reporting

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.

Today, we write regarding ongoing UPL activity concerns.

Litigation Raises Process Questions

The recent preliminary injunction (PI) in the Colorado PDAB's litigation regarding its upper payment limit setting activity for Enbrel raises questions for Maryland as well. Judge Domenico issued a PI that indefinitely prohibits the UPL from going into effect until the merits of the case are determined. PIs are only ever issued when a Court determines the litigant is likely to succeed on the merits and where lack of intervention poses substantial harm to a claimant. The PI focused on the determination that the UPL conflicted with federal patent law and jurisprudence of the District of Columbia Federal District Court in the *BIO* decisions. Not discussed in detail, but as awarded as cause for the PI also included due process concerns. On the expected merits, due process concerns will include the arbitrary and capricious nature of metrics used to determine "affordability" and lack of standardized definition of "affordable".

Importantly, Colorado and Maryland are similarly situated in failing to define "affordable", for whom, and refusing to adopt metrics considerations that accurately reflect costs and access of the prescription drug supply chain.

We are concerned that, despite all the time and financial resources expended thus far by the PDAB, Maryland also risks similar litigation in the near future that will require additional, unnecessary but readily foreseeable expenditures.

Moreover, the current scope of Maryland's upper payment application only includes state and local government entities. That, in large part, involves things like the state employee health plan, which is engaged with the state's PBM. Interacting with the state PBM is a matter of contract negotiation, not legislation or a regulatory mechanism through UPL rulemaking, and would better serve the state's interests as limited by this Board's designated power and obligations.

Additionally, the initial landscape of UPL application is not set to generate data to analyze the feasibility and potential negative or positive outcomes of applying UPL expansion powers to the entire state's commercial market. Without data justification or proof of concept, expanding into further complex markets affecting larger populations is tenuous and concerning and explicitly risks the same litigation weaknesses as Colorado's PDAB.

340B Reporting Paucity of Information is a Red Flag

The Board and staff acknowledge that the approved 340B Distribution Report is insufficient. The depth of financial analysis requested by the General Assembly was not achieved. Lack of meaningful data on the scope and finances of the program in the state is a fatal blind spot. The 340B program revenue is an essential source of funding for many covered entities. The paucity of information means there is no analysis of how the 340B program would be negatively or positively affected by UPL activity; thus, no data on the potential harms to covered entities and the patients they serve.

We would be remiss not to remind this Board that CANN has raised this very issue repeatedly in the last two years. The Board's refusal to take this concern at face value until now is an abject failure of thoughtful regulatory assessment and judicious use of state resources.

We know that there is a high probability of negative outcomes for 340B funding because UPLs reduce discount value by reducing reimbursement. Adversely affecting the 340B funding that entities depend on to serve their vulnerable populations equals the loss of services, treatment access, and the lifeline of a care continuum that many have no other way to engage. **Such a result objectively harms the very populations this Board is tasked to consider in their service, as defined in its own enacting statute.**

Additionally, the General Assembly is interested in knowing how covered entities reinvest 340B savings. It is important to understand how funds are reinvested and utilized to not only understand the breadth of services being administered, but also to analyze where abuses may be occurring, which would enable and inform corrective action. The report states that Maryland has 185 parent covered entities, 289 child sites, and 1,702 contract pharmacy relationships, which even includes on-campus 340B-eligible clinics.

It is unclear how responsible and effective analysis or implementation of any actions can be achieved without proper analysis of the 340B program. The sentiment implying that it is the General Assembly's purview to enact mandatory reporting requirements in light of the limited amount of voluntary participation with PDAB information requests does not negate the fact that currently the necessary data is not available. Thus, the analysis is incomplete and flawed.

While demanding review of 340B-related data is not within the scope of this Board's powers, the Board should consider making appropriate recommendations to the Legislature to ensure greater transparency and accountability among covered entities in order to appropriately assess benefit to served patient communities and potential impacts of any price-setting regulation or legislation.

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

July 22, 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 deeply 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, 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.

Despite the changes made with your proposed COMAR 14.01.06, the framework for implementing and monitoring Upper Payment Limits, the questions we raised earlier this year remain unanswered: What exactly are you measuring? How will you prove it works? And who will be accountable if it doesn't?

Before finalizing any UPL implementation framework, the Board must establish clear, transparent metrics for comparing price reductions against total downstream healthcare expenditures. The COMAR 14.01.06 framework should require the Board to publish a formal comparative analysis, what has worked or failed elsewhere and whether their cost interventions actually delivered savings and improved health outcomes for the patients they were intended to serve.

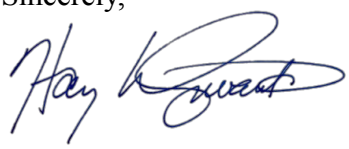
Regarding the Cost Review, any revisions to the process should incorporate total patient cost, not just list price into affordability determinations. A process fixated on list price, without measuring total patient costs or addressing the full spectrum of supply chain actors risks restricting access to essential medications while driving worse long-term health outcomes. Since the Board's statutory authority cannot reach all participants in the drug pricing and supply ecosystem, the risk of unintended harm is real and predictable. This is especially relevant for conditions that require continuous successful management with effective, personalized intervention regimens, such as diabetes, rheumatoid arthritis, lupus, multiple sclerosis and others.

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 asking the legislature to consider expanding your ability to develop methods of lowering actual drug costs, not just the list prices of drugs purchased by the State and Marylanders. Thank you for your attention to this critical issue.

Sincerely,



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

MARYLAND TECH COUNCIL
ADVANCING LIFE SCIENCES AND TECHNOLOGY

July 21, 2026

Submitted via email: comments.pdab@maryland.gov

Re: July 2026 Board Comments

Dear Members of the Prescription Drug Affordability Board,

On behalf of the Maryland Tech Council, I am writing to request an addition to the agenda of the July 2026 meeting of the Prescription Drug Affordability Board ("PDAB," or the "Board"). Specifically, we are requesting that the PDAB formally consider during its July 2026 meeting the implications of the recent decision issued by the United States District Court for the District of Colorado concerning the Colorado Prescription Drug Affordability Board and how it may apply to the PDAB's ongoing efforts to set Upper Payment Limits ("UPLs") and other price control mechanisms on drugs currently under review.

In *Amgen Inc. v. Mizner* (D. Colo. July 1, 2026), Judge Domenico of the U.S. District Court of Colorado issued an order that enjoined the Colorado Prescription Drug Affordability Board from enforcing a UPL on the drug Enbrel. The court found that Amgen would be "substantially likely to succeed on the merits" on its claim that the Colorado PDAB's actions are preempted by Federal law. The court's decision was based on the Federal Circuit's decision in *Biotechnology Industry Association v. District of Columbia* (Fed. Cir. 2007), in which the Federal Circuit held that price caps enacted under the District of Columbia's Prescription Drug Excessive Pricing Act were preempted by federal patent laws.

The Colorado decision raises significant legal questions regarding state prescription drug affordability programs and the extent to which state-imposed payment limitations may be preempted by federal law or otherwise conflict with federal statutory protections governing pharmaceutical manufacturers and the national prescription drug marketplace. Although the decision is currently limited to Colorado and may be subject to appeal, it provides a highly relevant judicial analysis of issues analogous to Maryland's ongoing cost review process and UPL implementation.

The Colorado decision and the Federal Court precedent on which it was based would also apply to a legal challenge in Maryland over UPL implementation. As such, we are requesting that the Board include an agenda item on this decision so that there can be a public discussion of its implications at the July 2026 Board meeting. We believe it is important for the Board to openly consider how this important judicial development impacts Maryland's efforts to impose UPLs or other price controls.

Thank you for considering our request.

Sincerely,

Kelly M Schulz

Kelly Schulz
CEO, Maryland Technology Council

National Pharmaceutical Council®
1717 Pennsylvania Avenue, NW, Suite 800, Washington, DC 20006 Phone: 202.827.2100 Web: www.npcnow.org

Dear Ms. Shaklee,

The National Pharmaceutical Council (NPC) appreciates the opportunity to provide comments on the Maryland Prescription Drug Affordability Board's (MD PDAB) proposed regulations on the implementation and monitoring of upper payment limits (UPLs). NPC serves patients and society with policy-relevant research on the value of patient access to innovative medicines and the importance of scientific advancement.[1] We envision a world where advances in medicine are accessible to patients, valued by society, and sustainably reimbursed by payers to ensure continued innovation. We have rich experience conducting research and disseminating information about the critical issues of evidence, innovation, and the value of medicines for patients.[2] Our research helps inform important healthcare policy debates and supports the achievement of the best patient outcomes in the most efficient way possible.

We are pleased to provide the MD PDAB with comments on the risks of UPLs that we find most concerning before its July 2026 meeting. In this letter, we urge the MD PDAB to abandon the implementation of proposed UPLs and the development of additional UPLs for medicines; UPLs are likely to increase access barriers for patients without guaranteeing medicines will be more affordable for patients at the pharmacy counter. Our full rationale and key points can be found in the Executive Summary and letter (below).

[1] About NPC. National Pharmaceutical Council. Accessed July 15, 2026. https://www.npcnow.org/about
[2] Resources. National Pharmaceutical Council. Accessed July 15, 2026. https://www.npcnow.org/resources?f%5B0%5D=resource_type%3A45

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EXECUTIVE SUMMARY

I. UPLs risk worsening patient affordability of medicines

- Establishing UPLs for medicines will not make medicines more affordable for patients.
- As experience with PDABs grows, states are questioning their effectiveness generally and the utility of UPLs specifically, while confronting increasing legal risk.
- Allowing UPLs to expand to all "purchases and payor reimbursements"[3] will expand the risk to patient access in MD.
- Patient groups and patient advocates have raised the concern that UPLs will not reduce what patients pay for medicines.[4,5,6]
- Payer interviews demonstrate that plans are unlikely to pass savings from UPLs on to patients and will increase patients' out-of-pocket costs and utilization management.[7]
- Utilization management and non-medical switching may increase under UPLs, risking increased adverse events and treatment delays. [8]
- Accordingly, the MD PDAB should abandon any plan to use UPLs.[9]

II. UPLs will cause financial harm to independent pharmacies and providers

- State pharmacy associations and pharmacists have voiced concerns about the adverse consequences of UPLs on pharmacies' financial viability.[10,11] Specifically, pharmacies may not be reimbursed at a rate that adequately accounts for acquisition and dispensing costs. We urge the MD PDAB to heed the warnings of pharmacists across the country regarding threats UPLs pose to their pharmacies and subsequent patient access to medicines.

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[3] Delegate Cullison. HB 424 of 2025. Maryland General Assembly. October 1, 2025. Accessed July 15, 2026. https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/HB0424?ys=2025RS

[4] Community Access National Network Testimony Re: Drug Selection Process Concerns. Washington State Prescription Drug Affordability Board. July 10, 2025. Accessed July 16, 2026. https://www.hca.wa.gov/assets/program/pdab-cann-written-comment-july-15-2025.pdf

[5] Let My Doctors Decide Action Network Testimony Re: Colorado Prescription Drug Affordability Board. November 12, 2025. Accessed July 16, 2026. Prescription Drug Affordability Board. https://doi.colorado.gov/sites/doi/files/documents/PDAB%20January%209%20Written%20Comments.pdf

[6] Patrick Ingham. Counterpoint | Minnesota's Prescription Drug Affordability Board must be inclusive of patient needs. The Minnesota Star Tribune. July 21, 2025. Accessed July 16, 2026. https://www.startribune.com/insurance-companies-affordable-prescriptions-mn/601434120

[7] Payer Perspectives Confirm UPLs Will Likely Raise Costs and Hinder Patient Access to Medicines. Partnership to Fight Chronic Disease and Avalere Health. March 2025. Accessed July 16, 2026. https://b11210f4-9a71-4e4c-a08f-cf43a83bc1df.usrfiles.com/ugd/b11210_1e92735a49744639ac37321c6320e8c8.pdf

[8] State Prescription Drug Affordability Boards (PDABs) and Analysis of Patient Impact: A US Physician Survey Study. Value of Care Coalition and Magnolia Access Solutions. Updated 2024. Accessed July 15, 2026. https://valueofcarecoalition.org/doctor-survey-study/

[9] Delegate Cullison. HB 424 of 2025. Maryland General Assembly. October 1, 2025. Accessed July 15, 2026. https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/HB0424?ys=2025RS

[10] Faulks J, Soefje S, Russell A. Minnesota Pharmacy MN-Prescription Drug Affordability Presentation. January 13, 2026. Accessed July 16, 2026. https://mn.gov/commerce-stat/insurance/pdab/2026/01-13-2026/mn_pharmacy_mn-pdab_presentation_1.13.2026_final.pdf

[11] Maryland Pharmacists Association in response to UNFAVORABLE - HB 424 - Prescription Drug Affordability Board - Authority for Upper Payment Limits. February 6, 2025. Accessed July 16, 2026. https://mgaleg.maryland.gov/cmte_testimony/2025/hgo/1orUlkazoh2z38b0HPDzFW5Lmm4YHlVAL.pdf

- Providers raise similar concerns. UPLs may be set too low to cover a provider's costs to acquire and administer the drug or otherwise reduce practice revenues.[12] We urge the MD PDAB to heed the warnings of providers regarding the implications of UPLs on their practices and subsequent patient access to medicines.

III. UPLs set to the MDPNP Maximum Fair Price ignore differences between Medicare patients and other patient populations

- Applying the Medicare Maximum Fair Prices to set UPLs is a miscalculated step in the wrong direction.
    i. Maximum Fair Prices, developed with data from the Medicare population, cannot appropriately be applied to other patient populations in Maryland.
    ii. The MD PDAB should not rely on Maximum Fair Prices developed with a lack of sufficient input from patients.[13]
- The MD PDAB should abandon the use of Medicare Maximum Fair Prices to set UPLs.

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[12] COA Position Statement on Prescription Drug Affordability Boards. Community Oncology Alliance. March 7, 2025. Accessed July 16, 2026. https://mycoa.communityoncology.org/publications/position-statements/coa-position-statement-on-prescription-drug-affordability-boards

[13] Patterson JA, Wagner TD, Salih RK, Shabazz GD, Campbell JD. CMS's Drug Price Negotiation Program 2023 Patient-Focused Listening Sessions: A Descriptive Analysis of Speaker Remarks. Pharmacoecon Open. 2025 Jan;9(1):103-113. doi: 10.1007/s41669-024-00530-6. Epub 2024 Nov 11. PMID: 39527364; PMCID: PMC11717761.

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I. UPLs risk worsening patient affordability of medicines

Establishing UPLs for medicines in MD will not improve patient affordability of medicines. UPLs will set a maximum payment or reimbursement rate for a pharmacy or other entity. The information below details evidence from multiple sources demonstrating that UPLs risk worsening patient affordability of medicines through changes in plan structures, incentives, and utilization management. For example, our recent study demonstrates the risks of UPLs to patient access, including potentially worsened formulary coverage, higher cost-sharing, and increased utilization management. [14] Our analysis showed patients in MD often have more favorable cost-sharing, and less favorable formulary coverage and prior authorization, than patients in states without UPL authority. Health plans also set patient out-of-pocket costs (e.g., coinsurance, copayment) based on their plan structure and practices. As such, there is no guarantee that patients taking a medicine subject to a UPL will have lower cost-sharing while taking that medicine. This is true for the initial year of a MD UPL, where there is no requirement that savings accrued by state and local government payers will benefit patients. The MD PDAB has recommended "supplemental rebates for payors to achieve the UPL amount,"[15] suggesting the UPL would not be applied to patient out-of-pocket costs. Allowing UPLs to expand to all "purchases and payor reimbursements"[16] in future years will expand the risk to patient access in MD.

States are reassessing PDABs and UPLs amid effectiveness and legal concerns

As experience with PDABs grows, states are questioning their effectiveness generally and the utility of UPLs specifically, while confronting increasing legal risk. The only other example of a state attempting to enforce a UPL has resulted in multiple lawsuits, including a preliminary injunction against the UPL.[17] A federal district court halted implementation of Colorado's UPL at the beginning of this month, reasoning that federal patent law preempted the state UPL and therefore the state UPL was likely unconstitutional.[18] Commenters have raised legal concerns in comments to the MD PDAB,[19] and efforts to implement a UPL for all payers in the state could face additional challenges.

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[14] A Cost of Caps: Risks to Patient Access Amid PDAB Upper Payment Limit Implementation. National Pharmaceutical Council Fact Sheet. April 21, 2026. Accessed July 16, 2026. https://www.npcnow.org/resources/cost-caps-risks-patient-access-amid-pdab-upper-payment-limit-implementation

[15] UPL Regulations: Implementation and Monitoring of Upper Payment Limits, PDAB Staff Presentation. Maryland PDAB. April 13, 2026. Accessed July 21, 2026. https://pdab.maryland.gov/Documents/meetings/2026/April%2013%2C%202026/2026.04.13.UPL%20Regulations-%20General%20Provisions.pdf

[16] Delegate Cullison. HB 424 of 2025. Maryland General Assembly. October 1, 2025. Accessed July 15, 2026. https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/HB0424?ys=2025RS

[17] Amgen Inc. et al. v. Mizner et al. II. Civil Action No. 1:25-cv-03452-DDD-STV. United States District Court for the District of Colorado. July 1, 2026. Accessed July 15, 2026. https://litigationtracker.law.georgetown.edu/wp-content/uploads/2025/10/gov.uscourts.cod_.248711.66.0.pdf

[18] Ibid.

[19] See, e.g., Public Comments to Maryland PDAB re: Proposed Revisions to COMAR 14.01.04 Cost Review Study Process. June 1, 2026. Accessed July 22, 2026. https://pdab.maryland.gov/Documents/comments/2026/COMAR%2014.01.04%20June%201%2c%202026%20Comments-%20Redacts%20%281%29.pdf

Meanwhile, other states are recognizing the ineffective nature of PDABs. Virginia's Governor Spanberger vetoed a bill to establish a PDAB with MFP-based UPL authority, stating PDABs "are expensive[20] undertakings that other states have either repealed or are considering repealing due to costs and ineffectiveness."[21] New Hampshire dissolved its PDAB, finding that the Board was unable to achieve the desired outcome of lowering prescription drug prices.[22,23] The Oregon PDAB gained authority to develop a plan for enacting UPLs in 2023, [24] but has not yet done so. Instead, as evident in its 2025 annual report recommendations, the Oregon PDAB is focused on making prescription drugs affordable through new authorities such as: pharmacy benefit manager (PBM) reform and cost-plus pharmacy reimbursement models – not UPLs for drugs.[25]

Patient out-of-pocket costs are likely to increase for UPL medicines

Setting a UPL will not lower the cost-sharing that a PBM or health plan may require from patients. In fact, many patient groups have raised the concern that the establishment of UPLs will not make prescription drugs more affordable for patients.[26,27] Patient cost sharing involves tiered formularies, in which patients pay copays or coinsurance out-of-pocket. Cost sharing is typically calculated based on tier placement. The concerns voiced by patient representatives are supported by survey results from health plan respondents covering an estimated 115.2 million patient lives.[28] In a survey of health plan leaders with experience in drug benefit design, an overwhelming majority of respondents (77%) believe that UPLs would impact patient access to medicines due to "changes in coverage, tiering, cost sharing, or broader supply chain issues, such as pharmacies not stocking drugs with UPLs." In addition, fifty percent of respondents indicated they expect cost-sharing to increase for UPL drugs, and fifty-three percent of respondents also expect that out-of-pocket costs for other drugs in the same class as UPL drugs will increase. In the same survey, fifty-seven percent of health plan leaders anticipate that UPLs will increase

[20] HB 483ER Fiscal Impact Statement. Virginia Department of Planning and Budget. March 31, 2026. Accessed July 21, 2026. https://lis.blob.core.windows.net/files/1214721.PDF
[21] Governor's Veto. HB 483 of 2026. Virginia General Assembly. May 19, 2026. Accessed July 21, 2026. https://lis.virginia.gov/bill-details/20261/HB483/text/HB483VG
[22] Dissolution of the Board. New Hampshire Prescription Drug Affordability Board. July 11, 2025. Accessed July 21, 2026. https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/inline-documents/sonh/letter-dissolving-pdab.pdf
[23] Murphy W. Opinion: Why ending New Hampshire's PDAB was the right move for patients. Concord Monitor. September 5, 2025. Accessed July 21, 2026. https://www.concordmonitor.com/2025/09/05/my-turn-new-hampshire-ends-prescription-drug-board/
[24] SB 192. Oregon State Legislature. September 24, 2023. Accessed July 15, 2026. https://olis.oregonlegislature.gov/liz/2023R1/Measures/Overview/SB192
[25] 2025 Annual Report for the Oregon Legislature. Oregon PDAB. December 20, 2025. Accessed July 22, 2026. https://dfr.oregon.gov/pdab/Documents/reports/PDAB-Annual-Report-2025.pdf
[26] Community Access Action Network Comment Re: Maryland Prescription Drug Affordability Board. May 12, 2026. Accessed July 15, 2026. https://pdab.maryland.gov/Documents/comments/2026/Board%20written%20comment%20packet%205.18.26%20PDAB%20meeting%20%281%29.pdf
[27] Let My Doctors Decide Action Network Comment Re: Maryland Prescription Drug Affordability Board. May 13, 2026. Accessed July 15, 2026. https://pdab.maryland.gov/Documents/comments/2026/Board%20written%20comment%20packet%205.18.26%20PDAB%20meeting%20%281%29.pdf
[28] Payer Perspectives Confirm UPLs Will Likely Raise Costs and Hinder Patient Access to Medicines. Partnership to Fight Chronic Disease and Avalere Health. March 2025. Accessed July 15, 2026. https://b11210f4-9a71-4e4c-a08f-cf43a83bc1df.usrfiles.com/ugd/b11210_1e92735a49744639ac37321c6320e8c8.pdf

premiums. In addition, since health plans dictate patient responsibility for out-of-pocket costs, patients taking a drug with a UPL could face increasing cost-sharing over time. The MD PDAB is not required by law to set UPLs.[29] Accordingly, we urge the MD PDAB to abandon the development and implementation of UPLs for medicines.

Utilization management and non-medical switching may increase under UPLs

There is evidence to suggest that in response to UPLs for medicines, health plans may also impose greater utilization management, which would negatively impact patient outcomes. In the survey noted above, fifty percent of health plan payers – covering 115.2 million lives – expect that UPLs on drugs will likely increase utilization management.[30] Evidence confirms that utilization management tools are associated with poor health outcomes, including medication abandonment and preventable hospitalization.[31,32] We are concerned that increased utilization management of medicines with UPLs will further reduce access to these medicines.

We are also concerned that UPLs will increase non-medical switching of medicines. Non-medical switching of medicines has been defined as: "a change in a patient's medication to a clinically similar but chemically distinct (i.e., not a bioequivalent generic) medication for reasons apart from lack of clinical effectiveness, tolerability or adherence."[33] The Value of Care Coalition interviewed endocrinologists, rheumatologists, and HIV specialists on their perceptions of PDABs.[34] Ninety-six percent of clinicians surveyed stated they were somewhat or very concerned that implementation of a UPL would lead to non-medical switching of medicines. Non-medical switching is harmful to patients because not all medications are interchangeable – patients with different baseline characteristics and risk factors may require specific medication treatments. Non-medical switching decreases patient choice and can have negative impacts on clinical and health economic outcomes such as adverse events and treatment delays.[35,36] We commend

[29] Delegate Pena-Melnyk, et al. HB 768 of 2019. Maryland General Assembly. July 1, 2019. Accessed July 15, 2026. https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/HB0768?ys=2019RS

[30] Payer Perspectives Confirm UPLs Will Likely Raise Costs and Hinder Patient Access to Medicines. Partnership to Fight Chronic Disease and Avalere Health. March 2025. Accessed July 15, 2026. https://b11210f4-9a71-4e4c-a08f-cf43a83bc1df.usrfiles.com/ugd/b11210_1e92735a49744639ac37321c6320e8c8.pdf

[31] Jay Pickerin. Prior Authorizations and Adverse Impact on Continuity of Care. *AJMC*; 2025: 31 (4): 163 – 165. https://www.ajmc.com/view/prior-authorizations-and-the-adverse-impact-on-continuity-of-care

[32] The Current Prior Authorization Landscape. *Health Affairs Insider Report*. March 25, 2026. Accessed July 16, 2026. DOI: 10.1377/hpb20260318.8289

[33] Weeda ER, Nguyen E, Martin S, Ingham M, Sobieraj DM, Bookhart BK, Coleman CI. The impact of non-medical switching among ambulatory patients: an updated systematic literature review. *J Mark Access Health Policy*. 2019 Oct 19;7(1):1678563. doi: 10.1080/20016689.2019.1678563. PMID: 31692904; PMCID: PMC6818107.

[34] State Prescription Drug Affordability Boards (PDABs) and Analysis of Patient Impact: A US Physician Survey Study. Value of Care Coalition and Magnolia Access Solutions. Updated 2024. Accessed July 15, 2026. https://valueofcarecoalition.org/doctor-survey-study/

[35] Weeda ER, Nguyen E, Martin S, Ingham M, Sobieraj DM, Bookhart BK, Coleman CI. The impact of non-medical switching among ambulatory patients: an updated systematic literature review. *J Mark Access Health Policy.* 2019 Oct 19;7(1):1678563. doi: 10.1080/20016689.2019.1678563. PMID: 31692904; PMCID: PMC6818107.

[36] Salam T, Duhig A, Patel AA, Cameron A, Voelker J, Bookhart B, Coleman CI. Physicians' perspectives regarding non-medical switching of prescription medications: Results of an internet e-survey. *PLoS One*. 2020 Jan 10;15(1):e0225867. doi: 10.1371/journal.pone.0225867. PMID: 31923201; PMCID: PMC6953849.

the state of Maryland for the steps it has taken to address non-medical switching.[37] We caution that the complexities of patient access hurdles, including health plan/PBM-induced utilization management tools (i.e., prior authorization and step therapy) and resultant non-medical switching, could be exacerbated by UPLs.

II. UPLs will cause financial harm to independent pharmacies and providers

Pharmacy practices will be financially harmed by UPLs

State pharmacy associations and pharmacists have voiced concerns about the unintended consequences of UPLs on community pharmacies' financial viability to the MD PDAB and to PDABs across the country. MD pharmacists expressed concern about the potential unintended consequences of UPLs on pharmacies, stating recent law, "lacks a process to ensure that upper payment limits will not force pharmacies to dispense medications below their acquisition cost."[38] The MD Pharmacist Association argued that to properly address the cost of prescription drugs, the General Assembly should address the role of PBMs. Concerns about access issues for rural areas were also raised by the Benefit Supervisor for Frederick, MD County Government.[39]

Pharmacists across the country have also said that pharmacies may not be reimbursed at a rate that accounts for the acquisition of the drug and the costs of the dispensing process.[40, 41] Not properly reimbursing pharmacies for stocking prescriptions with a set UPL could result in the pharmacy losing money on supplying the UPL drug or not stocking the medicine to avoid such losses. In a National Community Pharmacy Association (NCPA) survey, sixty-four percent of independent pharmacy owners and managers state that they are "considering not stocking" drugs in the MDPNP, and ten percent said they "won't stock" the first ten drugs in the MDPNP.[42] Implementing UPLs on drugs will only increase the financial pressure on independent pharmacies in MD.

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[37] Title 15 - Health Insurance Subtitle 8 - Required Health Insurance Benefits Section 15-831 - Coverage of Prescription Drugs. MD Insurance Code § 15-831. 2025. Accessed July 21, 2026. https://mgaleg.maryland.gov/mgawebsite/Laws/StatuteText?article=gin&section=15-831&enactments=false

[38] Maryland Pharmacists Association in response to UNFAVORABLE - HB 424 - Prescription Drug Affordability Board - Authority for Upper Payment Limits. February 6, 2025. Accessed July 16, 2026. https://mgaleg.maryland.gov/cmte_testimony/2025/hgo/1orUlkazoh2z38b0HPDzFW5Lmm4YHlVAL.pdf

[39] Grisier F. Public Comment on Maryland COMAR 14.01.06. March 30, 2026. Accessed July 16, 2026. https://pdab.maryland.gov/Documents/comments/2026/Written%20comments%20UPL%20Regs%203.30.26_Redacted.pdf

[40] Faulks J, Soefje S, Russell A. Minnesota Pharmacy MN-Prescription Drug Affordability Presentation. January 13, 2026. Accessed July 15, 2026. https://mn.gov/commerce-stat/insurance/pdab/2026/01-13-2026/mn_pharmacy_mn-pdab_presentation_1.13.2026_final.pdf

[41] Zadvorny E. Verbal Testimony at Colorado Prescription Drug Affordability Board Meeting. Colorado Prescription Drug Affordability Board. August 22, 2025. Accessed July 15, 2026. Speaking starts at 3:06:16. https://us06web.zoom.us/rec/play/pE6FxNXTaaOFxNnu2-MbW2962bc1xADiCPCBDnUfq6RGEMTF90HTzxulFxCH6BirL-k2vitM9CrDCcIh.CTPQQgVUuwmYCi1K?eagerLoadZvaPages=sidemenu.billing.plan_management&accessLevel=meeting&canPlayFromShare=true&from=share_recording_detail&continueMode=true&oldStyle=true&componentName=rec-play&originRequestUrl=https%3A%2F%2Fus06web.zoom.us%2Frec%2Fshare%2FE_KF6fdI_XEUQU7TwSBTsJ88b1Zow3ziMtgvGV0KSmk9KMjm2u0Y55eAuBUawglE.2Y1I_Mn3vX9qWGDq

[42] Report for February 2026 Survey of Independent Pharmacy Owners/Managers. National Community Pharmacists Association. February 26, 2026. Accessed July 16, 2026. https://www.ncpa.co/pdf/2026/advocacy/mtfsurveyletter.pdf

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We urge the MD PDAB to heed the warnings of pharmacists across the country regarding the threats UPLs pose to their pharmacies and subsequent patient access to medicines. University of Southern California's Pharmacy Access Initiative reports that over 525,000 Marylanders live in a pharmacy shortage area. 38.1% of those shortage areas were considered low-income.[43] When pharmacies close in these pharmacy shortage areas, Marylanders may lose appropriate access to their medicines altogether. In response to a UPL, pharmacies may choose not to stock medicines with a UPL due to under-reimbursement. Simply put, patients who take those medicines may be forced to drive to another pharmacy miles away or be switched to another medicine. Altogether, evidence suggests that UPLs will lead to financial losses for pharmacies and less access for patients.

Provider practices will also be financially harmed by UPLs

Providers of medicines with UPLs are very concerned about suffering from financial pressures if the reimbursement for a UPL drug is lower than the cost to acquire and administer the drug.[44] Independent providers, whose practices are not vertically integrated within a larger health system, may not have the resources to absorb the difference between their cost to acquire the drug and the reimbursement they receive from PBMs for the drug, and may cease to administer the UPL drugs to avoid this financial impact. The Community Oncology Alliance (COA) elaborated on this concern, "Specifically, COA cautions against the imposition of UPLs established by PDABs when such limits are potentially lower than the acquisition price that community oncology and other specialty practices pay to acquire these drugs. Practices cannot afford to pay more to acquire drugs than they are reimbursed."[45] While the WA PDAB examined UPL methodologies, providers commented with concerns about physician reimbursement and medical practices' bottom lines.[46] We urge the MD PDAB to heed the warnings of providers regarding the implications of UPLs for their practices and subsequent patient access to medicines.

III. UPLs set to MDPNP Maximum Fair Prices ignore differences between Medicare patients and other patient populations

Applying the Medicare Maximum Fair Prices to set UPLs is a miscalculated step in the wrong direction. Applying Maximum Fair Prices to markets outside Medicare ignores differences between Medicare patients and other patient populations. Congress designed the Medicare Maximum Fair Prices to be applied to a select group of drugs in the Medicare market, based on national data. State-enforced UPLs

[43] Pharmacy Access Initiative. University of Southern California-National Community Pharmacists Association. October 2022. Accessed July 16, 2026. https://pharmacydeserts.com/
[44] COA Position Statement on Prescription Drug Affordability Boards. Community Oncology Alliance. March 7, 2025. Accessed July 15, 2026. https://mycoa.communityoncology.org/publications/position-statements/coa-position-statement-on-prescription-drug-affordability-boards
[45] Ibid.
[46] National Infusion Center Association comment letter re: Concerns with Upper Payment Limits (UPLs). Washington Prescription Drug Affordability Board. March 18, 2026. Accessed July 15, 2026. https://www.hca.wa.gov/assets/program/nica-public-comment-march-2026.pdf

do not target the same market.[47] The Inflation Reduction Act statute is clear – the Maximum Fair Prices set price caps for the payment of drugs in the Medicare market (exclusively).[48]

Maximum Fair Prices, developed with data from the Medicare population, cannot appropriately be applied to other patient populations in Maryland, such as state and local government health plan populations.[49] Non-Medicare populations have a different median age, chronic condition profiles, and treatment patterns than the general Medicare population in the US. These differences, as the MD PDAB has acknowledged, may not result in additional savings.[50] Notably, NPC and others have discussed that CMS's process for determining the Maximum Fair Prices is not transparent,[51] limiting the ability of other entities such as PDABs to understand how that process relates to their state populations. Another concern in relying on Maximum Fair Prices is that they are developed with a lack of sufficient input from patients.[52] Setting a UPL at a Maximum Fair Price bypasses any opportunity for the MD PDAB to develop a transparent and patient-centered process to assess the affordability of medicines. The MD PDAB should abandon the use of Medicare Maximum Fair Prices to set UPLs.

Conclusion

We appreciate the opportunity to provide feedback to the MD PDAB regarding the potential implementation of UPLs on select medicines. Evidence suggests that UPLs on medicines will lead to increased out-of-pocket costs for patients, increased utilization management on UPL drugs, and increased financial burdens on community pharmacy and provider practices. Complex PBM and health plan practices (e.g., utilization management, step therapy, accumulators, maximizers, and AFPs) negatively impact patients' ability to access and afford their medications, and these practices may increase under UPLs. We urge the MD PDAB to abandon the implementation of proposed UPLs and the development of additional UPLs for medicines.

[47] Title 14 – Independent Agencies. Subtitle 01 – Prescription Drug Affordability Board. Maryland Regulations. Accessed July 16, 2026. https://pdab.maryland.gov/Pages/regulations.aspx
[48] H.R. 5376, 117th Cong, Inflation Reduction Act of 2022. Public Law No. 117-169. August 16, 2022. Accessed July 15, 2026. https://www.congress.gov/bill/117th-congress/house-bill/5376/text
[49] The effect of using existing pricing benchmarks to set state prescription drug payment limits. Johnson & Johnson Center for U.S. Healthcare Policy Research. June 2026. Accessed July 21, 2026. https://policyresearch.jnj.com/download/The%20effect%20of%20using%20existing%20pricing%20benchmarks%20to%20set%20state%20prescription%20drug%20payment%20limits%20June%202026
[50] Farxiga: Upper Payment Limit Framework. Maryland PDAB. November 4, 2025. Accessed July 22, 2026. https://pdab.maryland.gov/Documents/Cost%20Review/2025/Farxiga.Upper%20Payment%20Limit%20Framework.2025.11.04.1630.v.1.0.pdf
[51] Comments in Response to the Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028. National Pharmaceutical Council. July 2025. Accessed July 15, 2026. https://www.npcnow.org/resources/npc-submits-comments-cms-regarding-ipay-2028-draft-guidance
[52] Patterson JA, Wagner TD, Salih RK, Shabazz GD, Campbell JD. CMS's Drug Price Negotiation Program 2023 Patient-Focused Listening Sessions: A Descriptive Analysis of Speaker Remarks. *Pharmacoecon Open.* 2025 Jan;9(1):103-113. doi: 10.1007/s41669-024-00530-6. Epub 2024 Nov 11. PMID: 39527364; PMCID: PMC11717761.

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We are available for any questions from the Board and welcome the opportunity to speak with the Board for educational purposes. Please contact me at john.obrien@npcnow.org or (202) 827-2080 if we may provide any additional information.

Sincerely,

John O'Brien, PharmD, MPH
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