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VIA Electronic Delivery

May 2, 2023

Mr. Van Mitchell, Chair
Maryland Prescription Drug Affordability Board
16900 Science Drive, Suite 112-114
Bowie, MD 20715

Re: PRESCRIPTION DRUG AFFORDABILITY BOARD DEFINITIONS, COST REVIEW PROCESS, PUBLIC INFORMATION ACT, AND CONFIDENTIAL, TRADE-SECRET, AND PROPRIETARY INFORMATION

Dear Chairman Mitchell:

The Biotechnology Innovation Organization (BIO) appreciates the opportunity to comment on the Maryland Prescription Drug Affordability Board's (PDAB or Board) proposed regulations regarding: Definitions in the General Provisions (COMAR 14.01.01.01); Cost Review Process (COMAR 14.03.01-.05); Public Information Act (COMAR 14.01.04.01); and Confidential, Trade-Secret and Proprietary Information (COMAR 14.01.01.04).

BIO is the world's largest trade association representing biotechnology companies, academic institutions, state biotechnology centers and related organizations across the United States and in more than 30 other nations. BIO's members develop medical products and technologies to treat patients afflicted with serious diseases, delay their onset, or prevent them in the first place. In that way, our members' novel therapeutics, vaccines, and diagnostics not only have improved health outcomes, but also have reduced healthcare expenditures due to fewer physician office visits, hospitalizations, and surgical interventions. BIO membership includes biologics and vaccine manufacturers and developers who have worked closely with stakeholders across the spectrum, including the public health and advocacy communities, to support policies that help ensure access to innovative and life-saving medicines and vaccines for all individuals.

BIO has serious concerns regarding the impact that these regulations would have on access to medicines, particularly transformative therapies, including gene therapies and those approved through the accelerated approval process, which is reserved for treatments of diseases with no or very few therapies available.

Our comments follow:

General Comments

BIO is seriously concerned regarding the lack of specificity on how the board will determine whether the use of the drug has led to an affordability issue. The term "affordability" is vague and without a definition, leading to a great deal of subjectivity. We are concerned that the draft regulations create broad leeway – some that go beyond the statute – for the Board to identify drugs for a cost review, including permitting recommendations made by

the public and by Board members of certain drugs without explanation or justification and the inclusion of an entire class of drugs as a "metric" for cost review eligibility. This would result in a cache of information that could easily be misinterpreted and misapplied to policies that could hurt, not help patients in the long term.

Accelerated Approval Drugs

The draft regulations want to know whether the drug or biologic was approved through the accelerated approval process (AAP), without any explanation as to how that information will be used. AAP has been an essential regulatory tool to expedite patients' access to innovative products that address high unmet needs for conditions that have few or no other treatments. This pathway has tackled some of the most pressing public health needs and saved countless patients' lives. Using the same well established evidentiary standard as for traditional approvals, the pathway has facilitated approval of treatments for many severe diseases, such as a variety of cancers (including rare cancers), Human Immunodeficiency Virus (HIV), Various bacterial infections, Multiple Sclerosis, Sickle Cell Disease, rare diseases, and others that may fall into this same severe disease category.

The Board must consider the impact any draft regulations and policies it enacts on innovation for rare disease treatments. These treatments frequently address conditions for which there are no other treatments. Hundreds of new drugs or biologics to treat serious or life-threatening diseases or conditions with high unmet medical need have been approved through the AAP extending and, in certain cases, saving patients' lives by providing earlier access to novel therapies than would have been possible using the traditional approval pathway.

The utility of information regarding AAP drugs must be carefully considered, otherwise there is risk of disincentivizing investment in these critical areas. If the information collected will be used to identify whether a drug addresses a high unmet need, it may be appropriate for the Board to have that information. However, if having that information is to indicate that these drugs are simply creating affordability issues somehow, then the Board must consider the overall impact these policies would have because the disincentivizing of investment would lead to fewer innovative treatments for patients with high unmet needs. This would have disproportionate effect on patients with rare diseases, many of whom spend an average of 4.8 years and more than 7 specialist visits to receive an accurate diagnosis,[1] which can take far longer for patients within racial or ethnic minorities. For many of these patients, development of a treatment can only be accomplished through the accelerated approval pathway due to factors such as extremely small patient populations and uncertain endpoints for study due to the heterogenous nature of many rare diseases.

The draft regulations frequently reference "therapeutic alternatives," but what happens when there is no other therapeutic alternative? We believe drugs with no existing alternatives should be exempt from review, along with all drugs and biologics approved through the accelerated approval pathway.

[1] "The Diagnostic Journey for Rare-Disease Patients: Scaling Sustainable Solutions," Avalere, June 2021. https://avalere.com/wp-content/uploads/2021/07/Diagnostic_Journey_for_RD_Patients-June-2021.pdf (Accessed: May 2, 2023)

Out-of-Pocket Costs

We are also concerned that the draft regulations frequently reference as criteria the patient's copay and out-of-pocket costs (OOP). While these are some the biggest contributors to whether or not a medication is affordable, manufacturers do not set copayment or cost-sharing amounts, health plans do. Unfortunately, in most cases savings from manufacturers in the forms of rebates and discounts paid to pharmaceutical benefit managers (PBMs) and plan sponsors are not used to lower patient out-of-pocket costs. These savings are not passed onto the patient or beneficiary. Further, regarding how OOP costs will be measured, it is unclear whether the Board will consider actual amounts paid (i.e., whether a patient's OOP costs were off-set by a manufacturer assistance program) or what the OOP obligation is under a patient's plans. In many cases, "PBMs may also have an incentive to favor high-priced drugs over drugs that are more cost-effective. Because they often receive rebates that are calculated as a percentage of the manufacturer's list price, PBMs receive a larger rebate for expensive drugs than they do for ones that may provide better value at lower cost. As a result, people who have a high-deductible plan or have copays based on a drug's list price may incur higher out-of-pocket costs."[2]

A patient copay for a gene therapy, particularly a coinsurance, will be high and the draft regulations do not appear to recognize that there is an OOP cap most plans have to follow. Manufacturers often provide assistance to help patients with these OOP costs. However, PBMs have developed accumulator and maximizer programs to prevent manufacturer cost-sharing assistance from accruing toward patient deductibles and annual OOP maximums. The proliferation of these programs impedes the goal of increasing patient affordability. As a result, patients may struggle to afford and adhere to their medications as insurers and PBMs seek to shift more cost-sharing responsibility to patients.
We encourage the Board to consider other affordability solutions (e.g., accumulator adjustment program bans) as a more effective and meaningful way to help ensure patients are able to afford their medicines rather than additional regulation on biopharmaceutical manufacturers that would have little to no impact on OOP.

Therapeutic Benefit

Another issue of concern is that therapeutic benefit is mentioned several times in the draft regulations, however, none of the categories or criteria that the Board would consider would actually address therapeutic benefit. We believe that "disease burden" should be a separate criteria the Board must consider to determine whether a drug should be referred for Cost Review. Many transformative therapies, such as innovative gene therapies appear to be disadvantaged under the current criteria because of the one-time upfront costs, yet health benefits and the cost benefits to the healthcare system accrue over time for many patients on a gene therapy or another therapy meant for treatment of chronic conditions.

Appeals

Furthermore, Section 21–2C–14 of the statute clearly requires there to be an appeals process for Board decisions. While the statute establishes time frames for appeals, i.e., 30-days to appeal and 60-days to be heard and decided, there is nothing establishing the

[2] "Pharmacy Benefit Managers and Their Role in Drug Spending," The Commonwealth Fund, April 22, 2019. https://www.commonwealthfund.org/publications/explainer/2019/apr/pharmacy-benefit-managers-and-their-role-drug-spending (Accessed: May 1, 2023)

process, leaving that up to the Board. Unfortunately, we are concerned that there is no mention of the process in the draft regulations. We ask that the Board establish an appeals process and allow appropriate time for public comment.

Definitions in the General Provisions (COMAR 14.01.01.01)

BIO believes wherever possible, definitions should correspond to the Federal statutory definitions to avoid confusion and conflict with federal law. We offer our overall recommendations below.

Definitions:

- "**Active Ingredient**" is defined as "the ingredient in a drug that provides pharmacological activity or other direct effect in the diagnosis, cure, mitigation, treatment, or prevention of disease, as defined in 21 CFR §314.3." We believe this should be changed to ensure aid in clarity and alignment with federal law.

    - "**Active Ingredient**": *"Active ingredient" means the ingredient in a drug that provides pharmacological activity or prevention of disease, or affects the structure or any function of the body, as defined in 21 CFR §314.3*.

- "**Aggrieved Person**" is defined as "a person who has suffered actual loss or injury or is exposed to potential loss or injury to legitimate interest including, but not limited to, business and economic interests." While we recognize this term is in the statute, the term does not appear in any other place in the Board's other pending proposed regulations. We request that the Board provide more information regarding the use of this term in rulemaking, particularly as it relates to the process to be used to appeal of a Board decision, a process which we strongly recommend be created and put forth for public comment.

- "**Average Cost Share**" is defined as "a patient's total out-of-pocket costs divided by total spending for a prescription drug product." BIO believes this definition provided actually describes the percentage of costs paid by the patient versus the payer and is not an average. If the intent is to describe the average, the Board should calculate as an average across all patients and payers.

- "**Average Patient Copay**" is defined as the "average out-of-pocket [(OOP)] cost per prescription." BIO believes this definition is inconsistent with the proposed definition of "copay." If the intent is to reflect the average copayment for patients that are paying a copayment, then the definition should be changed to reflect that and only look at copayments versus other OOP variables. If what the Board is looking to reflect is the average OOP cost per prescription across all paid claims, BIO recommends the term be changed to "average out-of-pocket cost per prescription" and define as the total out of pocket costs across all patients divided by the number of prescriptions.

- "**Copay**" is defined as "the flat dollar amount that a patient pays for prescriptions or services covered by the patient's health insurance." The "coinsurance" definition includes mention that these are costs paid after the deductible is met. Therefore, BIO recommends the following:

  - We believe the "copay" definition should be changed to say, "'Copay' means the flat dollar amount that a patient pays for prescriptions or services covered by the patient's health insurance, after the deductible is satisfied."
  - It is important to ensure the various types of OOP costs are represented accurately and distinctly so that it will be easier to identify where benefit design is a contributing factor to affordability issues.

- "Discount" is defined as "a deduction from the usual cost, a charge back, or any other type of consideration provided by supply chain entities to a pharmacy that is not included on the invoice and may affect the price paid for a drug and may be based on the fulfillment of contractual terms such as prompt payment or volume purchased." The limitation in this definition to price concessions made "to a pharmacy" conflicts with how this term is used in the Draft Regulations, multiple sections of which reference "discounts" provided to payors. Assuming the Board intends this definition to include price concessions to payors, there is confusing overlap between this definition and the definition of "Rebates," discussed below.

- "**Drug specific patient access program**" is defined as "a program designed to provide a patient with assistance in obtaining a prescription drug or paying for a prescription drug, including but not limited to providing a drug to a patient, coupons provided by the manufacturer, donations to a non-profit or foundation associated with the manufacturer, and donations to independent nonprofit that are earmarked for the manufacturer's drugs." BIO has serious concerns regarding this definition. If the Board is referring to manufacturer patient assistance program then it should be limited to those programs specifically. Independent non-profit, charitable organizations are not "drug specific" and should not be treated as such. Furthermore, charitable donations to such organizations are not tied to coverage of a specific manufacturer's drug and they are simply meant to ensure those foundations are able to stay afloat and continue their charitable work of ensuring access and affordability for all eligible low-income or uninsured patients.

- "**Exclusivity**" is defined as "the period during which the manufacturer of an FDA-approved drug has exclusive marketing rights and no competing generic or biosimilar version so the product may be approved by the FDA." BIO is concerned that this may conflate different concepts and fails to capture important types of exclusivity, such as that granted under the Orphan Drug Act of 1983 or under section 505A of the of the Federal Food, Drug, and Cosmetic Act (i.e., pediatric exclusivity). For instance, market exclusivity may prevent a competitor from entering a specific market, while data exclusivity simply prevents the FDA from approving a competitor's product by relying on the innovator's data. Pediatric and orphan exclusivity, furthermore, may still allow for competitors to enter a market outside of those indications for which exclusivity was granted. The definition of "exclusivity" should be tailored to reflect the varying types of exclusivity. The broad regulatory exclusivity defined in the proposed regulations should be specified as such:

  - "***Regulatory exclusivity****" means a period defined by federal statute or regulations during which FDA may not approve a generic or biosimilar version of an FDA-approved drug or biologic, including but not limited to the following:*
    - "**180-day Exclusivity Period**": E*xclusivity provided for under 21 CFR 314.3.*

- "**Pediatric Exclusivity**": *Exclusivity provided for under Section 505A of the FDA Modernization Act.*
- "**New Drug Product Exclusivity**": *Exclusivity provided for under Sections 505(c)(3)(E)and 505 (j)(5)(F) of the Federal FDCA.*
- "**New Chemical Entity Exclusivity**": *Exclusivity provided for under 21 CFR 314.108.*
- "**Orphan Drug Exclusivity**": *Exclusivity provided for under* 21 CFR 316.108.

- "**Food and Drug Administration (FDA)**" is defined as the federal agency of the U.S. Department of Health and Human Services tasked with protecting and promoting public health through the control and supervision of food safety, tobacco products, dietary supplements, prescription and over-the-counter pharmaceutical drugs, vaccines, biopharmaceuticals, medical devices, and other consumer products. We believe this should be changed to ensure clarity and alignment with federal law to prevent any future conflict or confusion. We recommend the following definition:

  - *"**Food and Drug Administration (FDA)**" means the federal agency of the U.S. Department of Health and Human Services tasked with protecting and promoting public health through the control and supervision of food safety, tobacco products, dietary supplements, prescription and over-the-counter pharmaceutical drugs, vaccines, biopharmaceuticals, medical devices, and other consumer products.*

- "**Insurance benefit design**" is defined as "the rules that determine the services covered by the plan and any cost-sharing measures, such as deductibles, copays or coinsurance, and management tools such as formularies." We believe "benefit design" is separate from "coverage decisions". BIO has concerns that this definition includes rules that define cost sharing for covered services, as well as can also include in network vs out of network differentials. A "formulary" (for drugs) defines what is covered and how (e.g. utilization management) and we believe the term should be defined separately.

- "**Interchangeable biosimilar**" is defined as "a biological product deemed to be interchangeable by FDA if it produces the same result as a reference biologic in any given patient, and if there is no safety risk or diminished efficacy in switching." For reasons of clarity and consistency, as well as to avoid any conflict with federal law, we believe this should be consistent with federal statute. We believe this change will help to avoid any potential differences in interpretation and helps to preserve the integrity of interchangeable status for a biological product, for which the FDA has set a high bar. We recommend it be changed to:

  - *"**Interchangeable biosimilar**" means a biosimilar biological product, as defined in 42 USC 262(i)(3), that the FDA has found to meet the standard for interchangeability, as defined in 42 USC 262(k)(4).*

  "**Medicare**" is defined as "the public health program administered by the federal government for people over the age of 65 or with permanent disabilities." We believe this definition should cite federal statute rather than describe patient cohorts. Therefore, the definition should read, "Medicare means the public health program

administered by the federal government as authorized by Title XVIII of the federal Social Security Act."

- "**Net cost**" is defined as "the per-unit cost of a drug after accounting for rebates, discounts, and other price concessions negotiated between manufacturers and payors." This term presumably applies to the manufacturer's net cost (more commonly referred to as the manufacturer's "net price"), since the only use is in the Draft Regulations in Section .03.05 C(1)(a)(ii) regarding the information that the Board may estimate.

    - This definition, as drafted, may not encompass all the different types of discounts and fees that a manufacturer may be contractually required to provide to payors.
    - Information about a manufacturer's estimated or actual net price information is highly confidential and/or trade secret information. To the extent the Board is estimating a manufacturer's net price based – in part – on the data provided to the Board by the manufacturer, the Board should ensure it treats this information as confidential, proprietary, and trade secret.

- "**Payor**" is defined as "the entity other than the patient responsible for paying for health care costs including health insurance carriers, health plan sponsors, PBMs, Medicare, Medicaid, MCOs, and HMOs." We believe this definition should be amended to add "employers," who also act as payors in their own right. Further, it should be noted that this definition is defined broadly and encompasses many different categories of payors including PBMs, health plans, and government payors. These entities, particularly PBMs and health plans (whether they be commercial or government), can have competing interests and may pay for drugs in very different ways.

- "**Rebate**" is defined as "a partial refund by the manufacturer of the cost of goods or services but does not include purchase discounts based on invoiced purchase terms." However, BIO is concerned that the term "refund" denotes something very specific after the fact and is used in certain contexts.

    As discussed above, there is confusing overlap between the definition of "rebate" and the definition of "Discount."

    - Discounts and rebates are both types of price concessions offered by a manufacturer, directly or indirectly, to a payor or purchaser. Discounts and rebates are generally distinguished by when each is payable. A discount is a reduction in price payable at the time of purchase, and a rebate is a price concession payable sometime after the purchase. Since the Draft Regulations appear to use "price concession, discount, and rebate" collectively in every instance, the Board may consider a single definition that encompasses all three terms.
    - Further, it should be noted that the definitions of "Discount" and "Rebate" do not account for all monetary value exchanged in connection with a prescription drug in the supply chain. PBMs frequently solicit or demand additional amounts, such as administrative fees, data fees, portal fees, price protection, that may be calculated as a percentage of WAC and may or may

not be passed on to a health plan. Therefore, the Board will likely have incomplete visibility into the market dynamics that impact the supply chain.

- "**Therapeutic alternative**" is defined as a drug product that: (1) contains a different therapeutic agent than the subject drug, (2) is in the same or a different pharmacological or therapeutic class and (3) has similar therapeutic effects, safety profile, and expected outcomes when administered to patients in a therapeutically equivalent dose. We recommend the newly defined "active ingredient", as BIO suggests, be substituted for "therapeutic agent." However, BIO is also concerned about the inclusion of "a different pharmacological or therapeutic class" in the definition. If the Board intends to weigh the therapeutic options outside of the same therapeutic class as the reference drug, then it would be ignoring the intense innovation that may have gone into the drugs that resulted in the creation of a new therapeutic drug class or category. For instance, under this definition there could be similar therapeutic options that might be available in a different class, but the drug under review may be a first in class drug or biologic, likely with a completely new mechanism of action. Further, the inclusion of this language appears to suggest that the Board is justifying practices by the health plans and pharmaceutical benefit managers (PBMs), therapeutic interchange, that is prohibited in most states because of the inherent safety risks to patients because it allows substitution without the prior knowledge of the patient or prescriber. We object to the inclusion of this wording in the definition.

- "**Therapeutic Class**" is defined as "a group of active moieties (i.e., parts of molecules) that share scientifically documented properties and are defined on the basis of any combination of three attributes: mechanism of action, physiologic effect, and chemical structure." Because this term is not defined by the FDA, BIO recommends a more targeted, definition be considered.
    - The definition should be consistent with the classifications in that dataset, such as consistent with the United States Pharmacopeia Drug Classification (USP DC),[3] the American Hospital Formulary System (AHFS),[4]or other therapeutic classification systems allowed under the Medicare Part D program. Depending on the data source and its use, the category associated with a drug may also be important.

Cost Review Process (COMAR 14.03.01-.05)

Section.03.01, allows individuals to report a drug for consideration for a Cost Review. Individuals should not be permitted to report drugs in order for them to be considered for a Cost Review. This exceeds the statutory authority. It is also infeasible and could be overly burdensome for the Board.

The statute does not anticipate individuals being able to bring complaints to the Board and report drugs for a Cost Review. Individual or patient reports cannot be the basis for selecting or consideration of a drug for cost review, because the they do not fit any of the categories of information identified in 21-2C-08 (relevant to identifying drugs eligible for cost review) or 21-2C-09 (relevant to which drugs are selected for cost review).

[3] United States Pharmacopeia Drug Classification. https://www.usp.org/health-quality-safety/usp-drug-classification-system (Accessed: May 2, 2023)
[4] AHFS, American Society of Health-system Pharmacists. https://www.ashp.org/products-and-services/database-licensing-and-integration/ahfs-therapeutic-classification?loginreturnUrl=SSOCheckOnly (Accessed: May 2, 2023)

In addition, the regulations do not indicate how these reports of personal experience will be used in connection with the cost review. This could result in nothing more than the Board being provided disparate and unrelated anecdotes of unaffordable drugs, without the proper context. For example, there are key details that affect the affordability of a drug, such as whether the patient is uninsured or insured, what the patient's out-of-pocket costs are, and other key data. For much of this information the patient may be unaware of how it affects a drug's affordability, and this is often out of the manufacturer's control. Furthermore, affordability is highly subjective in nature. Two patients with the same exact insurance coverage, and copayment levels, may have very different experiences with affordability based upon salary or individual finances. Yet, there is no way of discerning these types of questions regarding an individual's affordability. In addition, there is nothing listed in the draft regulations that would demonstrate how the Board would validate any of the claims reported by an individual. We strongly urge the Board to remove this section. It is inconsistent with the statute to allow a single anecdote to warrant determination that a drug creates affordability challenges. It is more appropriate for individuals and patients to be given an opportunity to voice their concerns or share their affordability anecdotes during the meetings, where they can also answer questions as to their insurance status, etc.

Section .03.02. There are very broad interpretations of statute in additional metrics to determine drugs eligible for Cost Review and many metrics do not appear to correlate to affordability challenges.

BIO believes that many of the metrics identified in Section .03.02 do not correlate to affordability challenges. Further, information requests of spending and pricing data outside of the State of Maryland do not correspond with affordability challenges that might exist within the state. Information should be limited to spending within the State of Maryland only. We recommend that the draft regulations be narrowed to more closely align with the statute, and affordability and access challenges within the State of Maryland.

Section .03.02(D)(1)-(2) Some of the metrics/criteria lack sufficient detail or definitions to clearly understand the eligibility criteria and do not necessarily correlate to the cost or affordability of the drug. Also, in the case of patient out-of-pocket (OOP) costs, manufacturers do not control these costs.

In Section .03.02(D)(1), some criteria reference the wholesale acquisition cost (WAC) and others reference "price" without any definition of whether this a WAC or another price. This leaves the criteria open to a myriad of interpretation, such as gross price or net price. Several of the factors seem to be more a function of utilization (highest spend) or benefit design (highest spend per patient) and do not account for other variables necessary to assess affordability.

In Section .03.02(D)(2), there are several criteria linked to patient OOP costs and it is difficult to understand the utility of these measures, particularly (c) and (d), except to expand the number of drugs eligible for consideration without adding additional variables. Further, these OOP costs are not in the manufacturers control but are construct of benefit design and coverage. Therefore, we encourage the Board and the State of Maryland to consider additional levers available to reduce out of pocket costs for patients, such as controlling pharmacy benefit managers through banning of spread pricing and allowing patients to spread their OOP costs throughout the benefit year, which will now be allowed in Medicare under the *Inflation Reduction Act*. The cost of the drug is but one of many parts of

the overall healthcare costs for patients, and for the state, and thus, thinking beyond just the price of the drug is critical to helping achieve the goal of reduced OOP costs for patients.

The criteria in 03.02(D)(3)-(5), (E), and (F) do not clearly identify "Drugs That May Create Affordability Challenges"; these should be removed or narrowed.

In section .03.02(D) of the draft regulations, the Board lists five categories of metrics to be used to identify drugs eligible for a cost review. However, several of these categories do not relate to drugs "that may create affordability challenges" and provide broad leeway for the Board to identify drugs as being eligible for a cost review.

The draft regulation propose including "all insulins marketed in the State" as being eligible for a cost review. Considering an entire class of drugs as a "metric" seems inappropriate, because it assumes that the entire class could create "affordability challenges" which is inconsistent with the current statute. Specific to insulin, all three major insulin manufacturers that control approximately 90% of the U.S insulin market recently announced significant decreases to the list price of their insulins effective at the beginning of 2024, meaning that many insulins are currently - or will soon be available - for $35, the same level as in Medicare. By including insulin as a metric, the Board seems to assume that $35 will "create affordability challenges, which is inconsistent with the statute. We recommend the Board remove this metric.

Language in this section also provides broad leeway for drugs that may be considered to create an affordability challenge. In Section .03.02(D)(3), the language appears to propose considering any drug for which just a single individual in the state submits a report (as provided for in Section .03.01; see comments on page 8). BIO recommends this provision be removed.

Section .03.02(E) allows a Board member to propose one or more additional drugs for inclusion in the list of drugs eligible for a cost review at "an open meeting." Although this provision requires the Board member to "identify[] the reasons" why the drug should be included as eligible for a cost review, the provision does not require the Board member to "identify[] the reasons" why the drug creates or could create "affordability challenges." We recommend this provision be removed or more specifically tied back to the statutory requirement, such that Section .03.02(E)(2) reads, "Identifying the reasons why the prescription drug may create affordability challenges for the State Health Care system and patients."

Section .03.02 (F) allows the Board to vote to add drugs to the list, but this provision does not require that the Board discuss and/or identify why the drugs could create affordability challenges or what criteria would be used to determine a drug or biologic should be added. BIO recommends the Board clearly tie this provision back to the statutory requirement.

The proposed process to select drugs for a cost review in Section .03.03 is not clearly tied to the thresholds in statute or to drugs that could create affordability challenges.

As noted in comments above, given the broad identification criteria in Section .03.02 and the general selection criteria listed in Section .03.03, this subjective process could result in basically any drug being selected for a cost review. We recommend that the Board update

the draft regulations to clearly base the selection of drugs for a cost review on objective criteria that demonstrate affordability challenges.

Terms/factors the Board will review in Section .03.03 are not well defined or do not have anything to do with affordability.

The term "spending" is not defined at all and it is unclear whether this would be gross or net spending. This should also be clarified to reflect that it would take into consideration rebates a plan is receiving.

"Direct-to-Consumer Spending" has no bearing on affordability and should not be included in this process. It leads to misperceptions that the two are interrelated. We strongly oppose inclusion in this process.

In Section .03.03, the draft regulations continue to suggest the Board will consider spending beyond the State of Maryland. We believe this is not consistent with statute. It is unclear where the board will get some of the data it will consider and/or how it will be verified.

Collecting data and comparing spending in other states or markets, including internationally, as a basis for decisions on a cost review, will not accurately inform the Board about affordability and access in Maryland, as states and countries have different markets. Section .03.03 describes the data that the Board will review that may impact its selection of drugs for a cost review. However, the draft regulations do not specify the source of such data and whether or how the data will be verified. The Board will also consider, spending, price data, and patient out of pocket expenses. While we presume some of this information is from claims data in the Maryland Claims Data Base, not all information is available in this source. In addition, some commercial databases may have conflicting data for certain categories. We recommend that the Board update the draft regulations to specify the sources for the particular data and seek comments on such sources and/or methods of validation.

We also recommend that the Board provide a clear notice and comment period of at least 60 days between the identification of eligible drugs and the selection of drugs for the public comment.

Section .03.03(B)(1) requests information regarding whether the drug was approved through the FDA's accelerated approval pathway. Drugs approved through accelerated approval should be exempt from review given that they treat a high unmet need and have few or no treatment alternatives. This provision should be removed from the draft regulations.

In Section .03.03(B)(1), the Board requests information on whether the drug has been approved through accelerated approval, but there is no additional information as to how that information would inform the Board regarding affordability or access. Accelerated Approval drugs address those with a high unmet need and patients have few or no treatment options. This draft regulation and potential Board policy appear to raise the risk that use of these pathways which are typically geared towards providing access when there is high unmet need and no other therapeutic alternatives will be disincentivized. Unless this information is specifically meant to inform the Board regarding high unmet need, we strongly believe that drugs approved through accelerated approval should be omitted from the process.

For example, developing drugs for rare diseases is an exceedingly challenging proposition, and many rare diseases still lack an approved therapy. It is therefore essential that the State of Maryland exclude drugs approved through the accelerated approval pathway to encourage the continued development of rare disease drugs, consistent with the intent of the Orphan Drug Act (ODA). Although there has been a significant increase in the number of drugs approved to treat rare diseases since the ODA was enacted 40 years ago, between 93 and 95 percent of known rare diseases still do not have a treatment.[5] This is due, in part, to circumstances unique to rare diseases that further complicate the extremely costly[6] and high-risk[7] drug-development process. For example, it can be challenging to enroll a sufficient number of patients in clinical trials for rare diseases given small patient numbers, uneven distribution of disease across populations, and heterogeneity of diseases. It is similarly challenging to design clinical trials for rare disease populations given difficulties designating an appropriate comparator, validating novel endpoints, and obtaining sufficient data from small patient populations. Therefore, it is critically important to continue supporting patient needs, and scientific pathways available to meet those needs.

Section .03.03(B)(3)(b) requires consideration of the overall spending per patient but misses key data regarding affordability.

The information required by this provision will be considered without any mention of formulary and benefit design issues that could be a contributing factor. BIO believes the Board will be missing information on a key contributing factor to affordability issues for patients as they make decisions on which drugs to select for a cost review. In most cases, this is a much larger contributing factor than the list price of a drug which does not take into account overall discounts and rebates provided to the insurer.

Section .03.03(C) and (G)(6) is unclear regarding which drugs would be selected for the list of 25. The draft regulations need to be clarified.

The Board's proposed process to conduct a cost review is overly broad with regard to the selection of NDCs.

Section .03.03 (G)(6) of the draft regulations states that the Board "will identify and approve all NDCs with the same moiety or active ingredient to be included in the cost review." This is overly broad, as some drugs with the same moiety or active ingredient are approved by the FDA for different indications, under different brand names, pursuant to different NDAs or BLAs, and/or as combination products with other drugs. We recommend the Board remove this requirement as the results of the Board's analysis may be misleading.

[5] https://everylifefoundation.org/accelerated-approval/ (Accessed: May 2, 2023)

[6] The cost of the drug development process has been estimated to take 10 to 15 years and $1-2 billion. I.V. Hinkson, B. Madej, E.A. Stahlberg. Accelerating therapeutics for opportunities in medicine: a paradigm shift in drug discovery Front Pharmacol, 11 (2020), p. 770. (defining the cost of the drug development process to include all costs borne by a manufacturer leading up to FDA-approval or a particular drug).

[7] Ninety percent of clinical trials for candidate drugs ultimately prove unfeasible. H. Dowden, J. Munro. Trends in clinical success rates and therapeutic focus Nat Rev Drug Discov, 18 (2019), pp. 495-496.

Section .03.03(D)(2) discusses patient OOP costs. However, there is no mention of how the Board will collect this data. This needs to be clarified.

In section .03.03(D)(2) and in various sections of the draft regulations, the Board discusses it will consider patient OOP costs. However, the rule is deficient in discussing how the Board will gather any of this information, what sources of data will be reviewed, and how will it be used. Without this information it is impossible for stakeholders and members of the public to comment on the reliability of these sources and the appropriateness of their use.

In Section .03.03(D)(3) it is unclear why these data are listed separately from that of the criteria listed in Section .03.03(B) and how much one will be weighted over the other.

It is unclear which of these criteria, those established under Section.03.03(D)(3), and the criteria established under Section .03.03(B), would weight more heavily, the patient's cost-sharing or the overall other data factors.

In Section .03.04(A)(3), addresses when official information is requested by the Board from certain entities. The Board should be required to send official correspondence.

This section states the Board may request official information from corporate entities by either: posting notice of the request on its website; sending email or postal mail; or any combination of these. This is not the standard for an official request for information from the government to a corporation. Further, posting a notice of request for information on a public website is both inefficient and likely to risk public confusion, since the public will not have the opportunity to see the full response. Further, because many of the categories of information they intend to request involve confidential or trade secret information, official correspondence should be required. BIO believes strongly that Section .03.04(A)(3)(a) should be removed from the draft regulation.

In Section .03.04, there are multiple references to the Board considering the "therapeutic alternatives." This should be removed.

As a general matter, as we noted in earlier, regarding the proposed definition of "therapeutic alternative," if the Board intends to weigh the therapeutic options outside of the same therapeutic class as the reference drug, then it would be ignoring the intense innovation that may have gone in to the drugs that resulted in the creation of a new therapeutic drug class or category. For instance, under this definition there could be similar therapeutic options that might be available in a different class, but the drug under review may be a first in class drug or biologic, likely with a completely new mechanism of action. This would have required a great deal of innovation that justified the creation of a different class. Further, the inclusion of this language suggests that the Board is justifying practices by the health plans, therapeutic interchange, that is prohibited in the vast majority of states because of the inherent safety risks to patients because it allows substitution without the prescriber's knowledge. In addition, the Board does not appear to acknowledge in the draft that there are many conditions for which there is only one viable treatment. In these cases, there would be no therapeutic alternatives. The question regarding how the Board would treat these cases, is still outstanding.

Many of the elements listed in Section .03.04(B)(1) go far beyond the statute and should be removed from consideration, especially the referencing of international drug prices.

Many of the data elements listed in Section .03.04(B)(1) appear to go beyond what is in statute and should be removed. These subsections are:

- (b) and (c) Total amount of price concessions, discounts and rebates by payor type.
- (e) The units of the prescription drug product sold in the State;
- (f) The units of the prescription drug product sold nationally;
- (g) The total dollar amount of sales of the subject prescription drug product into the State;
- (i) Prices for the prescription drug product that are charged to purchasers outside the United States reported in U.S. dollars;
- (j) Prices charged to typical purchasers in the State, including but not limited to pharmacies, pharmacy chains, pharmacy wholesalers, or other direct purchasers;
- (k) The average profit margin of the prescription drug product over the prior five-year period and the projected profit margin anticipated for the prescription drug product;

While Subsection (l) is listed in statute listed in statute, it is only to the extent that the Board is unable to assess affordability with all of the other data outlined. This should be moved to Cost Review Section E.

To the extent that these criteria are not removed from the draft regulations, BIO is strongly opposed to the use of international drug prices as a consideration under the cost review. There is no indication as to what source it would use and international drug markets are extremely different than the United States, including the existence of widespread price controls in all other markets. In consideration over drug pricing differences between the U.S. and other countries, there is the oft-ignored and stark reality that the absence of price controls in the U.S. leads to more and newer medicines made available sooner to Americans, with better health outcomes for those with serious diseases. The differences in access are significant and offer a clear warning to those who want to import such systems into the U.S.[8]

- Of the 74 cancer drugs launched between 2011 and 2018, 95% are available in the United States. Compare this with 74% in the United Kingdom, 49% in Japan, and 8% in Greece.[9]
- Nearly 90% of all new medicines launched since 2011 are available in the U.S., compared to just 50% in France, 48% in Switzerland, and 46% in Canada.[10]

The draft regulations give no indication as to how the nuances of international pricing information would factor into decisions.

[8] Haninger, Kevin, "New Analysis Shows that More Medicines Worldwide are Available to U.S. Patients," Catalyst PhRMA, June 5, 2018. https://catalyst.phrma.org/new-analysis-shows-that-more-medicines-worldwide-are-available-to-u.s.-patients (Accessed: May 2, 2023)
[9] Ibid.
[10] Catalyst, PhRMA, June 5, 2018.

Under Section .03.04(D), the Cost Review Process should consider more appropriate factors.

Under Section (D) of the Cost Review Process, the Board should consider: (1) how long ago the drug was approved by the FDA, and (2) whether there is unmet need in the therapeutic area. It is unclear from the proposed regulation how FDA approval criteria, that is use of an expedited pathway such as accelerated approval, will inform drug selection. In Section .03.03(B)(1), the Board requests information on whether the drug has been approved through accelerated approval, but there is no additional information as to how that information would inform the Board regarding affordability. As noted earlier, this appears to raise risk that Board policy will disincentivize use of these pathways which are typically geared towards providing access when there is high unmet need and none or few other therapeutic alternatives.

For drugs selected for a cost review, the draft regulations would allow the Board to request broad disclosures from manufacturers and other stakeholders, much of which is proprietary and confidential trade secret information.

Much of the information listed in Section .03.04 (B)(1) is amongst a manufacturer's most sensitive proprietary and confidential trade secret information. Additionally, some of this information may not even be recorded by a manufacturer at the product-level. We strongly urge the Board to adopt more robust confidentiality protections for this data and request that the Board more clearly define why they need this information, how they will use it, and how it will impact their analysis.

Further, in Section .03.04(C)(5) it states, "[t]he Board may consider confidential, trade-secret and proprietary information in a closed session." If manufacturers are ultimately required to report this information, BIO strongly recommends "may" be changed to "shall". No confidential trade secret information should ever be discussed in an open session.

It is unclear how certain factors in Section .03.05 are not relevant and are unclear.

Additional factors considered in a Cost Review include impact on patient access, as in Section .03.05 (C)(1)(d)(i) and (iii). The cost to health plans is not a valid patient access measure. Further, if the patient access program utilization is considered as a metric, it should be related to the number of patients receiving benefits rather than how much money was spent.

In Section .03.05 (C)(1)(g) & (v) It is unclear what "representative" means in the context of this metric.

The draft regulations would allow the Board to consider unvalidated data "Derived from External Analyses and Modeling Studies" to determine whether a drug creates affordability challenges. This subjective and unvalidated process could be misleading.

Section .03.05 of the draft regulations allows the Board to broadly consider data and analyses some of which may be produced or derived by the Board or by external analyses or studies. Without input from knowledgeable stakeholders, this data or analyses may be misleading or incomplete. We recommend the Board collect stakeholder input before relying

on internal or third-party analysis. We also recommend that the Board specify how the information it analyzes impacts or could impact drug affordability.

Lastly, the report referenced in Section .03.05(F) should never disclose any confidential, proprietary and trade secret information. The Board should have a means to ensure that this confidential information is free from disclosure.

The statute indicates the protection of confidential, proprietary information is of the utmost importance. The possibility that this information could be shared in an open meeting is alarming. The protection of this information guarantees the innovative, healthcare ecosystem can thrive. We also urge the Board to include confidentiality procedures for third-party organizations it might contract with to carry out any functions.

Public Information Act (COMAR 14.01.04.01)

While BIO believes that disclosure of public information is an important aspect of transparency, never should the government disclose confidential, proprietary and trade secret information that it collects as part of its statutory responsibilities. In Section 14.01.11(C)(2), the draft regulation states that the "custodian is not required to . . . (2) Release an electronic record in a format that would jeopardize or compromise the security or integrity of the original record or of any proprietary software in which the record is maintained." This wording in this provision appears to give the custodian an "either/or" proposition. As a matter of legal principle, the custodian should be prohibited from disclosing any confidential, proprietary and trade secret information to the public in accordance with the statute. Section 21-2C-10(A)(2) of the statute states that trade secret, confidential, and proprietary information "is not subject to disclosure under the Public Information Act." The statute also states that the provisions of the Maryland Uniform Trade Secrets Act[11] apply to information deemed confidential, proprietary and trade secrets, also consistent with the federal Defend Trade Secrets Act.[12]

Disturbingly, this is the only reference to disclosure of proprietary information in this draft regulation. BIO requests an addition to this draft regulation that states that any confidential, proprietary and trade secret information submitted to the Board is not a public record under the Public Information Act and prohibits the custodian from disclosing this information as such.

Confidential, Trade-Secret and Proprietary Information (COMAR 14.01.01.04)

According to the statute, 21-2C-10, "all information and data obtained by the Board under the subtitle, that is not otherwise publicly available: (1) is considered to be a trade secret and confidential and proprietary information; and (2) Is not subject to disclosure under the Public Information Act."

BIO is deeply concerned that the Board's draft regulations, state that the "Board may also determine that information it has received is confidential, trade secret, or proprietary." The statute does not grant that authority to the Board to determine whether information is protected. That authority rests with those submitting data to the Board and the person certifying that information is designated as protected information. If data is not otherwise

[11] Maryland Code, Commercial Law § 11-1201 -1208 – last updated December 31, 2021.
[12] Federal Defend Trade Secrets Act, 18 USC § 1836.

publicly available, then its status under the statute is unambiguously protected information and the Board should recognize it as so.

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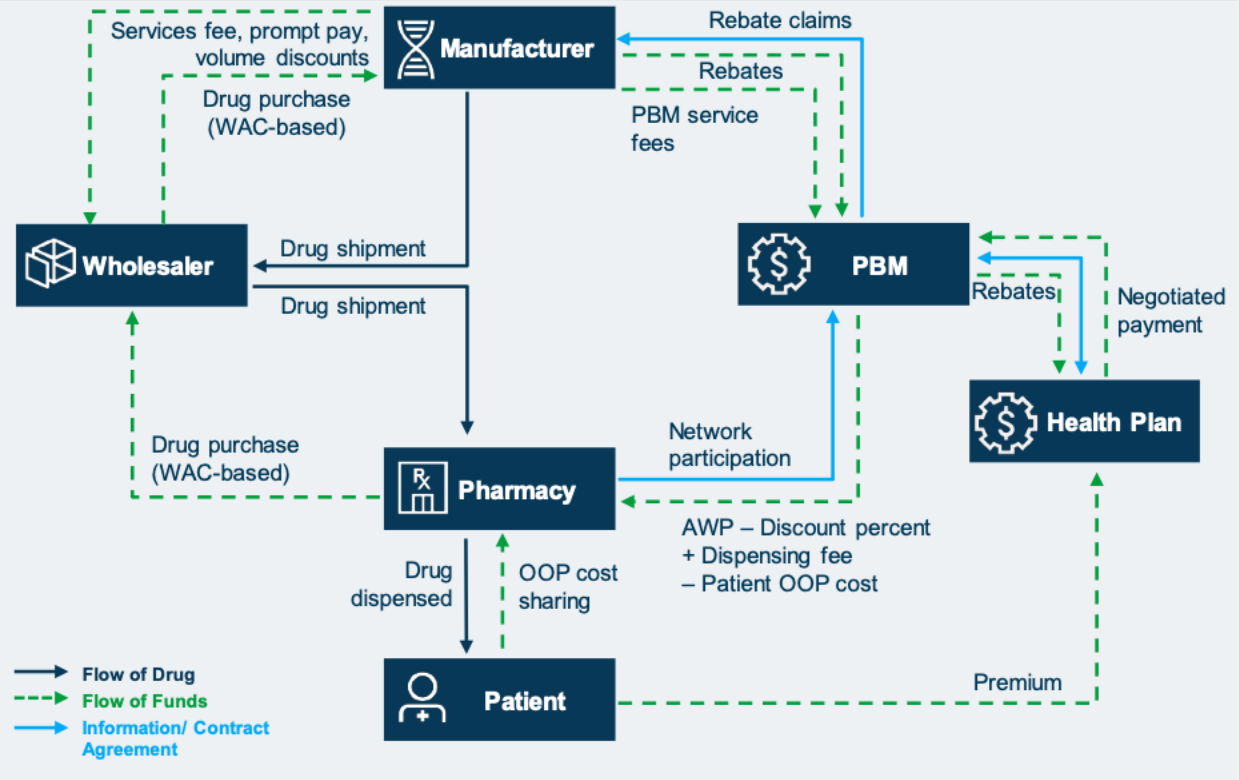
BIO appreciates the opportunity to provide feedback to the Maryland PDAB through these proposed rules for comment. We look forward to continuing to work with the Board to ensure Marylanders can access medicines in an efficient, affordable, and timely manner. Should you have any questions, please do not hesitate to contact me at 202-962-9200 or at jgeisser@bio.org.

Sincerely,

/s/

Jack Geisser
Senior Director, Healthcare Policy, Medicaid, and State Initiatives

Appendix:
Understanding the Prescription Drug Supply Chain: Note that manufacturers rarely, if ever, sell prescription drugs directly to consumers. Rather, manufacturers work with an array of wholesalers, pharmacies, and pharmacy benefit managers to distribute drugs.



Source: Avalere: Follow the Pill: Understanding the Prescription Drug Supply Chain – May 20,2020