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VIA Electronic Delivery

June 30, 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 Study Process (COMAR 14.03.01-.05); 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. 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. There are more than 7,000 known rare diseases and approximately 1 in 10 Maryland residents may have one. Approximately, 95% of all rare diseases have no approved treatments.[1] 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 a disproportionate effect on patients with rare diseases not only in Maryland but in other states as well, many of whom spend an average of 4.8 years and more than 7 specialist visits to receive an accurate diagnosis,[2] 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

[1] Kaufman, Petra, et al., "From Scientific Discovery to Treatments for Rare Diseases—A View from the National Center for Advancing Translational Sciences—Office of Rare Diseases Research," Orphanet Journal of Rare Diseases, November 6, 2018. Accessed: June 30, 2023. https://ojrd.biomedcentral.com/articles/10.1186/s13023-018-0936-x

[2] "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)

alternatives should be exempt from review, along with all drugs and biologics approved through the accelerated approval pathway.

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 offset 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."[3]

A patient copay for a cell or 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 must 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. While we are encouraged that "disease burden" has been added to the definitions and as a criterion in the Cost Review Study Process, it is still unclear how the Board would measure this in its evaluation. 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.

[3] "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)

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 process, leaving that up to the Board. Unfortunately, we are concerned that there remains 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.

More Specification is Needed on the Board's Safeguards for Confidential and Sensitive Information

BIO wants a commitment to confidentiality and appropriate safeguards for confidential and sensitive information from the Board to ensure that the Board is adequately protecting the confidentiality of all proprietary information.

For instance, BIO is concerned about the definition of "net price" listed in (COMAR 14.01.01.01). "Net price" is defined as "the per-unit cost received by manufacturers of a drug after accounting for price concessions, discounts, and rebates." 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.

BIO recommends the following minimum controls and safeguards for *all* confidential and sensitive information the Board receives:

First, the Board should ensure protections comparable to, not only those under the Maryland Public Information Act (PIA), but also those under the Maryland Uniform Trade Secrets Act[4] and the federal Defend Trade Secrets Act. [5]

Second, the Board should implement robust storage and access controls and safeguards to protect the confidentiality of sensitive information. Confidentiality requirements are only as meaningful as the data privacy and security protections that are implemented to safeguard sensitive information against inadvertent or malicious improper disclosure. Accordingly, the Board should implement robust systems and protocols, including by ensuring that all proprietary information stored on servers and in electronic communications with the Board is secure and accessible only to PDAB staff and only where there is a legitimate programmatic need for access to such information.

The Board should also specify how it will maintain the confidentiality of the subset of information that is required to be submitted via e-mail or in third party applications. With respect to e-mail, the Board should explain, among other things, how it will enforce access security controls. With regard to potential usage of third-party commercial platforms, BIO asks the Board to specify how submitted information will be kept confidential, including against misuse by third-party personnel.

[4] Md. Code Ann., Com. Law §§ 11-1201
[5] 18 U.S. Code § 1836

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 " a component of a drug that is intended to provide pharmacological activity or other direct effect in the diagnosis, cure, mitigation, treatment, or prevention of disease, or to affect the structure or any function of the body, 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*.

- "**Copayment**" is defined as "the set 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 "copayment" definition should be changed to say, "'Copay' means the set dollar amount that a patient pays for prescriptions or services covered by the patient's health insurance, after the deductible is satisfied."

      Without mention of this being post-deductible in the definition, there is the possibility for confusion or unintended consequences. Language should be added to specify that this is an amount paid after the deductible is met; otherwise, the Board could erroneously reflect deductible payments as a copayment and inflate copay amounts. 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.

- "**Drug specific patient access program**" is defined as "a program designed to provide a patient with assistance in affording a prescription drug or paying for a prescription drug, including but not limited to the provision of a drug to a patient, coupons supplied by the manufacturer, donations to a non-profit or foundation associated with the manufacturer, and donations to independent nonprofit that are earmarked expressly for the manufacturer's drugs." BIO has serious concerns regarding this definition, and the changes made do not adequately resolve our concerns regarding the Board's representation of independent patient assistance programs. 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.

- "**Insurance benefit design**" is defined as "the rules that determine the services covered by the plan and any other cost-sharing measures." We believe "benefit design" is separate from "coverage decisions." BIO continues to have 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.

- "**Medicare**" is defined as "the health insurance program administered by the federal government for people over the age of 65 or with certain 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."

- **"Other cost-sharing"** is defined as a "program, benefit design, or other mechanism that determines a patient's responsibility for a prescription drug product, such as a copayment, coinsurance, deductible, formulary, or other management tool. We believe that this definition is unclear, and it is uncertain what the Board is trying to capture here. Moreover, we are concerned that this language may validate Accumulator Adjustment Programs (and other similar programs) as programs that can be utilized by insurers to determine cost sharing responsibility. These programs impede the goals of increasing patient affordability and access, and any language which may—inadvertently or otherwise—allow their usage should be omitted.

- **"Out-of-pocket costs"** is defined as being the "expenses for medical care, including prescription drug therapy, that are not reimbursed by insurance and are paid by a patient, including copayments, coinsurance, and deductibles for covered services, and the costs for all non-covered services." The current proposed definition allows non-covered services to count towards out-of-pocket costs, as opposed to being represented distinctly as non-covered charges. This definition is unclear and leaves open the possibility that patient out-of-pocket costs for a given drug will be conflated with other costs, to the detriment of patients. It is imperative that costs borne by the patient as a result of their plan not covering it are separately accounted; such an accounting will better allow the Board to investigate potential sources of affordability issues.

- "**Payor**" is defined as "the entity other than the patient that is 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.

- "**Therapeutic alternative**" is defined as a drug product that has the same or similar indications for use as a particular drug but is not a therapeutic equivalent to that drug. BIO is concerned with the broad definition of "therapeutic alternative" here and in the Cost Review Study Process rule. The definition gives the board broad authority to "…determine the therapeutic alternatives for each prescription drug product selected for a cost study review." This could be easily construed as a "therapeutic alternative" means any drug with the same indication. The provisions should be narrowed to include guidelines that a therapeutic alternative would also look at methodology such as the drug being recommended for similar populations in clinical guidelines, have similar efficacy, contraindications, side-effects, and be similar when considering sub-populations. 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 such practices by the health plans and pharmaceutical benefit managers (PBMs) as 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. "Therapeutic Alternative" should be defined *to mean "a drug product that contains a different therapeutic agent than the drug in question, but is **FDA-approved for the same indication with** the same pharmacological or therapeutic class and has been shown through peer-reviewed studies to have similar therapeutic effects, safety profile, and expected outcome when administered to patients in a therapeutically equivalent dose or has been recommended as consistent with standard medical practice by medical professional association guidelines."*

- "**Therapeutic Class**" is defined as "a group of drugs containing 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),[6] the American Hospital Formulary System (AHFS),[7]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.

[6] United States Pharmacopeia Drug Classification. https://www.usp.org/health-quality-safety/usp-drug-classification-system (Accessed: May 2, 2023)
[7] 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)

Cost Review Study Process (COMAR 14.04.01-.05)

We remain concerned that many of the broad issues we raised in our first letter on the first draft regulations were not addressed. While some technical issues were addressed (such as clarification that some of the references of "price" were in reference to the WAC), there are larger, fundamental issues that remain unresolved.

Section.04.01, 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 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).

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 .04.02. 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 .04.02 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.

The PDAB should be limited to the drugs that have met the initial threshold, per the statute. While 04.02(D) references the statute, it also expands the statute's purview to include other drugs. The Board should be limited to the drugs that meet the initial threshold established in the statue, before considering others:

(1) Brand name drugs or biologics that, as adjusted annually for inflation in accordance with the Consumer Price Index, have:

(i) A launch wholesale acquisition cost of $30,000 or more per year or course of treatment; or

(ii) A wholesale acquisition cost increase of $3,000 or more in any 12–month period, or course of treatment if less than 12 months.

Section .04.02(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 .04.02(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 .04.02(D)(1), the Board makes the first of numerous references to requesting information on *gross* spending. The Board should reconsider their approach, and ask for *net* spending information. The *gross* spending metric gives an incomplete picture of the cost of the product.

Furthermore, in Section .04.02(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 manufacturer's control, but are a construct of benefit design and coverage which is why we are recommending that you look at OOP costs along with the formulary coverage and benefit design information to understand dynamics impacting OOP costs. 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 04.02(D)(3)-(5), (E), and (F) do not clearly identify "Drugs That May Create Affordability Challenges"; these should be removed or narrowed.

In section .04.02(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.

Language in this section also provides broad leeway for drugs that may be considered to create an affordability challenge. In Section .04.02(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 .04.02(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 reason(s)" 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 .04.02(E)(2) reads, "Identifying the reasons why the prescription drug may create affordability challenges for the State Health Care system and patients."

Section .04.02 (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.

Section 04.02(D) should be relocated to be included in existing Section E and existing Section E should be amended to allow the Board the opportunity to include or exclude prescription drug products from the eligible list.

We believe that Section D can be included in the existing Section E with the two sections merged. After this, the preexisting section E would become the new Section D. We suggest the below language be amended to be the new Section D (currently Section E):

> *D. At an opening meeting, a Board member may propose one or more additional prescription drug products for inclusion on or exclusion from the list of drugs eligible for cost review by:*
>
> - *(1) Moving that the prescription drug product(s) be added to or removed from the eligible list; and*
> - *(2) identifying the reason(s) why the prescription drug product(s) should be added, or*
> - *(3) Moving that the prescription drug product(s) be removed from the eligible list when it meets one of the following criteria:*
>   - *Designated by the Secretary of the United States Food and Drug Administration, under 21 U.S.C. 360bb, as a drug for a rare disease or condition; or*
>   - *Addresses an unmet medical need of an underserved population; or*
>   - *Has a unique mechanism of action or clinical data to suggest broad efficacy across multiple therapeutic classes.*

The proposed process to select drugs for a cost review in Section .04.03 is not clearly tied to the thresholds in statute or to drugs that could create affordability challenges.

As noted above, given the broad identification criteria in Section .04.02 and the general selection criteria listed in Section .04.03, 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.

Whenever possible, the Board should work to allow the public opportunity to engage and comment on its dashboard, and for manufacturers to respond. Additionally, the nature of the dashboard should be clarified.

In Section .04.03(A), the Board refers to a dashboard of prescription drug products identified under the statutory metrics and regulatory criteria. This would be a key opportunity for public engagement and feedback. Upon the public announcement of the dashboard, the public should be provided with a 60-day comment period to provide oral or written comments.

Additionally, manufacturers should have the ability to review the data input into the dashboard to ensure that the information is accurate and correct any inaccuracies. With such a process, manufacturers would be able to provide valuable feedback that would ensure the accuracy of the initial list of drugs.

We also request clarification on the nature of the dashboard. In Section .04.03(B), there is also a dashboard referenced, but it is unclear if this dashboard is also the initial list of drugs that meet the statutory threshold.

In Section .04.03, 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 .04.03 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.

For example, in Section .04.03(B)(1), the Board says that Board staff will look at certain pieces of information pertaining to FDA approval, such as "if applicable, the date the last patent expired or will expire[.]" It is unlikely for Maryland or any other state to have the

most up-to-date information on this topic; this example is illustrative of how such proposed information collection will harm the process and give a distorted picture of reality.

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 .04.03(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 .04.03(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.[8] This is due, in part, to circumstances unique to rare diseases that further complicate the extremely costly[9] and high-risk[10] 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.

[8] https://everylifefoundation.org/accelerated-approval/ (Accessed: May 2, 2023)
[9] 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).
[10] 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 .04.03(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 .04.03(B) should be amended to better capture certain information regarding prescription drug products.

There are opportunities to better incorporate datapoints about prescription drug products that are not currently incorporated into the draft regulations. Moreover, the Board has an opportunity to provide itself with a fuller breadth of data than the current guidelines outline. Our recommendations are below.

A new subparagraph should be added to Section .04.03(B)(1) to better help the Board in its consideration, looking at whether a drug treats a rare disease or condition. Our suggested addition is below:

> *(d) Whether the prescription drug product is designated by the Secretary of the United States Food and Drug Administration, under 21 U.S.C. 360bb, as a drug for a rare disease or condition.*

Additionally, another opportunity to construct a fuller picture of a given product is in adding new criteria in consideration of a treatment's impact. Our recommended text would be inserted in Section .04.03(B) as a new paragraph:

> *(7) Whether the prescription drug product meets one of the following criteria:*
> - *Utilization of the prescription drug product considered is less than 2% of the state population, for prescription drug products with multiple indications the utilization should be calculated for each approved indication, and*
> - *Prescription drug products that have fewer than 3 approved drugs on the market for a specific indication.*

In addition to the above text, we are supportive of assessing the burden of disease for treatments that may be included in the cost review process. However, we suggest having the statement of disease burden be added as an additional criterion for selection in addition to being considered again when conducting the cost study. Our recommended addition would also go in Section .04.03(B):

> *(8) The disease burden of the disease or condition that is treated by the prescription drug product*

Section .04.03(C) lacks key details and important public considerations, such as comment opportunity. The section should also be amended to give further transparency and allow for drugs to be removed from consideration for referral to the Stakeholder Council based on certain criterions.

In Section .04.03(C), the Stakeholder Council is outlined in some detail. However, there are some key details missing. For example, the process for referring drugs to the Stakeholder Council does not mention how far in advance the agenda (with names of products that are being considered) will be posted to allow those interested in providing public comment opportunity to prepare. In addition, members of the Board can recommend additional drugs not on the agenda and this could limit public comment opportunity as impacted patients and other stakeholders may not be at the meeting or have had time to prepare in advance of the meeting.

Additionally, Section .04.03(C)(2) should be amended to both ensure a transparent process as well as allowing the Board more latitude in removing drugs from consideration for the Stakeholder Council. Our proposed changes to Section .04.03(C)(2) are as follows:

> *(2) Prior to a Board meeting, a Board member may request that a prescription drug product or products be:*
> - *(a) placed on the Board's meeting agenda for consideration for referral to the Stakeholder Council by submitting the proprietary drug name or nonproprietary name, as applicable, and NDC to the Board Chair in writing, or*
> - *(b) removed from consideration for referral to the Stakeholder Council by submitting the proprietary drug name or nonproprietary name, as applicable, and NDC to the Board Chair in writing*

Section .04.03(D)(3) discusses patient OOP costs. However, there is no mention of how the Board will collect this data. This needs to be clarified.

In section .04.03(D)(3) 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 it will 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 .04.03(D)(3) it is unclear why these data are listed separately from that of the criteria listed in Section .04.03(B) and how much one will be weighted over the other.

It is unclear which of these criteria, those established under Section.04.03(D)(3), and the criteria established under Section .04.03(B), would weight more heavily, the patient's cost-sharing or the overall other data factors.

Section .04.03(G) gives too much flexibility to the Board. Additionally, it should be amended to limit selection of alternatives for drugs for rare diseases and to provide more opportunity for public comment.

Earlier, we highlighted our concerns with the definition of "therapeutic alternatives," saying that "the definition gives the board broad authority to '…determine the therapeutic

alternatives for each prescription drug product selected for a cost study review.' This could be easily construed as a 'therapeutic alternative' means any drug with the same indication." Given these issues with the definition, this section is even more concerning as it gives Board staff wide flexibility to determine the therapeutic alternatives of a product being considered for a cost review. This could have significant implications on the decision-making process, so it is alarming that the Board staff will have this vast amount of discretion in determining the therapeutic alternatives that might be available and used in cost comparisons.

Currently, there is no opportunity for public comment on the list of therapeutic alternatives. The Board may not have all of the information they need to gain a full picture, and manufacturers and the public should be able to provide accurate information. Moreover, the Board may harm patients without proper limits on the selection of products that treat rare diseases or conditions. Given these concerns, BIO recommends this section be removed.

Section .04.03(H) asks for direct-to-consumer advertising spending, which is extremely concerning.

Direct-to-consumer advertising spending costs have been newly added as a consideration in selecting a drug for an affordability review. This is another example of the Board looking to pull in factors they believe are impacting the cost of prescription drugs, as opposed to looking at factors that could help determine whether there is a potential affordability issue. It is also extremely concerning that this is being given the same consideration as a selection factor as something like patient out-of-pocket costs.

In Section .04.04(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 .04.04(A)(3)(a) should be removed from the draft regulation.

In Section .04.04, 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 health plans and PBMs, such as 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 .04.04(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 .04.04(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 prescription drug product into the State;
- (i) Invoice per unit for the prescription drug product that are charged to purchasers in the United Kingdom, Germany, France, and Canada reported in U.S. dollars;
- (j) Prices charged to purchasers in the State, including but not limited to pharmacies, pharmacy chains, pharmacy wholesalers, and 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;

Subsection (I) in particular does not have any state statute supporting the Board's supposed authority to request international prices. Also, the Board is selecting certain countries without giving any rationale for their selection and why they believe prices for these markets is relevant to the US market.

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.[11]

- 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.[12]
- 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.[13]

[11] 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)
[12] Ibid.
[13] Catalyst, PhRMA, June 5, 2018.

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

Additionally, this section contains several instances of the Board seeking to collect information from manufacturers—such as net price information in the US—that is confidential.

Section .04.05(C)(d) requires further definitional clarity on "standard medical practice."

This section would allow the PDAB to consider costs to health plans based on access consistent with FDA labeled indications OR standard medical practice. However, there is no definition of standard medical practice, so this would be another area where the Board would have broad authority on how to define this factor. We request that the Board provides a clear definition to reduce stakeholder confusion.

The Additional Board Factors under Section .04.05(C)(g) allows the board to consider certain datapoints that will not account for net cost to payor. In addition, there are certain data points outlined that have not been elaborated upon how the Board will take them into consideration.

These Additional Board Factors allows the Board to consider information concerning standard medical practice—which as outlined above lacks definitional clarity—and several gross spending measures that will not account for net cost to the payor.

In addition, there are a host of different data points (e.g. mean, median, and 90th percentile) that the board can consider without any mention of how they will take all of these data points into consideration. This is all the more reason why the Board needs to be transparent in their methodology, including elaborating on how they arrived at the numbers they ultimately decide to utilize.

Much of the data that the Board is looking to collect from manufacturers is highly sensitive and confidential information. This makes the position the Board appears to be taking on their ability to make determinations of whether information is considered confidential all the more concerning.

There is no definition of affordability or mention of how the Board will consider all of the information they are looking to collect. Given the significant amount of data they are looking to collect, this lack of specificity on how affordability will be measured or how they will consider all of the information the Board are collecting remains concerning.

Under Section .04.05(D), the Cost Review Process should consider more appropriate factors.

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 .04.03(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.

Again, much of the information listed in Section .04.04 (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.

It is unclear how certain factors in Section .04.05 are relevant and are unclear.

Additional factors considered in a Cost Review include impact on patient access, as in Section .04.05 (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.

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 .04.05 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.

Section .04.05(C)(e)(ii) mentions the use of information from health economics and outcomes research. We want to ensure that this information will not consist of Quality Adjusted Life Years (QALYs) or QALY-like measures.

A longstanding priority of BIO is fighting back against the use of discriminatory measurements of value, particularly the use of quality-adjusted life years (QALYs) and QALY-like measures. Such measures should not be used simply because there is deemed to be no "better" measurement available. It is incumbent on all stakeholders to work for patients to develop comprehensive, patient-centered, and non-discriminatory measures of value. Use of QALYs have no place in such a paradigm.

The Board should confirm that evidence that uses discriminatory approaches such as QALYs will not be considered. We also note that other measures that have been often promoted as alternatives to QALYs – such as the Equal Value of Life Years Gained (evLYG) – are similarly problematic as they limit the value of interventions that both extend life and improve the quality of life – and the Board should similarly reject evidence referencing or discussing evLYGs. The Board should consider and prioritize high quality, robust real-world evidence

(RWE), evidence provided by clinicians with the necessary expertise, as well as evidence submitted by manufacturers – who have a vast depth and breadth of clinical and scientific expertise regarding their marketed therapies. The Board should also focus on patient-centered outcomes, such as a patient's quality of life, and the broader societal benefit conferred by a therapy.

Sections .04.05(D) and (F) make reference to open meetings and public reports. There should be ample opportunity for public comment.

BIO believes that all draft study reports or final study reports should be open to a 60-day open public comment period. Manufacturers and the public should be able to review the data and provide input on all draft study reports.

Section (F) references the process for adopting a cost review study. However, there is little detail on whether this is in an open public meeting, how it will be adopted (will it be a live, in-person vote, for example?) and if there is an opportunity for the public to comment before the adoption of the report.

The report referenced in Section .04.05(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.

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 publicly available, then its status under the statute is unambiguously protected information and the Board should recognize it as so. We are doubly alarmed that this fundamental concern has not been addressed from the first draft, and ask the Board substantively address this.

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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