



VIA EMAIL

April 22, 2025

The Honorable Wes Moore, Governor
State of Maryland
100 State Circle
Annapolis, MD 21401

RE: Veto S.B. 357/H.B. 424 Expanding PDAB Upper Payment Limit Authority

Dear Governor Moore,

The Ensuring Access through Collaborative Health (EACH) and Patient Inclusion Council (PIC) urge you to veto S.B. 357/H.B. 424, which would expand the upper payment limit (UPL) authority of the Prescription Drug Affordability Board (PDAB).

EACH/PIC is a two-part coalition that unites patient organizations and allied groups (EACH), as well as patients and caregivers (PIC), to advocate for drug affordability policies that benefit patients. The coalition has actively engaged with the Maryland PDAB since its creation, and while we respect the efforts and intentions of board members and staff, we believe the PDAB approach has proven to be ineffective in lowering patient costs for prescription drugs and will ultimately cause more harm by creating added barriers between patients and their medically necessary treatment.

PDABs Are Unproven and Expensive

Despite laudable intentions, in its sixth year of operation the Maryland PDAB has yet to directly achieve cost savings for patients. The Maryland PDAB was projected in its [authorizing legislation](#) to cost \$4 million and [budget requests](#) (under H.B. 350) include another \$1.28 million for 2026.

Other states have similar experiences with PDAB costs. The Oregon PDAB is [projected](#) to cost over \$1 million per year, while the Colorado PDAB was [projected](#) to cost \$800,000 for its first year, but already [requested](#) a supplement of \$260,000.

We are concerned that the PDAB will continue to cost Marylanders in the ballpark of \$1 million each year without the ability to realize savings for patients.

Cost Reviews and UPLs Could Compromise Patient Access to Medications

While we applaud the legislature's commitment to supporting patients and lowering the costs of prescription medications, we are concerned that cost reviews and upper payment limits (UPLs) can further complicate an already complex healthcare marketplace and result in worse outcomes for patients.



At their core, cost reviews necessitate selecting individual drugs for review and implementing market interventions for the selected drugs. This alone puts PDABs in a position of creating inequities between patient populations by selecting and reviewing individual drugs, rather than evaluating systemic health costs.

While UPLs are intended to lower costs for patients, the reality is that they will create a new incentive structure for payers that could compromise patient access to the selected medications due to increased utilization management or reshuffling of formularies. This eventuality was outlined by the Centers for Medicare and Medicaid Services in their [May 3, 2024 Guidance on Medicare Drug Price Negotiation](#):

“CMS is concerned that Part D sponsors may be incentivized in certain circumstances to disadvantage selected drugs by placing selected drugs on less favorable tiers compared to non-selected drugs, or by applying utilization management that is not based on medical appropriateness to steer Part D beneficiaries away from selected drugs in favor of non-selected drugs.”

Additionally, many of the drugs under cost review are administered directly by physicians under a “buy and bill” model. Physician reimbursement rates are already being squeezed, and UPLs could additionally lower opportunities for treatment costs to be recouped. As a result, it is likely that physicians would adjust treatment recommendations to avoid facing financial deficits, leaving patients with fewer treatment options.

Finally, creating a unique pricing structure in Maryland will create state-specific conditions for coverage. We don’t know yet how either insurers or manufacturers will react to state-by-state exceptions, but this has potential to cause either of these stakeholders to limit availability in the state and could cause confusion for patients and providers in the state.

Upper Payment Limits Don’t Necessarily Translate to Patient Savings

As acknowledged by witnesses and members at the Finance committee hearing on S.B. 357, applying UPLs to selected drugs does not guarantee patients will realize any or all of the savings from the lower list price.

The assumption by bill proponents that UPLs directly translate to lower out-of-pocket (OOP) drug costs ignores the complicated nature of our healthcare system, in which patients are not responsible for paying the full cost of medications nor allowed to freely select from the full range of treatments medically-approved for their condition. Instead, these decisions are determined by their health plan and pharmacy benefit manager (PBM). These dominant players often do not derive the most value from the lowest cost drugs. As documented by [reporting on PBMs in the New York Times](#):

“Even when an inexpensive generic version of a drug is available, PBMs sometimes have a financial reason to push patients to take a brand-name product that will cost them much more. For example, Express Scripts typically urges employers to cover brand-name versions of several hepatitis C drugs and not the cheaper generic versions. The higher the original sticker price, the larger the discounts the PBMs can finagle, the fatter their profits — even if the ultimate



discounted price of the brand-name drug remains higher than the cost of the generic.”

Because of their market power, insurers and PBMs can extract huge rebates from manufacturers to include drugs on their formularies. As several witnesses testified at the Senate Finance Committee hearing for S.B. 357, when these rebates are lowered by UPLs an insurer/PBM can respond simply by excluding the UPL drug from the formulary in favor of drugs with higher rebates and/or shifting the UPL drug to a higher cost-sharing tier, which forces patients to incur higher cost-sharing obligations.

Proponents of these bills insisted at the hearing that insurers/PBMs will lower OOP costs for drugs with UPLs because “[Insurance Commissioner] Marie Grant will make them do it.” However, Commissioner Grant herself acknowledged at the hearing that this was an overstatement. She explained that the Maryland Insurance Administration can only reject or modify premium increases by insurers and **lacks authority to alter a health plan’s cost-sharing design** (i.e copays, coinsurance, deductibles) apart from asking plans to explain how they will accommodate new UPLs for selected drugs in their annual rate filings.

Patient Access Cannot Be Compromised

Once diagnosed with a chronic condition, each patient starts an often life-long journey to identify the correct treatments to successfully manage their symptoms and improve their health. Many chronic disease patients will ultimately rely on multiple medications to their condition. Some will face multiple chronic conditions or even need additional medications to treat the side effects of either their condition or the medication that keeps their condition manageable.

For these reasons, patients with chronic conditions often rely on a complicated and personalized course of treatment that is not easily altered. Substituting or requiring patients to change drugs based on cost considerations instead of medical needs can disrupt continuity of care and result in complications and higher overall medical costs.

Identify and Resolve Patient-Reported Obstacles to Care

While our health system is complicated, one principle is simple: every change that we make and policy we implement should ultimately benefit patients. We urge the Finance Committee to keep this principle as a singular focus as it evaluates health reform proposals and new legislation.

As we have outlined, while well-intentioned, UPLs fail to address many of the underlying causes and complicated factors that result in higher prescription drug costs for patients. Therefore, we urge lawmakers to focus efforts on identifying and addressing *patient-reported* obstacles to drug affordability.

Failing to resolve the underlying factors that lead to higher costs for patients can result in short-term relief and uneven benefits – aiding some but potentially leaving others with higher costs and drug accessibility challenges.

In closing, we ask you to veto this ineffective and expensive reform proposal and urge lawmakers to pursue more productive *patient-driven* reforms. While we support and appreciate



amendments to S.B. 357/H.B. 424 that will study the full impact of UPLs and increase patient representation on the stakeholder council, these do not change the fact that the PDAB is costing the state millions of dollars at a time where it faces a \$2.7 billion deficit and that expanding the board's UPL authority provides no assurance or probability of any future savings for patients or the state.

Thank you for considering the input of impacted patients and please feel free to use the EACH/PIC Coalition as a resource regarding drug affordability reviews. I can be reached at mark@aiarthritis.org with any questions or for additional information.

Sincerely,

A handwritten signature in black ink, appearing to read "Mark Hobraczka".

Mark Hobraczka, JD, MPA

Director of Public Policy, AiArthritis

Legislative Lead, EACH/PIC Coalition

Person living with Ankylosing Spondylitis (an AiArthritis disease)

cc: Jeremy Baker, Chief Legislative Officer (jeremy.baker1@maryland.gov)