



August 20, 2025

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

RE: Recommendations to the Stakeholder Council on UPL Implementation and Patient Protections

Dear Members of the Maryland Prescription Drug Affordability Stakeholder Council:

The Ensuring Access through Collaborative Health (EACH) and Patient Inclusion Council (PIC) is a two-part coalition that unites patient organizations and allied groups (EACH), as well as patients and caregivers (PIC), to advocate for drug affordability policies that benefit patients.

During their July meeting, the Maryland PDAB made the preliminary determination that both Farxiga and Jardiance present affordability challenges in Maryland. As the board and stakeholder council evaluate policy solutions to address the presumed affordability challenges, we urge both bodies to evaluate all potential policy tools, not simply move toward an Upper Payment Limit (UPL) as the default solution.

Our recent [*Patient Experience Survey: Prescription Drug Affordability and Unaffordability*](#) found that affordability challenges often stem from insurance design, access barriers, and the cumulative burden of managing chronic illness, not just the price of an individual drug. For that reason, a two-track approach is essential, one that considers other targeted reforms to address the underlying patient-reported problems alongside any price-based intervention.

UPLs Alone May Be Ineffective or Harmful

While intended to reduce costs, UPLs can create new incentives for insurers and pharmacy benefit managers (PBMs) that may ultimately restrict patient access to needed medications. These include increased utilization management, formulary reshuffling, and adverse tiering, all of which can delay or disrupt treatment. As our survey results highlight, access delays and insurance rules, not cost alone, are often the true barriers behind “affordability” labels. Implementing a UPL without complementary protections risks worsening these challenges.

Role of the Advisory Council in Policy Selection

We urge the PDASC to take an active role in helping the PDAB evaluate which policy tools are best suited to address the problems patients have identified. This means starting with the “why” behind affordability concerns and selecting interventions that directly target those causes, whether that is reforming prior authorization processes, protecting copay assistance, or addressing underinsurance. A patient-centered, evidence-based approach will produce more effective and equitable outcomes than relying on a single blunt instrument like a UPL.

Concerns About Recent Advocate Comments

We were deeply disappointed that a member of the PDASC appointed to represent patient interests used their own comment letter to criticize and cast doubt on the intentions of other patient organizations. All of us are working toward the same ultimate goal: improving patient access and affordability. We should be able to find common ground on that shared mission, not undermine each other's advocacy.

We are even more concerned that a patient advocate would argue against expanding patient considerations and protections. We urge that advocates and all members of the stakeholder council to put patient needs first, starting from patient-identified concerns and working toward policy solutions that address those concerns. Our coalition remains committed to engaging in good faith to ensure patient voices are central to every decision,

We recommend that members of the Stakeholder Council assist the board to:

1. Pursue a two-track policy approach, with UPLs only as one of multiple possible tools.
A UPL should be considered only after a full review of other targeted policy interventions that could directly address patient-identified affordability barriers. By running these options in parallel, the PDAB can ensure that the final solution addresses both acquisition cost and the systemic access barriers that drive patient unaffordability.
2. Begin with patient-reported drivers of affordability challenges to guide policy selection.
Our Patient Experience Survey found that insurance-related issues, not drug price alone, were the most common reason patients reported a medication as unaffordable. Beginning with this "why" ensures that chosen policies target the root causes of patient hardship, not just the surface-level costs.
3. Assess potential harms from UPL implementation before adoption.
UPLs can alter payer incentives in ways that reduce patient access, including increased utilization management, formulary reshuffling, and higher cost-sharing tiers for the affected drug. They may also impact provider reimbursement, particularly in buy-and-bill models, making it harder for physicians to offer certain treatments. The PDAB should gather concrete commitments and impact analyses from insurers, PBMs, providers, and manufacturers to understand likely market reactions before a UPL is implemented.
4. Strengthen patient protections in any affordability policy.
If a UPL or any other pricing intervention is pursued, safeguards should be implemented to ensure harm to patients is prevented. Monitoring for harm is insufficient for the patients who will be negatively impacted. These protections should include: prohibitions on non-medical switching, requirements to maintain current formulary placement for affected drugs, guardrails against increased prior authorization or step therapy, and monitoring for access impacts across the entire therapeutic class, not just the drug directly subject to review.

We appreciate the opportunity to provide these recommendations and stand ready to work with the stakeholder council to ensure that Maryland's drug affordability policies truly meet patient needs.

Sincerely,

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