EACH PIC COALITION

March 4, 2026

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

RE: Public Comments on UPL Framework for Jardiance

Dear Members and Staff of the Maryland Prescription Drug Affordability Board:

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.

We appreciate the opportunity to comment on the board's proposed upper payment limit (UPL) framework for Jardiance.

UPLs Do Not Guarantee Savings for Patients

We continue to underscore the limitations of a UPL in addressing patient affordability. UPLs may change what insurers or the state pay for a medication, but they do not cap or guarantee reductions in patient out-of-pocket costs. As our coalition has cautioned before, these policies can introduce new incentives for insurers and pharmacy benefit managers (PBMs) that may ultimately restrict access to needed treatments through greater utilization management, formulary reshuffling, or adverse tiering. These shifts risk delaying or disrupting care, and as our Patient Experience Study has demonstrated, insurance barriers, not price alone, are often the real drivers of patient hardship and perceived "unaffordability."

Furthermore, patients reported that treatments are not interchangeable and that accessing the correct medication is critically important for patients with chronic conditions. Therefore, while intended to reduce costs, implementing a UPL without complementary patient protections could worsen the very challenges patients already face.

We urge the board to establish clear safeguards before advancing any UPL frameworks and to continue exploring its policy alternatives, including reforms that directly address PBM and insurance practices that most influence patient costs.

Limitations of Applying Medicare MFP

Maryland's proposal to apply the "maximum fair price" (MFP) established by the Medicare Drug Price Negotiation Program (MDPNP) to state programs is concerning because those prices were negotiated specifically for the Medicare population and benefit design. Those rates reflect the structure and cost-sharing rules of Medicare, which are not the same as those that apply in state-regulated coverage. Applying those prices outside of Medicare assumes the markets function the same way, and they do not.

Further, the establishment of UPLs at MFP rates does not guarantee any savings for patients. Patients could instead face higher copay or coinsurance rates to retain access to that drug or

alternatively be forced to switch to a more expensive drug, which results in higher profits for their PBM. Recent research from the Pioneer Institute has shown that patient OOP costs have increased by an average of 32 percent under the MDPNP even before the maximum fair price caps for the first round of drugs went into effect on January 1st.

Simply importing Medicare pricing may create disruption without meaningfully improving what patients actually pay or experience.

Delinking PBM Compensation Is a More Effective Path Forward

We strongly support the board's consideration of non-UPL alternatives and endorse the proposal to delink PBM compensation from drug prices. The current rebate-driven PBM model creates perverse incentives to favor higher-priced drugs, as PBMs profit from larger rebates tied to inflated list prices. Delinking PBM compensation from drug prices and rebates is critical to realigning incentives toward lower costs and improved access for patients.

This approach offers a more targeted and sustainable solution to affordability challenges and addresses the mechanics of the drug supply chain rather than imposing blunt payment caps that may shift costs and restrict access. States such as Colorado have already taken steps in this direction, and similar reforms are being actively considered at both the state and federal levels.

As the board continues its deliberations, we urge it to establish a clear and transparent framework for evaluating non-UPL policy options and to ensure these alternatives are given equal weight alongside UPL proposals. Based on available evidence and lived patient experience, PBM delinking and related insurance reforms are far more likely to reduce patient costs without introducing new access barriers or disrupting care.

Conclusion

We appreciate the board's willingness to consider alternatives to UPLs and its ongoing engagement with patient stakeholders. We stand ready to work collaboratively with the board to advance policies that address the real drivers of patient affordability while preserving timely access to the treatments patients rely on.

Sincerely,

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