EACH PIC COALITION

May 1, 2026

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

RE: Comments on COMAR 14.01.07.02 Upper Payment Limit for Ozempic

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) rulemaking for Ozempic. We urge the board not to move forward with the proposed UPL since it does not directly address patient needs and alternative policy solutions have not yet been fully considered or evaluated by the board.

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 out-of-pocket 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.

Consider More Effective, Patient-Centered Reforms

We have long cautioned that UPLs are not a patient-centered solution and have urged the board to seek the authority to implement alternative reforms that will better address patient problems. We urge once again that the board ensures non-UPL policy alternatives are given equal weight alongside UPL proposals.

In the February 2025 comment letter on the rules and regulations concerning the UPL process submitted by the EACH Coalition and signed by more than 25 organizations, we raised this issue:

"[W]e continue to urge the board to seek authority to implement policy alternatives before proceeding with the UPL process. The board currently has no authority to implement alternative policies nor has it outlined any alternatives under consideration. Proceeding with the UPL process without taking these important steps increases the likelihood that the board will resort to implementing UPLs simply because other policy solutions have not been explored and are therefore not available to implement."

Unfortunately, the scenario we outlined has now come to fruition. The board is moving forward with establishing UPLs. Meanwhile, alternative policy options that may better address the needs of Maryland patients are advancing more slowly because the board lacks the authority to pursue them directly. Whether by design or simply ease of authority, the board has now demonstrated that UPLs are its preferred mechanism for intervention.

Moving forward with implementing UPLs will place more value on lowering system costs than on addressing real patient needs. We therefore urge the board not to move forward with approval of the UPL for Ozempic until the alternative policy recommendations under consideration also move forward.

We thank the board for its consideration of our comments.

Sincerely,

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