COMMUNITY ACCESS NATIONAL NETWORK

Mailing Address:

Attn: Jen Laws
PO Box 3009
Slidell, LA 70459

Chief Executive Officer:

Jen Laws
Phone: (313) 333-8534
Fax: (646) 786-3825
Email: jen@tiicann.org

February 10, 2026

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

RE: Informational Hearing Written Testimony (Cost Review Study Process)

Dear Honorable Members of the Maryland Prescription Drug Affordability Board,

The **Community Access National Network (CANN)** is a 501(c)(3) national nonprofit organization focusing on public policy issues relating to HIV/AIDS and viral hepatitis. CANN's mission is to define, promote, and improve access to healthcare services and support for people living with HIV/AIDS and/or viral hepatitis through advocacy, education, and networking.

While CANN is primarily focused on policy matters affecting access to care for people living with and affected by HIV, we stand in firm support of all people living with chronic and rare diseases and recognize the very reality of those living with multiple health conditions and the necessity of timely, personalized care for every one of those health conditions. State Prescription Drug Affordability Boards are of profound importance to our community.

Cost Review Study Process is Flawed

There has been an acknowledgement by staff that, thus far, there has been an inability to assess impacts on public budgets for state and local governments. Additionally, there seems to be a lack of information gathered concerning drug cost-related concerns among entities such as community hospitals, Ryan White clinics, ADAP providers, and those reliant on 340B program revenues. Decisions based on APCD data do not adequately inform any of these things.

Review research repeatedly acknowledges that overall U.S. expenditures have increased as a result of increases in utilization. Additionally, staff reporting acknowledges that in 2024, net price growth was flat, but increased use of medicines with significant clinical benefit drove the increase in spending. As more patients utilize effective medications, immediate spending may increase (assuming positive health outcomes, long-term spending may subsequently decrease), but that does not indicate affordability challenges for patients nor a specific “affordability challenge” for the state system.

Staff research also acknowledges that patient out-of-pocket costs are a product of benefit design. Reporting presented specifically even acknowledges a substantial number of prescriptions go unfilled due to payer rejection and, as a result of payor restrictions, patient abandonment. **Additionally, there is an acknowledgement that payer rejections could be driven by formulary design, including failure to satisfy prior authorization requirements.** This is based on national data, but with the assumption that Maryland data may possibly follow such trends, this does not support the conclusion that drugs pose affordability challenges.

The preliminary designation that certain drugs have caused "affordability challenges" is based on percentages of WAC increases over time, percentages of specific drug spend relative to overall state drug spend, and an acknowledgement that patient cost share in relation to net plan spend is higher in certain markets. It is unclear why a specific WAC increase trend is being utilized to define "unaffordability", how any increase is related to net state program spend or how such an increase in WAC is affecting patient cost sharing or adverse benefit design. Moreover, the way pricing has been discussed has inappropriately separated the price of drugs from their therapeutic value. When drugs are effective, more doctors prescribe them because of improved health outcomes, thus more patients use them as long as they have access to them. Thus, stating that exceeding 1% of gross prescription drug spend for state and local governments, as in the case of Farxiga, is an "affordability challenge", without delineating the definition of "affordable" spend percentage based on specific factors, including qualitative and quantitative patient health outcomes, is problematic.

The cost review study process to date has not contained enough informed data specific to Maryland. Board members have even acknowledged that the data concerning drug spending has a heavy focus on the increase in drug spending nationally, but a paucity of data on how it affects Marylanders specifically, along with their spending trends and the factors that may be affecting such. Therefore, making determinations and policy decisions based on data that is not specific to Maryland is not an accurate analysis and cannot result in a truly beneficial outcome for identifying or positively impacting Marylanders' needs or system pain points.

Statutory Requirements Are Not Being Met

To date, it is unclear how 340B, VA, or other federal program claims will be delineated to ensure a UPL would not be imposed on them. The statute requires inquiry that has not yet been met. Specifically, it states that:

BEFORE ESTABLISHING AN UPPER PAYMENT LIMIT THAT APPLIES TO THE MARYLAND MEDICAL ASSISTANCE PROGRAM, THE BOARD SHALL CONFER WITH THE MARYLAND MEDICAL ASSISTANCE PROGRAM TO APPROVE THE APPLICATION OF THE UPPER PAYMENT LIMIT BY ASSESSING WHETHER THE PROPOSED UPPER PAYMENT LIMIT WILL:
(I) CONFLICT WITH THE MEDICAID DRUG REBATES PROGRAM, THE COVERED OUTPATIENT DRUG RULE (CMS–2345–FC), OR ANY OTHER FEDERAL REQUIREMENTS AS APPLICABLE; AND
(II) REQUIRE ADDITIONAL FUNDING TO BE ALLOCATED TO THE MARYLAND MEDICAL ASSISTANCE PROGRAM BUDGET.

Policy Review Process Is Incomplete

The policy review process is heavily weighted upon UPL formulation. There has not been equal weight on planning and outlining timelines for non-UPL recommendations which may more adequately address both state program spending and patient cost sharing, as evidenced by the Federal Trade Commission's recent settlement with Express Scripts. Additionally, staff have concluded that using MFP domestic reference pricing for possible upper payment limits is an effective solution. However, staff do not have data to indicate from state partners what entities are paying in comparison to MFP pricing or any other metric. The board and staff acknowledge that better data are needed for a Maryland-specific cost-effectiveness analysis and budget impact analysis. Without this information, it is unclear how staff concluded that MFP is the best choice for UPL pricing. More importantly, without an analysis of non-UPL recommendations, it is unclear how a UPL could be deemed a solution at all.

Respectfully submitted,

Ranier Simons
Director of State Policy, PDABs
Community Access National Network (CANN)

On behalf of
Jen Laws
President & CEO
Community Access National Network