

May 13, 2026

The Honorable Michael Rodrigues
Chair, Senate Committee on Ways and Means
Massachusetts Senate
24 Beacon Street, Room 212
Boston, MA 02133

VIA ELECTRONIC SUBMISSION

Re: In Opposition to Amendment #490 (Friedman), Prescription Drug Upper Payment Limit

Dear Chair Rodrigues:

On behalf of the Pharmaceutical Research and Manufacturers of America (“PhRMA”) and the Massachusetts Biotechnology Council (“MassBio”), we write to express our opposition to Amendment #490, which would give the Health Policy Commission (“HPC”) authority to review prescription drug costs and value with the goal of setting price limits by way of an “upper payment limit” for the entire drug supply system.

PhRMA and MassBio share the legislature’s commitment to improving patient affordability and access to medicines. However, the approach contemplated in Amendment #490—authorizing government price setting—risks undermining patient access, disrupting the pharmaceutical supply chain, and weakening the innovation ecosystem that is central to Massachusetts’ leadership in biotechnology. This proposal shortsightedly targets drug spending in ways that will likely have long-term, harmful effects on patients, innovation, and the development of new life-saving therapies.

Regulating drug prices in-state could lead to a shortage of or limit access to medicines for patients.

Specifically, if a pharmacy or provider cannot obtain a medicine at the government-set price, the medicine may not be available to Massachusetts residents. In practice, the UPL proposal would disrupt how medicines move through the supply chain. Pharmacies purchase drugs from distributors, and distributors in turn acquire products from manufacturers. If Massachusetts pharmacies are prohibited from paying more than a state-imposed UPL, distributors may be required to absorb losses to supply those drugs. In many cases, this dynamic could lead distributors or pharmacies to stop stocking affected medicines altogether—particularly impacting independent and community pharmacies that operate on narrow margins.

This amendment would attempt to follow the steps of states that have established prescription drug affordability boards (“PDAB”). State PDAB implementation efforts to date have languished severely. State officials have encountered firsthand the complexity of the U.S. pharmaceutical supply chain and the lack of consensus across a broad range of stakeholders that would be impacted by potential UPLs as to whether a PDAB is necessary. As some states have endeavored to select drugs for affordability reviews and then to conduct such reviews—a precursor to UPLs—the experience has

been wrought with bureaucracy, public and private stakeholder expense, and unclear timelines.³ In the seven years since the first PDAB law passed in 2019, no savings have been achieved for patients or states.

PDABs are unlikely to help patients, because irrespective of the amount at which the UPL is set or the evidence and criteria for determining “unaffordability,” patients may find themselves worse off than before. This is largely due to how health insurers have stated they expect to react: by modifying benefit design, formularies, and provider reimbursement.⁴

Further, the amendment also requires onerous disclosure of pricing information which will not benefit patients and could jeopardize the competitive market. By disincentivizing the development of innovative treatments, this legislation could threaten the positive effect that the biopharmaceutical industry has on Massachusetts’ economy.

A recent survey of health plans reveals significant concerns about access to medicines and patient out-of-pocket costs with the implementation of upper payment limits.

The Partnership to Fight Chronic Disease (PFCD) released a white paper in 2025 that analyzed a survey of regional and national health plan payers with PDAB-related experience. These payers cover the majority of Americans. A key point included that “77% of health plan payers believe UPLs would disrupt patient access to prescription drugs due to coverage changes, tiering adjustments, increased cost-sharing, or supply chain complications, including pharmacies potentially refusing to stock medicines with UPLs.”¹ The paper also reported that, “67% of payers anticipate that patient cost-sharing for UPL-designated drugs will either increase (50%) or remain the same (17%), while 70% expect out-of-pocket (OOP) costs for drugs in the same class to either rise (53%) or stay unchanged (17%).”² These findings reinforce that UPL policies may lead to formulary changes, increased premiums, and reduced availability at the pharmacy counter—outcomes inconsistent with the Commonwealth’s affordability goals.

This proposal ignores that there are meaningful policies for addressing affordability without importing government price setting that could reduce treatment options.

PhRMA and MassBio are increasingly concerned that the substantial rebates and discounts paid by pharmaceutical manufacturers, approximately \$356 billion in 2024,³ do not make their way to offsetting patient costs at the pharmacy counter. Patients need concrete reforms that will help lower the price they pay for medicines at the pharmacy, such as sharing negotiated savings on medicines with patients, making cost-sharing assistance count toward a plan’s out-of-pocket spending requirements, and making monthly costs more predictable. These policies can be done without importing government price setting, which can reduce the options available to treat patients.

¹ The Partnership to Fight Chronic Disease. “Health Plans Predict: Implementing Upper Payment Limits May Alter Formularies And Benefit Design But Won’t Reduce Patient Costs.” March 2025. Available at:

http://www.fightchronicdisease.org/files/ugd/b11210_20c7d158bf93452395d6b4e2b0056bb0.pdf

² *Id.*

³ Fein, A. “The 2025 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers,” Drug Channels Institute. March 2025.

Price controls do not account for insurance benefit design issues that prevent discounts from flowing to patients, and Amendment #490 assumes incorrectly that the price a patient pays is determined solely by drug manufacturers.

This amendment singles out the biopharmaceutical industry and ignores the variety of stakeholders involved in determining what consumers ultimately pay for a medicine, including insurers, pharmacy benefit managers (“PBMs”), wholesalers, and the government. The important role that these entities play in determining drug coverage and patient out-of-pocket costs is overlooked by the requirements of this amendment. For example, PBMs and payers—which dictate the terms of coverage for medicines and the amount a patient ultimately pays—negotiate substantial rebates and discounts.

According to research from the Berkeley Research Group (“BRG”), rebates, discounts, and fees account for an increasing share of spending for brand medicines each year, while the share received by manufacturers has decreased over time. Manufacturers retain only 49.9% of brand medicine spending—the rest goes to others in the supply chain insurers/plan sponsors, the government, and PBMs.⁴ Increased rebates and discounts have largely offset the modest increases in list prices and reflect the competitive market for brand medicines.

Specifically, average net prices for protected brand medicines fell by -3.4% in 2025.⁵ Looking ahead, average net price growth is projected to be -1 to -4% per year through 2028.⁶

This, of course, does not necessarily reconcile with what patients are feeling at the pharmacy counter, which is why looking at the whole system is so important. For example, despite manufacturers’ rebates and discounts negotiated by health plans, nearly half of commercially insured patients’ out-of-pocket spending for brand medicines is based on the medicine’s list price rather than the negotiated price that health plans receive.⁷

Price controls on brand medicines raise constitutional concerns.

Application of this price control to patented medicines raises constitutional concerns under the Supremacy Clause because it would restrict the goal of federal patent law, which is to provide pharmaceutical patent holders with the economic value of exclusivity during the life of a patent. Congress determined that this economic reward provides appropriate incentive for invention and Massachusetts is not free to diminish the value of that economic reward. Specifically, in the case of *BIO v. District of Columbia*, 496 F.3d 1362 (2007), the U.S. Court of Appeals for the Federal Circuit overturned a District of Columbia law imposing price controls on branded drugs, reasoning that the law

⁴ BRG: The Pharmaceutical Supply Chain, 2013–2023. January 2025.

⁵ Drug Channels Institute. U.S. Brand-Name Drug Prices Fell in 2025 as the Net Pricing Drug Channel Emerges. Jan. 7, 2025. Available at: <https://www.drugchannels.net/2026/01/us-brand-name-drug-prices-fell-in-2025.html>

⁶ IQVIA. “Use of Medicines in the U.S.: Spending and Usage Trends and Outlook to 2028.” Published May 2024. Available at: <https://www.iqvia.com/insights/the-iqvia-institute/reports-and-publications/reports/the-use-of-medicines-in-the-us-2024>

⁷ IQVIA Institute for Human Data Science. Medicine spending and affordability in the United States. Published August 2020. Accessed August 2020. <https://www.iqvia.com/insights/theiqvia-institute/reports/medicine-spending-and-affordabilityin-the-us>

at issue conflicted with the underlying objectives of the federal patent framework by undercutting a company's ability to set prices for its patented products. The amendment gives the PDAB the authority to determine which products will be subject to a cost review, and which products will ultimately have a UPL imposed on them, but provides no clear and consistent standard for how the PDAB will conduct price reviews or set UPLs. The amendment also raises constitutional concerns about Massachusetts' ability to regulate commercial activity beyond its own borders. See *Nat'l Pork Producers Council v. Ross*, 143 S. Ct. 1142, 1157 n.1 (2023); *Association for Affordable Medicines v. Frosh*, 887 F.3d 664 (4th Cir. 2018). A law that Colorado enacted, which is similar to provisions of S.868, is currently the subject of litigation.

This legislation could harm Massachusetts' economy.

On average, it takes more than 10 years and \$2.6 billion to research and develop a new medicine. Just 12% of drug candidates that enter clinical testing are approved for use by patients. Efforts to impart price controls on innovative manufacturers could chill the research and development of new medicines by taking away the incentives that allow manufacturers to invent new medicines. Price controls also could severely reduce Massachusetts patients' access to medicines, as is seen abroad.

The biopharmaceutical sector is committed to bringing new treatments and cures to patients. This commitment to innovation supports high-quality jobs and is a vital part of Massachusetts' economy and its economic competitiveness. The biopharmaceutical sector directly accounted for 92,733 jobs in Massachusetts in 2022 and supported another 260,302 jobs in Massachusetts for a total of 353,035 jobs. These jobs generate over \$9.6 billion in state and federal tax revenue in 2022. This amendment could place these jobs, and tax revenue, in jeopardy.

For the above-stated reasons, PhRMA and MassBio oppose Amendment #490 and respectfully urge it not be enacted.

Sincerely,

Kevin J. Bourque
Regional Vice President, State Advocacy
PhRMA

Kendalle Burlin-O'Connell
CEO & President
Massachusetts Biotechnology Council (MassBio)

CC: Senate President Karen E. Spilka;
Senator Cynthia Stone Creem, Majority Leader;
Senator Cindy Friedman, Chair, Joint Committee on Health Care Financing;
Senator Bruce E. Tarr, Minority Leader