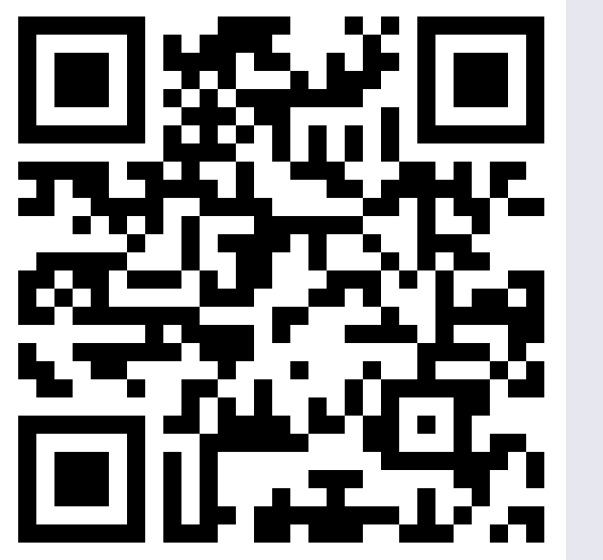


# Comparison of Drug Affordability Decisions Across State-Level Prescription Drug Affordability Boards and the Centers for Medicare and Medicaid Services in the United States

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## Objective

To compare the evaluations performed by state-level prescription drug affordability boards (PDABs) during drug affordability assessments and those performed by the Centers for Medicare & Medicaid Services (CMS) during maximum fair price (MFP) negotiations.

## Background

- Following passage of the Inflation Reduction Act (IRA) in 2022, CMS began negotiations to establish MFPs for selected drugs covered by Medicare. To date, CMS has negotiated MFPs for 25 drugs over the initial price applicability years (IPAYs) 2026 and 2027 and plans to establish MFPs for an additional 15 drugs for IPAY 2028.<sup>1-3</sup>
- Simultaneously, several states have established PDABs to review state-level drug pricing and spend, and have initiated affordability reviews of select drugs.<sup>4</sup>
- Research from 2025 identified initial CMS-selected and Colorado PDAB-reviewed drugs,<sup>5</sup> but IPAY 2028 drugs, CMS-negotiated MFPs, and Maryland and Oregon PDAB reviews were not yet available. This research builds upon past work to compare CMS and state PDAB drug selections, decision-making factors, and negotiation outcomes.

## Methods

- Targeted searches conducted in December 2026 identified PDAB reviews completed since January 2025. A PDAB was defined as any state-appointed entity tasked with evaluating and regulating prescription drug prices to ensure they remain affordable for consumers, regardless of target population (i.e., state-level public payers, commercial health plans, individuals).
- State PDAB and CMS websites were reviewed for details on drug selections and affordability reviews/negotiations. For drugs with published affordability/MFP decisions, justifications were comprehensively reviewed and extracted into a prespecified grid.

## Results

### PDABs

- As of April 2026, Colorado, Maryland, and Oregon PDABs have published affordability reviews for most selected drugs (Figure 1).
- Drugs reviewed by Colorado and Maryland did not overlap. Three drugs reviewed by Colorado or Maryland and classified as affordability challenges were also reviewed by Oregon, but Oregon did not make explicit affordability conclusions during their reviews.
- Both Colorado and Maryland are authorized to set upper payment limits (UPLs). To date, Colorado has set an UPL for 1/3 drugs deemed “unaffordable”; while Maryland recommended UPLs be established for 2/4 drugs deemed “affordability challenges”, the UPLs have not yet been set for those two drugs.

### PDAB versus CMS Decisions

- A total of 11/40 CMS-selected drugs were reviewed by ≥1 PDAB, and PDABs drew affordability conclusions for 7/11 (all “unaffordable” or “affordability challenges”). The CMS-negotiated discounts for these same drugs ranged from 66–71% (excluding 2/7 IPAY 2028 drugs awaiting MFP publication) (Figure 1).
- Enbrel was the single drug with both an UPL (Colorado) and an MFP, which were approximately equivalent (Table 1).

- A ≥75% discount was negotiated for 6/25 CMS-selected drugs with published MFPs, but 0/6 were reviewed by any PDAB.

### PDAB versus CMS Affordability Considerations

- Considerations were similar across PDABs, emphasizing out-of-pocket (OOP) cost, wholesale acquisition cost (WAC), WAC changes versus inflation, drug accessibility, and therapeutic alternatives.
- PDAB and CMS considerations overlapped, but each entity considered additional factors not considered by the other (Figure 2). CMS reports included limited detail on factors driving decision making, preventing further comparison between the entities.

## Conclusion

PDABs and CMS converge on affordability drivers, but notable differences persist. There remains a need for alignment and transparency around factors underlying drug affordability in these settings to better support negotiation preparedness and timely, evidence-based engagements.

FIGURE 1

Comparison between drugs chosen by PDABs and CMS for affordability review or MFP negotiation<sup>1-3,6-8</sup>



\*Drugs labeled as affordability challenges were designated “unaffordable” by Colorado or an “affordability challenge” by Maryland. Oregon did not make explicit affordability conclusions; CMS IPAY 2028 drugs do not yet have published discounts; Percentages presented for IPAY 2026/2027 reflect the discount of CMS-negotiated price from list price; The drugs reviewed by Colorado and not considered unaffordable (Genvoya and Trikafta) were concluded to be “not unaffordable” to the patients of Colorado at the time of review; While Oregon has completed their reviews of the selected drugs, they did not make explicit affordability conclusions. Drugs for review by Oregon’s PDAB in 2026 were published after the time of this analysis and are not included in Figure 1; Other comparable products were reviewed simultaneously with the listed drug.

TABLE 1

Key factors considered in Enbrel evaluations by the Colorado PDAB and CMS

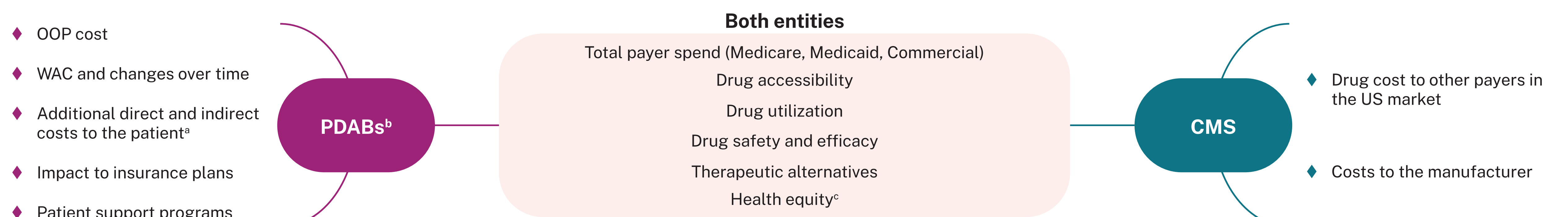
Factor	Colorado PDAB <sup>a</sup>	CMS <sup>10</sup>
WAC/list price <sup>a</sup>	WAC: \$4,166.67–5,000.00 for a 4-week supply (\$50,000.04–60,000.00 annually)	List price: \$7,106.00 for a 30-day supply (\$85,272.00 annually)
UPL/MFP	UPL: \$600.00 per 50 mg/mL weekly injection (\$2,400.00 for a 4-week supply)	MFP: \$2,355.00 for a 30-day supply
OOP cost	Noted OOP cost is relatively higher than some therapeutic alternatives. Additionally noted concerns that patients in Colorado may be paying higher OOP costs or have more affordability concerns than patients outside of Colorado	
WAC and changes over time	Noted that WAC has increased 1,582% since introduction, an increase significantly more than inflation	
Total payer spend (Medicare, Medicaid, Commercial)	Considered the proportion of Enbrel users by payer type, and the total payer-paid and Medicaid-paid amounts over one year	Considered prices and volume dispensed to each payer in the United States (US) market
Drug cost to other payers in the US market		Considered in order to align with CMS’s aim to agree on the lowest possible MFP
Costs to the manufacturer		Considered costs (research and development, production, distribution) and costs recouped
Additional direct and indirect costs to the patient	Considered financial impact not explicitly related to drug price, including time and money spent going to the doctor and ability to work	
Drug accessibility	Considered the proportion of plans that require prior authorization or step therapy, and the formulary tier the drug is classified under	Details were not reported
Impact to insurance premiums	Noted carriers reported Enbrel as a top drug that increased premiums, with 10/19 reporting Enbrel as a top 15 drug, and seven of those reporting it as a top five drug	
Patient support programs	Considered a broad range of assistance programs and the difficulty of accessing the assistance programs	
Drug utilization	Noted the annual utilization of Enbrel by payer type and changes over time	Details were not reported
Drug safety and efficacy	Noted Enbrel is an effective drug	Explicitly considered the relevance and credibility of available evidence, giving priority to well-designed and well-conducted studies, in considerations of drug safety and efficacy. Additionally reviewed mixed/indirect treatment comparisons and real-world evidence (RWE) when available
Therapeutic alternatives	Considered the extent to which Enbrel represents a therapeutic advance compared to alternatives, and the cost and utilization of the alternatives. Explicitly considered RWE when making comparisons	Considered the extent to which Enbrel represents a therapeutic advance compared to alternatives
Health equity	Noted concerns that patients in rural counties may be going undiagnosed or are unable to access medications	Noted considerations made for subpopulations such as children and elderly, but geographic/racial/socioeconomic disparities were not discussed

<sup>a</sup>Colorado reported Enbrel’s 2022 average WAC per course of treatment per person and CMS reported Enbrel’s 2023 list price.

Legend: Factor considered (dark blue), Factor not considered (light blue), Unclear extent to which factor was considered (orange)

FIGURE 2

Key factors for affordability decision-making across PDABs and CMS



<sup>a</sup>Considered by Colorado; <sup>b</sup>Unless otherwise noted, PDAB-considered factors noted in this figure were included across all three PDABs; <sup>c</sup>CMS has made considerations for subpopulations such as children, but the extent to which they considered health equity is unclear.

Abbreviations: CMS: Centers for Medicare and Medicaid Services; IPAY: initial price applicability year; IRA: inflation reduction act; MFP: maximum fair price; OOP: out-of-pocket; PDAB: prescription drug affordability board; RWE: real-world evidence; UPL: upper payment limit; US: United States; WAC: wholesale acquisition cost.

References: <sup>1</sup>Centers for Medicare & Medicaid Services (2024). Medicare drug price negotiation program: negotiated prices for initial price applicability year 2026. Available at <https://www.cms.gov/files/document/fact-sheet-negotiated-prices-initial-price-applicability-year-2026.pdf> [Last accessed 30 Mar 2026]; <sup>2</sup>Centers for Medicare & Medicaid Services (2025). Medicare drug price negotiation program: negotiated prices for initial price applicability year 2027. Available at <https://www.cms.gov/files/document/fact-sheet-negotiated-prices-ipay-2027.pdf> [Last accessed 30 Mar 2026]; <sup>3</sup>Centers for Medicare & Medicaid Services (2026). Medicare drug price negotiation program: selected drugs for initial price applicability year 2028. Available at <https://www.cms.gov/files/document/factsheet-medicare-negotiation-selected-drug-list-ipay-2028.pdf> [Last accessed 30 Mar 2026]; <sup>4</sup>NASHP (2025). State Laws Passed to Lower Prescription Drug Costs: 2017–2025. Available at <https://nashp.org/state-tracker/state-drug-pricing-laws-2017-2025/> [Last accessed 30 Mar 2026]; <sup>5</sup>Allen, E and Rawal, A. HPR135. Presented at ISPOR International 2025, 13–16 May 2025, Montreal, Quebec, Canada; <sup>6</sup>Colorado Department of Regulatory Agencies. Colorado prescription drug affordability review board & advisory council. Available at <https://doi.colorado.gov/types-of-insurance/health-insurance/prescription-drug-affordability-review-board> [Last accessed 27 Apr 2026]; <sup>7</sup>Maryland.gov. Board selected drugs and any applicable information. Available at <https://pdab.maryland.gov/Pages/board-selected-da-info.aspx> [Last accessed 27 Apr 2026]; <sup>8</sup>Oregon.gov. 2025 Oregon PDAB drug review resources. Available at <https://dfr.oregon.gov/pdab/Pages/archive/2025-review-archive.aspx> [Last accessed 27 Apr 2026]; <sup>9</sup>Colorado Prescription Drug Affordability Board (2024). 2023 affordability review summary report: Enbrel; <sup>10</sup>Centers for Medicare & Medicaid Services. Maximum fair price explanation for Enbrel. Available at <https://www.cms.gov/files/zip/mfp-explanation-enbrel.zip> [Last accessed 30 Mar 2026].

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