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Comparison of Prescription Drug Affordability Boards Across the United States

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Objective

To understand the landscape of state-level PDABs, categorize their structures and methodologies, and compare their defined goals.

Background

- The US federal government finances prescription drugs through Medicare, Veteran's Affairs, and other federal programs, whereas state governments manage Medicaid. However, with Medicare expenditures rising to $944.3 billion and Medicaid to $805.7 billion in 2022, healthcare budgets are becoming increasingly strained.[1]
- Despite Medicare's historical constraints on price negotiations, the Inflation Reduction Act (IRA) recently empowered it to negotiate prices for select drugs due to growing pricing concerns.[2]
- To address drug costs at a state level, states have begun establishing Prescription Drug Affordability Boards (PDABs), with Maryland establishing the first in 2019.[3]

Methods

- Targeted searches were conducted in December 2023 to identify PDABs and their corresponding legislation. A PDAB was considered to be any state-appointed entity tasked with evaluating and regulating prescription drug prices to ensure they remain affordable for consumers.
- Identification of PDABs was initially informed by the National Academy for State Health Policy State Tracker for Laws Passed to Lower Prescription Drug Costs.[3] This was complemented by supplemental searches on State websites to ensure a comprehensive review of the full legislation.
- Data on the purpose, scope, drug eligibility criteria, and affordability review processes were extracted into a prespecified extraction grid, and PDABs were classified based on common authorities and goals.

Results

- As of April 2024, eight state PDABs have been legally authorized, at various stages of implementation (**Figure 1**). Identified PDABs fell into two categories, developed based on analysis of details extracted:
  - "**Affordability Review**" Boards, tasked with identifying and reviewing medicines creating affordability challenges, and when appropriate, setting legally binding upper payment limits (UPLs) for payors.
  - "**Strategic**" Boards, tasked with recommending spending targets for public purchasers and/or strategies to optimize affordability.
- As of April 2024, three Affordability Review PDABs were active, while two were authorized but had not begun their work; all Strategic PDABs had published annual reports, providing recommendations for policies to improve prescription drug affordability.

Affordability Review PDABs

- Common criteria used to identify review-eligible drugs include using minimum annual wholesale acquisition cost (WAC) or annual WAC increase thresholds (**Table 1A**). While most PDABs have focused on specific cost thresholds for individual treatments, other relevant criteria for prescription drug negotiation in the US includes pricing history and patent status, as examined by Oregon's PDAB, and overall spending impacts within Medicare, as examined by the IRA (**Table 1B**).
- The PDABs in Colorado, Minnesota, and Washington are authorized to set UPLs. Oregon's PDAB was authorized in 2023 to analyze the feasibility of and propose a plan for establishing and enforcing UPLs, while Maryland's PDAB has the authority to propose a similar plan should UPLs be considered necessary (**Figure 1**).
- Identified PDABs can select 5–24 drugs for review annually; the level of external (e.g. patient) input considered in a review varies across states, with the majority of PDABs considering stakeholder and manufacturer input.

FIGURE 1

Strategic and Affordability Review PDABs established in the US

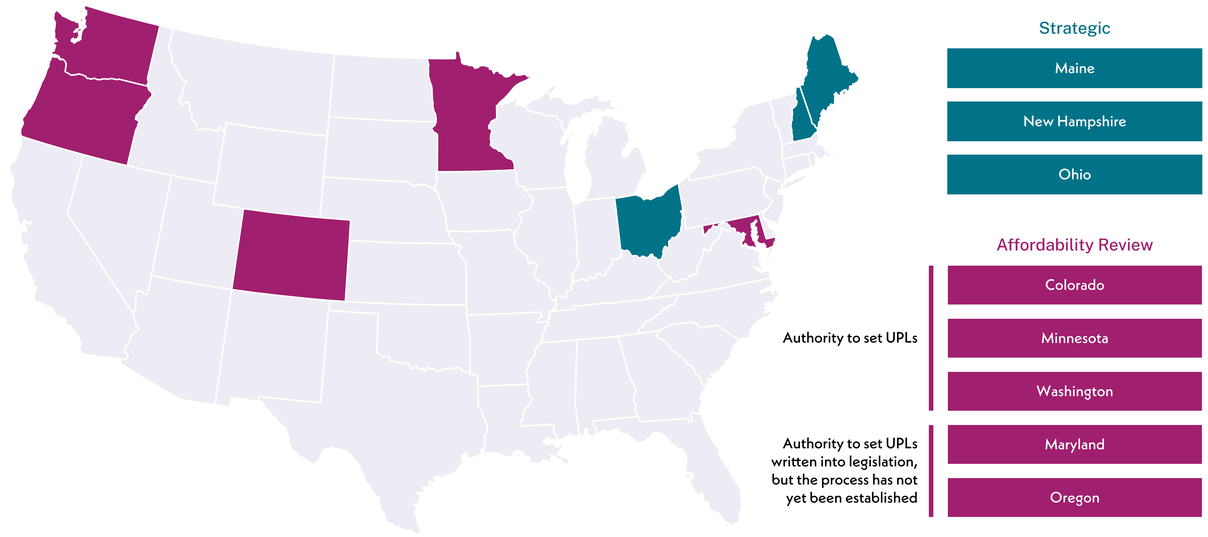

TABLE 1

Prescription drug affordability review eligibility criteria

A. Common pricing criteria used by select PDABs to identify review-eligible prescription drugs

PDAB	WAC, USD	WAC increase, USD	WAC increase, %	Biosimilar criteria	Generic criteria
Colorado	≥$3,000	≥$300	≥200%	Initial WAC <15% below referenced biologic WAC	–
Maryland	≥$30,000	≥$3,000	–	Initial WAC <15% below referenced biologic WAC	≥$100 WAC for ≤30-day supply or ≥200% WAC increase
Minnesota	≥$60,000	≥$3,000	–	Initial WAC <20% below referenced biologic WAC	Price increase ≥15% of WAC over preceding year or ≥40% over preceding 3 years; price increase >$30 for ≤30-day supply
Washington	≥$60,000	–	≥15%	Initial WAC <15% below referenced biologic price	≥$100 for ≤30-day supply or ≥200% price increase

B. Other relevant criteria for prescription drug negotiation in the US

Oregon	Drugs listed on an insurer top 25 list; included in a manufacturer new drug report or price increase report; with historical or current manufacturer drug price increases; approved through an expedited pathway; or with patent expiration within 18 months. The selection criteria for insulin products may include overall spend; per-patient spend; and patient out-of-pocket spend
IRA	Drugs for which at least seven years/biologics for which at least 11 years have elapsed between FDA approval or licensure of the drug or biologic; there is no generic or biosimilar competition; and there are high gross Part D covered prescription drug costs

Strategic PDABs

- Maine's and New Hampshire's PDABs develop annual reports to provide detailed spending targets for selected drugs and recommend specific policies to reduce spending overall (**Table 2**).
- In a 2020 report, Ohio's PDAB provided policy suggestions for achieving prescription drug transparency, adopting payment models to achieve affordability, and creating efficiencies across health care systems.

TABLE 2

Legislative criteria of the Maine and New Hampshire PDABs

Maine | New Hampshire | Both

	Legislative criteria
Impact	Public plan enrollees
Objectives	Determine annual spending targets for drugs purchased by public payors
	Determine spending targets on specific drugs that may cause affordability challenges in a public payor health plan
	Determine the public payors likely to exceed spending targets
	Establish methods for public payors to meet spending targets
Data	Public payor prescription drug spending data
	Data compiled by State Health Data Organization
Output	Annual report of findings and recommendations
	Annual lists of the 25 most frequently prescribed drugs, 25 costliest drugs, 25 drugs with highest year-over-year cost increases (both brand and generic)

Conclusion

- PDABs have varying levels of authority and scope but have the capability to reduce drug spending and out-of-pocket costs through recommendations and UPLs.
- Compared to the IRA's focus on overall Medicare spending and impact on manufacturer pricing, state-level PDABs focus on drugs with rapid price increases and employ other methods of price control, which can impact public and/or private payors.
- The real-world impact of affordability review vs strategic PDABs requires future assessment once additional recommendations are made.

Abbreviations: FDA: Food and Drug Administration; IRA: Inflation Reduction Act; PDAB: Prescription Drug Affordability Board; UPL: upper payment limit; US: United States; USD: United States Dollar; WAC: wholesale acquisition cost.

References: [1]CMS (2023). NHE Fact Sheet. Available at: https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet [Last accessed 17 April 2024]; [2]CMS (2024). Medicare Drug Price Negotiation. Available at: https://www.cms.gov/inflation-reduction-act-and-medicare/medicare-drug-price-negotiation [Last accessed 10 January 2024]; [3]NASHP (2024). State Laws Passed to Lower Prescription Drug Costs: 2017–2024. Available at: https://nashp.org/state-tracker/state-drug-pricing-laws-2017-2024/ [Last accessed 17 April 2024]. **Acknowledgements:** The authors thank Danielle Hart, Costello Medical, for graphic design assistance and Molly Atkinson, Costello Medical, for review and editorial assistance in the preparation of this poster.

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