Policy Brief: Prescription Drug Affordability Boards (PDABs)

Background

In response to the growing burden of prescription drug prices, several U.S. states have established Prescription Drug Affordability Boards (PDABs)—independent bodies tasked with evaluating the affordability of high-priced medications and, in some cases, recommending payment limits. While some drug pricing negotiations are underway for Medicare at the national level, in the absence of comprehensive action to address unsustainable drug pricing overall, PDABs represent an approach to help states address the impact of drug costs on both their residents as well as state budgets.

As of 2024, seven states have authorized PDABs, including Maryland, Colorado, Maine, Oregon, Washington, New Hampshire, and Minnesota, each with varying levels of authority and operational scope. Maryland was the first to establish a PDAB in 2019, and five states (Colorado, Maryland, Minnesota, Oregon, and Washington) possess the legal authority to control price on certain drugs within the state system.[1]

Where implemented, PDABs have been established as advisory bodies composed of experts in clinical care, health economics, pharmacology, and public health. They are charged with reviewing the cost of prescription drugs that meet certain criteria, e.g., sharp price increases or extraordinarily high launch prices. The goal is to assess whether these costs are justified based on clinical benefit, market dynamics, and impact on patients and public purchasers (e.g. state employee health plans). If the PDAB's analysis determines a drug's price cannot be justified, it may establish an upper payment limit (UPL). The UPL is a state-specific maximum reimbursement rate certain payers (such as state employee health plans or public purchasers) may not exceed.

The intent of UPLs is to improve transparency and address pricing practices that expose patients to high out-of-pocket costs. However, PDABs face several challenges. Their authority is limited to state-regulated programs, reducing their potential impact on the broader commercial market. Pharmaceutical manufacturers and trade associations have pushed back against PDABs, arguing they could restrict access or reduce innovation.[2] PDABs also must navigate complex federal laws—including Employee Retirement Income Security Act of 1974 (ERISA)[3] and Medicaid Best Price rules[4] —that may constrain state efforts to influence pricing. Despite these hurdles, many states view the advisory functions of PDABs as a transparent mechanism for evaluating value and cost-effectiveness while providing political leverage in their rebate negotiations with manufacturers.

Concerns for ASCO Members & Where ASCO Stands

ASCO understands the need to address rising drug costs, but the growing prevalence of PDABs raises concerns about unintentional disruptions in access to life-saving therapies for patients with cancer. Drugs targeted for affordability reviews or UPLs could include novel oncology agents—treatments that, while costly, often represent the standard of care or are the only option for patients with aggressive or late-stage disease. PDABs that impose UPLs without accounting for real-world clinical nuance may create inappropriate access barriers, particularly in smaller practices or rural settings where administrative support and finances are more constrained.

Further, the structure of PDABs may not adequately represent the complexity of cancer care. Affordability decisions made without input from frontline clinicians could lead to formulary exclusions, reimbursement gaps, or delays in treatment, all of which can compromise outcomes in a disease where timely treatment is critical.[5] In addition, community oncology practices operate with leaner margins and may struggle to absorb reimbursement shortfalls if UPLs are set below acquisition costs. Activities such as storage, handling and administration often are not accounted for by UPLs, meaning additional fees would be needed to sustain the ability of such practices to acquire, manage and administer such drugs to their patients. Cost containment is a necessary goal, but it is essential that reimbursement

policies, including PDABs, include robust clinical input and safeguards to ensure that well-intentioned reforms do not result in diminished care quality for patients with cancer.

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[1] https://nashp.org/comparison-of-state-prescription-drug-affordability-review-initiatives/
[2] https://www.npcnow.org/resources/new-primer-highlights-unanswered-questions-and-unintended-consequences-state-prescription
[3] https://www.dol.gov/general/topic/retirement/erisa
[4] https://www.healthaffairs.org/content/briefs/medicaid-best-price
[5] https://www.fightcancer.org/sites/default/files/prescription_drug_affordability_boards_12-23.pdf