

Maine Prescription Drug Affordability Board: Understanding UPLs & State PDAB Progress

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About NASHP



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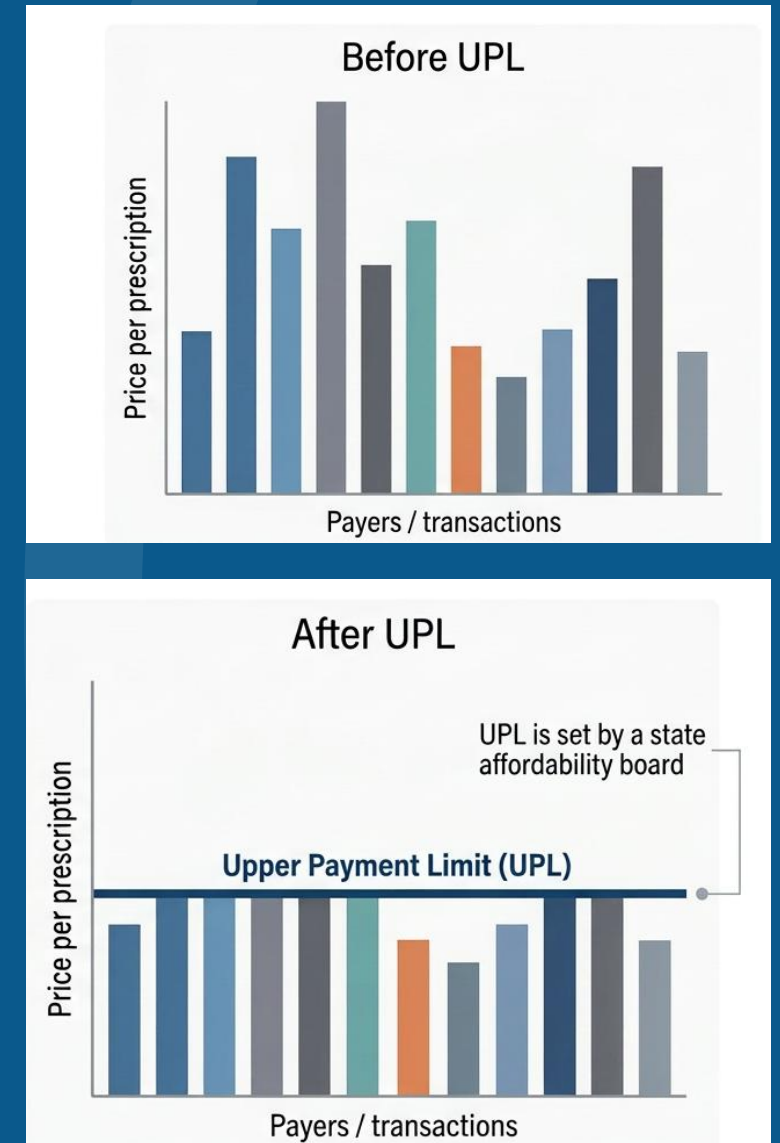
-  To improve the health and well-being of all people across every state.
-  To be of, by, and for all state by providing nonpartisan support for the development of policies that promote and sustain healthy people and communities and advance high quality, affordable health care.

Where do UPLs fit in the Rx policy menu?

Supply Chain Challenge	Policy Tools
Lack of Transparency	• Reporting by drug manufacturers, wholesalers, PBMs, and health plans on prescription drug prices, spending and rebates
High Costs for Public Purchasers	• Strengthening, amending PBM contracts • Pooling state purchasing or leveraging purchasing power • Directly negotiating for high-cost drugs or participating in federal partnerships (Medicaid) • Outcomes-based contracting (Medicaid)
Rising Spending	• Prohibiting price gouging • Penalizing manufacturers for excessive price increases
High Prices	• Setting upper payment limits via Prescription Drug Affordability Boards (PDABs) or by referencing Medicare's negotiated prices (Maximum Fair Prices) or international rates.

Using Upper Payment Limits to Address High Prices

- States can lower prescription drug costs by imposing **upper payment limits (UPLs)** to cap or limit reimbursement for a product, service, etc.
- In the prescription drug pricing context, UPLs act as a **ceiling on the amount that a payer can reimburse** for the purchase of a drug
- UPLs can be set by a PDAB or could be set by another state agency or authority by referencing something like the Medicare Maximum Fair Prices
- For state PDABs, a UPL is often established after an affordability review where a Board finds a drug to be unaffordable



Why use a UPL structure?

- Importantly, UPLs are not intended to regulate the **price** a manufacturer is able to **charge** for a product
- Instead, **UPLs regulate the purchase of a product**, setting a limit on what a payer can reimburse for a product
- UPL policy mechanism reflects lessons learned from legal challenges, including BIO vs. DC (2007)
 - DC passed a law that limited the sale of patented drugs at excessive prices
 - PhRMA and BIO argued that the law was unconstitutional in part due to federal preemption – the DC law was preempting federal patent law
 - The federal circuit agreed and struck down the law
- In contrast to the DC law, **UPLs regulate payment/reimbursement vs. price**

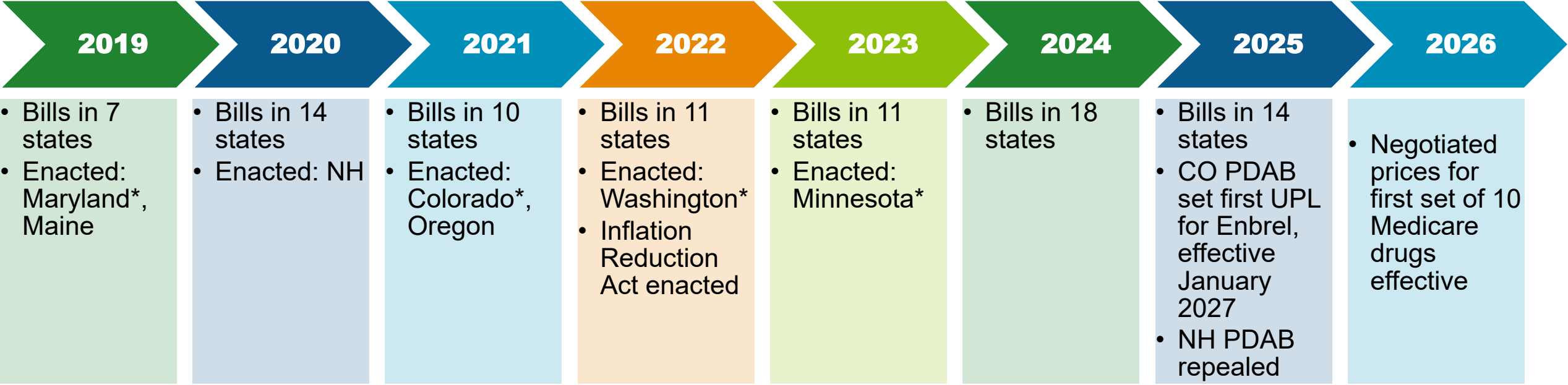
Determining UPLs

- Boards are typically tasked by statute to consider drug administration costs, delivery costs, status on FDA shortage list, and other administrative costs associated with manufacturing
- Boards may consider:
 - Is the drug overpriced relative to the prices of available therapeutic alternatives or relative to prices paid by other entities?
 - Do patients using the drug incur significant out-of-pocket costs?
 - Does spending on the drug place excessive financial burdens on the health care system?
- PDABs may consider both **comparative effectiveness** (how does this compare to alternatives) and **cost-effectiveness** (is the price justified given the impact or health outcomes), although some states are limited in how they use cost-effectiveness information.

Potential Strategies for UPLs

	Description	Considerations
(1) Internal Reference Pricing	UPLs based on the prices of a drug's comparators or therapeutic alternatives with the goal to pay similar prices for drugs that offer similar benefits to patients	• Used in other countries (e.g. Germany) • Not effective if therapeutic alternatives are also high cost
(2) External Reference Pricing - UPLs based on prices negotiated or set by other entities		
(2a) External – International Prices	UPLs set by benchmarking prices in other high-income, industrialized countries	• Used in other countries (e.g. Canada) • Prices in other countries may be confidential • Lower, international prices may be based on analyses prohibited by state statutes
(2b) External – Medicare Maximum Fair Prices (MFPs)	UPLs based on MFPs negotiated by CMS for certain eligible drugs in the Medicare program per authority in the Inflation Reduction Act (2022)	• Medicare will only negotiate for up to 20 drugs each year and only certain drugs are eligible

State Momentum on Prescription Drug Affordability Boards (PDABs)



*upper payment limit (UPL) authority

States Setting UPLs (MD, CO)

As of June 2026, 4 PDABs (MD, CO, WA, MN) have authority to set UPLs. 2 states (MD, CO) have completed affordability reviews and set UPLs.

Colorado

- Completed affordability reviews for 5 drugs across 2023 & 2024: Trikafta, Enbrel, Genvoya, Stelara, & Cosentyx
- Enbrel, Stelara, & Cosentyx were deemed unaffordable (2024)
- Set UPL for Enbrel effective January 2027
- Hearing on Cosentyx UPL planned for June 26

Maryland

- Selected 6 drugs for review in May 2024: Ozempic, Trulicity, Farxiga, Jardiance, Dupixent, Skyrizi
- Set UPL for Jardiance & Ozempic for MD government purchasers, effective January 2027
- Farxiga considered unaffordable but no UPL set as a generic version is coming to market

States Earlier in Implementation (WA, MN)

Washington (est. 2022)

- 2023 – 2024: WA developed infrastructure and methodologies for identifying drugs eligible for review, established a review process, and compiled relevant data.
- 2025: WA selected 4 drugs for affordability review (Enbrel, Xtandi, Cabometyx, and Humira) and initiated review for Enbrel and Xtandi
- 2026: Board began exploring UPL methodologies and will review data and reports for Enbrel and Xtandi in July
- UPLs are expected to be announced in early 2027, with a potential effective date 6 months after (per statute)

Minnesota (est. 2023)

- 2024: MN developed initial board infrastructure (website, staffing), engaged with experts and stakeholders, and finalized internal policies (conflict of interest, dealing with proprietary data)
- January 2025: Board received initial data from the Dept of Health on drugs eligible for an affordability review
- May 2026: Board began discussing potential criteria for selecting initial drugs for an affordability review and discussed data sources to consult.
- Board expects to solidify selection criteria in July with plans to begin the affordability review process this Fall/Winter

States Leverage Medicare MFPs

- States can leverage Medicare drug price negotiations by using Medicare's Maximum Fair Prices (MFPs) as upper payment limits - even outside of establishing a PDAB
- The Maryland and Colorado PDABs have found drugs to be unaffordable that have Medicare Maximum Fair Prices (MFPs):
 - Colorado: Enbrel & Stelara
 - Maryland: Farxiga & Ozempic
- Minnesota's PDAB has language that would set a UPL as the Medicare MFP if one is available.
- [Vermont's Green Mountain Care Board analysis](#) found that commercial plans in the state would have achieved \$29.9 million in savings in 2023 from referencing [the first ten drugs for which MFP were published](#), and that the bulk of those savings would come from just two specialty biologics, Stelara and Enbrel

Thank you!



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