



May 11, 2026

*Via Electronic Correspondence*

Gerald “Beau” Beaulieu, IV  
Committee on House and Governmental Affairs  
Louisiana House of Representatives  
900 North Third Street  
Box 94062  
Baton Rouge, LA 70804  
re  
RE: SB 401 – Provides for a Prescription Drug Affordability Board

Dear Chairman Beaulieu:

Aimed Alliance is a not-for-profit health policy organization that seeks to protect and enhance the rights of healthcare consumers and providers. We write to respectfully urge you to oppose S.B. 401, as establishing a Prescription Drug Affordability Board (PDAB) raises significant concerns regarding cost, effectiveness, and whether it would deliver meaningful savings for patients.

**I. PDABs Require Significant Resources but Have Demonstrated Limited Return for Patients**

While PDABs are often presented as an effective strategy to address drug costs, several years of real-world implementation demonstrate that they have not functioned as intended. Experience across states shows that PDABs require substantial public investment while delivering little-to-no measurable affordability relief for patients.

For example, Maryland’s PDAB, which has been operational since 2019, spent more than \$3.2 million in public funds by 2024, yet has not produced any documented savings for Maryland patients.<sup>1</sup> In Oregon, board members have expressed reservations regarding the pace, methodology, and practicality of conducting affordability reviews. Those concerns were substantial enough that Oregon paused its affordability review process in 2024, with subsequent discussions examining the future role and direction of the Board. Most notably, New Hampshire dismantled its PDAB in 2025, citing concerns regarding feasibility and effectiveness.

These challenges point to a fundamental disconnect between the theoretical promise of PDABs and their practical operation. Authorizing statutes typically provide high-level direction, leaving boards to develop the necessary procedures, methodologies, and regulatory frameworks to operate. As a result, PDABs often spend years working to understand existing drug pricing frameworks and stakeholders and identifying the rules and internal processes necessary to conduct

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<sup>1</sup>Stami Turk, *Four years later, Maryland board still hasn’t delivered for patients*, PhRMA, <https://phrma.org/blog/four-years-later-maryland-board-still-hasnt-delivered-for-patients>.

affordability reviews. Importantly, during this time, consumers don't experience improved affordability, and the state does not receive any savings.

## **II. PDABs Should Focus on Studying Prescription Drug Pricing Processes Rather than Mandating Price-Setting Frameworks**

Senate Bill 401, as drafted, focuses on understanding the costs of prescription drugs and their role in overall healthcare spending in the state. Aimed Alliance supports research efforts that allow the state to better understand the multiple factors and stakeholders that contribute to establishing prescription drug costs. Aimed Alliance supports this initiative as informed research ensures legislation accurately addresses drivers of health care costs and consumer unaffordability.

The legislation does not currently grant the PDAB authority to impose upper payment limits (UPLs) or reimbursement caps tied to Medicare's "maximum fair price" (MFP) for drugs subject to negotiation by the Centers for Medicare & Medicaid Services (CMS) under the Inflation Reduction Act (IRA). Experience in other states demonstrates that once established, the PDAB may seek to expand its mandate through recommendations to pursue such pricing authorities. For the below reasons, Aimed Alliance does not support the Board expanding the mandate to include any price-setting frameworks.

### **A. Price Caps May Fail to Deliver Out-of-Pocket Savings for Patients**

Price caps, whether implemented through UPLs or by limiting reimbursement to Medicare MFPs, apply only to what payers reimburse pharmacy benefit managers (PBMs), not to what patients pay at the pharmacy counter. As a result, they offer no guarantee of meaningful out-of-pocket savings for patients.

Moreover, existing research suggests that UPLs, which function similarly to MFP-based caps, may produce adverse effects on access and affordability. A recent *Avalere* study found that health plans anticipate increasing the use of utilization management tools, such as step therapy and prior authorization, when UPLs are imposed on certain drugs.<sup>2</sup> Plans also expect to modify formularies by shifting drugs and their therapeutic alternatives into different tiers.<sup>3</sup> These changes risk raising costs for patients and restricting access to necessary medications, underscoring the need for caution when implementing price cap policies.

Price caps may also undermine patient access in other ways. Providers may stop dispensing medications if reimbursement rates fall below acquisition costs. Payers may also prioritize drugs that are not subject to price caps or may steer patients toward alternative therapies, as many PBM rebates are tied to the drug's price, reducing PBMs' incentives to offer these options. Conversely, even if price caps operate as intended, patients who are clinically stable on therapeutic alternatives may be subject to non-medical switching to drugs targeted by these price caps. In each of these scenarios, continuity of care may be disrupted, health outcomes compromised, and safety-net providers strained, ultimately increasing overall healthcare costs. Ultimately, Aimed Alliance

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<sup>2</sup> Avalere Health, *Update: Health Plans' Perceptions of PDABs and UPLs* (Mar. 28, 2025), <https://advisory.avalerehealth.com/insights/update-health-plans-perceptions-of-pdabs-and-upls>.

<sup>3</sup> *Id.*

supports addressing the underlying systems and practices that steer patients to certain drugs and interfere with the patient-provider relationship.

## **B. Challenges of UPL- and MFP-Based Price-Setting Frameworks**

Price-setting frameworks, including UPLs and MFP-based caps, are largely experimental in the United States and have consistently struggled to meaningfully incorporate patient perspectives. Establishing and administering these frameworks is resource-intensive, often exceeding the operational capacity of state PDABs, which has led some states to rely on Medicare's MFP as a substitute. However, federal drug price negotiation is itself new and lacks robust transparency and accountability with respect to how patient, provider, and caregiver input is incorporated into final pricing decisions. This challenge is not unique to CMS. Aimed Alliance's review of 23 international drug pricing systems found that regulators across countries consistently struggle to engage patients and caregivers in ways that meaningfully inform pricing decisions. When patient and caregiver perspectives are not integrated, price caps may fail to reflect what patients value most, such as greater independence, improved quality of life, reduced symptom burden, or the ability to work and care for family, as these outcomes are often difficult to capture through traditional value-assessment frameworks.

Moreover, Medicare's MFP framework is tailored to a specific program with built-in patient protections, mandatory coverage requirements, and formulary oversight that do not exist in state-regulated markets.<sup>4</sup> Importing the MFP into a state-based pricing framework risks replicating these engagement and accountability gaps while introducing new equivalent protections for non-Medicare patients through increased utilization management and formulary restrictions, ultimately undermining patient-centered affordability goals.

## **III. Cautious, Evidence-Based Path Forward to Improve Prescription Drug Affordability**

We commend the Committee's commitment to addressing prescription drug affordability. Given the experience of other states, we recommend the scope of the PDAB's work be limited to pursuing a research-based project that focuses on understanding the costs of prescription drugs and their role in overall healthcare spending in the state. Moreover, we urge the Committee to use caution in establishing additional mandates for the PDAB, such as UPLs.

We also urge the Louisiana legislature to pursue alternative measures to improve prescription drug affordability that address the underlying systems that interfere with the patient-provider relationship and decision-making. These approaches include strengthening transparency and accountability in pharmacy benefit management practices, such as through SB 387, which

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<sup>4</sup> CMS, *Medicare Drug Price Negotiation Program: Revised Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2026*, <https://www.cms.gov/files/document/revised-medicare-drug-price-negotiation-program-guidance-june-2023.pdf>; Juliette Cubanski and Tricia Neuman, *Key Facts About Medicare Drug Price Negotiation*, KFF, <https://www.kff.org/medicare/key-facts-about-medicare-drug-price-negotiation/?entry=table-of-contents-potential-savings-for-medicare-beneficiaries-from-medicare-s-negotiated-drug-prices-depend-on-several-factors>; CMS, *Medicare Drug Price Negotiation Program: Revised Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2026*, <https://www.cms.gov/files/document/revised-medicare-drug-price-negotiation-program-guidance-june-2023.pdf>.

would delink pharmacy benefit manager compensation from drug prices. These measures offer a more direct path to lowering patient costs.

#### **IV. Conclusion**

Aimed Alliance appreciates and supports your effort to improve patient access and affordability of prescription drugs. Please contact us at [policy@aimedalliance.org](mailto:policy@aimedalliance.org) if you have any questions or would like to further discuss our concerns.

Sincerely,

Olivia Backhaus  
Staff Attorney

