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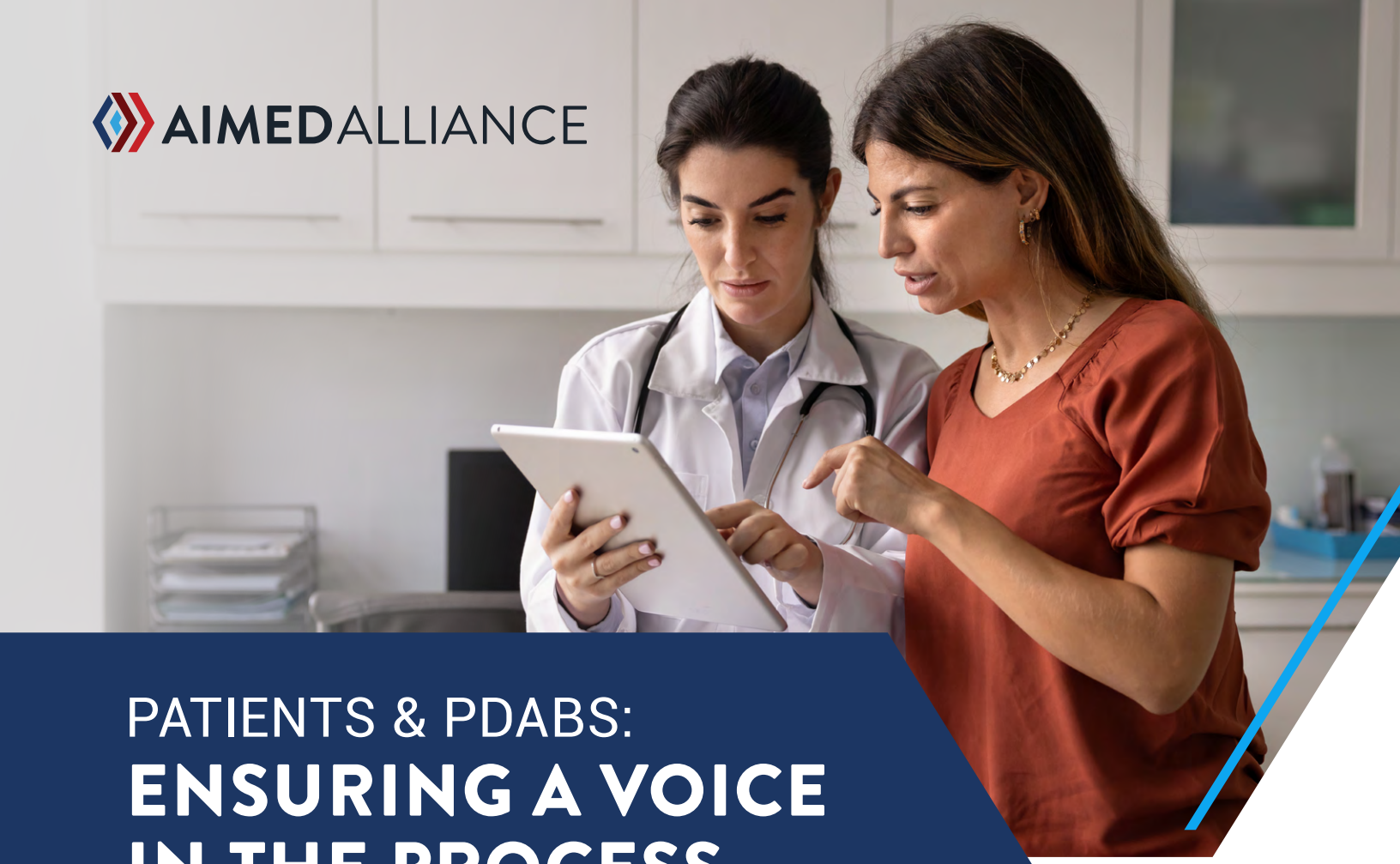

PATIENTS & PDABS: ENSURING A VOICE IN THE PROCESS

THE BASICS

What are PDABs?

In an effort to address the rising costs of prescription drugs, several states have created Prescription Drug Affordability Boards, commonly known as PDABs. These state-created boards are designed to examine prescription drugs with high list prices and identify, recommend, and implement strategies to lower prescription drug costs.

PDAB mandates vary across states because boards are required to review the cost of prescription drugs, but don't specify "cost" to whom. Therefore, some states review the state's cost of a prescription drug, while others review the cost to consumers. However, not every board is required to consider how proposed reforms will ultimately impact consumer access or improve consumer affordability.

This is why patients must engage PDABs to share their lived experience navigating health and insurance systems, and the factors that make prescription drugs inaccessible and unaffordable. Using lived experience to inform policy decisions ensures that reforms accurately address the specific barriers and challenges impacting consumer prescription drug affordability.

How are PDABs Created?

PDABs are created through state legislation. While the mandate of each PDAB varies, legislation typically outlines key features such as:

1. Who serves on the board;
2. What types of drugs the board can review (ex. Brand name drugs above a certain price, generics, or specific products like insulin or biosimilars); and
3. What authorities the board has (ex. Provide recommendations for additional reforms, impose upper payment limits, issue a report, etc.)

The authority of PDABs also varies. Some PDABs can implement recommendations and policies immediately, while others serve as advisors to the state legislature and must request additional authority if they deem it appropriate.

How do PDABs Work?

Though their responsibilities vary by state, most PDABs carry out similar tasks, such as:

- Monitoring and reporting on drug prices and market trends;
- Selecting and reviewing specific "high-cost" drugs to review;
- Conducting "affordability reviews" to determine whether a drug's price is too high;
- Holding public meetings and hearings to gather feedback on "high-cost" drugs; and
- Recommending or setting policies known as "upper payment limits" which limit how much a payer can reimburse for a prescription drug.

Where do PDABs Exist?

Colorado, Maine, Maryland, Minnesota, Oregon, Washington, and Louisiana[1] have enacted PDABs.[2] New Hampshire previously operated a board, but it has since been dismantled. For detailed information on each state's PDAB structure, authority, opportunities for public engagement, and current status, you can refer to Aimed Alliance's **resource** on enacted PDABs.

What States are Considering Establishing PDABs?

States actively considering PDAB legislation in 2026 include Georgia, Hawaii, Illinois, Michigan, Virginia, Ohio, Louisiana, and West Virginia.

Which Type of Health Plans Do PDAB Apply to?

Most PDABs have authority over health plans purchased on a state health exchange, public health plans, such as Medicaid, and state employee health plans. Depending on each state's statute, they may also apply to fully insured commercial health plans. They generally do not have authority over Medicare or self-funded employer (ERISA) plans.

How Will a PDAB Impact Me?

While legislators hope these reforms will improve costs for consumers, most states don't require that any potential savings get passed on to consumers.[3] Therefore, a UPL could save the state or health plan money, but consumers may not see an improvement in their premiums or prescription drug costs.

Importantly, no PDAB has implemented a UPL yet, leaving the full impact on consumers unclear. Federally, Congress has adopted similar price caps in Medicare. Since these price caps were established in 2025, health care providers have found that plans have narrowed their formularies, raising concerns that the price caps could reduce access and, for some beneficiaries, increase costs.[4]

This resource is part of Aimed Alliance's Consumer Education Series on PDABs. If you want to learn more, check out our resources on Upper Payment Limits and Getting Involved.

REFERENCES

1. Louisiana established its board in 2026; however, it is not yet operational.
2. New Jersey has similarly enacted a Drug Affordability Unit which formulates legislative and regulatory policy recommendations.
3. Colorado and Washington require health plans to apply any potential savings generated from UPLs toward reducing costs for consumers. See Colo. Rev. Stats. § 10-16-1401(1) and Rev. Code of Wash. § 70.405.060.
4. Kirsten Axelsen and Hely Jeppson, Keeping watch on Medicare: 2026 maximum fair prices for ten selected drugs, DLA PIPER, https://www.dlapiper.com/en-us/insights/publications/2026/01/keeping-watch-on-medicare-2026-maximum-fair-prices-for-ten-selected-drugs (finding that 61% of Medicare beneficiaries will not receive cost savings from the MFP and may experience higher premiums, narrower formularies, and greater cost sharing, with only 5% experiencing net savings after accounting for premium changes); Colorado Prescription Drug Affordability Board Meeting, at 2:42 (May 15, 2026), Zoom Recording.

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