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ResearchReport

Prescription Drug Affordability Boards

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Issue

Provide information about state-established Prescription Drug Affordability Boards, including funding methods, board membership, stakeholder involvement, affordability review requirements, and authority to set upper payment limits.

Summary

While Maryland was the first state to authorize a Prescription Drug Affordability Board (PDAB) in 2019, seven states now have a PDAB, according to the National Academy for State Health Policy (NASHP). (NASHP is a nonpartisan organization that develops and advances state health policy innovations and solutions.) The states with a PDAB are Colorado, Maine, Maryland, Minnesota, New Hampshire, Oregon, and Washington.

A PDAB is an independent entity appointed by state government officials that reviews the high cost of prescription drugs. Some states also authorize their PDAB to set upper payment limits on a prescription drug when the board determines it is unaffordable to the state's consumers or health care system. In general, PDABs strive to reduce prescription drug costs and increase access to prescription drugs.

This report addresses several PDAB topics, including funding mechanisms, board membership and appointments, stakeholder advisory council membership, affordability review requirements, and authority to set upper payment limits, among other things. Information comes from NASHP resources, state statutes, and the PDABs in Maine, Maryland, Oregon, and Washington.

State PDABs, Year Authorized, and Funding

Table 1 below identifies the seven state PDABs, the year each was authorized by statute, the initial funding appropriation (if any) to establish the board, and the annual budget to administer it (if known). (Information from NASHP comes from a comparison chart found here.)

Table 1: State PDABs, Year Authorized, and Funding

State	Year Authorized	Funding
Colorado	2021	According to NASHP, for FY 22, the state appropriated $730,711 for implementation of the PDAB.
Maine	2019	There was no General Fund appropriation to establish or administer Maine's PDAB, according to the board. Instead, costs were absorbed initially by the Office of Employee Health and Wellness, and subsequently by the Office of Affordable Health Care.
Maryland Md. Code Ann., Health – Gen., § 21-2C-11	2019	The initial funding for Maryland's PDAB came from a General Fund appropriation, but the board was required to independently fund its ongoing operating costs and repay the General Fund's initial funding. The PDAB is currently funded through the non-lapsing Prescription Drug Affordability Fund that is capitalized by a $1,000 annual assessment on prescription drug manufacturers, pharmacy benefit managers, health insurance carriers, and wholesale distributors that sell prescription drugs in the state. According to the board, the PDAB raises approximately $1 million annually in assessment revenue and generally plans operations based on a $1 million annual budget.
Minnesota	2023	According to NASHP, the board was appropriated $568,000 for FY 24 and $537,000 for FY 25 to create and maintain the PDAB. The base appropriation for FY 26 is $500,000.
New Hampshire N.H. Rev. Stat. Ann., § 126-BB:8	2020	According to NASHP, the 2020 legislation did not include an initial appropriation. As of 2022, the PDAB operates with a $350,000 annual budget. By law, the PDAB's expenses and operation costs must be funded by general funds or by voluntary contributions deposited in the board's dedicated PDAB Administration Fund.
Oregon Or. Rev. Stat. §§ 646A.695 & 705.146	2021	According to NASHP and the PDAB, the state initially appropriated $1,786,192 to the Department of Consumer and Business Services for the PDAB's first biennium. The department must reimburse the General Fund once it collects sufficient fee revenue from prescription drug manufacturers. After initial start-up costs, the PDAB is funded by the annual fees and must be self-sustaining. Oregon's PDAB is currently finalizing rules to set the annual fees and fee collection should begin in late 2024. It operates with an annual budget of approximately $1 million.

Table 1 (continued)

State	Year Authorized	Funding
Washington	2022	The Washington PDAB was initially funded by a General Fund appropriation of $950,000. Its continuous operations cost approximately $875,000 in annual appropriations, according to board representatives. (Additional budget requests have been made but not yet approved.)

Board Membership

While board membership varies by state, most include individuals with experience or expertise in health care economics or clinical medicine. Table 2 below lists the statutory membership of each state PDAB, including the members' required experience and the appointing authorities.

Table 2: PDAB Membership, Qualifications, and Appointing Authorities

State	Membership and Qualifications	Appointing Authority
Colorado Colo. Rev. Stat. § 10-16-1402	Five members, each with an advanced degree and experience or expertise in health care economics or clinical medicine. A member cannot be an employee of, board member of, or consultant to a manufacturer, carrier, or pharmacy benefit manager, or a related trade association.	The governor appoints each, subject to Senate confirmation.
Maine Me. Rev. Stat. Ann. tit. 5, § 2041(2)	Five members, each with expertise in health care economics or clinical medicine, who are not affiliated with or represent a public payor (i.e., generally a state, county, or municipal government division that administers a health plan for its employees or a related association).	The Senate president and House speaker each appoint two members and the governor appoints one. Each appointing authority also appoints one alternate member in case their appointee elects to be recused due to a conflict of interest.
Maryland Md. Code Ann., Health – Gen., § 21-2C-03	Five members, each with expertise in health care economics or clinical medicine. At least one member must have expertise in the federal 340B Program, the state's all-payer model contract, how the two interact, and how the board's decisions will affect them.	The governor, Senate president, House speaker, and attorney general each appoint one member. The Senate president and House speaker also jointly appoint one additional member who serves as chair.

Table 2 (continued)

State	Membership and Qualifications	Appointing Authority
Maryland (continued)	A member cannot be an employee of, board member of, or consultant to a manufacturer, pharmacy benefits manager, health insurance carrier, HMO, managed care organization, or wholesale distributor or related trade association. Board membership must reflect the state's racial, ethnic, and gender diversity to the extent practicable.	The governor, Senate president, and House speaker each appoint an alternate member who serves when a member is recused due to a conflict of interest.
Minnesota Minn. Stat. Ann. § 62J.87	Nine members, including seven voting and two non-voting members. Each must have knowledge and expertise in pharmaceutical economics and finance or health care economics and finance. A member cannot be an employee of, board member of, or consultant to a manufacturer or pharmacy benefit manager, or a related trade association.	The governor appoints seven voting members. The Senate majority leader and House speaker each appoint one non-voting member.
New Hampshire N.H. Rev. Stat. Ann. § 126-BB:2	Five members with expertise in health care economics or clinical medicine. A member cannot be, or be directly related to, anyone affiliated with, employed by, or representing a public payor, pharmacy or pharmaceutical company, pharmacy benefit manager, or health insurer.	The Senate president and House speaker each appoint two members and the governor appoints one. Each appointing authority also appoints two alternate members in case an appointee elects to be recused due to a conflict of interest or is absent.
Oregon Or. Rev. Stat. § 646A.693	Eight members who are state residents with expertise in health care economics and clinical medicine. A member cannot be an employee of, board member of, or consultant to a manufacturer or related trade association.	The governor appoints each, subject to Senate confirmation.
Washington Wash. Rev. Code § 70.405.020	Five members with expertise in health care economics or clinical medicine. A member cannot be an employee of, board member of, or consultant to a prescription drug manufacturer or wholesale distributor, pharmacy benefit manager, health carrier, or related trade association.	The governor appoints each.

Stakeholder Input — Advisory Councils

Five of the seven state PDABs (Colorado, Maine, Maryland, Minnesota, and New Hampshire) have standing advisory councils made up of representatives from throughout the prescription drug supply chain. In addition, Washington's PDAB establishes a separate advisory group for each drug affordability review it conducts. Generally, advisory councils provide stakeholder input to the PDAB on the affordability of prescription drugs and assist the board on making decisions. Table 3 identifies the members on each advisory council, as required by state law.

Table 3: PDAB Advisory Council Membership

State	Advisory Council Membership
Colorado Colo. Rev. Stat. § 10-16-1409	The advisory council has 15 members, including the Department of Health Care Policy and Financing executive director (or designee) and 14 members the PDAB appoints, as follows: • Two health care consumers or who represent health care consumers • One representing a statewide health care consumer advocacy organization • One representing health care consumers living with chronic diseases • One representing a labor union • One representing employers • One representing insurance carriers • One representing pharmacy benefit managers • One representing health care professionals with prescribing authority • One employed by an organization that researches prescription drugs, including pricing information • One representing manufacturers of brand name drugs • One representing manufacturers of generic drugs • One representing pharmacists • One representing prescription drug wholesalers To the extent possible, members must have experience serving underserved communities and reflect the state's diversity with regard to race, ethnicity, immigration status, income, wealth, disability, age, gender identity, and geography. Each member must have knowledge of at least one of the following: • pharmaceutical business model • supply chain business models • the practice of medicine or clinical training • health care consumer or patient perspectives • health care cost trends and drivers • clinical and health services research • the state's health care marketplace

Table 3 (continued)

State	Advisory Council Membership
Maine Me. Rev. Stat. Ann. tit. 5, § 2041(10)	The 12-member advisory council consists of six ex officio members and six members appointed by the governor. The ex officio members (or their designees), are the following: • governor • Department of Administrative and Financial Services commissioner • Department of Corrections commissioner • Department of Health and Human Services commissioner • attorney general • executive director of Employee Health and Benefits (within the Department of Administrative and Financial Services, Bureau of Human Resources) The appointed members are as follows: • One representing the Maine State Employees Association • One representing the Maine Education Association • One representing the Maine Municipal Association • One representing the University of Maine System • One representing the Maine Community College System • One representing consumer interests
Maryland Md. Code Ann., Health – Gen., § 21-2C-04	The 26-member stakeholder council consists of eight House speaker appointees, nine Senate president appointees, and nine gubernatorial appointees. The House speaker appoints the following members: • One representing generic drug corporations • One representing nonprofit insurance carriers • One representing a statewide health care advocacy coalition • One representing a statewide advocacy organization for seniors • One representing a statewide organization for diverse communities • One representing a labor union • One health services researcher specializing in prescription drugs • One public member The Senate president appoints the following members: • One representing brand name drug corporations • One representing physicians • One representing nurses • One representing hospitals • One representing dentists • One representing managed care organizations • One representing the Department of Budget and Management • One clinical researcher • One public member

Table 3 (continued)

State	Advisory Council Membership
Maryland (continued)	The governor appoints the following members: • One representing brand name drug corporations • One representing generic drug corporations • One representing biotechnology companies • One representing for-profit health insurance carriers • One representing employers • One representing pharmacy benefit managers • One representing pharmacists • One pharmacologist • One public member To the extent possible, the council's membership must reflect the state's racial, ethnic, and gender diversity. Collectively, the council members must have knowledge of the following: • pharmaceutical business model • supply chain business models • the practice of medicine or clinical training • health care consumer or patient perspectives • health care cost trends and drivers • clinical and health services research • the state's health care marketplace
Minnesota Minn. Stat. Ann. § 62J.88	The advisory council consists of 18 members appointed by the governor, as follows: • Two representing patients and health care consumers • Two representing health care providers • One representing health plan companies • Two representing employers, with one representing large employers and one representing small employers • One representing government employee benefit plans • One representing pharmaceutical manufacturers • One health services clinical researcher • One pharmacologist • One representing the health commissioner with expertise in health economics • One representing pharmaceutical wholesalers • One representing pharmacy benefit managers • One from the Rare Disease Advisory Council • One representing generic drug manufacturers • One representing pharmaceutical distributers • One oncologist not employed by or affiliated with a hospital

Table 3 (continued)

State	Advisory Council Membership
Minnesota (continued)	The governor must appoint members based on their knowledge and expertise in one or more of the following areas: • the pharmaceutical business • practice of medicine • patient perspectives • health care cost trends and drivers • clinical and health services research • the health care marketplace
New Hampshire N.H. Rev. Stat. Ann. § 126-BB:4	The 12-member advisory council consists of 11 ex officio members (or their designees) and one gubernatorial appointee, as follows: • governor • Department of Administrative Services commissioner • Department of Corrections commissioner • Department of Health and Human Services commissioner • attorney general • Department of Administrative Services' Division of Risk and Benefits director • New Hampshire State Employees Association president • New Hampshire Education Association president • New Hampshire Municipal Association executive director • New Hampshire University System chancellor • New Hampshire Community College System chancellor • a representative of consumer interests, appointed by the governor
Washington Wash. Rev. Code § 70.405.020(3) & (5)	The PDAB must establish advisory groups consisting of relevant stakeholders for each drug affordability review conducted. Stakeholders must include patients, patient advocates for the condition treated by the drug under review, and one representative of the prescription drug industry. A member generally cannot be an employee of, board member of, or consultant to a prescription drug manufacturer or wholesale distributor, pharmacy benefit manager, health carrier, or related trade association. However, a representative of the prescription drug industry on an advisory group may be an employee of, board member of, or consultant to a prescription drug manufacturer or related trade association.

Patient Interactions With PDABs

In addition to public members participating in advisory councils or groups as described above, PDABs also encourage public participation and input during public board meetings. Boards that provided comment for this report (Maine, Maryland, Oregon, and Washington) generally accept written public feedback on agenda items prior to meetings. They also allow public members to

attend public meetings and speak during meetings. For example, in Maryland, public members may sign up to speak during the public comment portion of a board meeting. The Maryland PDAB allows each public member 90 seconds to speak at meetings, whereas the Oregon and Washington PDABs allow public members three minutes to speak at board meetings. (Oregon also allows public members up to 10 minutes when speaking at an affordability review meeting.)

PDAB Affordability Review Responsibilities

By law, five of the seven state PDABs (Colorado, Maryland, Minnesota, Oregon, and Washington) are authorized to perform reviews of certain drugs to determine potential affordability challenges within the state. The drugs to be considered for an affordability review and the board's review considerations generally vary by state and are summarized in Table 4 below. (While Oregon has an affordability review program in statute, the program is suspended for the 2024 calendar year as the board considers whether to recommend changes to state law, according to Oregon's PDAB executive director.)

In contrast, the other two state PDABs (Maine and New Hampshire) are authorized by law to set spending targets for prescription drugs purchased by public payors that may cause affordability challenges to enrollees in a public payor health plan. The laws also authorize these PDABs to determine which public payors may exceed the targets and recommend ways for them to meet them. In setting spending targets, the PDABs may consider expenditures and utilization data for prescription drugs for each plan a public payor offers; each plan's formulary (i.e., list of covered prescription drugs); pharmacy benefit manager and other administrative expenses; and enrollee cost sharing (Me. Rev. Stat. Ann. tit. 5, § 2042 and N.H. Rev. Stat. Ann. § 126-BB:5).

Table 4: PDAB Affordability Review Requirements

State	Drugs Covered	Affordability Review Considerations
Colorado Colo. Rev. Stat § 10-16-1406	Until January 1, 2025: • Brand name drugs or biologics with (1) an initial wholesale acquisition cost (WAC) of $30,000 or more per 12-month supply or a shorter course of treatment or (2) a WAC increase of 10% or more in the preceding 12 months • Biosimilar drugs with an initial WAC that is not at least 15% lower than the WAC for the referenced biologic	The board must consider, to the extent practicable, the following when performing an affordability review of a prescription drug: • the prescription drug's WAC • the cost and availability of therapeutic alternatives in the state • the price's effect on state consumers' access to the prescription drug • the relative financial effects on health, medical, or social services costs compared to therapeutical alternatives

Table 4 (continued)

State	Drugs Covered	Affordability Review Considerations
Colorado (continued)	• Generic drugs with a WAC (1) of $100 or more for a 30-day supply or course of treatment or (2) that increased by 200% or more in the preceding 12 months Beginning January 1, 2025: • Any prescription drug with (1) a WAC of $3,000 or more; (2) an increase of $300 or more above the WAC in the preceding 12 months; (3) an increase of 200% or more above the WAC in the preceding 12 months; or (4) a WAC for an average course of treatment per person, per year, of $30,000 or more • Biosimilar drugs with an initial WAC that is not at least 15% lower that the WAC for the referenced biologic	• the patient copayment or other cost sharing associated with the prescription drug and typically required under health benefit plans issued by insurers in the state • the impact on safety net providers if the drug is available through the federal 340B program • orphan drug status • input from (1) patients and caregivers affected by the condition or disease treated by the prescription drug, (2) people with scientific or medical training in that condition or disease, and (3) the state's rare disease advisory council • information that a drug manufacturer, insurance carrier, pharmacy benefit manager, or other entity provides
Maryland Md. Code Ann., Health – Gen., §§ 21-2C-08 & 21-2C-09	• Brand name drugs or biologics with (1) an initial WAC of $30,000 or more per year or course of treatment or (2) an WAC increase of $3,000 or more in any 12-month period or course of treatment if less than 12 months • Biosimilar drugs with an initial WAC that is not at least 15% lower that the WAC for the referenced biologic • Generic drugs with a WAC (1) of $100 or more for a 30-day supply or shorter course of treatment or (2) that increased by 200% or more in the preceding 12 months • Other prescription drugs that may create affordability challenges for the state health care system and patients	The board must consider, to the extent practicable, the following when determining if a prescription drug presents an affordability challenge: • the prescription drug's WAC and any other relevant cost index • the average price concession, discount, or rebate the manufacturer gives to health plans in the state (as a percentage of WAC) • the average price concession, discount, or rebate the manufacturer gives to pharmacy benefit managers operating in the state (as a percentage of WAC) • the cost of therapeutic alternatives in the state • the costs to health plans based on patient access • the impact of the prescription drug's cost on patient access relative to insurance benefit design

Table 4 (continued)

State	Drugs Covered	Affordability Review Considerations
Maryland (continued)		• the expected dollar value of the manufacturer's drug-specific patient access programs • the relative financial impacts on health, medical, or social services costs compared to therapeutical alternatives • the average patient cost sharing for the prescription drug in the state The board may also consider the following information if it cannot determine potential affordability challenges using the above factors: • the manufacturer's research and development costs for the most recent tax year in proportion to the manufacturer's sales in the state • the portion of direct-to-consumer marketing costs eligible for favorable federal tax treatment in the most recent tax year multiplied by the ratio of total in-state sales to total U.S. sales • gross and net manufacturer, pharmacy benefit manager, and wholesale distributor revenues for the prescription drug under review for the most recent tax year • factors proposed by the drug manufacturer, insurance carriers, wholesale distributors, and pharmacy benefit managers that the board deems relevant
Minnesota Minn. Stat. Ann. §§ 62J.90 & 62J.91	• Brand name drugs or biologics with a WAC of $60,000 or more per calendar year or course of treatment • Brand name drugs or biologics for which the WAC increases by more than 15% or more than $3,000 in any 12-month period or shorter course of treatment • Biosimilar drugs with an initial WAC that is not at least 20% lower that the WAC for the referenced biologic	In reviewing a prescription drug's cost, the board may consider the following: • the prescription drug's sale price in the state • manufacturer price concessions, discounts, or rebates and patient assistance • the price of therapeutic alternatives • the cost to group purchasers based on patient access

Table 4 (continued)

State	Drugs Covered	Affordability Review Considerations
Minnesota (continued)	• Generic drugs with a WAC (1) of $100 or more for a 30-day supply or shorter course of treatment or (2) that increased by 200% or more in the preceding 12 months	• patient access measures, including cost sharing • the extent to which the attorney general or a court has determined that a price increase for a generic or off-patent prescription drug was excessive • information a manufacturer chooses to provide
Oregon Or. Rev. Stat. § 646A.694	Each calendar year, the board must identify nine prescription drugs and at least one insulin product (based on drugs reported by the state's Prescription Drug Price Transparency Program) that may create affordability challenges for health care systems or high out-of-pocket costs for patients in the state (excluding any prescription drug designated by the U.S. Food and Drug Administration (FDA) as treating a rare disease or condition)	The board must use at least the following criteria to identify the drugs: • if the prescription drug has led to health inequities in communities of color • the number of state residents prescribed the drug • the prescription drug's sale price in the state • the average price concession, discount, or rebate the manufacturer gives health insurance plans in the state (as a percentage of the drug's price) • the total amount of the price concession, discount, or rebate the manufacturer gives each pharmacy benefit manager registered in the state (as a percentage of the drug's price) • the cost of therapeutic alternatives in the state • the average price concession, discount, or rebate the manufacturer gives to health insurance plans and pharmacy benefit managers for therapeutic alternatives • the cost to health insurance plans based on patient use of the prescription drug • the impact on patient access relative to insurance benefit design • the relative financial impacts on health, medical, or social services costs compared to therapeutical alternatives

Table 4 (continued)

State	Drugs Covered	Affordability Review Considerations
Oregon (continued)		• the average patient cost sharing for the prescription drug in the state • information a manufacturer chooses to provide
Washington Wash. Rev. Code §§ 70.405.030 & 70.405.040	Each year, the board must identify prescription drugs that have been on the market for at least seven years; are dispensed at retail, specialty, or mail-order pharmacies; are not FDA-designated as treating a rare disease or condition; and meet the following criteria: • Brand name drugs and biologics with a (1) WAC of $60,000 or more per year or shorter course of treatment or (2) price increase of 15% or more in any 12-month period or shorter course of treatment, or a 50% cumulative increase over three years • Biosimilar drugs with an initial WAC that is not at least 15% lower than the WAC for the referenced biologic • Generic drugs with a WAC of $100 or more per 30-day supply or less that increased in price by 200% or more in the preceding 12 months	The board may conduct an affordability review of up to 24 identified prescription drugs annually, and when conducting a review, must consider the following: • relevant factors contributing to the prescription drug's cost, including the WAC, discounts, rebates, and other price concessions • average patient cost sharing for the prescription drug • the effect of the prescription drug's price on consumers' access to it in the state • orphan drug status • the dollar value and accessibility of any manufacturer patient assistance programs • the price and availability of therapeutic alternatives • input from (1) patients affected by the condition or disease treated by the drug and (2) people with medical or scientific expertise related to the condition or disease • information the manufacturer or other relevant entity chooses to provide • the impact of pharmacy benefit manager policies on the price consumers pay for the drug The board may also consider the following: • life-cycle management • the prescription drug's average cost in the state • market competition and context • projected revenue • off-label use of the drug

Upper Payment Limits

Four of the seven state PDABs (Colorado, Maryland, Minnesota, and Washington) have authority to set upper payment limits (UPLs) for prescription drugs that they find to be unaffordable within the state after conducting an affordability review. (Table 5 below describes this UPL authority.) A UPL sets a maximum rate at which a drug can be purchased in the state. It does not set the price that a manufacturer can charge.

According to Oregon's PDAB executive director, their PDAB is currently studying whether to recommend to the legislature that it be allowed to set a UPL for certain drugs and what financial impacts UPLs would have on the state, insurers, hospitals, pharmacies, and consumers. The Oregon PDAB will report on the topic to the legislature later in 2024.

There may be different ways to develop or implement a UPL (e.g., using reference prices, net price, or budgetary thresholds (see discussion here)) and these different methods will likely have different impacts on reimbursement rates for pharmacists and providers. For example, according to Maryland's PDAB, its board has discussed implementing UPLs through rebates from manufacturers to payors, which the board says would not impact reimbursement rates for pharmacists and providers. Similarly, Washington's PDAB shared that a UPL is intended to impact the payment between a purchaser and a drug manufacturer.

Table 5: PDAB Authority to Set Upper Payment Limits (UPLs)

State	UPL Setting Authority	Population Impacted
Colorado Colo. Rev. Stat § 10-16-1407	The board may set a UPL for any prescription drug for which it conducted an affordability review and determined that the drug is unaffordable for state consumers, but only for up to 12 prescription drugs in each of the three years starting April 2022, 2023, and 2024 (however, the board may set a UPL for up to 18 drugs if it determines a need to do so and has sufficient staff support).	All state consumers, except enrollees in self-funded health benefit plans that elect not to participate
Maryland Md. Code Ann., Health – Gen., §§ 21-2C-13 & 21-2C-14	If the board determines that it is in the state's best interest to establish a process for setting UPLs for prescription drugs that it determines have led or will lead to an affordability challenge, the board and stakeholder council must draft an action plan to do so for approval by (1) the Legislative Policy Committee or (2) if the committee does not approve the plan, the governor and attorney general. If approved, the board may set UPLs for prescription drugs purchased by public payors.	Enrollees of public payors, as follows: • state or local governments, including state or county correctional facilities, state hospitals, and health clinics at state higher education institutions

Table 5 (continued)

State	UPL Setting Authority	Population Impacted
Maryland (continued)		• state or local government employee health benefit plans • the state medical assistance program
Minnesota Minn. Stat. Ann. § 62J.92	If the board finds that spending on a prescription drug that the board reviewed creates an affordability challenge for the state health care system or for patients, it must establish a UPL.	All state consumers
Washington Wash. Rev. Code § 70.405.050	Each year, the board may set a UPL for up to 12 prescription drugs. (The state's Health Care Authority must adopt rules setting a methodology the board established for setting UPLs for prescription drugs it has determined have led or will lead to excess costs based on its affordability review.)	All state consumers, except enrollees in self-funded health benefit plans that elect not to participate

PDAB Reporting to Legislature

State laws establishing PDABs require the boards to report to the state legislature annually to summarize the board's work and provide legislative and regulatory recommendations. Table 6 identifies the specific reporting requirements in each state.

Table 6: PDAB Annual Reporting Requirements

State	Reporting Requirements
Colorado Colo. Rev. Stat. § 10-16-1414	By July 1 annually, the board must report the following to the governor and the House Health and Insurance and Senate Health and Human Services committees: • price trends for prescription drugs • the number of prescription drugs that were subject to board review and the review results • each prescription drug the board established a UPL for and its UPL • the impact of any UPLs the board set on health care providers, pharmacies, and patients • a summary of any judicial reviews of board decisions • a description of any conflict of interest disclosed to the board in the prior year • a description of any violations of the PDAB statutes and related enforcement actions

Table 6 (continued)

State	Reporting Requirements
Colorado (continued)	• recommendations the board may have for legislative or regulatory changes to increase the affordability of prescription drugs and mitigate excess costs on consumers and commercial health insurance premiums
Maine Me. Rev. Stat. Ann. tit. 5, § 2042(4)	By January 30 annually, the board must report the following to the Health and Insurance Committee: • prescription drug spending targets for public payors (e.g., any division of state, county, or municipal government that administers an employee health plan) • recommendations for how public payors can meet the prescription drug spending targets and progress on implementing them
Maryland Md. Code Ann., Health – Gen., § 21-2C-09(c)	By December 31 annually, the board must report the following to the Senate Finance and the House Health and Government Operations committees: • price trends for prescription drugs • the number of prescription drugs that were subject to board review and the review results • recommendations on further legislation needed to make prescription drugs more affordable
Minnesota Minn. Stat. Ann. § 62J.93	By March 1 annually, the board must report the following to the governor and legislature: • price trends for prescription drugs • the number of prescription drugs that were subject to board review and analysis and the analysis results • the number and disposition of appeals and judicial reviews
New Hampshire N.H. Rev. Stat. Ann. § 126-BB:5(IV)	By November 1 annually, the board must report the following to the governor and Health and Insurance Committee: • prescription drug spending targets for public payors • recommendations for how public payors can meet the prescription drug spending targets • strategies for optimizing the affordability of prescription drugs for the state and its residents • the progress of implementing those recommendations • annual net spending by public payors on prescription pharmaceutical products as a measure of the efficacy of implementing the recommendations to date The report must also include the following information about prescription drugs, both brand name and generic: • the 25 most frequently prescribed drugs in the state • the 25 costliest drugs as determined by the total amount spent on those drugs in the state • the 25 drugs with the highest year-over-year cost increases as determined by the total amount spent on those drugs in the state

Table 6 (continued)

State	Reporting Requirements
Oregon Or. Rev. Stat. §§ 646A.696 & 646A.697	Health Care Cost Growth Report: By December 31 annually, the board must report the following to the state's Health Care Cost Growth Target program and the legislature's health committees: • price trends for certain prescription drugs • the prescription drugs that were subject to board review • recommendations the board may have on further legislation needed to make prescription drugs more affordable Generic Drug Report: By June 1 annually, the board must report to the legislature on its findings of the board's annual study of the U.S. generic drug market. They must study the following: • prices of generic drugs on a year-to-year basis • the degree to which generic drug prices affect insurance premiums • annual changes in health insurance cost sharing for generic drugs • generic drug shortages (including potential shortages) • the degree to which generic drug prices affect annual spending in the state medical assistance program
Washington Wash. Rev. Code § 70.405.080	By December 15 annually, the board must report to the legislature on all board actions taken in the past year, including the following: • any rules adopted to set processes, such as the methodology for setting an upper payment limit • the list of prescription drugs identified for possible review • the prescription drugs that were subject to board review • any determinations of if the reviewed drugs led to or will led to excess costs • any upper payment limit set

Affiliations With Select Groups

NASHP provides technical assistance to states that have created PDABs and partners with the Program on Regulation, Therapeutics, and Law (PORTAL) at Harvard Medical School. (For more information about PORTAL, see OLR Report 2024-R-0123.) NASHP and PORTAL have developed various publications and tools for states with - or considering - PDABs, some of which are available here.

NASHP holds regular meetings with each of the state PDAB directors to share insights learned from their work. Colorado, Oregon, and Washington PDABs also contract directly with PORTAL for technical assistance. Additionally, Washington's PDAB works with the Institute for Clinical and Economic Review (ICER), which holds regular meetings to discuss their drug evaluation tools. (ICER

is an independent, non-profit research institute that conducts evidence-based reviews of health care interventions, including prescription drugs, other treatments, and diagnostic tests.)

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