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# Health Plans Predict: Implementing Upper Payment Limits May Alter Formularies And Benefit Design But Won't Reduce Patient Costs

*This report is based on research conducted by Avalere under contract to the Partnership to Fight Chronic Disease.*



## Overview of PDABs and UPLs

State policymakers are touting Prescription Drug Affordability Boards (PDABs) and upper payment limits (UPLs) as ways to control state spending and lower patient costs on prescription drugs in recent years. As of February 2024, eight states (Colorado, Maine, Maryland, Minnesota, New Hampshire, New Jersey, Oregon, and Washington) had enacted PDAB laws, with four states (Colorado, Maryland, Minnesota, and Washington) also authorizing UPLs. UPLs impose a limit on how much purchasers (such as health plans, pharmacy benefit managers (PBMs), or public payors) within a state may pay or reimburse for drugs found to be “unaffordable” after review by the PDAB. Products may be identified for review based on meeting certain pricing thresholds.

One of the aforementioned states, Colorado is in the process of conducting affordability reviews with Colorado's PDAB completing reviews of three drugs. Trikafta, for cystic fibrosis, and Genvoya, for HIV, were found to be “affordable” for patients in Colorado, while Enbrel, used for rheumatoid arthritis and other autoimmune conditions was found “unaffordable” and the PDAB initiated the UPL setting process.

Little is known about how states will operationalize UPLs if established. Because the laws limit “payment” as opposed to drug prices, they raise several challenges and unanswered questions which may lead to unanticipated impacts on plan benefit design and patient out-of-pocket (OOP) costs across health insurance markets. State lawmakers supporting PDABs and UPLs intend to reduce what patients pay for prescription drugs but may see the opposite happen if new access restrictions, product exclusions, or shortages appear in markets with UPLs in place.

## Research Background

To better understand how payers are viewing PDABs and UPLs, including challenges to implementation and anticipated changes (e.g., plan benefit design), PFCD commissioned primary research by Avalere to gather national and regional health plan perspectives. In December 2023 and January 2024, Avalere conducted a series of double-blinded interviews with health plan representatives who (1) had current or recent experience in prescription drug benefit design, and (2) were able to speak to an organization's perception of UPLs and preparedness for implementation.

A consistent script of interview questions focused on the implementation and implications of UPLs, including payers' view of drug coverage and access changes that may result in the commercial insurance market and Medicaid.

## Interview Findings

### *Payer Reaction to UPLs*

*"While well intentioned, state lawmakers did not place a ton of thought into the implementation of a UPL and how this will impact the supply chain." – CEO of Western Region, National Plan*

*"Lower prices may not be preferred overall since UPLs fail to consider the entirety of the drug supply chain that may be altered by a UPL, such as PBMs and distributors. Payers are not going to be the ones to make up the difference." – Chief Medical Officer of Northeast Region, National Plan*

Payers were first asked what preparation they were taking in advance of UPL implementation in Colorado. All interviewees disclosed that their organizations have not spent much time contemplating potential downstream issues with PDABs and subsequent UPL implementation.

### *Shifts in Plan Benefit Design*

*"Utilization management will undoubtedly go up with UPLs, whether for the drugs subjected to them or for competition. This is going to depend on how low or high the UPLs are set at and what changes this brings to classes and volume." – Vice President of Strategic Business Operations, Regional Plan*

Plan benefit designs heavily influence how patients access treatments for their health and the related costs they must pay. Payers indicated that formulary constraints are likely within a therapeutic class that has a product with a UPL. All payers interviewed noted that UPL drugs and competitors in the therapeutic class are likely to see increased utilization management (e.g., step therapy, prior authorization) should the UPL restructure new benefit designs.

Additionally, five of six payers cited in their interviews that UPL implementation would result in changes to formulary designs, such as movement up or down tiers for UPL drugs. These interviewees stated that there would likely not be significant benefit design changes, such as decreases to patient deductibles or maximum out of pocket (MOOP) limits that apply to all covered drugs. The payers indicated that plan responses would depend on where the UPL is set as well as how competitive the therapeutic class is.

Another five of the six payers interviewed noted that their respective plans were unlikely to make mid-year formulary shifts or coverage replacements mid-year; however, the same majority of payers stated that these coverage shifts would take place between six months and one year after UPL implementation.

***Impact to Patient Access and Costs***

*“Payers will not pass their savings (if any) onto individuals. It’s not realistic and somebody will need to make up the differences.” –Executive Director, Health Plan Services*

*“UPLs will alter how formularies are determined by plans which will likely mean changes to patient copays and coinsurance amounts.” – Vice President of Business Operations, Regional Plan*

*“There is a good chance beneficiaries on these (UPL) drugs also have hospitalization or physician expenses that would add to OOP max, UPLs won’t change that.” – CEO of Western Region, National Plan*

PDABs and UPLs are being implemented by states in part with the intention to lower patient OOP costs, however most payers interviewed did not perceive this to be likely. When asked for their opinion on the impact of UPLs on patient out of pocket costs:

- Most payers (five of six) did not anticipate that UPL-related savings would be passed on to patients in the form of lower premiums, deductibles, or cost sharing.
  - Three payers noted that while patients could anticipate shifts to formulary tiering, overall changes to plan benefit design, such as premiums, deductibles, and MOOP amounts, were unlikely to decrease.
  - Two payers noted that any patients on prescription drugs subject to a UPL would likely still meet their plan’s maximum out-of-pocket limits, so they would not see their overall costs reduced.

Payers did note that if a manufacturer were to stop providing drugs in a state due to the financial constraints of a UPL, the majority of payers interviewed noted that patients could cross state lines for a prescription; however, not everyone has this ability, and this could alter patient access to products.

***Provider Access Issues and Site of Care***

*“Anything that impacts product reimbursement over time will impact patient access. Providers will not want to take financial risks regarding inadequate reimbursement under UPL.” – Executive Director of Health Plan Services, National Plan*

Payers expressed that UPLs may place unintended financial pressures on provider administered UPL drugs. Most payers indicated that they base commercial provider reimbursement on Average Sales Price (ASP), and if a drug were to shift to a UPL, providers may experience challenges acquiring the product at a price consistent with the UPL. Accordingly, providers may be unwilling to accept the additional financial burden and risk of inadequate reimbursement, which will limit access to medicines for those providers and their patients. One payer explained

that if a UPL is set lower than a selected drug's ASP and a provider practices buy-and-bill acquisition processes, then providers could experience financial challenges with drug acquisition from UPLs.

## Conclusion

This research offers early indication that some payers in Colorado and other states with PDABs and UPLs have not prepared extensively for implementation of UPLs. States implementing and considering PDABs with UPL authority should consider potential impacts on plan benefit design and other downstream consequences for patient cost sharing, provider reimbursement, and access to care. Most importantly, states should take note that payers believe UPLs are likely to alter how patients in these states will be able to access their prescriptions and they do not believe UPLs are likely to reduce patients' costs.

## Policy Changes Needed

UPLs are being pursued under the banner of promoting patient access and reducing patient costs, however, this primary research highlights that the initial processes for implementing UPLs is flawed and may decrease patient access and affordability over time. PFCD supports actions that improve access and affordability and accordingly opposes efforts to adopt PDABs. To that end, we urge policymakers to understand that:

- UPLs do not reduce costs for patients and could create additional barriers to medication access for drugs subject to UPLs and others in the same drug class.
- UPLs rely on discriminatory determinations of value that include the quality-adjusted life year (QALY), the equal value life year gained (evLYG), and other metrics that undervalue benefits to older adults, people living with disabilities, and people with chronic conditions by discounting benefits outside the health care system and the value patients place on those benefits.
- Redirecting policy efforts to the barriers to care that matter to patients will yield greater benefits: banning non-medical switching; streamlining prior authorization requirements; banning copay accumulator and maximizer and alternative funding programs are areas deserving of greater legislative and regulatory efforts.

For states implementing PDABs with UPL authority, state policymakers and regulators should:

- Consider and pursue other affordability measures with a greater impact on reducing patient costs, such as copay caps, copay accumulator and maximizer bans, and requiring rebate pass-throughs to consumers at the pharmacy counter.
- Prioritize patient engagement and testimony in UPL rulemaking and decisions, including requiring patient and care partner participation as voting members of PDABs.
- Work more closely with stakeholders that a UPL could affect, including pharmacies and providers who purchase and/or administer medications.
- Define value from a patient-focused societal perspective and include benefits relating to caregiving need, improved health status and well-being, enhanced productivity, better quality of life, increased life expectancy, and reductions in disability as well as changes in health care utilization in the short and longer term.

- Reject value measures that discriminate against people living with disabilities or chronic conditions or advanced age, including the QALY and similar measures.
- Focus affordability on patient affordability, including the availability of patient assistance programs. Payer costs should be net spending, inclusive of manufacturer rebates and discounts, instead of gross spending or list price.

As the UPL setting process is moved forward by many states, PDABs should consider the risks to patient access that UPLs could bring and work more closely with stakeholders to refine both goals and intended outcomes.