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Payer Perspectives Confirm UPLs Will Likely Raise Costs and Hinder Patient Access to Medicines

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

Key Findings

Prescription Drug Affordability Boards (PDABs) aim to improve affordability for prescription drugs, but payers believe that PDABs setting upper payment limits (UPLs) would likely raise patient out-of-pocket medicine and premium costs while disrupting medicine access for patients and the state healthcare system overall.

- 77% of health plan payers surveyed believe that UPLs would disrupt patient access to prescription drugs due to changes in coverage, tiering, cost sharing, or broader supply chain issues, such as pharmacies not stocking products with UPLs.
- 67% of health plan payers anticipate that patient cost sharing for UPL drugs will increase (50%) or stay the same (17%). Similarly, most payers (70%) anticipate that out-of-pocket (OOP) costs for drugs in the same class as a UPL drug will increase (53%) or stay the same (17%).
- 57% of payers surveyed anticipated changing premiums if a UPL is implemented.
- 50% of payers surveyed indicated their plan would increase utilization management on the UPL drug.

In addition, plans anticipate disruption affecting pharmacy and provider reimbursement, further exacerbating harms to patient access.

- 60% of respondents believe that pharmacies may not stock UPL drugs; Even more respondents (73%) expressed concerns that UPLs could lead to shortages of critical medicines, all of which leading to access challenges for patients.
- 57% of respondents agreed that if a UPL were to be implemented on a provider-administered product, a provider would be reimbursed less for a drug with a UPL than what the provider would otherwise be paid for that product.

Overview of PDABs and UPLs

State policymakers are touting PDABs and UPLs as ways to control state spending and lower patient costs on prescription drugs. As of March 2025, eight states (Colorado, Maine, Maryland, Minnesota, New Hampshire, New Jersey, Oregon, and Washington) had enacted PDAB laws, with four of those (Colorado, Maryland, Minnesota, and Washington) also authorized to set UPLs on drugs determined to be "unaffordable".[1] Concepts of "unaffordable" vary by state, with at least one PDAB noting they have been unable to define unaffordability.

PDABs may identify products to target for "affordability" review or a UPL based on pricing thresholds or other more subjective criteria. UPLs would impose a limit on how much purchasers (such as health plans, pharmacy benefit managers (PBMs), or public payers) within a state may pay or reimburse for drugs found to be "unaffordable" after review by the PDAB. The laws limit "payment" or reimbursement as opposed to drug prices. As a result, they raise several challenges and unanswered questions, which may lead to unanticipated impacts on plan benefit design, patient OOP costs, pharmacy reimbursement, and a pharmacy's ability to stock medicines.

[1] This analysis only included states that have passed legislation that establish PDABs that are required to conduct affordability reviews. For example, VT's Green Mountain Care Board has the option to conduct an affordability review of a set selection of drugs, but it is not a requirement.

State lawmakers supporting PDABs and UPLs intend to reduce what patients pay for prescription drugs but may see the opposite happen if OOP costs rise or fail to decline and new access restrictions, product exclusions, or shortages appear in markets with UPLs in place.

Research Background & Methodology

Health plans have a unique perspective to inform the possible implications of a UPL on coverage decisions and consequences for other stakeholders that may affect patient costs and access. To understand the implications, PFCD commissioned Avalere to gather insight into plan perceptions and preparedness for PDABs and UPLs.

Avalere updated and built on previous payer interviews done in 2023, released by PFCD in 2024. The previous research revealed doubts among payers that UPLs would be implemented, but this update shows that payers are now paying closer attention to PDABs and UPLs. Issues raised in the previous payer interviews prompted concern that patients would not benefit from UPLs, and those issues remain unresolved today. Payers were more focused on system-wide impacts this year, including concern that administrative burdens related to UPL implementation would raise costs. Clearly, Boards need to do more work and research to address unintended consequences of PDABs.

As payers refer to the cost of the drug throughout the responses described in this paper, it is important to note that they may be referring to their organization's cost – not the cost to the patient. Considering those plan costs, some interviewees implied that they believe PDABs could deem a drug unaffordable but simultaneously set a UPL higher than what payers already negotiate, negating the impact of the UPL and highlighting the savings in the system without UPLs that do not reach the patient or plan sponsor.

Interviews

Between January and February 2025, Avalere conducted six, in-depth, 30-to-45-minute interviews with current and recent representatives from national and regional plans who 1) had experience with plan decision-making on formularies and prescription drug benefit design and 2) were able to speak to their plan's perceptions of UPLs. Cumulatively, interviewees represented health plans with 115.2 million covered lives. The interviews were double-blinded and did not include interviewees from the 2023 project. Interview questions were asked consistently across interviewees and covered benefit design, patient costs and access, contracting, pharmacy access, reimbursement, and UPL implementation.

Surveys

In February 2025, Avalere conducted a survey with a different pool of 30 representatives from national and regional plans who 1) had experience with plan decision-making on formularies and 2) were able to speak to their plan's perceptions of UPLs. Cumulatively, survey respondents represented health plans with 476.3 million total enrollees.[2] The survey was double-blinded and did not include individuals who were interviewed in 2023 or 2025. The 37 survey questions focused on benefit design, patient access and costs, contracting, pharmacy access, reimbursement, appeals process, and UPL implementation.

[2] Surveyed payers did not identify their organization, thus there may be overlap of covered lives.

Detailed Findings

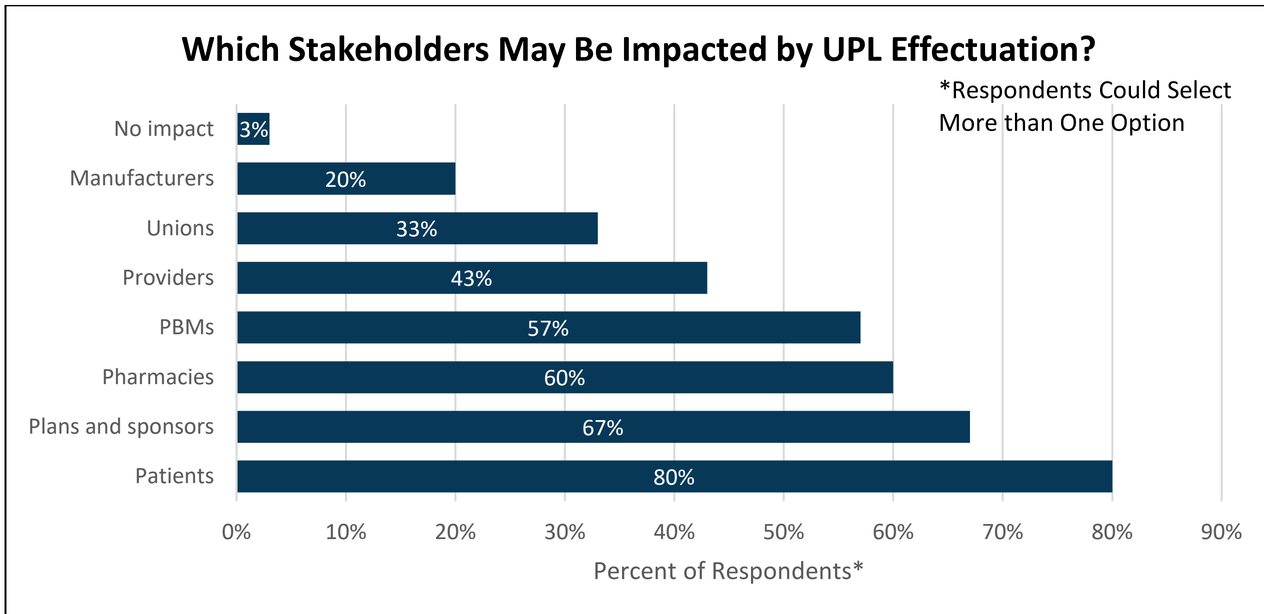
Disruption to Prescription Drug Ecosystem

Payers suggested that PDABs have "noble" goals but also raised concerns about unintended consequences of UPLs. For example, 77% of payers surveyed believe that effectuation of a UPL would disrupt patient access to prescription drugs. This disruption could come in the form of plan changes, such as adjustments to coverage, tiering, or cost sharing, or broader supply chain issues, such as pharmacies not stocking products with UPLs. The Analytics Lead at a national plan illustrated this idea, saying:

> ***"If a drug is out of stock or low stock in a specific state, depending on the formulary design, patients may not be able to get their preferred drugs, and the other alternative drugs may have higher out of pocket costs and require a prior authorization."***

When provided with a list of stakeholders susceptible to disruption due to UPLs, patients were identified most often by surveyed payers (80%) – higher than any other stakeholder group. Specifically, patients could see higher OOP costs, disruption to access, increased premiums, and added utilization management (UM).

Figure 1. Stakeholders That May be Impacted by UPL Effectuation



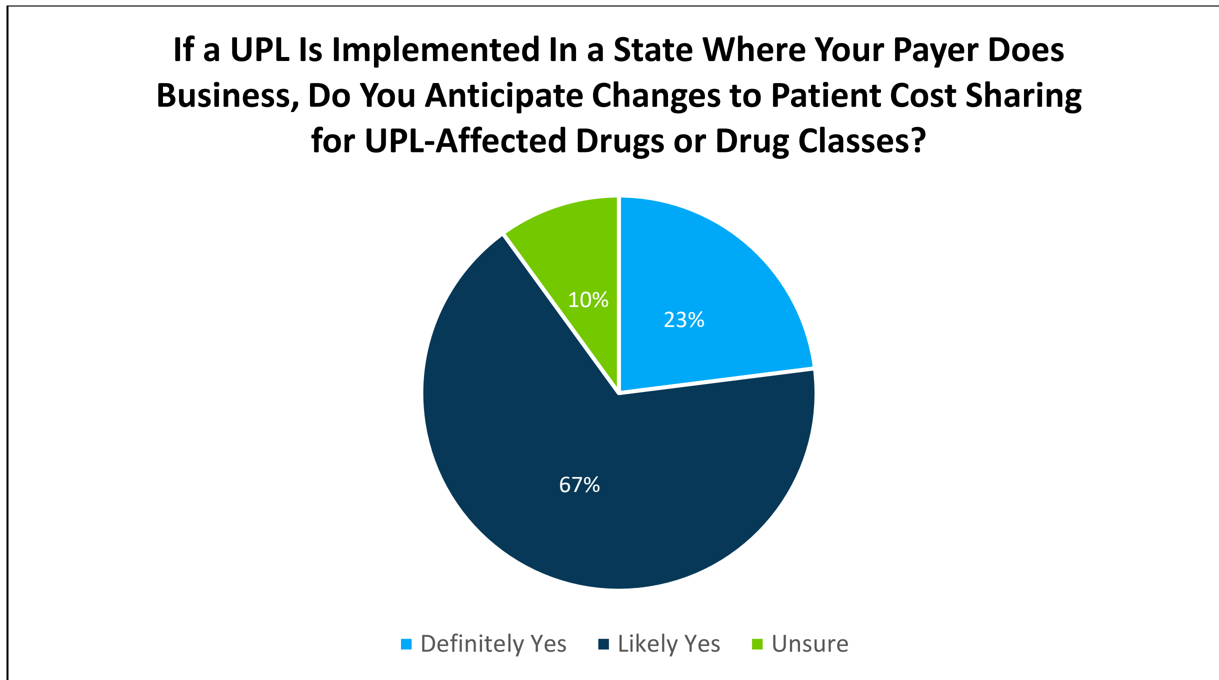
Considering plan and PBM impacts, payers highlighted that UPLs would necessitate changes to PBM contracts and that UPLs would impact plan profits—both of which could contribute to patient impact. The Senior Product Director of Consumer Experience at a national plan noted, "*[Setting a UPL lower than current price] would have an impact on access for sure, just because of the trickle effect it's going to have on plans and PBMs needing to remain sustainable.*"

Payers noted that plans will not absorb additional costs generated by UPLs but will instead pass those costs along to others in the system including enrollees. In the words of the Vice President of Operations at a regional plan, "*that cost has to be absorbed by somebody, and … the carrier is not going to absorb it because we might reduce our profitability*."

Respondents anticipate these additional costs will be driven by changes to claims systems and reimbursement practices, timing of implementation, and changes to cost sharing or formularies which were all identified as the primary challenges resulting from effectuation. More broadly, 63% of payers believe that a UPL would lead to disruption in the state's health insurance market. Respondents identified changes in reimbursements to pharmacies or providers, higher administrative burden, and changes to rebating as the primary disruptions.

Surveyed and interviewed payers both discussed the administrative burden likely to be incurred from UPL implementation. 40% of survey respondents agreed that UPL implementation would result in higher administrative burden on plans, provider, pharmacies, or even patients.

Figure 2: Changes to Patient Cost Sharing



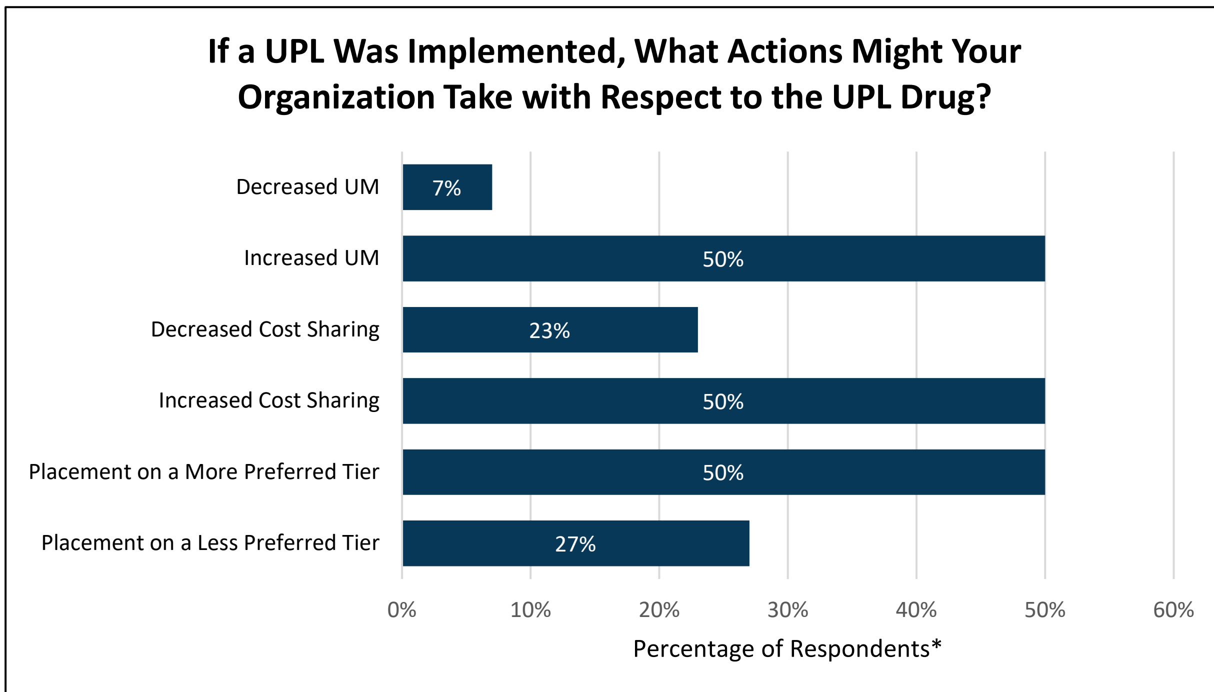
Benefit Design

Benefit design could change significantly in the face of UPLs. As shown in Figure 2, plans expect that patients will face changes to their costs as a result of UPL implementation, such as increased premiums or cost sharing. 90% of respondents said that there would "definitely" or "likely" be changes to patient cost sharing for UPL-affected drugs or drug classes, with interviewees noting complex negotiation and contracting dynamics as changes that could increase patient costs. Overall, payers (60%) expected changes to OOP costs, with 50% of all surveyed payers expecting increased copays or coinsurance on the UPL drug. Specifically with regard to premiums, 57%

anticipated increasing premiums if a UPL is implemented, and only 10% said they would decrease premiums for enrollees.

Payers also noted increased use of prior authorization (PA) and other UM techniques in the event of UPL effectuation. 50% of respondents indicated their plan would increase UM on the UPL drug. Increased UM could extend even to provider-administered products if PDABs place UPLs on those types of drugs. A Technical Product Director at a National Plan, referring to physician-administered products, noted that "stricter utilization management criteria and medical necessity criteria and possible site of care restrictions [would be needed]" in the case of a UPL.

Figure 3: Plan Responses to UPL Implementation



Pharmacy Access and Provider Payment

Payers expressed concerns that setting UPLs below current prices* could disrupt pharmacy contracts. Since PDAB legislation establishes a reimbursement cap on drugs with UPLs, PBMs would likely only be able to reimburse pharmacies up to the UPL while pharmacies' acquisition costs could exceed UPL. In line with this, 70% of respondents agreed that pharmacy reimbursement would decrease due to UPL effectuation. This could lead to strain on pharmacy operations. 60% of respondents thought that negative impacts to pharmacy reimbursement would decrease the likelihood that the pharmacy keeps the UPL drug in stock, leading to access challenges for patients. An even greater number of respondents (73%) believe that lower stock of UPL drugs

*Participants considered the impact of a UPL compared to the price the plan is currently paying for a drug. Because the amount paid by a plan varies widely, it is likely that some UPLs could be below the current cost to some payers but above other payers' current cost for a drug.

could lead to shortages in states with a UPL. When asked to elaborate on the impact of UPLs on pharmacies, payers responded:

> ***"If reimbursement is impacted, pharmacies will be less likely to stock the medication as they cannot afford to lose money on every fill."*** **– Mail Order Pharmacy Lead, National Plan**
>
> ***"I think there could be pharmacies that say that they don't want to participate because they can't do it at a loss because they're the last transaction in the supply chain."*** **– Vice President of Pharmacy Operations, Regional Plan**

The survey also asked specifically about physician-administered drugs. 57% of respondents agreed that if a UPL were to be implemented on a provider-administered product, a provider would be reimbursed less for a drug with a UPL than what the provider would otherwise be paid for that product. When asked who would make up the difference to the provider, 47% indicated that patients would be responsible for making up the difference, and 6% noted that providers would be responsible, i.e. that providers would not be made whole.

> **A Vice President of Operations at a regional plan emphasized this idea, saying,**
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> ***"That cost has to be absorbed by somebody, and … the carrier is not going to absorb it because we might reduce our profitability."***

Conclusion

While PDABs have a goal of improving patient affordability and overall financial sustainability for the state and larger healthcare system, these interviews and surveys demonstrate that UPLs would not achieve that goal, but rather could result in higher premiums, increased UM, and decreased patient access.

Payers agreed that PDABs often simplify or fail to understand the complexities of the prescription drug supply chain, and that has led to proposed UPL effectuation plans that threaten to push a new administrative burden and cost onto various players in the system, including patients.

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