Follow the Upper Payment Limit

Upper payment limits (UPLs) will not fix drug affordability for patients. They will disrupt the supply chain in ways that threaten access, and no one will feel that more than patients. Especially those with rare disease.

For years, states have implemented various legislative policies to lower prescription drug costs. The first wave was pharmacy benefit management transparency rules, theorizing that greater transparency would reduce prices. The second wave focused on manufacturer price transparency reporting requirements, with legislators believing that requiring manufacturers to report and justify price changes would prevent drug prices from increasing. Neither has reduced costs nor improved affordability for states or patients, because the solutions ignored the workings of the healthcare system.

The most recent wave started in 2019, when state legislatures began implementing prescription drug affordability boards (PDABs) to lower the price of specified high-cost drugs. While Maryland was the first, as of mid-2026 nine states have active PDABs, with many more states considering it. Whereas, New Hampshire and Ohio have backed away from their PDAB initiatives.

A PDAB is a state-based oversight entity created to evaluate and manage the cost of prescription drugs. Equipped with legislative authority that varies by state, PDABs are tasked with monitoring drug prices, implementing price controls, conducting data analysis, reporting on pricing trends and drug markets, and formulating policy recommendations to improve consumer prescription drug affordability. Membership on PDABs varies, but in general they have a mix of five to seven board members who meet regularly, at least quarterly. Their remits differ. Some states seek to reduce spending for Medicaid; others focus on state employee health programs; others take a broader view and look at state and local government purchases or even all payers in the state. In some states, PDABs study prescription drug costs and make recommendations to negotiate additional Medicaid supplemental rebates. In other states, they establish spending targets, set UPLs, or employ other strategies.

The Promise vs. Reality

Prescription drug affordability pressures are real for families, employers, and public budgets. The PDAB model offers an appealing response: create an independent expert board, conduct rigorous affordability reviews, and use the findings to set an upper limit on what the state will pay. The concept sounds targeted rather than blunt, expert-driven rather than political. For legislators facing constituent distress and constrained state authority, it is an appealing tool.

Theory has not matched reality. As of mid-2026, two states have adopted UPLs. Colorado set a $600 per dose limit for the arthritis biologic Enbrel, effective January 2027 (although that is currently blocked and on hold while courts review.) Maryland followed in April 2026, setting a UPL for the diabetes treatment Jardiance at $204 for a 30-day supply, also effective January 2027. Maryland considered a UPL for Farxiga as well but declined to proceed after the FDA approved the drug's first generic just days before the board's vote.

Colorado's experience illustrates how slow and resource-intensive this work is in practice. The PDAB reviewed five drugs over two years, found three unaffordable, including Enbrel, Cosentyx, and Stelara, all treatments for autoimmune conditions, and is completing rulemaking for the first. Cosentyx rulemaking is underway. Stelara's status is contested following the arrival of biosimilars. Amgen, which manufactures Enbrel, filed a second federal lawsuit in October 2025 after the UPL was finalized, asserting constitutional challenges that have not yet been resolved. That case is actively proceeding.

Maryland has moved on a different set of drugs. The Maryland PDAB completed affordability reviews for four diabetes and weight-loss medications, including Jardiance, Farxiga, Ozempic, and

Trulicity, and is moving to set UPLs for Jardiance and Farxiga using Medicare's Maximum Fair Price as a benchmark. Washington and Minnesota are still building administrative infrastructure and have not yet initiated affordability reviews. Oregon reviewed 23 drugs but has set no UPLs.

And yet, after all this work, no patient has seen a lower copayment because of a PDAB-set UPL. It reflects the fundamental mechanics of how UPLs interact with the supply chain, which this brief examines in detail.

Years of work. Significant state resources. One drug.
Not one dollar saved for patients at the pharmacy counter.

How a UPL Is Set: Methodology and Data Challenges

A UPL is a maximum amount that payers can reimburse a pharmacy or provider for dispensing or administering a specific drug. While a UPL sets a ceiling on what payers can pay for a drug, it does not dictate the price a manufacturer can charge for it. PDAB advocates have stated that they hope the UPL will pressure manufacturers to lower prices, but the state does not have the authority to set the manufacturer's price. This distinguishes the UPL from the Inflation Reduction Act's Medicare Drug Price Negotiation Program, under which manufacturers must, as a condition of participating in Medicare, lower the acquisition price to the negotiated level.

What a UPL is and is not

A UPL sets a ceiling on what payers can reimburse for a drug. It does not set the price a manufacturer charges. It does not require a manufacturer to sell at the capped price. It does not guarantee that savings reach patients. It is a reimbursement cap, and like any ceiling, it affects everyone below it while leaving the underlying market price unchanged.

States use different methodologies to calculate the specific UPL value. The most used options are described below.

- **Reference Pricing.** PDABs can use internal reference pricing, comparing the UPL drug's price to the prices of therapeutic alternatives within the same class. External reference pricing involves benchmarking against prices negotiated by federal programs, most notably Medicare's Maximum Fair Price (MFP) under the Inflation Reduction Act. Colorado used MFP as the benchmark for its Enbrel UPL. Minnesota's statute goes further, requiring that any UPL be set at the MFP if one exists for that drug.
- **Net Price Modeling.** PDABs can set the UPL at the average net price of the drug, meaning the list price after accounting for rebates and discounts negotiated between the manufacturer and pharmacy benefit managers (PBMs) or health plans. The intent is to ensure that the payment limit reflects the actual cost experienced by payers rather than the inflated list price. The problem is that net pricing data is not publicly available. States must purchase rebate estimates from commercial data vendors because they do not have direct access to the confidential discount arrangements between manufacturers and PBMs.
- **Budget Impact Thresholds.** PDABs can consider the drug's impact on overall budgets and set a UPL intended to limit the drug's contribution to health insurance premium growth or to achieve specific spending reduction targets.
- **Premium Growth Thresholds.** A UPL can be calculated to minimize commercial insurance premium growth across the state, directly linking the savings to tangible premium reductions for enrollees.

Maryland's proposed methodology for Farxiga offers the most detailed public example of how a state is attempting to operationalize a UPL. Maryland's PDAB proposed using the federally published Medicare MFP as the baseline, rounding up to the nearest five cents to establish a standard starting point, then adjusting that baseline annually using the Consumer Price Index for All Urban Consumers (CPI-U) to account for inflation over time. This approach, while more systematic than most, still depends on a federal price that was designed for a Medicare population and a Medicare payment system, and translating it to a multi-payer commercial state market creates complications that are discussed further below.

Washington State has outlined five separate UPL methodological options, each with distinct advantages and operational limitations. Therapeutic reference pricing is straightforward but offers limited utility if all alternatives in a class are also priced at high levels. External reference pricing based on international prices faces the problem that foreign prices are frequently confidential or calculated using Quality-Adjusted Life Years (QALYs), which Washington's statute prohibits. MFP referencing faces timing mismatches between federal negotiation cycles and state PDAB review timelines. Net price modeling is conceptually sound but depends on data that states cannot independently obtain. Premium growth threshold modeling requires actuarial analysis and cannot easily isolate the impact of a single product.

A single product at a lower price is a drop in the overall ocean of healthcare spending. It does not cause a ripple; it simply is absorbed.

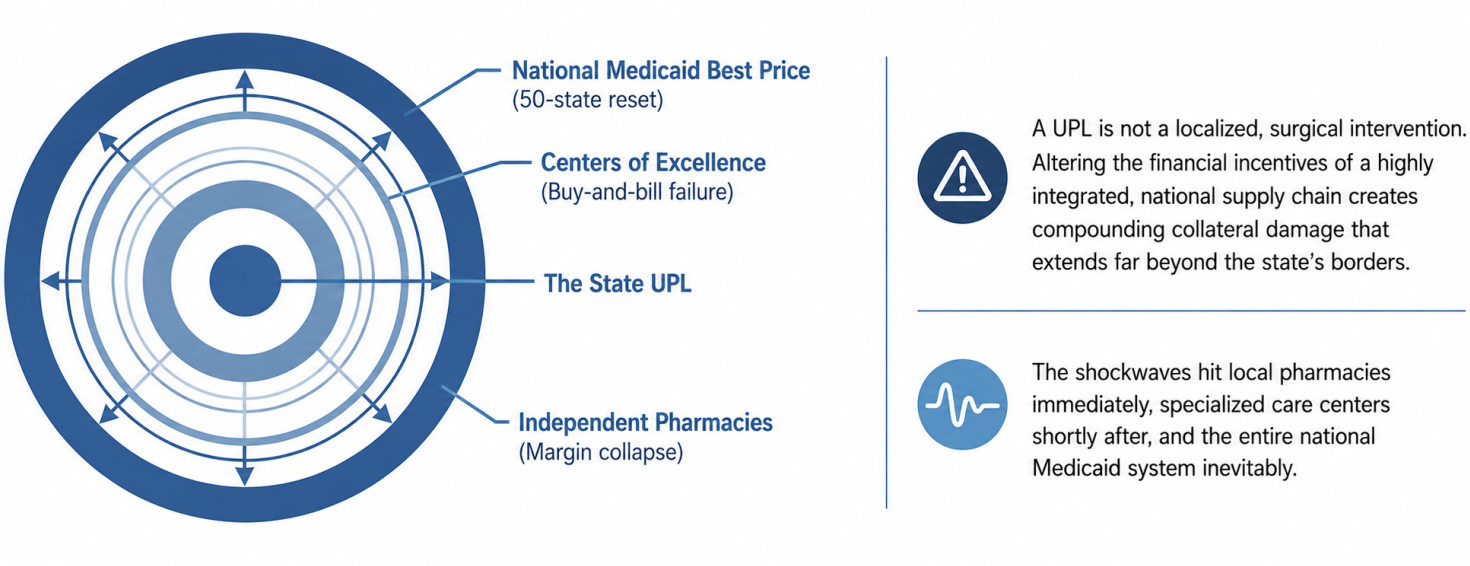
The fundamental challenge across all methodologies is that the "unaffordability" determination, even when eligibility triggers are quantitative, remains a multi-factor qualitative assessment. State laws do not mandate a standardized formula to define affordability, meaning PDABs retain substantial administrative discretion. The same drug could be found affordable in one state and unaffordable in another using the same underlying data.

Oregon's experience illustrates the risk of statutory mandates. The Oregon PDAB was required by statute to find at least one insulin product unaffordable annually. When board members initially concluded that none of the reviewed insulin products met the standard for unaffordability, the statute required the board to revisit its findings. The board reversed its determination without conducting a new systematic evaluation. This outcome illustrates how rigid legislative requirements can force regulatory bodies into subjective decisions that satisfy a political mandate rather than reflect a genuine affordability analysis.In 2024, Connecticut, Illinois, Iowa, Kentucky, Michigan, Nebraska, Rhode Island, South Carolina, Vermont, Wisconsin, and West Virginia all had proposed PDAB legislation. Legislative efforts have continued into 2025, with states like Arizona, Kansas, Michigan, Pennsylvania, Virginia, West Virginia, and Wisconsin considering similar measures.

Follow the Dollar: What Happens to the Supply Chain

To understand why UPLs do not reliably help patients, it is helpful to see how the money flows through the pharmaceutical supply chain. The supply chain is a system of interdependent financial relationships between manufacturer, wholesaler, pharmacy, PBM, and health plan. Changing one part of that system does not simply move money from one place to another. It alters incentives across the entire chain in ways that can reduce access without delivering the savings that motivated the policy in the first place.

The UPL Blast Radius



The supply chain begins with the pharmaceutical manufacturer, which sets the Wholesale Acquisition Cost (WAC). Wholesalers purchase the drug at WAC and then resell it to pharmacies at a contracted discount. In return for their distribution services, manufacturers pay wholesalers a distribution service fee, typically structured as a percentage of WAC. That fee covers financial management, inventory management, and logistics. Pharmacies, once they have dispensed the drug to a patient, are reimbursed by a PBM working on behalf of the patient's insurer. PBMs also negotiate rebates from manufacturers in exchange for favorable formulary placement. Those rebates flow back through the system, with a share going to the health plan and ultimately used to offset premiums, reduce deductibles, or contribute to plan revenue.

The following illustrative example uses a self-administered specialty drug with a WAC of $4,000 per month. This is conservative for the class of drugs most likely to trigger PDAB review. Biologics for autoimmune conditions, oncology, and rare diseases routinely cost between $4,000 and $12,000 per month. The UPL is set at $3,000, reflecting a 25 percent average commercial rebate, consistent with how states using net price approaches are currently modeling limits. Specific percentages and dollar amounts vary by contract, drug, and payer. These examples show the direction and magnitude of change across stakeholders and the structural problems a UPL creates.

Illustrative Example

Scenario A: Standard Commercial Transaction (No UPL)

Self-administered specialty drug, WAC = $4,000 per month. All figures are illustrative.

Stakeholder and Transaction	Amount	Calculation
MANUFACTURER		
Sets national list price (WAC) $4,000 WAC	$4,000	WAC
Pays wholesaler distribution fee -$180 WAC x 4.5%	-$180	WAC x 4.5%
Pays PBM rebate -$400 WAC x 10%	-$400	WAC x 10%
Pays PBM administrative fee	-$180	WAC x 4.5%
Manufacturer retains	~$3,240	
WHOLESALER		
Buys drug from manufacturer at WAC	-$4,000	WAC
Collects distribution fee from manufacturer	$180	WAC x 4.5%
Sells to pharmacy at discount	$3,840	WAC minus 4.0%
Wholesaler retains	~$20	
PHARMACY		
Acquires drug from wholesaler	-$3,840	
Patient pays pharmacy (coinsurance)	$797	20% of ingredient cost (AWP minus 17%)
PBM pays pharmacy (ingredient cost minus patient cost-sharing, plus dispensing fee)	$3,189	$3,984 minus $797 plus $2 dispensing fee
Pharmacy retains	~$146	
PBM		
Collects rebate from manufacturer	$400	WAC x 10%
Collects admin fee from manufacturer	$180	WAC x 4.5%
Passes share of rebate to health plan	-$350	87.5% pass-through
Pays pharmacy (UPL cost minus patient cost-sharing plus dispensing fee)	-$3,189	
Gets paid by health plan for drug claim	$3,189	
PBM retains	~$230	
HEALTH PLAN		
Pays PBM for drug claims (ingredient cost minus patient copay, plus dispensing fee)	-$3,189	$3,984 minus $797 patient copay plus $2 dispensing fee
Collects rebate pass-through from PBM	$350	87.5% of rebate passed through
Health plan net cost after rebate	~-$2,839	
PATIENT		
Patient pays pharmacy directly (coinsurance at 20% of ingredient cost)	$797	Based on full, unrebated price

Illustrative Example

Scenario B: Same Drug, UPL in Effect at $3,000. Assuming Manufacturer Agrees to Lower UPL

What changes across the supply chain when the state imposes a UPL set at average net price (WAC minus 25%).

Stakeholder and Transaction	Amount	Calculation	
MANUFACTURER			
Sets national list price (WAC)	$4,000	No change	
Pays wholesaler distribution fee -$180 WAC x 4.5%	-$180	No change	
Pays PBM rebate -$400 WAC x 10%	-$400	No change	
Pays PBM administrative fee	-$180	No change	
Gives wholesaler UPL discount to pass along	-$1,000	$-1,000	
Manufacturer net impact	$2,240	-$1,000	May reconsider market participation; innovation incentives affected. All payments tied to WAC.
WHOLESALER			
Buys drug from manufacturer at WAC	-$4,000	No change	Won't know at time of sale who patient is so can't apply UPL pricing
Collects distribution fee from manufacturer	$180	No change	
Sells to pharmacy at discount	$3,840	No change	
Submits state-specific UPL chargeback to manufacturer	$1,000	New administrative step	Must isolate and track state-specific transactions; cash flow timing uncertainty
Provides UPL discount to pharmacy	-$1,000	New administrative step	
Wholesaler retains	~$20	No change	
PHARMACY			
Acquires drug from wholesaler	-$3,840	No change	20% of ingredient cost (AWP minus 17%)
Patient pays pharmacy (coinsurance)	$797	$0	
UPL discount from wholesaler (passed from manufacturer)	$1,000	$1,000	
PBM pays pharmacy (ingredient cost minus patient cost-sharing, plus dispensing fee)	$2,205	-$984	UPL is a ceiling, not a floor; PBM may reimburse below it
Pharmacy retains	~$162	$16	PBM might adjust, UPL is a ceiling.
PBM			
Collects rebate from manufacturer	$400	No change	
Collects admin fee from manufacturer	$180	No change	
Passes share of rebate to health plan	-$350	No change	
Pays pharmacy (UPL cost minus patient cost-sharing plus dispensing fee)	-$2,205	$984	
Gets paid by health plan for drug claim	$2,205	-$984	
PBM retains	~$230	No change	
HEALTH PLAN			
Pays PBM for drug claims (at UPL ceiling)	-$2,205	$3,984 minus $797 patient copay plus $2 dispensing fee	
Collects rebate pass-through from PBM	$350	No change	
Health plan net cost after rebate	-$1,855	$984	
PATIENT			Only if state mandates pass-through and monitors compliance.
If plan passes savings through (Colorado only)	$600	**-$197**	
If plan does not pass savings through	$797	No change	Most likely scenario in most states; patient bears access risk without financial benefit

The two scenarios above reveal four structural problems that persist regardless of how carefully a state sets its UPL.

- **The ceiling has no floor.** A UPL caps what a PBM can reimburse a pharmacy, but nothing prevents a PBM from reimbursing below that ceiling. Pharmacies are already losing money on high-cost drugs under current PBM reimbursement, before any UPL is applied. A UPL does not fix that problem. It gives PBMs additional cover to compress pharmacy margins further while protecting their own revenue streams.
- **The rebate disappears, but savings do not reliably flow to patients.** When acquisition price drops to the UPL, the manufacturer's rebate to the PBM largely evaporates. That rebate historically flowed to health plans and was used to reduce premiums or offset cost-sharing. Under a UPL, it is gone from the rebate stream. Unless the state mandates that savings be passed directly to patients at the point of sale, which only Colorado has done and without a clear monitoring mechanism, the health plan captures whatever savings exist and patients bear the access risks of supply chain disruption without any financial benefit.
- **The chargeback creates real operational complexity.** When Colorado requires Enbrel at $600 per dose, the wholesaler must buy at the national list price, supply at the state-mandated limit, and then submit a state-specific chargeback to the manufacturer to recoup the difference. This requires wholesalers to isolate, verify, and track Colorado-specific commercial transactions separately from the rest of their national operations.

  If the economics of managing that complexity do not justify the return, wholesalers may decline to stock the drug in that state entirely.
- **Drug diversion risk increases.** When legitimate reimbursement rates are suppressed below acquisition costs, financially stressed pharmacies may face pressure to source medications from less secure, grey-market online channels. The introduction of counterfeit or diverted products into the state's drug supply chain is a documented risk associated with state-level price caps. This is a patient safety issue.

Other Concerns

The Medicaid Best Price Complication

There is a consequence of UPL implementation that most state legislators do not fully account for when they vote to create UPL authority: the effect on Medicaid Best Price.

If a state PDAB sets a UPL at a level that falls below the drug's current Medicaid Best Price, the UPL becomes the new national Best Price for that drug. This is not a local consequence. A pricing decision made in Colorado resets the Medicaid rebate floor in all fifty states. Every state Medicaid program's rebate calculation is affected. Manufacturers face increased Medicaid liability nationwide, which can affect their willingness to do innovative research for the Medicaid population, the types of drugs they bring to market, and in extreme cases their decision to continue participating in the Medicaid program at all.

A price cap set in one state does not stay in that state. If a UPL falls below Medicaid Best Price, it resets the rebate floor for every state's Medicaid program nationwide.

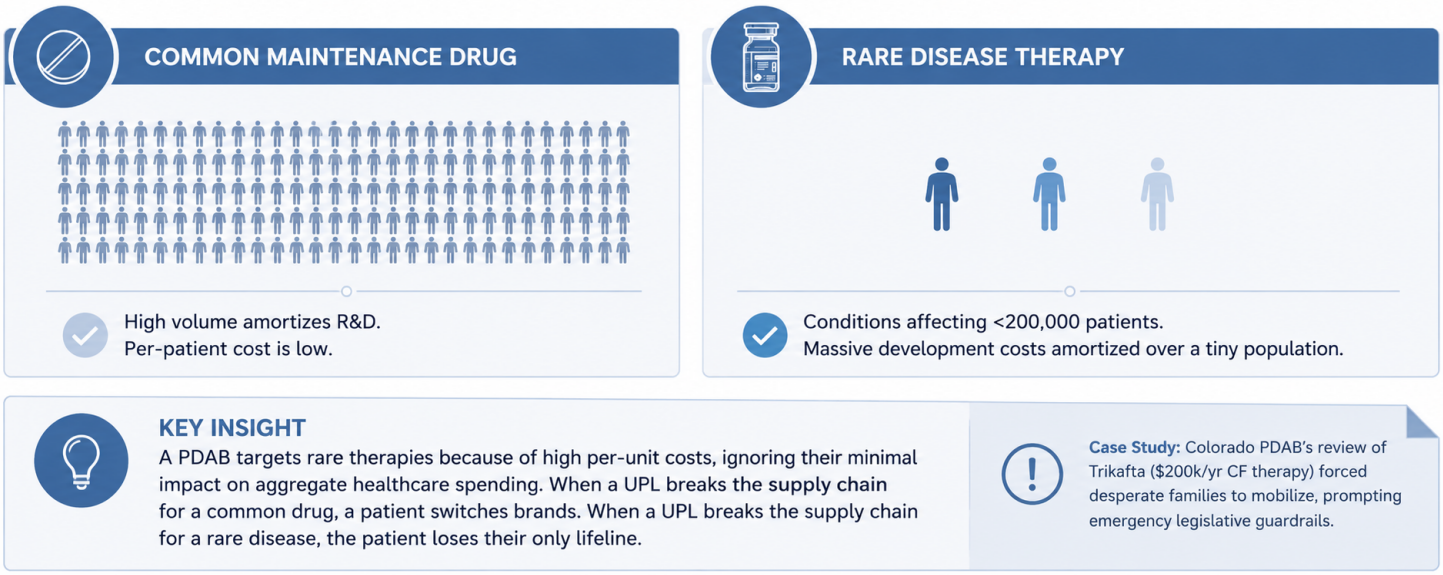
Maryland has recognized this problem and specifically legislated a carve-out to prevent its UPLs from affecting Best Price. Most states have not addressed this issue. The gap deserves explicit attention in any state considering UPL authority, and it is not included in most of the model legislation currently circulating in state capitals.

The Rare Disease Problem

Everything described in the sections above creates problems for any patient whose drug ends up subject to a UPL. For patients with rare diseases, the stakes are categorically different.

Rare disease drugs carry high prices for reasons rooted in the economics of drug development. Rare diseases are defined as conditions affecting fewer than 200,000 people in the United States. High per-unit costs reflect the economic reality of developing treatments for conditions that may affect only a few thousand patients nationally. For some manufacturers of orphan drugs, the difference between one or two patients in a quarter can affect their ability to remain financially viable.

The Rare Disease Crisis: The Economics of the Few



A PDAB may select a rare disease therapy for a full cost review because of its high per-unit cost to state Medicaid or public employee budgets, even though the drug's aggregate impact on overall healthcare spending is minimal compared to widely prescribed maintenance medications for common conditions.

Unlike patients with common conditions, rare disease patients often have no alternatives. If a PDAB sets a UPL that disrupts supply chain economics and a wholesaler declines to stock the drug or a manufacturer exits the state market, the patient is not merely inconvenienced. In a state where a UPL creates conditions under which the drug is no longer distributed, a patient may lose access to a therapy that has no substitute anywhere.

The experience in Colorado illustrates the concern. In 2023, the PDAB considered whether to set a UPL for Trikafta, the cystic fibrosis therapy that can cost upwards of $200,000 per year. Families of children on the medication mobilized to ask a direct question: is Colorado going to take away access to a medicine that their children need to survive? The board ultimately found Trikafta was not unaffordable and did not proceed to UPL rulemaking.

The experience prompted the legislature to pass a 2024 law requiring the PDAB to consider formal input from consumers and the state's Rare Disease Advisory Council before proceeding with reviews. Colorado is currently debating SB 26-140, a bill that would create a complete statutory exemption for FDA-designated rare disease drugs and plasma-derived therapies from PDAB review.

Table: State-level Rare Disease Protections

State	Exemption Level	Key Provisions	QALY Prohibition
Oregon	Complete exemption	Any FDA-designated rare disease drug is fully excluded from affordability reviews. The exemption does not apply if the drug is used for non-rare indications.	Prohibited by statute
Washington	Partial (narrow)	Only drugs approved solely for a single rare disease are exempt. Adding a second indication strips the protection, even if that second indication is also for a rare disease.	Prohibited by statute
Colorado	None (guardrails only)	No automatic exemption. A 2024 law requires setting Rare Disease Advisory Council input before review. SB 26-140, pending as of mid-2026, would create a full exemption.	Prohibited for UPL-
Minnesota	None (advisory only)	No statutory exemption. One seat on the PDAB Stakeholder Advisory Council is reserved for a Minnesota Rare Disease Advisory Council representative.	No explicit prohibition
Maryland	None (mandated consideration)	HB 424/SB 357 (2025) requires the board to consider rare disease status when setting UPLs but does not bar caps on these products.	No explicit prohibition

The Single-Indication Trap

One of the most consequential and least discussed structural problems in PDAB design is the way exemptions are constructed for rare disease drugs. Both the federal Inflation Reduction Act orphan drug exemption from Medicare price negotiation and Washington State's PDAB exemption protect a drug only if it is approved solely for a single rare disease indication.

If a manufacturer seeks Food and Drug Administration (FDA) approval for a second rare disease indication on an already approved product, the drug immediately loses its protection under both federal and state frameworks. This is true even if the second indication is also for a rare disease affecting a similarly small patient population.

A manufacturer with an approved rare disease drug would be financially discouraged from pursuing additional rare disease research on that product, because doing so would expose the drug to both federal price negotiation and state UPL authority.

The exemptions that were designed to protect rare disease patients simultaneously create a disincentive to expand access to additional rare disease populations. This kind of second-order consequence rarely surfaces in state floor debates, but it will show up in pharmaceutical company research and development decisions over time.

Site of Care Concerns

For patients with rare diseases, access issues extend beyond the retail pharmacy. Many rare disease treatments are administered in clinical settings by specialists, often at Centers of Excellence that concentrate expertise in conditions affecting small populations. These providers operate under a buy-and-bill reimbursement model, in which they purchase the drug upfront, administer it to the patient, and then seek reimbursement from the health plan or public program. The provider's margin depends on the spread between the acquisition cost and the reimbursement rate.

If a state UPL caps provider reimbursement below the acquisition cost, the provider faces an immediate, unrecoverable loss on every dose administered. Centers of Excellence and specialty practices may respond by declining to administer UPL-affected drugs, referring patients to other states, or reducing the number of patients they are able to serve. For a rare disease patient who may already be traveling significant distances to access specialized care, the loss of in-state administration may make treatment practically inaccessible.

Many rare disease drugs are also available only through a sole-source specialty pharmacy, frequently located out of state. If that specialty pharmacy's economics are disrupted by a UPL set in a patient's home state, there may be no alternative distribution channel to turn to.

What This Means Going Forward

Pending court decisions, Colorado's Enbrel UPL takes effect in January 2027. Cosentyx rulemaking is underway in Colorado. Maryland is moving forward on Jardiance and Farxiga. Washington and Minnesota are building the infrastructure to conduct their first reviews. Oregon has reviewed 23 drugs and is issuing final affordability determinations. The pipeline is active and expanding.

After years of effort across multiple states, no patient has seen a lower copayment because of a PDAB-set UPL. That outcome reflects the fundamental mechanics of how UPLs interact with the supply chain. A UPL caps reimbursement at the payer level, not cost sharing at the patient level. Unless states mandate that savings flow through to patients at the point of sale and establish a mechanism to monitor and enforce that requirement, the savings remain with the health plan. Patients bear the access risks of supply chain disruption without the financial benefit that was supposed to justify those risks.

The supply chain disruption risks are real and unequally distributed. They fall hardest on independent community pharmacies operating on margins that are already negative for some high-cost drugs. They fall on Centers of Excellence and specialty practices that cannot absorb reimbursement rates set below their acquisition costs. And they fall most heavily on patients with rare diseases, who have no alternatives if the supply chain for their specific therapy stops functioning in their state.

States that want to reduce what patients pay have patient-focused alternatives that work with supply chain economics rather than against them:

- Risk pooling and reinsurance spread the cost of high-cost specialty and rare disease therapies across a broader enrollment base, reducing the pressure on individual health plans to restrict access to expensive drugs.
- Capped copay programs set a direct ceiling on patient out-of-pocket costs for specialty drugs, directing financial relief to beneficiaries rather than leaving savings at the plan level.
- Restricting copay accumulator and copay maximizer programs restores the intended value of manufacturer patient assistance funds. More than two dozen states have already acted, ensuring those payments count toward a patient's deductible and out-of-pocket maximum rather than being captured by health plans and PBMs.
- Alternative Funding Programs present a growing safety and transparency problem: they redirect employer plan enrollees away from covered drug benefits toward patient assistance programs designed for the uninsured, or toward internationally sourced drugs that fall outside FDA oversight.

These approaches share a design principle: savings follow the dollar all the way to the patient.

UPLs as currently designed redirect money within the system without reliably directing it toward patients. Policymakers who want to lower what patients pay should follow the dollar all the way to the pharmacy counter. Right now, it stops well short of that.

Policymakers who want to lower what patients pay should follow the dollar all the way to the patient. Under current UPL designs, the dollar stops at the health plan.

Sources

1. Rare Access Action Project. Solving for Access and Affordability: PDABs Are Not the Answer. August 2025.
2. Rare Access Action Project. Importing Most Favored Nation Pricing into States Is Not the Answer. March 2026.
3. Rare Access Action Project. Why Medicare's Maximum Fair Price Is Not a Model for State Drug Pricing. February 2026.
4. Drug Channels Institute. Follow the Dollar: How the Pharmaceutical Distribution and Payment System Shapes the Prices of Brand Medicines. February 2025.
5. Drug Channels Institute. The 2025 to 2026 Economic Report on Pharmaceutical Wholesalers and Specialty Distributors.
6. MultiState Associates. Here's What Prescription Drug Affordability Boards Have Been Doing in 2025. December 15, 2025. https://www.multistate.us/insider/2025/12/15/heres-what-prescription-drug-affordability-boards-have-been-doing-in-2025
7. MultiState Associates. Prescription Drug Affordability Boards Face Legal Challenges as States Tackle Drug Costs. February 25, 2026. https://www.multistate.us/insider/2026/2/25/prescription-drug-affordability-boards-face-legal-challenges
8. Colorado Division of Insurance. PDAB UPL Benchmark Data Staff Memo. November 22, 2024. https://doi.colorado.gov/sites/doi/files/documents/UPL%20Benchmark%20Data%20Staff%20Memo.pdf
9. Congressional Research Service. Litigation over State Attempts to Lower Drug Costs: Prescription Drug Affordability Boards. LSB11390. January 2026. https://www.congress.gov/crs-product/LSB11390
10. NASHP. District Court Dismisses Challenge to Colorado's Prescription Drug Affordability Board. April 2025. https://nashp.org/district-court-dismisses-challenge-to-colorados-prescription-drug-affordability-board/
11. Goodwin Law. Prescription Drug Affordability Review Boards: 2025 Update. June 2025. https://www.goodwinlaw.com/en/insights/publications/2025/06/alerts-lifesciences-prescription-drug-affordability-review-boards
12. Partnership to Fight Chronic Disease and Avalere Health. Health Plans Predict: Implementing Upper Payment Limits May Alter Formularies and Benefit Design But Will Not Reduce Patient Costs. March 2025.
13. Maryland Prescription Drug Affordability Board. Farxiga Upper Payment Limit Methodology. 2026. https://pdab.maryland.gov/Documents/Cost%20Review/2026/Farxiga.Upper%20Payment%20Limit.METHODOLOGY.v1.0.pdf
14. Colorado Newsline. Colorado Bill Seeks to Exempt Some Drugs from Affordability Review over Access Concerns. April 3, 2026. https://coloradonewsline.com/2026/04/03/exempt-drugs-affordability-review/
15. EACH Coalition. Letter to Colorado PDAB on Enbrel, Cosentyx, and Stelara UPL Process. May 2025. https://doi.colorado.gov/sites/doi/files/documents/Written%20Testimonies_5.23.25.pdf
16. Washington State Health Care Authority. PDAB Upper Payment Limit Methodology Slides. March 2026. https://www.hca.wa.gov/assets/program/pdab-upper-payment-limit-slides.pdf
17. ADVI. Prescription Drug Affordability Boards: Access Concerns and Implications for Rare Diseases and Conditions. https://advi.com/insight/prescription-drug-affordability-boards-and-rare-diseases/
18. Aimed Alliance. IRA, PDABs, and Orphan Drugs. August 2024. https://aimedalliance.org/wp-content/uploads/2024/08/AA-OrphanDrug-FactSheet-August2024.pdf
19. Partnership for Safe Medicines. PDAB Activity Reports, 2025 to 2026. https://www.safemedicines.org
20. National Community Pharmacists Association. Report for January 2025 Survey of Independent Pharmacy Owners and Managers. https://ncpa.org
21. National Academy for State Health Policy. Prescription Drug Affordability Boards: Potential Risks to Pharmacy Reimbursement. https://naspa.us/blog/resource/pdab/
22. CRA Life Sciences. Upper Payment Limits (UPLs) Explained. December 2025. https://media.crai.com/wp-content/uploads/2025/12/15121242/CRA-LS-Upper-Payment-Limits-Explained-December2025.pdf

Prepared by Apteka LLC for the Rare Access Action Project. June 2026.

Illustrative Example

Scenario C: Same Drug, UPL in Effect at $3,000. Assuming Manufacturer Does Not Agree to UPL Price

What changes across the supply chain when the state imposes a UPL set at average net price (WAC minus 25%).

Stakeholder and Transaction	Amount	Change vs. Scenario A	
MANUFACTURER			
National WAC is unchanged	$4,000	--	
Sells to wholesaler at WAC	$4,000		
Pays wholesaler distribution fee	-$180	--	WAC x 4.5%
Pays PBM rebate	-$400	--	WAC x 10%
Pays PBM administrative fee	-$180	--	WAC x 4.5%
Manufacturer net impact	~$3,240		
WHOLESALER			
Buys drug at WAC price	-$4,000	--	
Distribution fee based on WAC	$180	--	WAC x 4.5%
Sells to pharmacy at discount	$3,840	--	WAC minus 4.0%
Wholesaler retains	**~$20**		
PHARMACY			
Acquires drug from wholesaler	-$3,840	--	WAC minus 4.0%
Patient pays pharmacy (coinsurance)	$797	--	
PBM reimburses at UPL ceiling and dispensing fee minus patient coinsurance	$2,205	-$984	UPL is a ceiling, not a floor; PBM may reimburse below it.
Pharmacy retains	-$838	-$984	UPLs are about reimbursement, not about price. Pharmacy would get reimbursed at UPL – even if manufacturer didn't sell it at that price.
PBM			
Collects rebate from manufacturer	$400	--	WAC x 10%
Collects admin fee from manufacturer	$180	--	WAC x 4.5%
Passes share of rebate to health plan	-$350	--	87.5% pass-through
Pays pharmacy (UPL cost minus patient cost-sharing plus dispensing fee)	-$2,205	$984	
Gets paid by health plan for drug claim	$2,205	-$984	
PBM retains	$230	--	
HEALTH PLAN			
Pays PBM for drug claims (at UPL ceiling)	-$2,205	$984	
Collects rebate pass-through from PBM	$350	--	
Health plan net cost after rebate	-$1,855	$984	
PATIENT			
If plan passes savings through (Colorado only)	$600	-$197	Only if state mandates pass-through and monitors compliance.
If plan does not pass savings through	$797	No change	Most likely scenario in most states; patient bears access risk

If a manufacturer decides not to lower their price to the UPL, someone must absorb the lower UPL reimbursement. Because of vertical integration, chain pharmacies may be made whole (or closer to it) by PBMs. Independent pharmacies would not have this vehicle.

Support for this paper was provided by Apteka.