# PR

THE PDAB ISSUE

PATIENTS RISING

"THE MORE LAYERS YOU ADD BETWEEN A PATIENT AND THEIR MEDICINE, THE WORSE IT GETS."

# PATIENTS DON'T ACTUALLY BENEFIT

*VIRGINIA IS REVISITING PDABS PATIENTS ARE ASKING WHY.*

# FROM THE FOUNDER

## No One Should Consider It A Financial Risk to Seek Medical Care in America

When PDABs were first introduced, they were framed as a patient-first solution to rising drug prices to identify high-cost medications, apply oversight and create relief for patients struggling to afford care.

That promise has not materialized. Maryland established the nation's first PDAB in 2019, offering the most complete real-world test of how these boards function in practice. Six years later, the record is clear. The state has spent millions of taxpayer dollars on infrastructure, staffing, analyses and administrative processes designed to support the board's work. What remains absent is evidence that any of that activity has translated into meaningful savings for patients at the pharmacy counter. There are no documented reductions in out-of-pocket costs, no data showing improved access to treatment and no clear pathway linking the board's actions to better patient outcomes.

Instead, PDABs operate upstream, focused on pricing benchmarks and cost-effectiveness models that never reach the point of care. Their authority stops short of the insurance practices that most directly determine what patients pay, including formularies, utilization management, step therapy and prior authorization. The result is a system that appears active while leaving the patient experience unchanged.

In some cases, the consequences are worse.

PDABs rely on economic tools such as

quality-adjusted life year calculations to assess whether a treatment is "worth" its price. These models reduce complex human lives to averages and projections, often disadvantaging people with disabilities, chronic illnesses and rare diseases. When these calculations influence pricing decisions, patients can face tighter coverage restrictions, delayed approvals or fewer treatment options, even when a medication is clinically appropriate.

This is not hypothetical. Patients already navigating pharmacy benefit managers and insurer denials are acutely aware that adding another layer of cost control does not simplify access. They know it makes it more complicated.

Virginia is now revisiting PDAB legislation, despite having access to Maryland's experience.

Before creating another board with broad authority and limited accountability, lawmakers should ask a basic question: where is the evidence that PDABs help patients?

At Patients Rising, we believe affordability efforts must be judged by outcomes, not intent. If a policy does not lower what patients pay, does not improve access and does not strengthen the patient-provider relationship, it is not a patient solution. Healthcare policy should reduce friction, not add new decision-makers between patients and care. It should prioritize transparency, accountability and real-world impact. PDABs, as currently structured, have failed that test.

Patients deserve policies that work where it matters most: at the point of care, in the pharmacy and in real lives.

Yours in Advocacy,

Terry Wilcox

Terry Wilcox
Co-Founder and Chief Mission Officer
Patients Rising

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# MARYLAND'S PDAB WAS MEANT TO LOWER DRUG COSTS

## SIX YEARS AFTER LAUNCHING THE COUNTRY'S FIRST PDAB, MEASURABLE RELIEF FOR PATIENTS REMAINS ELUSIVE.

As the cost of drugs continued to rise for Americans, states felt pressure to act in the absence of federal solutions. The results, however, have since drawn increasing scrutiny and raised questions about effectiveness.

Prescription Drug Affordability Boards, or PDABs, emerged as the solution some states chose to pursue. The boards were designed to identify medications considered excessively expensive and apply oversight intended to curb rising costs. Lawmakers promoted the approach as a pragmatic response in the absence of comprehensive federal reform in an effort to frame PDABs as a way to protect patients from prices that had become increasingly difficult to afford.

Maryland's Prescription Drug Affordability Board was sold as a lifeline for patients drowning in pharmacy bills, but years after its creation, it has yet to lower a single copay or deductible for Marylanders at the counter. The numbers show a board that has spent millions, produced plans and presentations, but delivered no direct, measurable financial relief to the patients it promised to protect.

When Maryland lawmakers passed the nation's first PDAB bill in 2019, the idea was simple enough to fit on a bumper sticker: take on high drug prices and make medicines affordable again. The statute laid out a timeline in which the board would study the drug supply chain, design a process, and, if approved by legislative leaders, begin imposing "upper payment limits" on selected drugs paid for by state and local government plans.

Supporters framed Maryland as a national model that other states would follow, pointing to future upper payment limits as a tool to force down prices and ease pressure on families rationing insulin, inhalers, and cancer drugs. For patients who had already been cutting pills or skipping doses, the creation of the PDAB sounded like the first real structural response coming out of Annapolis in years.

**The Machinery Without Results**
On paper, the board has been busy. It built staff, developed a detailed "Upper Payment Limit Action Plan," and began cost reviews of high-priced drugs in diabetes, heart failure, inflammatory disease, and weight loss, including Ozempic, Jardiance, Farxiga, Trulicity, Dupixent, and Skyrizi. In September 2024, the board unanimously approved its UPL framework; by October, the Legislative Policy Committee signed off, clearing the way for UPLs tied in part to federal Medicare "Maximum Fair Price" negotiations.

**The Cost to Patients**
For patients, the clock has been ticking the entire time. A 2022 survey of Maryland residents found that nearly 1 in 4 respondents—23 percent—either did not fill a prescription, cut pills in half, or skipped doses in the prior year because of cost. These hardships hit low-income households hardest, but they are "alarmingly prevalent" even in middle-income families who thought they had done everything right by securing coverage.

National polling echoes the same story: a 2023 Kaiser Family Foundation survey reported that about 28 percent of U.S. adults have difficulty affording prescription drugs, and roughly three in ten admitted they did not take medicines as prescribed at least once in the past year due to cost. Against that backdrop, the absence of any quantifiable, documented reduction in out-of-pocket spending attributable to Maryland's PDAB is not an abstraction; it is measured in skipped insulin doses, untreated infections, and hospitalizations that could have been avoided.

**Millions Spent, No Clear Savings**
The financial record cuts against the rhetoric of affordability. Patient advocacy analyses estimate that Maryland has appropriated at least $1 million dollars per year for PDAB operations and has spent more than $3 million dollars to date on staff, consultants, and infrastructure.

Even sympathetic observers concede that PDABs have been costly to implement and operate, with states spending millions without demonstrably lowering patient costs, placing Maryland alongside 11 other states as an example of high administrative spend with no clear patient savings.

Broader research on PDABs suggests that even when UPLs are eventually implemented, most payers expect little or no benefit for patients. A double-blind 2025 survey of payers from Avalere Health reported that 67 percent anticipated patient cost-sharing on UPL-designated drugs would either increase (50 percent) or stay the same (17 percent), not decrease. In other words, the best-case scenario in the minds of many insurers is that the board becomes a budget tool for plans and governments, not a relief valve for the person at the register.

**A System Designed Upstream**
Critics argue that the core design flaw is structural: Maryland's PDAB focuses on "top-line" costs in the supply chain, but has no direct, enforceable mechanism to make sure any negotiated savings flow through to patients' out-of-pocket costs. Draft regulations emphasize protecting Medicaid "best price," minimizing adverse market consequences, and avoiding disruption to manufacturers' federal obligations, but say nothing explicit about capping copays or coinsurance for individuals.

Meanwhile, policy experts warn that PDAB-driven negotiations could encourage payers and pharmacy benefit managers to respond with tighter formularies, more prior authorizations, or step therapy requirements—changes that may lower plan spending while making access harder and less predictable for patients. For Maryland residents still cutting pills and skipping refills, the board has become another distant institution speaking in the language of frameworks and action plans, while the cash price at the counter remains unchanged.

# WHAT PATIENTS NEED TO KNOW ABOUT PDABS

**PDABS OFTEN DO NOT LOWER WHAT PATIENTS ACTUALLY PAY FOR MEDICATIONS. AS A RESULT, PATIENTS ARE LIKELY TO RUN INTO THE FOLLOWING ISSUES:**

## REDUCED ACCESS

PDABs block patient access to the right treatment by removing drugs from formularies, imposing stricter prior authorization rules, or requiring patients to "fail first" on a less expensive medication before they can access the treatment their doctor prescribed. This practice, known as non-medical switching, can cause needless suffering and even be life-threatening.

## HIGHER COSTS

There's no guarantee that any savings from a PDAB's price cap will be passed on to patients. In fact, some studies show that patients may end up paying more for drugs subject to price controls.

## DRUG SHORTAGES

Patient advocates and economists agree that government-imposed price controls, including those set by PDABs, can lead to drug shortages.

## DISCRIMINATION

PDABs often use discriminatory measures, like the Quality-Adjusted Life Year, to determine a drug's "value". QALYs are a flawed metric that devalues the lives of people with chronic and life-threatening illnesses.

## LIMITS ON PROVIDERS

PDABs create policies that override a doctor's prescribing recommendations, shifting the decision-making power from medical experts to government bureaucrats.

## LOSS OF PROGRAMING

Manufacturers may reconsider or alter the eligibility for their patient assistance programs if a drug is subjected to a UPL, which could leave patients with high out-of-pocket costs.

# AS VIRGINIA REVISITS DRUG PDABS, PATIENTS WORRY ABOUT ACCESS

Greg Josephs has learned to move through the world carefully, because his body does not always respond when he expects it to.

“If I approach a curb, my eyes tell my brain to lift my feet,” he said. “But if I stumble, my feet say, ‘We never got the message.’”

That disconnect is part of living with myasthenia gravis, a rare autoimmune disease that interferes with the communication between nerves and muscles. On a walk with his dog, Remy, a curb that looks ordinary can become an obstacle.

Greg, 64, says his condition requires constant vigilance, and, increasingly, complex medication management. He currently receives an FDA-approved infusion every two weeks, a treatment his insurance is covering for now, but he knows that “for now” is doing a lot of work.

“I’m already dealing with middlemen,” he said. “The more levels things have to go through to get the medicine you need, the worse it is.”

That concern has taken on new urgency as Virginia lawmakers prepare for the 2026 legislative session, where prescription drug pricing is expected to be a major focus. Among the proposals under renewed consideration is the creation of a Prescription Drug Affordability Board, or PDAB, a state entity that would review the costs of certain medications and potentially impose limits on what insurers can pay.

Supporters of PDABs say the boards are designed to address high drug prices and protect patients. Delegate Karrie Delaney of Fairfax County, who has introduced PDAB legislation in previous sessions, has argued that medications cannot do their job if patients cannot afford them. Similar measures have passed the General Assembly in recent years, only to be vetoed by Governor Glenn Youngkin.

But for patients like Greg, the promise of affordability raises uneasy questions about access. He believes that the connection between between pharmacy benefit managers, the intermediaries that manage drug benefits for insurers and employers, and PDABs, is worth paying attention to.

“Even though I don’t see them directly, I do feel their influence,” he said. “They look at something and think, ‘That needs to be managed.’ ”

What’s worth noting is that Maryland established the nation’s first PDAB in 2019, and more than six years later, there is no clear evidence that the board has reduced what patients pay out of pocket at the pharmacy counter. What has been documented is spending: millions of dollars in taxpayer funds to staff and operate the board, years of rulemaking, and limited action with direct patient impact.

Critics argue that PDABs focus on setting upper payment limits for insurers, not on redesigning insurance benefits, copays, or deductibles. As a result, they say, patients may still face the same hurdles they do now, including prior authorizations, step therapy requirements, and delays in approval.

Brunswick Delegate Otto Wachsmann shares concerns about PDABs in other states. “To me, the PDAB is sexy; it sounds like it's going to work. Nobody can explain to me how it works,” he told Radio IQ in an interview in January.

Greg approaches the debate less as a policy expert than as someone who has learned, over time, how quickly access can shift.

Delegate Karrie Delaney

Delegate Otto Wachsmann

“Healthcare is a right, not a privilege,” he said. “Healthcare professionals exist to aid us, not the other way around.” His advocacy, shaped by years of living with a rare disease, is rooted in empathy and pragmatism. He understands the desire to control costs, and he also understands what happens when systems prioritize abstractions over people.

“Just because you think you’re on the outskirts of society doesn’t mean you don’t have something to say,” he said.

As Virginia lawmakers weigh their options in the coming months, patients like Greg are watching closely. For them, the outcome of the PDAB debate is not theoretical. It will be felt in appointment schedules, infusion centers, and pharmacy counters, in the calculations patients make every day about whether the care they need will remain within reach.

# PATIENTS RISING

*Empowering every patient in America to advocate for reforms placing them, alongside their doctors, in control of their healthcare choices.*

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