Upper Payment Limit Methodologies

PDAB Meeting

March 18, 2026

Washington State Health Care Authority

Background

- Each year, the board may set an upper payment limit (UPL) on up to 12 prescription drugs that have led or will lead to excess costs[1]
- There are legislative requirements and prohibitions that must be considered for each UPL
- Before setting a UPL on a specific prescription drug, the board needs to define a methodology for how UPLs will be determined, for example:
    - Reference Pricing
    - Net Price
    - Budgetary Thresholds (Premium Growth Thresholds)

1. RCW 70.405.050(1)

Legislative Requirements

- The methodology must take into consideration:[1]
  - (a) The cost of administering the drug;
  - (b) The cost of delivering the drug to patients;
  - (c) The status of the drug on the drug shortage list published by the United States food and drug administration; and
  - (d) Other relevant administrative costs related to the production and delivery of the drug.
- Board must post notice of proposed UPLs on PDAB website and give 30 days for public comment[2]
- Board must monitor the supply of drugs in the state and may suspend UPL if there is a supply shortage[3]

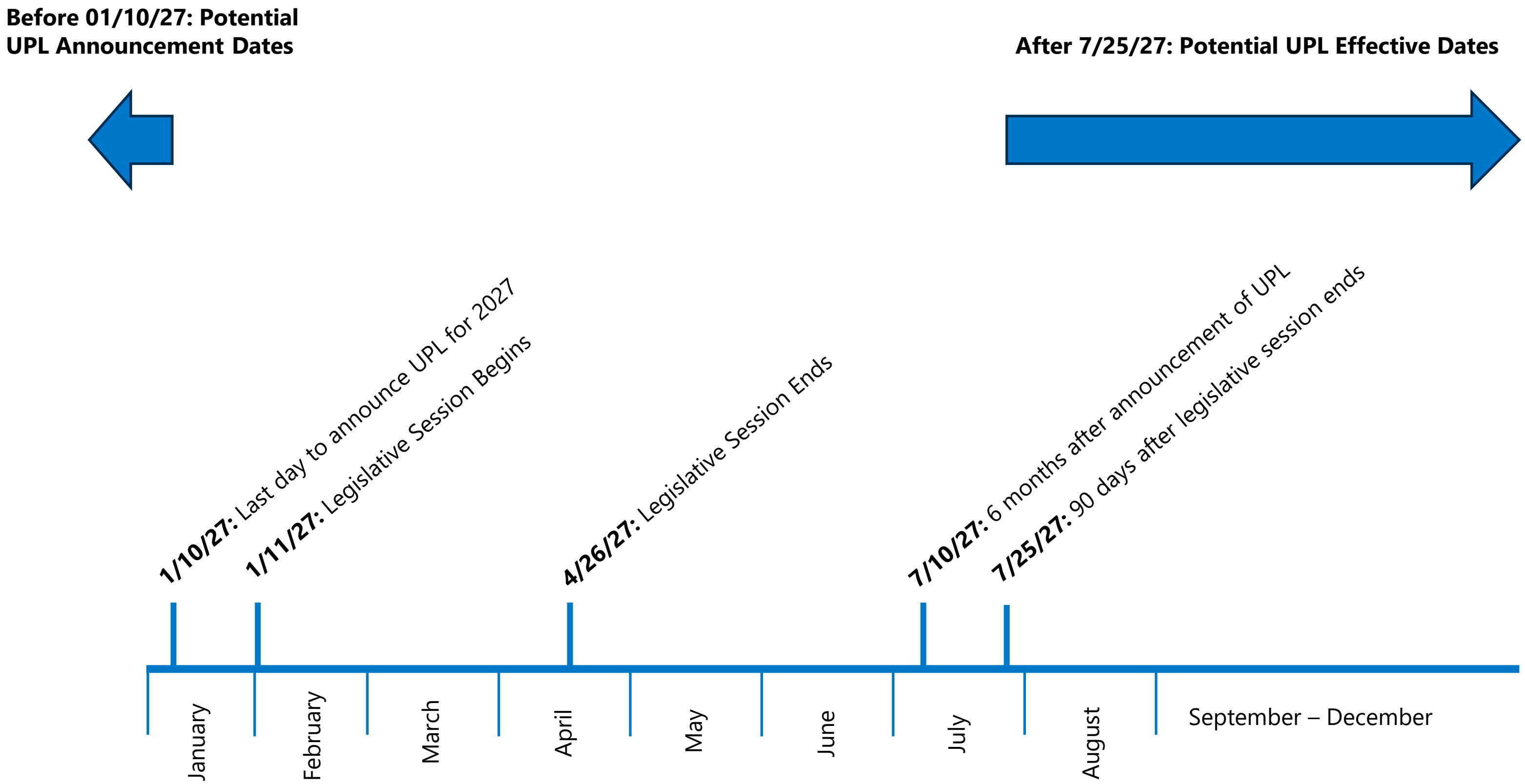
1. RCW 70.405.050(2)
2. RCW 70.405.050(4)
3. RCW 70.405.050(5)

Legislative Prohibitions

- The methodology must not use quality-adjusted life years that take into account a patient's age or severity of illness or disability to identify subpopulations for which a prescription drug would be less cost-effective.[1]
- Board may not establish a UPL before January 1, 2027.[2]
- A UPL may not go into effect until at least 90 days after the next regular legislative session [3]
- The effective date must be at least six months after the adoption of the UPL.[4]

1. RCW 70.405.050(3)
2. RCW 70.405.050(12)
3. RCW 70.405.050(8)
4. RCW 70.405.050(8)

UPL Timing 2027



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Which Entities Are Covered

- A UPL applies to all purchases of the drug by any entity and reimbursements for a claim for the drug by a health carrier, or a health plan offered under chapter **41.05** RCW[1]
- When the drug is dispensed or administered to an individual in the state in person, by mail, or by other means.[2]
- An employer-sponsored self-funded plan may elect to be subject to the upper payment limits as established by the board.[3]
- Applies only to purchases, contracts, and plans that are issued on or renewed after the effective date.[4]

1. RCW 70.405.050(6)
2. RCW 70.405.050(6)
3. RCW 70.405.050(7)
4. RCW 70.405.050(8)

Appeal of UPL

- Any entity affected by a decision of the board may request an appeal within 30 days of the board's decision, and the board must rule on the appeal within 60 days. Board rulings are subject to judicial review pursuant to chapter **34.05** RCW.[1]
- For any upper payment limit set by the board, the board must notify the manufacturer of the drug and the manufacturer must inform the board if it is able to make the drug available for sale in the state and include a rationale for its decision. The board must annually report to the relevant committees of the legislature detailing the manufacturers' responses.[2]
- The board may reassess the upper payment limit for any drug annually based on current economic factors.[3]
- Any individual denied coverage by a health carrier for a prescription drug because the drug was unavailable due to an upper payment limit established by the board, may seek review of the denial pursuant to RCW **48.43.530** and **48.43.535**.
  - (b) If it is determined that the prescription drug should be covered based on medical necessity, the carrier may disregard the upper payment limit and must provide coverage for the drug.[4]

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1. RCW 70.405.050(9)
2. RCW 70.405.050(10)
3. RCW 70.405.050(11)
4. RCW 70.405.050(13)

UPL Methodologies

Reference Pricing

Net Price

Budgetary Thresholds

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1. *See*, Martin, M. J. Rome, B. N., et al. (2024, February 27). *Determining upper payment limits: Considerations for state prescription drug affordability board (PDABs)*. Program on Regulation, Therapeutics, and Law (PORTAL), Division of Pharmacoepidemiology and Pharmacoeconomics, Harvard Medical School/Brigham and Women's Hospital.

Approach 1: Reference Pricing

- Therapeutic Reference Pricing
  - Compare a drug's price and value to its therapeutic alternatives
- External Reference Pricing
  - Benchmark against prices negotiated by other entities
    - International Prices or Other States
    - Medicare Maximum Fair Price
    - VA Federal Supply Schedule

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Approach 1: Therapeutic Reference Pricing

- Strengths
  - Ensures that a drug's price is reflective of its value relative to therapeutic alternatives
  - Uses a straightforward analysis, if PDABs have access to the data
- Limitations
  - Limited if alternatives also have high prices
  - Identifying a drug's therapeutic alternatives may be challenging
  - May have implications for a drug's formulary placement

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Approach 1: External Reference Pricing

- International Prices
  - Summary
    - Select a group of comparator countries or states and anchor a drug's price to either the lowest price, an average across countries, or a weighted average
  - Pros
    - Leverages lower international prices and reduces burden of conducting independent UPL analyses
  - Cons
    - Prices negotiated by other countries may be confidential or rely on QALYs

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Approach 1: External Reference Pricing

- Medicare Maximum Fair Price
  - Summary
    - Medicare sets a ceiling on the Maximum Fair Price (MFP) based on the lesser of:
      - The weighted average net price of the drug under Part D, or
      - A percentage of the non-federal average manufacturer price (non-FAMP)
  - Pros
    - Leverages the negotiating power of Medicare
  - Cons
    - Differences in which drugs are eligible for review by PDAB vs. Medicare Fair Price negotiations

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Approach 1: External Reference Pricing

- Veterans Affairs / Federal Supply Schedule Pricing
  - Summary
    - Manufacturers must offer the VA a price no higher than the Federal Ceiling Price (FCP), which is set at 76% of the non-FAMP (non-federal average manufacturer price).
    - The non-FAMP is calculated as the average price wholesalers pay manufacturers, minus certain discounts, for sales to non-federal entities.
  - Pros
    - Leverages a long-standing price negotiation regime to derive a UPL
  - Cons
    - Prices negotiated by wholesalers and the VA may be confidential

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Approach 2: Net Price

- Summary
  - Set UPL based on a drug's average net price (after rebates and discounts
- Pros
  - Ensures that rebates and discounts will be reflected in patient out-of-pocket costs
- Cons
  - Rebate information is difficult to obtain / confidential

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Approach 3: Premium Growth Thresholds

- Summary
  - Assess a drug's insurance premium impacts to identify a UPL that minimizes premium growth
- Pros
  - Can tie the savings from a UPL to specific patient premium reductions
- Cons
  - Difficult to assess premium impact of a specific drug
  - Even drugs with large aggregate spending can have small premium impacts

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State Comparators

- Colorado
  - Current Enbrel UPL is anchored to Medicare's Maximum Fair Price (MFP), with a floor at Medicaid "best price"
- Maryland
  - Plan to select the best methodology on a drug-by-drug basis
    - Allows flexibility for a tailored approach to addressing the factors that cause each drug's price
  - In the process of setting UPLs for Jardiance and Farxiga based on the negotiated MFP

Recommendation

- Write the WAC to allow the board to use the methodology that best fits each drug, allowing for flexibility in setting each individual UPL

Thank you!

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