APCI Insights

SNAPSHOT

GROSS, NOT NET:
*WHY GAO'S 30-MONTH PART D AUDIT COULDN'T DETERMINE WHAT DRUGS ACTUALLY COST**

* This is an initial assessment of GAO-26-107393

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Executive Summary

GAO examined how four vertically integrated Part D sponsors' payments, cost sharing and contract terms differed between the pharmacies they own and other pharmacies in 2023. Its headline finding is that point-of-sale payments and cost sharing were generally lower at owned, primarily mail-order pharmacies, though owned pharmacies were often paid more for the costliest specialty drugs. However, that core finding is undermined by what GAO could not measure. After more than 30 months of work, GAO's comparisons rest on gross prices, not net prices, because it could not attribute post-sale adjustments such as DIR clawbacks and effective-rate true-ups to individual pharmacies. Despite Part D's any-willing-pharmacy requirement, the report offers evidence of steering to owned pharmacies, likely through lower gross point-of-sale prices at preferred-network pharmacies. Because retroactive DIR and the any-willing-pharmacy requirement are unique to Part D, the report's findings, even on gross prices, are not representative of commercial, employer or FEHB plans. Above all, GAO's inability to assess net prices underscores the need for audit parameters that capture them, including all post-adjudication adjustments, whether tied to a specific claim or reconciled in aggregate within a plan or across a PBM's network or book of business. Without them, no audit can determine what drugs actually cost or compare the prices and economics of PBM-owned and other pharmacies.

Assessment

GAO spent more than 30 months (February 2024 to September 2026) examining how four vertically integrated Part D sponsors paid their own pharmacies compared with other pharmacies, and still could not determine what pharmacies were actually paid after post-sale adjustments.[1] GAO's headline finding is that point-of-sale payments and cost sharing were generally lower at owned, primarily mail-order pharmacies, including for at least 94 percent of the 100 most-used drugs, mostly generics costing $10 or less per 30-day supply. The report also documents evidence that steering occurs. Owned pharmacies' share of utilization was generally higher in employer plans, which have more flexibility in network design and in communicating with enrollees. The largest employer/non-employer gaps were on drugs with higher manufacturer rebates, where the parent company can earn both the rebate and the dispensing margin. For about half of the 20 costliest drugs, owned pharmacies were paid more, and for about half, cost sharing in non-employer plans was higher at owned pharmacies. Because Part D plans must admit any willing pharmacy and generally cannot require beneficiaries to use specific pharmacies, steering in Part D likely runs through preferred network designations and point-of-sale pricing. Those tools can lower cost sharing at plan- or PBM-owned pharmacies and push patients toward them.

As noted above, GAO's central comparison rests on point-of-sale payments, and that is where the report misses the mark. The audit period, 2023, was the last year of retroactive pharmacy DIR, when post-sale clawbacks left retail point-of-sale prices above what pharmacies actually kept, inflating reported retail prices relative to net. GAO leaves those clawbacks out of its owned vs. non-owned comparison, along with the effective-rate true-ups it acknowledges "could be substantially lower than point-of-sale payment rates." For most sponsors, GAO could not compare effective rates at all, because owned-pharmacy contracts either lacked them or structured them differently. As a result, the report does not show whether owned pharmacies are lower-cost on a net basis. DIR also inflated drug prices at the pharmacy counter: beneficiaries at non-owned pharmacies paid cost sharing on prices that were later clawed back, so part of their out-of-pocket spending effectively flowed to the same integrated companies being studied.

The blind spots in this audit come at least in part from the complex drug pricing arrangements implemented by vertically integrated PBMs. Post-sale adjustments are reported to CMS in aggregate, not by individual pharmacy, so an audit that relies on that standard reporting cannot establish true drug prices by channel. Getting there requires going beyond CMS data to pharmacy contracts, remittance records and post-sale reconciliations, and to what the parent company earns across its plan, PBM and pharmacies.

Here, it's also important to note that because Part D is programmatically unique (any willing pharmacy, preferred networks, DIR), the findings offer little guidance for commercial, employer, or Federal Employees Health Benefits (FEHB) plans, where PBMs can mandate mail and specialty use directly.

[1] See U.S. Government Accountability Office, Medicare Part D: Payments and Contracts Between Pharmacies and Plan Sponsors That Are Vertically Integrated, GAO-26-107393 (Sept. 2026, revised Oct. 6, 2026).

Finally, this report shows why audit rights and audit parameters must be exacting and comprehensive. A study of more than 30 months on drug pricing that fails to identify net drug prices simply misses the mark. An audit has to be able to determine what drugs actually cost, including all post-adjudication adjustments, whether tied to a specific claim or reconciled in aggregate within a particular plan or across a PBM's network or book of business.

By comparison, OPM Office of Inspector General audits of four FEHB plans examined these aggregate arrangements and identified roughly $580 million in principal overcharges.[2] That included more than $415 million in spread generated through aggregate pharmacy discount guarantees and more than $100 million in retail pharmacy transaction fees not passed through to the plans. Defending its "Overall Effective Rate" arrangements, one PBM told auditors there is "no way to untangle the mass of claims and data down to a specific claim, member, and/or client." That is the same kind of opacity that left GAO unable to determine net prices. What separates the two outcomes is whether an audit is designed and contractually empowered to follow the money after the point of sale.

[2] See U.S. Office of Personnel Management, Office of the Inspector General, Final Audit Report: Audit of the American Postal Workers Union Health Plan's Pharmacy Operations as Administered by Express Scripts, Inc. for Contract Years 2016 through 2021, Report No. 2022-SAG-029 (Mar. 29, 2024); Final Audit Report: Audit of Compass Rose Health Plan's Pharmacy Operations as Administered by Express Scripts, Inc. for Contract Years 2017 through 2022, Report No. 2023-SAG-019 (Nov. 20, 2024); Final Audit Report: Audit of the National Association of Letter Carriers as Administered by Caremark for Contract Years 2018-2023, Report No. 2024-SAG-022 (Dec. 2025); Final Audit Report: Audit of the Blue Cross Blue Shield Association's Service Benefit Plan's Retail and Mail Order Pharmacy Programs as Administered by CVS Caremark for Contract Years 2018-2021, Report No. 2024-SAG-013 (Mar. 13, 2026). See also APCI Insights, "Discrepant: How OIG Audits Exposed Federal Subcontractor PBMs Diverting Hundreds of Millions in Taxpayer Dollars Under FEHBP Contracts," Issue 009 (Sept. 2026).