APCI Insights

AMERICA'S DRUG REBATE ADDICTION: BILLIONS IN BENEFICIARY OVERPAYMENTS, COST-RELATED MEDICATION NON-ADHERENCE, AND POORER HEALTH OUTCOMES

Drug Pricing Policy

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Executive Summary

As pharmacy benefit managers ("PBMs"), insurers, and private and governmental entities collect billions of dollars in drug manufacturer rebates each year, America's patients, including children, seniors, and those with chronic illnesses, are forced to bear the cost, both literally and figuratively.

The scheme is far from simple, but in broad strokes, PBMs demand rebates from drug manufacturers in exchange for favorable formulary placement. Rather than passing those savings to beneficiaries at the pharmacy counter, PBMs overwhelmingly calculate cost-sharing based on pre-rebate gross drug prices and then divvy up the rebates on the backend between themselves, their insurer clients, and, depending on the market, their employer or governmental clients. PBMs claim that this scheme lowers net costs for payers and can suppress premium growth, but it is a Faustian bargain in which the sickest amongst us are expected to subsidize lower programmatic prices and corporate profit by overpaying for prescription drugs at the pharmacy counter. The perverse phenomenon - PBMs knowingly overcharging sick patients for medications as a pharmacy benefits strategy - is a practice that has been coined as "money from sick people."

PBM rebate practices are employed by the largest PBMs on a grand scale with far-reaching implications. The implications include increased costs at the pharmacy counter, reduced access to and choice of drugs, cost-related medication non-adherence, poorer health outcomes, and even death, with cost-related medication non-adherence recently being associated with higher all-cause mortality rates for patients with diabetes, cardiovascular disease and hypertension.

Fortunately, there are policy solutions that can ensure beneficiaries are not being overcharged for drugs by PBMs. One solution is to revisit policies pursued by President Trump in his first term that would make it illegal for PBMs to receive rebates from drug manufacturers.

Another approach for federal plans is to require PBMs to share a majority of rebates collected from drug manufacturers with beneficiaries at the pharmacy counter, using the remaining portion to lower premiums. A similar model was implemented in West Virginia, resulting in savings for beneficiaries at the pharmacy counter while also reducing insurer premiums.

Lower drug prices remain a key focus for Congress and President Trump. In light of the outsized role rebates play in the American prescription drug system, with billions of dollars in rebates changing hands between drug manufacturers and PBMs annually, rebate reform should figure centrally into President Trump and Congress's efforts to lower drug prices.

Incorporating rebate pass-through requirements in federal plans will bring system alignment, increase transparency, and lower costs to beneficiaries by billions of dollars, resulting in improved medication adherence, improved health outcomes, and lives saved, and as such, should be the Administration and Congress's north star.

PBM Rebate Practices = GROSS Drug Prices at the Pharmacy Counter

Overwhelmingly, PBMs withhold drug manufacturer rebates from beneficiaries at the pharmacy counter,[1] calculating beneficiaries' out-of-pocket payments based on gross pre-rebate prices for drugs ("gross prices"), rather than post-rebate net prices for drugs ("net prices").[2]

In 2023, out of $2.12 billion in rebates collected by PBMs in Texas, only $15 million was shared with beneficiaries at the pharmacy counter.[3] According to that same report, PBMs retained approximately $91 million in rebates for themselves, representing over 500% more rebate dollars accruing to PBMs than to beneficiaries.[4]

In Medicare Part D, a prescription drug program for America's seniors, PBMs also withhold rebates from beneficiaries at the pharmacy counter to the tune of billions of dollars a year, despite federal law providing that beneficiaries should have access to the negotiated price of medications.[5] In 2021 alone, approximately $50 billion in manufacturer rebates were withheld from Part D beneficiaries at the pharmacy counter in the form of direct and indirect remuneration ("DIR").[6]

The result of PBMs calculating beneficiary cost-sharing based on gross prices, rather than net prices, routinely results in beneficiaries paying more for drugs than the PBMs/plan sponsors pay for drugs after accounting for rebates. In 2021, Part D beneficiaries paid more in cost-sharing than the total net cost of a drug 8% of the time,[7] with beneficiaries paying more than plan sponsors on 79 of the 100 drugs that received the most rebates.[8]

In one Part D plan, the median out-of-pocket cost for an asthma/COPD drug was 156% higher than the drug's net price.[9] In those cases, the PBM is not only paying zero for the drug, but the PBM and/or the prescription drug plan is making money in rebates, all while the beneficiary is forced to overpay for the drug.

By calculating beneficiary out-of-pocket costs based on gross drug prices, PBMs are subsidizing lower costs to themselves, Part D prescription drug plans, and other clients, by knowingly raising costs for the very beneficiaries who most need the drug coverage. This practice has been coined "money from sick people.[10]"

[1] For purposes of this paper, where not otherwise delineated, drug manufacturer rebates shall include rebates to PBMs, their affiliate group purchasing organizations, and affiliate pharmacies. Pharmaceutical rebates shall also include all discounts and fees paid to PBMs and their affiliates. Hereinafter drug manufacturer rebates may be referred to as ("rebates,").
[2] Erin Trish, et al., "How Would Sharing Rebates at the Point-Of-Sale Affect Beneficiary Cost-Sharing in Medicare Part D?," USC Leonard D. Schaeffer Institute for Public Policy & Government Service, May 17, 2020, available online at: https://schaeffer.usc.edu/research/how-would-sharing-rebates-at-the-point-of-sale-affect-beneficiary-cost-sharing-in-mediErcare-part-d/. Out-of-Pocket costs or out-of-pocket payments shall include deductible payments, cost sharing, copays, and any other payment required to be made by a beneficiary under a prescription drug plan; see also Charlie Katebi, "Middlemen favor unaffordable prescription drugs," America First Policy Institute, November 22, 2024, available online at: https://www.americafirstpolicy.com/issues/middlemen-favor-unaffordable-prescription-drugs (hereinafter "AFPI Middlemen Research Report").
[3] Texas Department of Insurance, "2023 Prescription drug cost transparency review: Pharmacy benefit managers," available online at: https://tdi.texas.gov/reports/life/2023-pharmacy-benefit-managers.html (hereinafter referred to as "2023 Texas Rebate Report").
[4] Id.
[5] Medicare Payment Advisory Commission, "Medicare and the Health Care Delivery System," Chapter 2, June 2023, available online at: https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf (hereinafter "MedPAC Report June 2023"); see also 42 U.S.C. § 1395w-102 (d)(1).
[6] Id.
[7] Id.
[8] United States Government Accountability Office, "Medicare Part D – CMS Should Monitor Effects of Rebates on Plan Formularies and Beneficiary Spending," Sept. 2023, available online at: https://www.gao.gov/assets/gao-23-105270.pdf (hereinafter referred to as "GAO Report 2023").
[9] MedPAC Report June 2023.
[10] 46 Brooklyn, "Drug Pricing's $268 billion non-event," January 21, 2020, available online at: https://www.46brooklyn.com/research/2020/1/21/2018-medicare-part-d-data-review-sxfn7.

PBM Rebate Practices: Driving Higher Drug List Prices

Despite PBM arguments to the contrary,[11] "drug rebates and list prices are positively correlated."[12] More specifically, "on average, a $1 increase in rebates is associated with a $1.17 increase in list price," with single-source drugs having both higher average list prices and higher rebates than drugs with therapeutic equivalents, i.e., multi-source drugs."[13]

A U.S. House Committee on Oversight and Reform minority report concluded that one of the ways PBMs drive up drug costs is through their rebate practices, which result in drug manufacturers "raising 'list' prices for their drugs."[14]

The U.S. Senate Finance Committee found that "drug manufacturers increased insulin's WAC in part to give them room to offer larger rebates to PBMs and health insurers, all in the hopes that their product would receive preferred formulary placement.[15]"

Significantly, PBMs benefit from higher list prices, resulting in "perverse incentives for PBMs" to demand increasing rebates and prefer drugs with higher list prices.[16] PBMs capitalizing on these "perverse incentives" have not gone unnoticed by the FTC, which, in a recent lawsuit, alleged that PBM rebate practices "have allowed the PBMs and GPOs to line their pockets while certain patients are forced to pay higher out-of-pocket costs for insulin medication."[17]

PBM Rebate-Driven Formulary Practices: Reduced Access and Higher-Priced Rebated Drugs Preferred

With three PBMs in control of more than 80% of the prescription drug market, drug manufacturers are often faced with a stark choice: pay rebates demanded by PBMs in exchange for formulary placement, or find their drug[s] uncovered or with unfavorable formulary placement by large PBMs.[18]

This pay-to-play tactic by PBMs results in formulary exclusion of (1) single-source drugs; (2) drugs treating life-threatening diseases; and (3) therapeutically equivalent lower-cost drugs in favor of preferred higher-cost drugs.[19]

[11] See Alex Brill, "Understanding Drug Rebates and Their Role in Promoting Competition," February 28, 2022, available online at: https://www.affordableprescriptiondrugs.org/resources/understanding-drug-rebates-and-their-role-in-promoting-competition/. This paper was sponsored by the Coalition for Affordable Prescription Drugs. PBMs argue that extracting more rebates does not drive higher list prices, i.e. correlation does not imply causation argument, and PBM affiliated groups have sponsored studies attempting to support their position.
[12] Neeraj Sood et al., "The Association Between Drug Rebates and List Prices," USC Leonard D. Schaeffer Institute for Public Policy & Government Service, Feb, 2020, available online at: https://schaeffer.usc.edu/wp-content/uploads/2024/10/SchaefferCenter_RebatesListPrices_WhitePaper-1.pdf; see also AFPI Middlemen Research Report.
[13] Id.
[14] House Committee on Oversight and Reform Minority Staff, "A View from Congress: Role of Pharmacy Benefit Managers in Pharmaceutical Markets," Dec. 10, 2021, available online at: https://oversight.house.gov/wp-content/uploads/2021/12/PBM-Report-12102021.pdf.
[15] United States Senate Finance Committee Staff Report, "Insulin: Examining the Factors Driving the Rising Cost of a Century Old Drug," Jan. 2021, available online at: https://www.finance.senate.gov/imo/media/doc/Grassley-Wyden%20Insulin%20Report%20(FINAL%201).pdf.
[16] 46 Brooklyn, "How Money from sick people works, Part II: The 340b story," March 6, 2024, available online at: https://www.46brooklyn.com/news/030624-money-from-sick-people-part-ii-the-340b-bounty-hunt-fmve; see also House Committee on Oversight and Reform Minority Staff, "A View from Congress: Role of Pharmacy Benefit Managers in Pharmaceutical Markets," Dec. 10, 2021, available online at: https://oversight.house.gov/wp-content/uploads/2021/12/PBM-Report-12102021.pdf, noting that
"PBMs encourage this practice [higher manufacturer prices] because they pocket the higher rebates received from higher priced drugs."
[17] Caremark Rx, LLC, et al., No. 9437, Nov. 26, 2024 (FTC) (administrative complaint) available online at: https://www.ftc.gov/system/files/ftc_gov/pdf/612314.2024.11.26_part_3_administrative_complaint_-_revised_public_redacted_version.pdf.
[18] Xcenda, "Issue Brief: Assessing the impact of formulary exclusion on healthcare costs and outcomes for patients on therapy for certain chronic conditions," May 2023, available online at: https://www.xcenda.com/-/media/assets/xcenda/english/content-assets/white-papers-issue-briefs-studies-pdf/formulary_excl_issue_brief.pdf (hereinafter referred to as "Xcenda Report (2023)").
[19] Id. See also Xcenda, "Skyrocketing growth in PBM formulary exclusions continues to raise concerns about patient access," May 2022, available online at: https://www.xcenda.com/-/media/assets/xcenda/english/content-assets/white-papers-issue-briefs-studies-pdf/xcenda_pbm_exclusion_may_2022.pdf (hereinafter referred to as "Xcenda Report (2022)").

The practice of PBMs excluding medications from their formularies is a relatively recent phenomenon.[20] In 2014, there were 109 medicines excluded from at least one of the three largest PBMs.[21] By comparison, 1,126 medicines were excluded from at least one of the big three PBMs in 2022, representing a greater than 950% increase.[22] In 2023, each of the big three PBMs excluded approximately 600 drugs.[23]

Single-source medications, for which there are no therapeutic equivalents, are increasingly being excluded from PBMs' formularies. The number of single-source medications excluded from the formularies of at least one of the three largest PBMs has grown from 50 single-source drug exclusions in 2014 to 548 single-source drug exclusions in 2022, representing a 996% increase.[24]

Many of the drugs excluded from PBM formularies are used to treat severe conditions. For example, 225 medications used to treat autoimmune diseases, 209 medications used to treat diabetes, and 117 medications used to treat cancer, were excluded by at least one of the three largest PBMs for one plan year between 2014 and 2022.[25]

Another practice that has emerged is PBMs preferring highly rebated, higher-gross-cost brand-name medications when a therapeutically equivalent or generic of that drug is available, including in Medicare Part D.[26]

By way of example, in 2020, more than half of Medicare Part D beneficiaries using Hepatitis C drugs were enrolled in plans where the formularies included higher-cost brand-name drugs but excluded lower-cost generic drugs that were offered at as much as a 70% percent discount, resulting in beneficiaries paying thousands more out-of-pocket and nearly doubling Medicare reinsurance.[27]

Similarly, in 2021, 50% of Part D beneficiaries were enrolled in plans that required brand-name multiple sclerosis medication Tecfidera, despite therapeutically equivalent generic drugs being available at a discount of up to 99%, compared to the brand drug's list price.[28]

Omitting single-source and lifesaving drugs on PBM formularies and preferring higher-priced drugs for which PBMs receive a rebate over lower-cost alternatives leads to higher prices at the pharmacy counter, which, as more fully elaborated below, has severe and far-reaching implications.

Consequences of Higher Prices for Patients at the Pharmacy Counter

While higher drug prices at the pharmacy counter are the most obvious harm resulting from PBM rebate practices, the downstream implications of higher drug prices are, unfortunately, far-reaching.

Formulary exclusions can lead to treatment disruptions, negatively impact medication adherence, create access-to-care issues, and result in poorer health outcomes. Documented adverse effects of exclusionary formulary practices include increased A1C levels for diabetics, and increased frequency and severity of symptoms and side effects for hypertension.[29]

One analysis of patients treated with cardiovascular therapy found that they were more likely to be hospitalized (51% more likely) and have an outpatient emergency department visit (29% more likely) in the six months following a formulary exclusion than in the six months preceding it.[30] In some cases, formulary exclusions can give rise to life-threatening conditions and even death.[31]

[20] Xcenda Report 2022.
[21] Id.
[22] Id.
[23] Maia Anderson, "Drugs left off PBM lists can lead to worse patient outcomes, higher costs," Healthcare Brew, April 4, 2023, available online at: https://www.healthcare-brew.com/stories/2023/04/04/drugs-left-off-pbm-lists-can-lead-to-worse-patient-outcomes-higher-costs.
[24] Xcenda Report 2022.
[25] Id.
[26] GAO Report 2023.
[27] U.S. Dept. of Health and Human Services Office of Inspector General, "Part D Plan Preference for Higher-Cost Hepatitis C Drugs Led to Higher Medicare and Beneficiary Spending," August 2022, available online at: https://oig.hhs.gov/documents/evaluation/3214/OEI-BL-21-00200-Complete%20Report.pdf (hereinafter referred to as "OIG Hep C Report").
[28] 46 Brooklyn, "Wreck-fidera: How Medicare Part D has hidden the benefits of generic competition for a blockbuster Multiple Sclerosis Treatment," Dec. 1, 2021, available online at: https://www.46brooklyn.com/research/2021/12/1/tecfidera.
[29] Xcenda Report (2023).
[30] Id.
[31] Id. See also Aaron Katersky, "Wisconsin man dies after inhaler cost jumps $500, according to lawsuit," ABC News, Feb. 3. 2025, available online at: https://abcnews.go.com/US/wisconsin-man-dies-after-inhaler-cost-jumps-500/story?id=118422131.

PBM rebate practices that raise cost-sharing obligations for covered medications also have implications regarding adherence and outcomes.

In a recent review of research published between January 2010 and August 2020 assessing the relationship between cost-sharing, medication adherence, and clinical outcomes, the aggregate data indicated that regardless of disease states, increased cost-sharing was associated with worse medication adherence or discontinuation of drug therapy.[32] Additionally, the review found that the greater the magnitude of cost-sharing, the worse the medication adherence.[33]

Another well-known review concluded that increased patient cost-sharing "was associated with declines in medication adherence, which in turn was associated with poorer health outcomes."[34] Importantly, it also found that increased adherence was associated with a statistically significant improvement in outcomes.[35]

Regarding more specific disease states and the association between copayment, medication adherence, and outcomes in patients with heart failure and Diabetes Mellitus, a review found evidence that "higher copayments may result in poorer health outcomes," and "that lower copayments may result in higher medication adherence, which in turn may lead to better health outcomes."[36]

In addition, a study found that one in six patients with a history of asthma experienced cost-related medication non-adherence, including skipping doses to save money, taking less medication to save money, and delaying filling medications to save money.[37]

Cost-related medication non-adherence has also been associated with increased mortality rates for patients with certain chronic diseases. One multi-year study found cost-related medication non-adherence was associated with 15% to 22% higher all-cause mortality rates for diabetes, cardiovascular disease, and hypertension, with 8% to 18% higher disease-specific mortality rates.[38] In Medicare Part D, a model projected that high out-of-pocket costs could cause 1.1 million premature deaths of seniors in the Medicare program and lead to more than $1.7 billion in avoidable medical costs.[39]

Importantly, findings also run counter to the premise that lower cost-sharing raises plan costs and increasing beneficiary cost-sharing reduces plan costs. One review found that the reduction or elimination of cost-sharing did not increase total plan costs. Similarly, research on patients with heart failure and diabetes has found that lower copayments can lead to lower total healthcare expenses.[41]

Notably, despite aggressive use of formulary exclusions and not sharing rebates with patients at the pharmacy counter, at least one of the large PBMs acknowledges the benefit of eliminating out-of-pocket costs in connection with treatments for diabetes, stating that this can result in "savings for plan sponsors through improved adherence and a reduction in overall medical costs."[42]

In summary, by engaging in rebate practices that increase costs for beneficiaries at the pharmacy counter, PBMs are contributing to cost-related medication non-adherence, which in turn leads to poorer health outcomes, higher costs, and, in some cases, increased mortality.

[32] Nicole Fusco et al., Cost-sharing and adherence, clinical outcomes, healthcare utilization, and costs: a systematic literature review," Jan. 29, 2023, available online at: https://pmc.ncbi.nlm.nih.gov/articles/PMC10394195/. With regard to outcomes, the research reviewed was more limited but there was some evidence to suggest that increased cost-sharing is associated with more inpatient care and less outpatient care.
[33] Id.
[34] Eaddy MT, et al, "How patient cost-sharing trends affect adherence and outcomes: a literature review," Jan. 2012, available online at: https://pubmed.ncbi.nlm.nih.gov/22346336/.
[35] Id.
[36] George Gourzoulidis et al., "Association between copayment, medication adherence, and outcomes in the management of patients with diabetes and heart disease," April 2017, available online at: https://www.sciencedirect.com/science/article/abs/pii/S0168851017300362?via%3Dihub.
[37] Tong Xia et al., "Cost-related medication non-adherence in US adults with Asthma," Annals of Allergy, Asthma, & Immunology, Nov. 2023, available online at: https://www.annallergy.org/article/S1081-1206(23)00518-5/abstract.
[38] Sarah Van Alsten, Jenine Harris, "Cost-Related Nonadherence and Mortality in Patients With Chronic Disease: A Multiyear Investigation," Dec. 3 2023, available online at: https://pmc.ncbi.nlm.nih.gov/articles/PMC7735485/.
[39] Xcenda, "Modeling the Population Outcomes of Cost-related Nonadherence: Model Report, September 21, 2020, available online at: https://global-uploads.webflow.com/5e5972d438ab930a0612707f/5fa9bf4419f4da03a7daf190_WHPC-Xcenda_NonAdherence%20Population%20Model_Report_22Oct2020r.pdf.
[40] Nicole Fusco et al., Cost-sharing and adherence, clinical outcomes, healthcare utilization, and costs: a systematic literature review," Jan. 29, 2023, available online at: https://pmc.ncbi.nlm.nih.gov/articles/PMC10394195/.
[41] George Gourzoulidis et al., "Association between copayment, medication adherence, and outcomes in the management of patients with diabetes and heart disease," April 2017, available online at: https://www.sciencedirect.com/science/article/abs/pii/S0168851017300362?via%3Dihub.
[42] CVS, "CVS Health RxZero Solution Eliminates Out-of-Pocket Costs for Diabetes Medications," Jan. 29, 2020, available online at: https://www.cvshealth.com/news/prescription-savings/cvs-health-rxzero-solution-eliminates-member-out-of-pocket-costs.html.

In summary, by engaging in rebate practices that increase costs for beneficiaries at the pharmacy counter, PBMs are contributing to cost-related medication non-adherence, which in turn leads to poorer health outcomes, higher costs, and, in some cases, increased mortality.

The PBM Rebate Shell Game

PBMs broadly claim to pass nearly 100% of rebates back to their clients.[43] However, these assertions oversimplify what is a complex, almost unnavigable web of legal structures and practices that leverage vertical integration to obscure where rebates are going and who the rebates benefit.

Even a surface-level review reveals that PBMs are retaining billions of dollars in rebates and retaining more than the 2% asserted in a recent white paper sponsored by the big three PBMs.[44] For example, publicly available Texas reports reveal that PBMs passed back 79% and 87% in 2020 and 2021, respectively.[45] Similarly, a Washington state report revealed PBMs in the aggregate retained 29% of the rebates received in 2020, presumably passing back 71% to clients.[46]

For additional context, over the past four years, PBMs in Texas have retained more than $1.7 billion in rebates, as shown below:

Year	Rebate Dollars Retained by PBMs in Texas
2020	$476,352,005[47]
2021	$751,896,528[48]
2022	$409,000,000[49]
2023	$91,000,000[50]
4-year total	**$1,728,248,533**

Consistent with publicly available reporting, a recent employer survey reflected that only approximately 60% of employers report receiving 100% of rebates for traditional drugs and "specialty" drugs.[51]

While the foregoing reports and surveys indicate that PBMs are retaining more than the 2% of rebates claimed by PBMs, as more fully elaborated below, the reports offer no insight into the actual dollars being passed on to employer clients and fail to account for the complex structures and practices that obscure rebate dollars.

PBMs Leverage Vertical Integration to Obscure Rebate Dollars

As more fully elaborated below, large PBMs are vertically integrated with insurers, pharmacies, and group purchasing organizations. These different levels of integration afford opportunities to obscure where drug rebates are going and who retains them.

[43] "On average, Optum Rx passes through 98% of the discounts we negotiate to our customers." Dr. Patrick Conway, CEO Optum Rx, House Committee on Oversight and Accountability, 118th Cong., July 23, 2024, available online at: https://oversight.house.gov/wp-content/uploads/2024/07/Conway-Testimony.pdf. See also, Dennis W. Carlton et al., PBMs and Prescription Drug Distribution: An Economic Consideration of Criticisms Levied Against Pharmacy Benefit Managers," Compass Lexecon, April 2025, available online at: https://compass-lexecon.files.svdcdn.com/production/files/documents/Carlton-PBM-Report-Sections-I-VII-2025.04.22.pdf?dm=1745347921 (hereinafter referred to as "Carlton Report").
[44] "[O]verall PBM pass-through of rebates from manufacturers to plan sponsors is very high – around 98% of all rebates and fees received by the three largest PBMs in recent years were passed through to plan sponsors." Carlton Report.
[45] Texas Department of Insurance, "2020 Prescription drug cost transparency review: Pharmacy benefit managers," available online at: https://www.tdi.texas.gov/reports/life/documents/2020-hb2536-pbm.pdf (hereinafter referred to as "2020 Texas Rebate Report"). See also Texas Department of Insurance, "2021 Prescription drug cost transparency review: Pharmacy benefit managers," available online at: https://www.tdi.texas.gov/reports/life/documents/2021-hb2536-pbm.pdf (hereinafter referred to as "2021 Texas Rebate Report").
[46] See Adam J Fein, "Transparency VS. Reality: Troubling Lessons from PBM Disclosure Laws," Drug Channels Institute, March 5, 2025, available online at: https://www.drugchannels.net/2025/03/transparency-vs-reality-troubling.html.
[47] 2020 Texas Rebate Report.
[48] 2021 Texas Rebate Report.
[49] Texas Department of Insurance, "2022 Prescription drug cost transparency review: Pharmacy benefit managers," available online at: https://tdi.texas.gov/reports/life/2022-pharmacy-benefit-managers.html (hereinafter referred to as "2022 Texas Rebate Report").
[50] 2023 Texas Rebate Report.
[51] Adam J Fein, "Surprising Data on Employer-Rebate Pass-Through Arrangements in 2023," Drug Channels Institute, August 15, 2023, available online at: https://www.drugchannels.net/2023/08/surprising-data-on-employer-pbm-rebate.html.

1. PBM Vertical Integration with Insurers

The Texas data does not require PBMs to report rebates passed back to employers; instead, it requires reporting of the amounts passed to health plan issuers, defined as "an insurance company, a health maintenance organization, or a hospital and medical service corporation."[52] With each of the big three PBMs being vertically integrated with insurance companies,[53] Texas reporting provides no insight into the percentage of rebates that were passed back to employers versus those retained by vertically integrated insurers.

Similarly, data and reporting that indicate PBMs pass 99% of rebates back to plans in Part D[54] means little when large PBMs are administering benefits on behalf of vertically integrated Part D plans. This is because in those circumstances, the PBMs are passing rebates back to themselves. For example, in Medicare Part D, in 2021, the five most prominent Part D plan sponsors, accounting for 75% of all Part D beneficiaries, were vertically integrated with the PBMs administering the prescription drug benefits.[55] These plans accounted for $40.5 billion of the $50 billion in rebates in Part D in 2021.[56] That is $45 billion being passed back to vertically integrated entities. For additional context, even if PBMs retained only 1% of rebates in Part D in 2021, this still represents approximately $500 million in PBM retained rebates in Part D.

2. PBM Vertical Integration with Group Purchasing Organizations (GPOs)

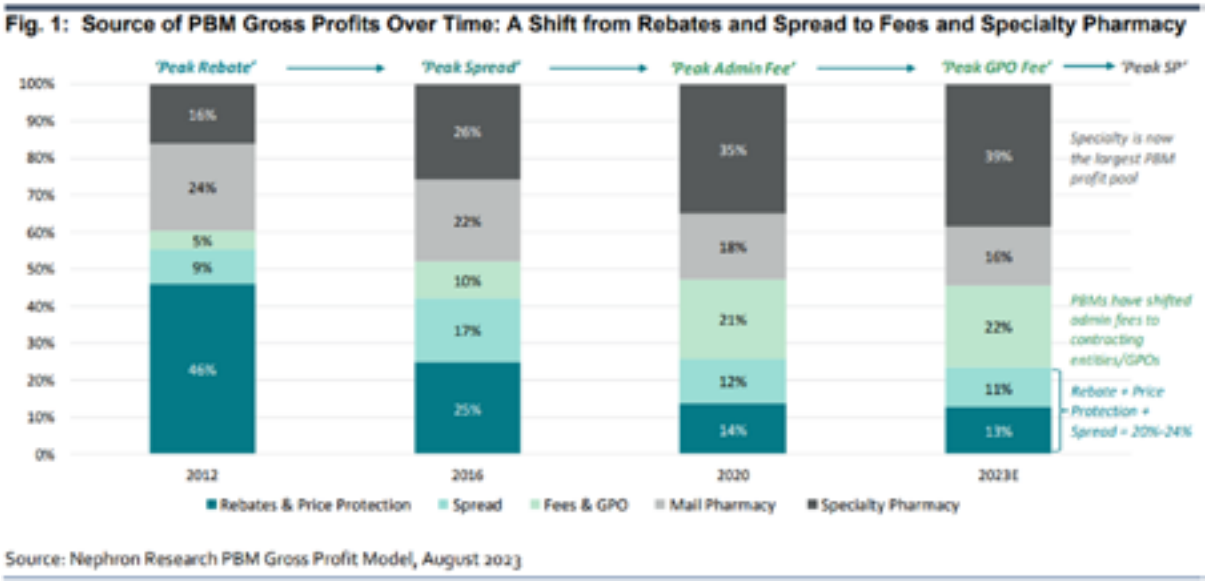
As PBM practices have come under increased scrutiny and emergent regulatory oversight, particularly at the state level, PBMs and their affiliate insurers have created GPOs, which are used to negotiate and aggregate rebates on behalf of PBMs, thereby adding a layer of complexity between drug manufacturers and PBMs.[57] Although relatively new, these vertically integrated PBM-affiliated GPOs already hold a significant market share, as outlined below.[58]

GPO	Year Formed	Headquarters	Ownership	% of Total Commercial Lives
Ascent Health Services	2019	Switzerland	Cigna/Evernorth/Express Scripts & Prime Therapeutics	33%
Emisar Pharma Services	2021	Ireland	Optum/United Health	16%
Zinc Health Services	2020	U.S.	CVS Health/Elevance Health	30%

The emergence of these GPOs adds a level of complexity that further obscures rebate dollars, enabling PBMs to leverage vertical integration to generate additional revenue from drug manufacturers, while also potentially circumventing PBM transparency requirements. This may explain the Texas reporting, which shows increasing percentages of rebates being passed back to clients in 2022 and 2023, along with decreasing rebate dollars being reported.[59]

[52] Tex. Insurance Code Ann. § 1369.501.
[53] Adam J Fein, Mapping the Vertical Integration of Insurers, PBMs, Specialty Pharmacies, and Providers; DCI's 2025 Update and Competitive Outlook," Drug Chanels Institute, April 9 2025, available online at: https://www.drugchannels.net/2025/04/mapping-vertical-integration-of.html.
[54] See Amy Baxter, "PBMs Passed on 99% of Rebates," HealthExec, Aug. 15, 2019, available online at: https://healthexec.com/topics/healthcare-policy/pbms-passed-99-rebates.
[55] MedPAC Report June 2023.
[56] Id. The five largest Part D plans accounted for 81% of DIR reported in Part D in 2021. For context, rebates reported as DIR in 2021 were $50 billion dollars.
[57] "Increasing rebate transparency demands, growing generic equivalents, and anti-PBM sentiment among regulators created a perfect storm of threats to the 'Big 3's' cash cows. By establishing PBM-led GPOs, they would ensure further rebate negotiation leverage over biopharma companies while adding revenue from GPO fees.," Eversana, "Peaking Behind the PBM-lead GPO Curtain," April 13, 2023, available online at https://www.eversana.com/insights/peeking-behind-the-pbm-led-gpo-curtain/. See also Ada J Fein, "Five (or Maybe Six?) Reasons that the Largest PBMs Operate Group Purchasing Organizations," Drug Channels Institute, May 24, 2023, available online at: https://www.drugchannels.net/2023/05/five-or-maybe-six-reasons-that-largest.html#disqus_thread.
[58] Eversana, "Peaking Behind the PBM-lead GPO Curtain," April 13, 2023, available online at: https://www.eversana.com/insights/peeking-behind-the-pbm-led-gpo-curtain/.
[59] Adam J Fein, "Texas Shows Us Where PBM Rebates Go," Drug Channels Institute, Aug. 9, 2022, available online at: https://www.drugchannels.net/2022/08/texas-shows-us-where-pbms-rebates-go.html. Noting that with the emergence of rebate aggregators likely played a role in decreasing rebates reported in Texas as " a smaller share of those revenues [from pharmaceutical companies] are passed through to plan sponsors."

The chart below supports this thesis and reveals that traditional rebates account for materially less gross profit over time, while administrative fees from drug manufacturers to PBM-affiliated GPOs have emerged and have grown as sources of gross profit.[60] Regarding GPO administrative fees, they are estimated to have accounted for more than $1.7 billion in 2022 alone.[61]



Source: Nephron Research PBM Gross Profit Model, August 2023

While a relatively new phenomenon, PBM-affiliated GPOs have received no shortage of attention in their short existence, including:

- A 2024 Office of Inspector General Audit uncovered over $14.4 million in manufacturer rebates withheld by a PBM rebate aggregator sister company in the American Postal Workers Union Health Plan, despite the existence of a pass-through contract.[62]
- A 2024 Office of Inspector General Audit uncovered over $9.5 million in manufacturer rebates by PBMs' sister company GPO, in the Compass Rose Health Plan, despite the existence of a pass-through contract.[63]
- 2023 FTC supplemental 6(b) order to a PBM affiliated GPO to learn more about their operations and obtain data and documents.[64]
- The Ohio Attorney General filed suit against a PBM, its affiliated GPO, and others, alleging, amongst things, use of "a little-known, Switzerland-based company to illegally drive-up drug prices and ultimately push those higher costs onto patients who rely on lifesaving drugs such as insulin."[65]

The foregoing demonstrates how PBM practices have evolved to leverage vertically integrated GPOs in a manner that obscures the money drug manufacturers pay to PBMs, and enables PBMs to continue to retain rebate dollars.

[60] Eric Percher, "Trends in Profitability and Compensation of PBMs & PBM Contracting Entities," Nephron Research, Sept. 18, 2023, available online at: https://nephronresearch.com/trends-in-profitability-and-compensation-of-pbms-and-pbm-contracting-entities/. Noting PBMs have "systematically shifted fees from PBMs to PBM contracting entities which add additional non-transparent layers to the system between manufacturers and sponsors."
[61] Id.
[62] U.S. Office of Personnel Management Office of the Inspector General Office of Audits, "Audit of the American Postal Workers Union Health Plan's Pharmacy Operations as Administered by Express Scripts, Inc. for Contract Years 2016-2021," March 29, 2024, available online at: https://oig.opm.gov/reports/audit/audit-american-postal-workers-union-health-plans-pharmacy-operations-administered-0 (hereinafter referred to as "OIG APWUHP Audit").
[63] U.S. Office of Personnel Management Office of the Inspector General Office of Audits, "Audit of Compass Rose Health Plan's Pharmacy Operations as Administered by Express Scripts, Inc. for Contract Years 2017-2022," Nov. 14, 2024, available online at: https://www.oversight.gov/sites/default/files/documents/reports/2025-01/2023-SAG-019.pdf (hereinafter referred to as "OIG Compass Rose Audit").
[64] Federal Trade Commission, "FTC Further Expands Inquiry Into Prescription Drug Middlemen Industry Practices," June 2023, available online at: https://www.ftc.gov/news-events/news/press-releases/2023/06/ftc-further-expands-inquiry-prescription-drug-middlemen-industry-practices.
[65] Ohio Attorney General, "Yost Sues Express Scripts, Prime Therapeutics and 5 Others, Blaming Exorbitant Drug Prices on Their Collusion," March 27, 2023, available online at: https://www.ohioattorneygeneral.gov/Files/Briefing-Room/News-Releases/Yost-v-Ascent.aspx.

3. PBM Vertical Integration with Pharmacies

The big three PBMs all own mail-order and specialty pharmacies, with one of them owning one of the largest retail pharmacy chains in the country.[66] PBMs can leverage their vertically integrated pharmacies in various ways, including directing payments from drug manufacturers to PBM-affiliated pharmacies, which further obscures the payments that drug manufacturers make to PBMs.

For example, in recent OIG audits of PBM practices in two Federal Employee Health Benefit Plan (FEHBP) carrier plans, the OIG uncovered payments by drug manufacturers to PBM-affiliated pharmacies that were not passed back to the client, despite the existence of pass-through contracts.[67] These audits uncovered over $6.1 million in drug purchasing discounts that the PBM received for drugs filled by its mail-order and specialty pharmacies between 2016 and 2021, across both plans combined. The OIG concluded that this amount ran afoul of the applicable pass-through contracts.[68]

While the OIG audits uncovered drug manufacturer payments to PBM-affiliated pharmacies that the OIG believed violated applicable federal contracts, PBMs can also attempt to retain rebates through contracting that excludes certain payments, including those to PBM-affiliated pharmacies, from the definition of rebates.

For example, in a PBM agreement with a health benefit plan[s], despite a seemingly broad definition of rebates, and a provision agreeing to "remit to the clients the rebates received by [the PBM]," the agreement references discounts based on purchases from PBM-affiliated dispensing pharmacies and exempts out from the term "Rebates," fees, compensation, and concurrent or retrospective discounts which belong exclusively to [PBM] or its affiliates as follows:[69]

> retrospective discounts from pharmaceutical companies which are attributable to or based on products purchased by Caremark affiliated dispensing pharmacies. Other than Manufacturer Administrative Fees described above, the term "Rebates" shall not include any fees, compensation, and concurrent or retrospective discounts associated with the purchase price of products described in this Agreement, which belong exclusively to Caremark or its affiliates.

Additionally, regarding specialty drugs, the same PBM agreement provides:[70]

> **Specialty Drug Rebates.** Client acknowledges and agrees that Caremark negotiates rebates and discounts for Specialty Drugs on its own behalf as a purchaser of pharmaceutical products over its aggregate book of business and not on behalf of any client or plan. Caremark shall have the exclusive right to enter into contracts with any pharmaceutical company with respect to rebates or discounts for any and all Specialty Drugs provided under this Agreement. Neither Client nor Plan shall have any right to or interest in such rebates or discounts.

Contractual provisions like the foregoing enable PBMs to leverage their vertically integrated retail, mail-order, and specialty pharmacies in a manner that allows them to direct drug manufacturer rebates and/or discounts to pharmacies that are vertically integrated with PBMs, rather than to PBM clients. As reflected in the OIG audits of FEHBP plans referenced above, PBMs can divert millions of dollars in drug manufacturer rebates to their affiliated pharmacies.

[66] Adam J Fein, Mapping the Vertical Integration of Insurers, PBMs, Specialty Pharmacies, and Providers; DCI's 2025 Update and Competitive Outlook," Drug Chanels Institute, April 9 2025, available online at: https://www.drugchannels.net/2025/04/mapping-vertical-integration-of.html.
[67] OIG APWUHP Audit; OIG Compass Rose Audit.
[68] Id.
[69] High Mountain Corp. v. MVP Health Care, Inc., 592 F. Supp. 3d 325 (D. Vt. 2022) - Document 91-29 filed Sept. 24, 2021, Exhibit G. Exhibit G is Prescription Benefit Management Services Agreement entered into on Jan. 1 2025 between Caremark PCS Health, L.L.C. and MVP Health Plan, Inc.
[70] Id.

Rebate and Premium Relationship

PBMs have long claimed (1) that rebates are used to lower premiums; and (2) any attempt to require rebates to be shared with patients at the pharmacy counter will raise premiums.[71] Despite these claims, research is limited regarding the link between premiums and rebates, as well as between premiums and drug spending.[72] The complexities associated with assessing the relationship between rebates and premiums was noted by Rand in a recent report, providing, amongst other things, that "premiums are only one of many levers that insurers can adjust when prescription drug pricing changes," and that "the net effects of rebates on patients through premiums . . . are difficult to assess."[73]

Nonetheless, as more fully elaborated below, available data reveals that (1) sharing drug manufacturer rebates with beneficiaries at the pharmacy counter can lower drug costs and lower premiums; and (2) PBM rebate practices can increase programmatic costs.

West Virginia's Share the Savings Law has Suppressed Premium Growth

A landmark West Virginia Commissioner of Insurance report runs counter to PBM claims regarding rebate reform leading to increased premiums.[74] Specifically, insurer filings in West Virginia reveal suppressed premium growth as a result of a 2021 law requiring PBMs to calculate a beneficiary's cost-sharing for a drug based on a price net of all rebates received, with any remaining rebates required to be passed to the health plans to reduce insurance premiums ("share the savings").[75]

More specifically, while premiums in West Virginia did increase, the premium growth was reduced between 1.8% to 14% because of West Virginia's share the savings law for plan year 2024, and between 0.7% to 11.7% for plan year 2025.[76]

These filings are instructive for policymakers, revealing that lowering costs for patients at the pharmacy counter can and does lower premiums, rather than raising premiums. It also underscores the need for incredulity from policymakers when confronted by PBM interests opposing rebate reform under the auspices of rising premiums. In sum, these insurer filings tell a very different story than that of PBMs, who use the fear of rising premiums as a tool to thwart legislation that would reduce costs for patients at the pharmacy counter.

[71] See PCMA, "PCMA Statement on the Administration's Prescription Drug Rebate Proposed Rule," Jan. 31, 2019, available online at: https://www.pcmanet.org/press-releases/pcma-statement-on-the-administrations-prescription-drug-rebate-proposed-rule/01/31/2019/; see also Visante, "Increased Costs Associated With Proposed State Legislation Impacting PBM Tools - Prepared for PCMA," Jan, 2019, available online at: https://www.pcmanet.org/wp-content/uploads/2019/01/Visante-Study-on-the-Increased-Costs-Associated-With-State-Legislation-Impacting-PBM-Tools-Jan-2019-FINAL.pdf.

[72] See Andrew W. Mulcahy et al., "Prescription Drug Prices, Rebates, and Insurance Premiums," Rand, Dec. 5, 2024, available online at: https://www.rand.org/pubs/research_reports/RRA1820-3.html.

[73] Id.

[74] West Virginia Office of the Commissioner of Insurance, "WEST VIRGINIA INSURANCE BULLETIN No. 25-01," Feb. 13, 2025, available online at https://www.wvinsurance.gov/Portals/0/pdf/pol_leg/IB_25-01_Prescription_Drug_Rebate_Impact_to_Commercial_Health_Insurance.pdf (hereinafter referred to as "WV Insurance Bulletin").

[75] Id.

[76] Id. For plan year 2025, One of the seven health insurers that had two plans reflected zero impact to premiums in one plan and an 11.7% reduction in another plan.

PBM Rebate Practices in Part D are Increasing Programmatic Costs

As addressed above, because Part D beneficiaries' cost-sharing is calculated based on gross prices rather than net prices, the costs for beneficiaries are significantly higher at the pharmacy counter. In addition to reduced medication adherence leading to poorer health outcomes and increased medical costs, PBM rebate practices also incur programmatic costs in Part D, which impact reinsurance and premiums in several ways.

- Because Part D provides low-income enrollees with cost-sharing assistance, higher cost-sharing on rebated drugs increases program spending.[77]
- When enrollees pay disproportionately higher cost-sharing, they reach Part D's catastrophic phase more quickly, at which point Medicare reinsurance pays for 80% of each prescription.[78]
  An analysis by the Brookings Institute found that:
  "36 percent of non-LIS beneficiaries who reached catastrophic coverage in 2017 would not have done so had cost sharing been based on net rather than list prices, which would have reduced federal reinsurance spending on the non-LIS beneficiaries by 19 percent."[79]
- Increased program costs via low-income copay assistance and reinsurance costs are exacerbated by PBM formulary practices preferring higher-priced brand-name medications over cheaper generics.[80]
- In studying Part D plan preferences for higher-cost medications treating Hepatitis C, the OIG found that Part D's programmatic structure encourages plan sponsors to prefer higher-cost versions, resulting in "beneficiaries paying thousands more out-of-pocket and nearly double Medicare reinsurance."[81] The expanded role of higher-priced drugs has played a substantial role in Part D spending, attributable to the catastrophic phase jumping from 20 percent to 42 percent between 2010 and 2020.[82]
- Part D's programmatic structure has allowed prescription drug plans to underestimate rebates in their bids, which in turn results in higher premiums.[83]

To the extent that Part D prescription drug plans and their PBMs have incentives to and have used rebates to lower premiums, there is little transparency into what portion of those rebates have been used to lower premiums, including in governmental programs.

For purposes of illustration, in Part D, MedPAC has estimated an average of a $6 per member per month decrease in premiums between 2018 and 2022 and has also reported $50 billion in drug manufacturer rebates treated as DIR in 2021.[84] Without accounting for the nuances of Part D program plan designs, premium calculations, and profit structures, a simple back-of-the-napkin analysis reveals that a $6 premium reduction in 2021 would amount to approximately $3.5 billion in premium savings, or 7% of the $50 billion in pharmacy rebates earned in 2021.[85] Even with approximately1/3 of the $50 billion in manufacturer rebates returned to Medicare to offset reinsurance subsidies($16.5 billion), it can be estimated that approximately $30 billion in drug manufacturer rebates did not go towards premium savings, to CMS, or towards lowering drug costs at the pharmacy counter.[86] The foregoing estimate underscores the potential for rebate dollars that aren't being shared with beneficiaries at the counter to be used by Part D drug plans for purposes other than reducing premiums. This is particularly relevant as a portion of rebates can be returned to plans as profits.[87]

In summary, West Virginia's experience suggests that sharing rebates with beneficiaries at the pharmacy counter can lower premiums. In contrast, PBM rebate practices in Part D reveal increased programmatic costs, with limited data indicating what portion of rebates collected by PBMs are used to lower beneficiary premiums as opposed to increasing drug plan and PBM profits.

[77] MedPAC Report June 2023.
[78] Id.
[79] Steven M. Lieberman et al., "Sharing drug rebates with Medicare Part D patients: Why and how," Brookings, Sept. 14, 2020, available online at: https://www.brookings.edu/articles/sharing-drug-rebates-with-medicare-part-d-patients-why-and-how/
[80] MedPAC Report June 2023.
[81] OIG Hep C Report.
[82] MedPAC Report June 2023.
[83] Department of Health and Human Services Office of Inspector General, "Concerns with Rebates in the Medicare Part D Program," March 2011, available online at: https://www.govinfo.gov/content/pkg/GOVPUB-HE-PURL-gpo67469/pdf/GOVPUB-HE-PURL-gpo67469.pdf.
[84] "Between 2018 and 2022, average enrollee premiums declined from about $32 per month to $26 per month.," MedPAC Report June 2023.
[85] See Id. $6 per month premium reduction multiplied by 12 months equals $72 in premium savings per beneficiary a year. $72 multiplied by 49 million enrollees equals $3.5 billion. Note for simplicity this example assumes all beneficiaries enjoyed $6 per month in reduced premiums.
[86] See Id. $50 billion less $20 billion (6.5 billion to Medicare plus 3.5 billion in premium savings equals).
[87] "The actual DIR that plans collect may be higher or lower than what they anticipated at the time that they submitted their bids. Some or all of the excess amount collected may be retained by the plan as profit.," Id.

Policy Solutions

Policy makers at the federal level have recognized the need to rein in PBM practices concerning rebates and have put forth various solutions, including transparency and reporting requirements, as well as delinking PBM profits from the price of prescription drugs.[88] While representing positive steps forward, neither would mitigate the effects of beneficiaries overwhelmingly paying cost-sharing obligations based on gross prices and therefore would not lower beneficiary cost-sharing obligations in Medicare Part D. Policies that end drug manufacturer rebates to PBMs, or require PBMs to share rebates with beneficiaries at the pharmacy counter, represent the best path forward to lower drug prices for beneficiaries across market channels and to remove the incentives driving problematic formulary practices. While the specific policy solutions outlined below address Part D, similar policies can also be implemented at the state level.

Safe Harbor Reform

With the anti-kickback statute prohibiting the offering and receiving of remuneration to induce or reward business in key federal healthcare programs, including Medicare Part D, manufacturers, drug plans, and PBMs rely on the discount safe harbor in connection with the negotiation, payment, and receipt of discounts, including rebates for prescription drugs.[89] Reforming the safe harbor protections for rebates in connection with transactions between manufacturers, plans, and PBMs has been proposed to lower costs for patients, increase transparency, and remove PBM incentives that favor higher drug prices, including in the first Trump administration,[90] and, more recently, from U.S. Senator Hawley.[91]

President Trump's efforts to end PBM rebate games and return drug manufacturer discounts to beneficiaries at the pharmacy counter were projected by the CMS Actuary to save Medicare Part D beneficiaries $93 billion at the pharmacy counter over ten years.[92] However, the CBO projected increased costs to the federal government to the tune of $170 billion based on the assumption that drug manufacturers would withhold 15% of the amounts they currently rebate back to PBMs.[93] Regarding the presumption that manufacturers would withhold 15% of the discounts, no analysis was provided; instead, it relied on CMS actuary projections and "consultations with stakeholders and outside experts."[94] The CBO provided no alternative scenario calculations.[95]

In contrast to the CBO score, Milliman, in an analysis prepared for the U.S. Department of Health and Human Services, estimated the financial impact based on seven scenarios and found overall programmatic savings in five out of the seven scenarios.[96]

Although the rule was finalized, the Inflation Reduction Act delayed implementation until 2032, with the CBO projecting that the delay in implementation would save taxpayer money.[97]

With President Trump in his second term and increased scrutiny of PBM rebate practices, safe harbor reform is a policy worthy of serious consideration by the administration and Congress. Removing the safe harbor for drug manufacturer rebates to plan sponsors and their contracted PBMs and replacing it with a point-of-sale discount will lower costs at the pharmacy counter for America's seniors by billions of dollars, remove perverse incentives that cause PBMs and plan sponsors to favor higher-cost medications,

[88] Cissy Jackson and Daniel Sjostedt, Progress Towards PBM Reform: Insights, Political Considerations, and Outlook for 2024-2025, ArentFox Schiff, Feb. 27, 2024, available online at: https://www.afslaw.com/perspectives/alerts/progress-towards-pbm-reform-insights-political-considerations-and-outlook-2024

[89] 42 U.S.C. § 1320a-7b; Health and Human Services Department, "Fraud and Abuse; Removal of Safe Harbor Protection for Rebates Involving Prescription Pharmaceuticals And Creation of New Safe Harbor Protection for Certain Point-of-sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees," Nov. 30, 2020, available online at: https://www.federalregister.gov/documents/2020/11/30/2020-25841/fraud-and-abuse-removal-of-safe-harbor-protection-for-rebates-involving-prescription-pharmaceuticals (hereinafter referred to as "Final Rebate Rule").

[90] The U.S Department of Health & Human Services, "American Patients First – The Trump Administration Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs," May 2018, available online at: https://www.hhs.gov/sites/default/files/AmericanPatientsFirst.pdf; Trump, Donald, "Executive Order on Lowering Prices for Patients by Eliminating Kickbacks to Middlemen, July 2024, available online at: https://trumpwhitehouse.archives.gov/presidential-actions/executive-order-lowering-prices-patients-eliminating-kickbacks-middlemen/; Final Rebate Rule; see also AFPI Middlemen Research Report.

[91] U.S. Congress, Ending the Prescription Drug Kickback Act of 2023, S . 1217, 118th Congress, April 19, 2023, available online at: https://www.congress.gov/bill/118th-congress/senate-bill/1217.

[92] Center for Medicare and Medicaid Services, Office of the Actuary, "Proposed Safe Harbor Regulation," August 30, 2018.

[93] Congression Budget Office, "Incorporating the Effects of the Proposed Rule on Safe Harbors for Pharmaceutical Rebates in CBO's Budget Projections – Supplemental Material for Updated Budget Projections: 2019 to 2029," May 2019, available online at https://www.cbo.gov/system/files/2019-05/55151-SupplementalMaterial.pdf.

[94] Id.

[95] See Id.

[96] Milliman, "Impact of Potential Changes to the Treatment of Manufacturer Rebates," prepared for the Assistant Secretary for Planning and Evaluation U.S. Dept. of Health and Human Services, Jan, 2019, available online at https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//186681/MillimanReportImpactPartDRebateReform.pdf.

[97] Juliette Cubanski et al., "Explaining the Prescription Drug Provisions in the Inflation Reduction Act, Kaiser Family Foundation, Jan. 24, 2023, available online at: https://www.kff.org/medicare/issue-brief/explaining-the-prescription-drug-provisions-in-the-inflation-reduction-act/.

and increase transparency. By removing incentives to favor higher-cost drugs, the federal government can potentially achieve savings through lower payments for low-income subsidies and reduced reinsurance costs. Additionally, lower costs at the pharmacy counter are expected to increase adherence, which in turn is anticipated to lead to improved outcomes and lower medical costs.

While there may be questions regarding the fiscal impact on premiums and the federal government's subsidization of premiums, with projections of increased and decreased costs, the concrete savings at the pharmacy counter, combined with savings from other programmatic efficiencies and improved adherence and outcomes, should prevail. Finally, removing the safe harbor will align the Part D program with federal law itself, which contemplates beneficiaries having access to negotiated discounts and will end the practice of plan sponsors and PBMs shifting the burden of insurance to the sickest beneficiaries via overcharging patients for drugs to subsidize plan profits and lower premiums.[98]

Hybrid Share the Savings

A hybrid approach that requires PBMs to afford beneficiaries access to rebates for cost-sharing purposes, while allocating a portion of or any remaining rebate dollars to drug plans to suppress premium growth, is a similarly sound policy. This approach can realign incentives, lower costs for patients at the pharmacy counter, and also lower premiums.

As elaborated above, West Virginia's law requiring PBMs to reduce drug prices by 100% of all rebates received and passing any excess rebates back to the client to reduce premiums has proven to be a viable model that has lowered prices for patients at the pharmacy counter while reducing the growth of premiums across large and small plans.[99]

At the federal level, the 2024 Pharmacists Fight Back Act proposed a similar model for large federal health plans, requiring 80% of rebates to be shared with patients at the pharmacy counter to lower drug prices for patients, while allowing plans to retain 20% of rebates.[100] Recall that in 2021, there were $50 billion in rebates that were not passed to patients at the pharmacy counter.[101] Under the Pharmacists Fight Back Act, up to $40 billion would be returned to patients at the pharmacy counter, leaving $10 billion for the plans to lower premiums.[102] Importantly, the Pharmacists Fight Back Act enjoys a broad definition of rebate that includes payments and concessions from "pharmaceutical manufacturers to PBM-affiliated "offshore entities, and "group purchasing organizations."[103]

There also exists a regulatory path forward to ensure PBMs share drug manufacturer rebates with beneficiaries at the pharmacy counter. Federal law is seemingly unambiguous, concerning Medicare Part D beneficiaries getting access to negotiated prices, including discounts, providing:

> [T]he sponsor or organization shall provide enrollees with access to negotiated prices used for payment for covered Part D drugs . . .[104]

Notably, federal law requires that negotiated prices "shall take into account negotiated price concessions, such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations, for covered Part D drugs. . ."[105]

Despite federal law, CMS's definition of negotiated price does not include price concessions from drug manufacturers, such as rebates paid to PBMs.[106] The omission of drug manufacturer rebates and other discounts from the definition of negotiated price empowers the prescription drug plans to calculate beneficiary cost-sharing based on gross prices.[107]

By adding drug manufacturer rebates and discounts to CMS's definition of negotiated price, prescription drug plans and their PBMs will be required to calculate beneficiary out-of-pocket costs based on net prices thereby achieving President Trump's goal of requiring PBMs to share discounts with beneficiaries and lowering beneficiary costs at the pharmacy counter by billions of dollars.

[98] "[T]he sponsor or organization shall provide enrollees with access to negotiated prices used for payment for covered part D drugs . . .;" 42 U.S.C. § 1395w-102 (d)(1).
[99] WV Insurance Bulletin.
[100] U.S. Congress, the Pharmacists Fight Back Act, H.R. 9096, 118th Congress, July 23, 2024, available online at: https://www.congress.gov/bill/118th-congress/house-bill/9096 (hereinafter referred to as "PFBA (2024)").
[101] MedPAC Report June 2023.
[102] See PFBA 2024.
[103] Id.
[104] 42 U.S.C. § 1395w-102 (d)(1).
[105] Id.
[106] 42 CFR § 423.100.
[107] Id. See also CMS, "Medicare Part D – Direct and Indirect Remuneration (DIR)," Jan. 19 2017, available online at https://www.cms.gov/newsroom/fact-sheets/medicare-part-d-direct-and-indirect-remuneration-dir, ("Beneficiaries' cost-sharing is calculated based on the drug price at the point-of-sale, without regard to rebates and other price concessions received after the point-of-sale. Therefore, while DIR may hold down total program expenses (and beneficiary premiums), it does not reduce the cost of drugs for beneficiaries at the point-of-sale.").

Conclusion

PBM rebate practices in Medicare Part D are increasing drug prices at the pharmacy counter for beneficiaries by billions of dollars annually, representing efforts by PBMs to shift the burden of drug costs from prescription drug plans and PBMs to beneficiaries. These practices, empowered through existing CMS regulations, are misaligned with federal law that contemplates beneficiaries having access to negotiated prices that consider discounts and rebates. PBM rebate practices not only raise drug prices for beneficiaries, but they also lead to reduced access to care, cost-related medication non-adherence, poorer health outcomes, and increased mortality.

With both President Trump and Congress focused on lowering drug prices, ending current PBM rebates should figure centrally into these efforts. Policy solutions worthy of consideration include (1) addressing the existing anti-kickback statute safe harbor to exclude rebates paid by drug manufacturers to PBMs and prescription drug plans as President Trump sought to do in his first term; (2) requiring PBMs to share rebates with beneficiaries at the pharmacy counter with the ability of some portion of rebates to be retained to lower beneficiary premiums via legislation in line with the Pharmacists Fight Back Act or through CMS regulation.

The foregoing policy solutions will increase transparency and reduce drug prices for beneficiaries at the pharmacy counter by billions of dollars a year, thereby improving medication adherence and outcomes while potentially lowering premiums. Moreover, these solutions will put a stop to PBMs and prescription drug plans' burden shifting rebate practices that allow them to lower their costs and subsidize their profits by taking "money from sick people," and will put an end to the federal government's addiction to drug manufacturer rebates.