A Bipartisan Framework for Reducing Prescription Drug Costs by Modernizing the Supply Chain and Ensuring Meaningful Relief at the Pharmacy Counter

Medicare and Medicaid have the potential to deliver higher-quality, more affordable, and more accessible prescription drug benefits to patients across the country. Over the years, however, interactions between the entities involved in delivering and paying for prescription drugs (e.g., pharmaceutical manufacturers, health insurance plans, pharmacy benefit managers, pharmacies) have grown increasingly complex and opaque. Many supply chain stakeholders, which were once separate companies, have also consolidated under common corporate ownership.

Federal policy has not kept pace with these developments and evolving market dynamics, which have a significant impact on prescription drug costs for health programs within Senate Finance Committee jurisdiction and for the patients they serve. Between Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the individual marketplace, the Committee oversees coverage for more than half of all Americans—roughly 180 million people. Prescription drug spending under these programs accounts for a significant portion of national pharmaceutical spending, which totaled $577 billion in 2021, and supply-chain complexity has complicated efforts to track the flow of these dollars. The Chairman and Ranking Member agree that the Committee has a critical responsibility to examine supply chain practices to make prescription drug spending under these programs more efficient for patients and taxpayers. As part of its long history of bipartisan work on this front, including during our recent hearing entitled "Pharmacy Benefit Managers and the Prescription Drug Supply Chain: Impact on Patients and Taxpayers," the Committee has identified four key challenges that call for policy solutions:

I. Misaligned Incentives that Drive Up Prices and Costs

Ideally, all stakeholders participating in the supply chain, including pharmacy benefit managers (PBMs), should have an incentive to prefer medications that deliver the best results at the lowest cost. Unfortunately, under the current system, higher drug list prices often translate into higher compensation for intermediaries. By tying administrative fees, rebate-based compensation, and other payments to a percentage of list price, current arrangements incentivize increases in sticker prices. These dynamics can result in higher out-of-pocket costs for consumers, particularly in Medicare Part D, where a list-price benchmark can determine cost-sharing amounts.

Furthermore, intermediaries in the health care system often earn revenue on both sides of the transactions in which they engage. For example, PBMs are paid fees both by health plans and the manufacturers with which they negotiate. These misaligned incentives and the multi-sided nature of the market can create potential conflicts of interest.

II. Insufficient Transparency that Distorts the Market

The complexity and opacity of the supply chain have hindered efforts by patients, plans, and policymakers to make informed choices at virtually every level. Incomplete disclosure requirements have constrained accountability, eroding Part D plans' ability to select the services that best serve seniors. Policymakers and researchers lack adequate line of sight into the financial flows and incentives that inform pricing. Perhaps most importantly, beneficiaries need better

tools to make decisions with major implications for their health care quality, access, and affordability. The current system must do more to address information asymmetries and gaps.

III. Hurdles to Pharmacy Access

Pharmacies have long played a pivotal role in providing vital services to Americans from all walks of life, and are often one of the primary points of care in rural and underserved communities. As the market has evolved through ramped-up vertical integration with national PBMs and major changes in contracting practices, however, many independent and regional pharmacies have struggled, and some have been forced to shut their doors altogether, leading to access gaps for patients and consumers. While a range of factors have triggered these trends, ambiguities in Medicare's "Any Willing Pharmacy" rules, significant growth in pharmacy fees, and unpredictable performance-based quality measures appear to have contributed, limiting the freedom of choice at the core of the Medicare program.

IV. Behind-the-Scenes Practices that Impede Competition and Increase Costs

In recent years, reports have pointed to a range of practices that appear to drive up out-of-pocket costs for seniors, in addition to increasing taxpayer spending. Studies suggest, for instance, that seniors and the Medicare program overpay for certain generic prescriptions that should lend themselves to a competitive, low-cost market. Medicaid audits have also found that intermediaries sometimes drive up costs by charging health plans more for pharmacy reimbursement than what they ultimately pay pharmacies, and pocketing the difference. The rising success of a number of disruptors also indicates that beneficiaries could sometimes achieve a better deal for certain prescriptions outside of conventional channels and drug benefits, raising questions around the dynamics underlying the large and concentrated firms at the center of our current programs.

Next Steps: Achieving Results for Patients and Taxpayers

The Finance Committee plans, with input from Committee members on a bipartisan basis, to pursue commonsense legislative solutions that modernize and enhance our federal prescription drug programs. The Committee is focusing its work immediately on the four key challenges identified, with the goal of reducing drug costs for patients and taxpayers. Potential policy solutions to address these and other challenges will be designed with input from Committee members and may include, but are not limited to:

- Delinking PBM compensation from drug prices to align incentives for lower costs;
- Enhancing PBM accountability to health plan clients to drive cost-cutting competition and produce better choices for beneficiaries;
- Ensuring discounts negotiated by PBMs produce meaningful savings for seniors;
- Addressing and mitigating practices that unfairly inflate the prices patients and government programs pay for prescription drugs;
- Modernizing Medicare's "Any Willing Pharmacy" requirements to improve options and access for seniors; and
- Increasing transparency to foster a better understanding of how financial flows across the prescription drug supply chain impact government health care programs.