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Pharmacy Benefit Manager Reform and Medicare Maximum Fair Prices: A Status Update

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Part I.

Recent Pharmacy Benefit Manager Reforms

Concerns About PBMs

- **Negotiated rebates from drug manufacturers are confidential, which obscures and distorts the market for prescription drugs.**
 - Makes it difficult to measure the “**net**” **cost** of prescription drugs after rebates/discounts.
 - Rebates do not lower **out-of-pocket costs**, which are based on the pre-negotiation list cost.
- **Misaligned incentives lead PBMs to prefer higher list prices**
 - In some cases, PBMs retain a portion of rebates or charge a percentage of drug prices as fees.
 - In other cases, PBMs charge health plans a markup over what they pay pharmacies for a drug and retained the difference (i.e. **spread pricing**).
- **PBM market is increasingly concentrated and vertically consolidated.**
 - Three PBMs handle ~80% of all prescriptions in the US (CVS Caremark, OptumRx, Express Scripts)
 - PBMs now affiliated with health plans and pharmacies (e.g., specialty, chain), which raises concerns about steering patients to fill medications at an affiliated pharmacy for a higher cost.

Changes in the Consolidated Appropriations Act of 2026 (H.R. 7148)

• Transparency and Reporting Requirements

- Requirements for semi-annual reports to **private insurers** (Sec 6701) and annual reports to **Medicare Part D plans** (Sec. 6224) with drug-level information, including:
 - Gross and net costs of prescriptions after rebates
 - Amount of spread pricing
 - Details about prescriptions filled at PBM-owned/affiliate pharmacies
 - Rationale for formulary placement
 - Compensation of brokers/consultants
- **Auditing rights** for Part D plan sponsors (Sec. 6224)

• Changes to how PBMs get paid by health plans

- **Medicare Part D:** PBM compensation must be **bona fide service fees** that cannot be linked to drug prices or rebates (Sect. 6224)
- **Private insurers:** PBMs must **pass through 100% of rebates and fees** (Sec. 6702)

What's NOT Included in the New Law

- **Protections for patient out-of-pocket costs**

- Requires PBMs to pass rebates through health plans, but no requirement that health plans share the rebates with patients in the form of lower out-of-pocket costs based on net prices.

- **Public drug pricing transparency**

- Reports about net prices and rebates/discounts are to health plans, not the public.

- **Protections for pharmacies**

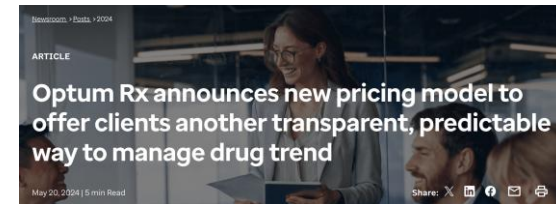
- No prohibition of spread pricing (was considered in earlier bipartisan packages)
- No guarantee that PBM payments to pharmacies will exceed the pharmacy's acquisition cost.

- **Tackling vertical integration between PBMs and pharmacies**

- Some information included in reporting requirements to plans, but no prohibition on steering patients to PBM-owned/affiliated pharmacies or differences in remuneration by pharmacy type.

Other PBM News to Watch

- **Changes announced by the “Big Three” PBMs**
 - Each has announced new models touting improved transparency for health plans and pharmacies.
- **FTC Settlement with Express Scripts**
 - In a case related to insulin prices, Express Scripts agreed to implement several changes, including not favoring high-priced drugs over lower-priced equivalents, and ensuring patient out-of-pocket costs are based on net prices.
 - CVS Caremark has reportedly also reached an agreement with the FTC in a similar case, though the terms are not yet public.
- **Arkansas bans PBMs from owning or operating pharmacies in the state**
 - Law passed in April 2025, but implementation was blocked in July 2025 by a Federal District Court preliminary injunction.
- **Federal Department of Labor proposed price transparency rule**
 - PBMs would be required to disclose details about their compensation, rebates, claw-back payments from pharmacies, and other payments to employer clients.



Many Outstanding Questions Remain

- **How will different actors respond to these changes?**
 - **PBMs:** New contracting strategies? Formulary changes?
 - **Drug manufacturers:** Will list prices fall if rebates are phased out?
 - **Health plans (e.g. employers):** Benefit design changes?
 - **Pharmacies:** Changes in pharmacy networks? Brick-and-mortar vs mail-order?
- **How will these changes affect the cost of prescription drugs?**
 - To the health care system (premiums)?
 - To patients (out-of-pocket costs)?



Part II.

Medicare Maximum Fair Price Implementation

Medicare Drug Price Negotiation Program

- Enacted under the **Inflation Reduction Act** of 2022, allows Medicare to negotiate prices for **20 drugs per year** across Part D and Part B.
- Drugs are selected every February and negotiated **Maximum Fair Prices (MFPs)** announced in November. MFPs take effect 2 years after negotiation.
- Drugs are eligible if they will be **≥9 years old when price takes effect (≥13 years for biologics)** and have **>\$200M Medicare spending**.
 - Exclusions for small biotechs; plasma-derived products; drugs with approaching biosimilar competition; and drugs exclusively approved for rare conditions.
- Negotiations are bounded by a **statutory ceiling price** and are **based on several factors**, including:
 - **Comparative cost and safety/effectiveness** with therapeutic alternatives
 - R&D costs, public funding, cost of production/distribution, patents

Three Rounds of Negotiation (So Far)

- **First Round:** MFPs published August 2024; in effect as of January 2026.
 - MFPs an average **22% lower** than what Medicare previously paid.
- **Second Round:** MFPs published November 2025; take effect in 2027.
 - MFPs an average **44% lower** than what Medicare previously paid.
- **Third Round:** MFPs expected to be published by November 2026; take effect in 2028.

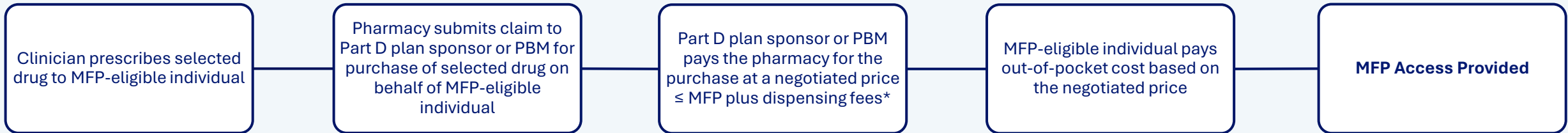
IPAY 2026	IPAY 2027	IPAY 2028
<ul style="list-style-type: none"> • Eliquis • Enbrel • Entresto • Farxiga • Fiasp; NovoLog • Imbruvica • Januvia • Jardiance • Stelara • Xarelto 	<ul style="list-style-type: none"> • Austedo • Breo Ellipta • Calquence • Ibrance • Janumet • Linzess • Ofev • Otezla • Ozempic; Rybelsus; Wegovy • Pomalyst • Tradjenta • Trelegy Ellipta • Vraylar • Xtandi 	<ul style="list-style-type: none"> • Anoro Ellipta • Biktarvy • Botox • Cimzia • Cosentyx • Entyvio • Erleada • Kisqali • Lenvima • Orencia • Rexulti • Tradjenta* • Trulicity • Verzenio • Xeljanz • Xolair

IPAY = Initial Price Applicability Year; * Drug selected for re-negotiation

MFP Implementation

Individual Access to MFP

Negotiated price used to set patient cost-sharing cannot exceed the MFP + dispensing fees

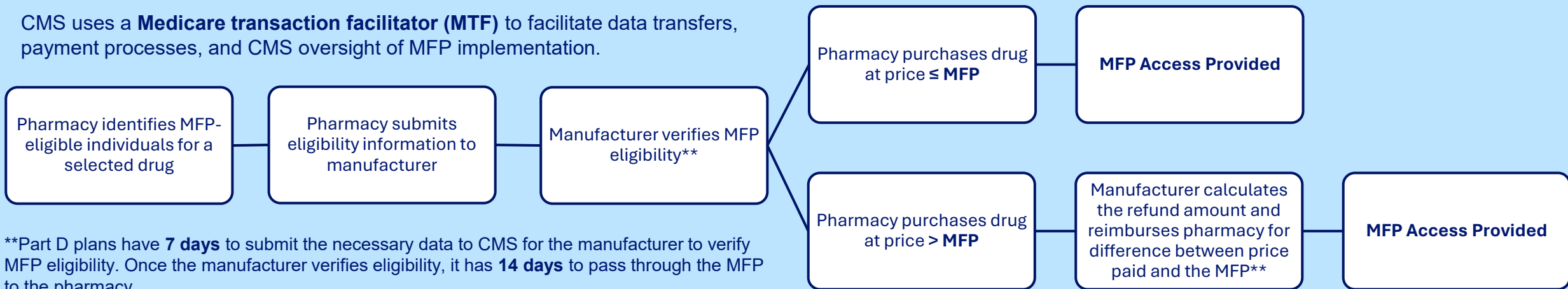


*Under Part D regulations, plans are required to pay their share of the claim to the pharmacy within **14 days**.

Dispensing Entity (e.g., Pharmacy) Access to MFP

Final amount paid by the pharmacy for the selected drug cannot exceed the MFP

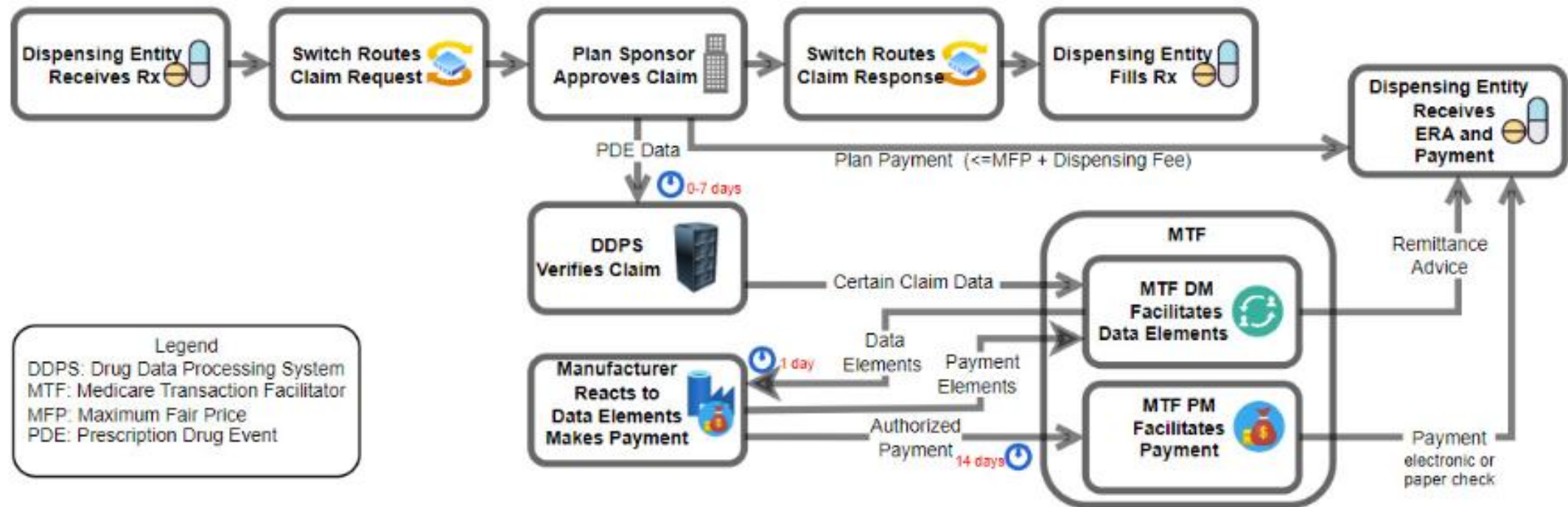
CMS uses a **Medicare transaction facilitator (MTF)** to facilitate data transfers, payment processes, and CMS oversight of MFP implementation.



Part D plans have **7 days to submit the necessary data to CMS for the manufacturer to verify MFP eligibility. Once the manufacturer verifies eligibility, it has **14 days** to pass through the MFP to the pharmacy.

MFP Implementation

- **All 10 IPAY2026 drug manufacturers are using a retrospective refund model** routed through the CMS Medicare Transaction Facilitator to enable pharmacy access to MFPs.
- Additional third-party services (e.g., Beacon MFP) are used to manage MFP refund tracking and facilitate manufacturer-pharmacy communication.



Emerging Issues

- **Some stakeholders have raised concerns about operational aspects of the MFP:**
 - **Delays in MFP Refunds:** Pharmacies receive payment from Part D plans within 14 days but can wait up to 21 days to receive MFP refunds from manufacturers. Some independent pharmacies report longer delays. These delays may cause **cash flow issues that may impact a pharmacy's willingness to stock drugs with an MFP.**
 - CMS enables pharmacies to self-identify as having cash flow issues, but it is unclear how the agency is acting on these reports.
 - Manufacturers can face monetary penalties if they are not paying refunds within required timelines.
 - **340B Deduplication:** Manufacturers must **identify whether a Part D claim is associated with 340B** and therefore ineligible for MFP, but doing so may be challenging. The manufacturer may be **subject to penalties** in both Medicare and the 340B program if it misidentifies claims.
 - CMS has plans to create a centralized voluntary repository of 340B Part D claims which may enable deduplication infrastructure in the future.
 - HRSA's proposed 340B rebate model would have focused on drugs with MFPs with this issue in mind.

Broader Impacts

- **As of April 2026, empirical evidence on the effects of MFP implementation remains limited.** As the rollout continues this year, more data will become available to assess the early impact on Medicare spending and utilization.
- **Other questions to consider as the program continues:**
 - How does CMS plan to **implement the MFP for Medicare Part B drugs** in 2028?
 - Will MFPs impact **Part D reimbursement levels** for pharmacies?
 - How will Part D plans and PBMs approach **formulary placement** of drugs with MFPs?
 - Will there be **spillover effects** of the MFP to other payer negotiations?
 - How will the Trump administration's efforts to implement **international reference pricing** in Medicare intersect with the negotiation program?

Questions?

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