

PCMA Response to Questions for the Record

May 4, 2026

The H. Morgan Griffith (R-VA)

1. Your companies are owned for the most part by insurance companies. Does a higher priced drug lead to better formulary placement for a drug?

No, in fact the opposite is typically true. Pharmacy benefit managers (PBMs) are the only entities in the pharmaceutical supply and payment chain with the mission of lowering costs. Their work to bring down costs for plan sponsors and patients provides savings to keep health care affordable and accessible. For many brand drugs, PBMs negotiate directly with drug manufacturers, which compete for formulary placement by offering rebates. PBMs negotiate \$148 billion in savings from manufacturers and pharmacies annually,¹ which benefits health plans, employers, retirees, and patients directly.

Formulary placement is developed by a group of independent clinicians called a Pharmacy & Therapeutics (P&T) Committee. The P&T Committee evaluates clinical data for FDA approved drugs, determines the drugs available to treat medical conditions, and if the options are equally safe and effective. The P&T Committee indicates to the PBM which medical conditions have multiple safe and effective options, and which drugs lack an equally effective alternative treatment. Given this information, the PBM examines the comparatively few competing drugs, which ones will be the lowest net cost—which for brand drugs also entails negotiating with the drug companies—and creates a suggested formulary. **The plan sponsor may choose to make changes to the suggested formulary and ultimately has the final decision on what drugs end up on this list.**

Furthermore, the cost of the drug is considered only after the robust clinical assessment of a drug's safety and efficacy and comparisons to alternatives. Importantly, PBMs encourage the coverage and use of the lowest-net-cost drug. It stands that PBMs recognize the value of biosimilars, and when competitively priced, coverage is often recommended to plan sponsors. Additionally, PBMs strongly support policies that can increase biosimilar production to enhance competition in the market.

a. Do you call this a rebate?

A rebate, as used by pharmacy benefit managers, is a price concession paid by a drug manufacturer to a PBM or plan sponsor that reduces the overall cost of a prescription drug. A rebate is a discount and PBMs use them to generate savings from manufacturers, which lowers the net cost of drugs for plan sponsors. These savings are then used to offset overall prescription drug spending, help stabilize premiums, and support more affordable coverage for beneficiaries. It is important to note that PBMs pass through nearly 100 percent of rebates back to health plan sponsors. **Following enactment of the Consolidated Appropriations Act (CAA), all PBMs will pass through 100% of rebates.**

¹ Mulligan. 2022. https://www.nber.org/system/files/working_papers/w30231/w30231.pdf.

Importantly, for more than a third of the brand-name drugs reviewed, the Department of Health and Human Service (HHS) Office of the Inspector General (OIG) found that rebates declined as costs increased. That's because the most expensive drugs often have no competition in the market, making it hard to negotiate lower prices. It also found that the majority (95.6%) of Medicare Part D brand-name drug costs increased regardless of rebates over the five-year period examined.² Pharmaceutical manufacturers secure enormous price increases for Part D drugs without rebates and for Part B drugs, for which PBMs do not negotiate rebates.³

b. Does this “rebate” cause higher list prices for a drug because that means more money for PBMs and insurance companies?

No, statistical analysis of the top brand drugs found **no correlation** between rising list prices set by drug manufacturers and the change in rebate levels negotiated with PBMs.⁴ PBMs save health plans, including Part D plan sponsors and employers, an average of \$1,154 per person per year,⁵ and are the only ones in the drug supply chain with the primary mission of lowering drug costs.

Drug companies set the list price, and these list prices have steadily increased. From January 2022 to January 2023, over 4,000 drugs experienced a price increase with the average increase being 15.2%. Of those price increases, 46% were greater than the Consumer Price Index.⁶ Though list prices continue to rise, PBMs leverage competition among manufacturers and help drive lower drug costs overall. When rebates are available, PBMs pass back close to 100% of the value to health plan sponsors.⁷ As noted, the CAA means all PBMs will pass on 100% of rebates. Plan sponsors then determine how to apply the savings, which are often used to reduce premiums or cost sharing. Additionally, under the recent Department of Labor proposed rule and provisions in the CAA, employers face a significant expanded responsibility to oversee, validate, and act on detailed prescription drug cost.

However, over the last several years, increased expenditures on specialty drugs have been a key driver in keeping overall drug spending high. According to the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE), “The cost of specialty drugs has continued to grow, totaling \$301 billion in 2021, an increase of 43% since 2016. Specialty drugs represented 50% of total drug spending in 2021.”⁸ Between 2008 and 2021, launch prices for new drugs increased exponentially by 20% per year. From 2020 to 2021, 47% of new drugs were initially

² HHS OIG. 2019. <https://oig.hhs.gov/oei/reports/oei-03-19-00010.pdf>.

³ Visante. 2018. <https://www.pcmanet.org/wp-content/uploads/2018/08/Reconsidering-Drug-Prices-Rebates-and-PBMs-08-09-18.pdf>

⁴ Visante. 2024. <https://www.pcmanet.org/wp-content/uploads/2024/07/Price-Increases-NotCorrelated-with-Rebate-Changes47-1.pdf>.

⁵ <https://www.pcmanet.org/wp-content/uploads/2025/02/ROI-on-PBM-Services.pdf>

⁶ <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet>

⁷ CVS indicated it passed back 98% of rebates to its clients—and effectively 100% in Medicare. See CVS article and CNBC article—and Express Scripts passes back 95%—see Fierce Pharma article.

⁸ ASPE. 2022.

<https://aspe.hhs.gov/sites/default/files/documents/88c547c976e915fc31fe2c6903ac0bc9/sdp-trends-prescription-drug-spending.pdf>.

priced above \$150,000 per year. Prices increased by 11% per year, even after adjusting for estimated manufacturer discounts and changes in certain drug characteristics, such as more oncology and specialty drugs (e.g., injectables, biologics) introduced in recent years.⁹

It follows then that rising prescription drug costs are driven in large part by drug manufacturer decisions to set and increase list prices.

The H. Earl L. “Buddy” Carter (R-GA)

1. Long-term care (LTC) pharmacies provide 24/7 medication access and highly specialized services to medically vulnerable seniors in nursing homes, assisted living facilities and other long-term care settings, making them a critical endpoint in the prescription drug supply chain. It is typically the case that the only network pharmacy a Part D beneficiary will have access to is the LTC pharmacy serving the nursing home or assisted living facility in which the beneficiary resides. I understand, however, that in recent years several Part D Plans and the PBMs that represent them wait until the very last moment to offer “take it or leave it” contracts to LTC pharmacies, and this year several PBMs did not have the needed LTC pharmacies in network even after the 2026 Plan year began. In my view, to best meet the needs of these patients, PBMs and Plans should finalize contracts with LTC pharmacies well in advance of the plan year and before “open enrollment” in order to ensure continuity of care and to meet CMS network adequacy requirements.

We agree that, in the interest of beneficiary continuity of care, agreements between Part D plans and long-term care (LTC) pharmacies ideally should be finalized well in advance of the plan year. Unfortunately, plan sponsors and their PBMs are increasingly encountering situations in which an LTC pharmacy, or its Pharmacy Services Administration Organization (PSAO), refuses to accept standard terms or engage in reasonable negotiations. As a result, even when plans make good faith efforts to contract broadly, they may be unable to satisfy CMS’s LTC “convenient access” requirements unless they agree to terms demanded by the exclusive pharmacy.

By limiting plans’ ability to introduce competitive cost-reducing alternatives, or alternatives that may better meet beneficiary needs while still meeting network adequacy requirements, this conduct can undermine competition and delay negotiations. More importantly, it can create real challenges for patients in LTC settings, who may face access barriers, administrative disruption, or higher medication costs when pharmacy choice is constrained by facility-level exclusivity.

PBMs are committed to developing solutions that support access and encourage timely LTC contracting. In contrast, the role of PSAOs in delaying pharmacy negotiations raises broader questions about whether current policy and oversight adequately account for the influence PSAOs exert as intermediaries that are not accountable to beneficiaries.

a. What steps are PBMs taking to ensure that their contracting practices are timely, transparent, and honored as executed?

⁹ JAMA. 2021. <https://jamanetwork.com/journals/jama/fullarticle/2792986>.

PBMs and the Part D plan sponsors they represent take multiple steps to promote timely and transparent contracting with LTC pharmacies. Plans generally seek to initiate negotiations well in advance of the plan year, offer standard terms and conditions on a nondiscriminatory basis, and finalize agreements as early as possible to ensure network stability, continuity of care, and compliance with CMS network adequacy requirements. Once agreements are executed, PBMs and plans have strong incentives to honor those contracts as written, given CMS compliance obligations, operational dependencies in LTC settings, and the need for predictable pharmacy access for medically vulnerable beneficiaries. But, when LTC pharmacies or their PSAOs decline to accept standard terms or delay negotiations, plan sponsors and their PBMs may lack viable alternative contracting options. These dynamics can prolong negotiations despite good-faith efforts by plans and PBMs to execute agreements earlier in the year.

b. Should PBMs be held to clear timelines and enforceable standards for finalizing and honoring contracts with LTC pharmacies prior to open enrollment, and if not, why?

PBMs and plans support timely contracting and agree that earlier execution of LTC pharmacy agreements is in the best interest of beneficiaries. However, holding PBMs to rigid deadlines without addressing external constraints such as situations where a pharmacy is unwilling to meet a plan sponsor's standard terms and conditions would effectively hold plans accountable for circumstances beyond their control. In practice, this approach could even exacerbate existing challenges by increasing negotiating leverage for LTC pharmacies operating under exclusive facility arrangements, thereby incentivizing acceptance of non-standard terms that increase program costs without corresponding improvements in quality or access.

This is why it is critically important that policy and contracting structures do not unintentionally incentivize exclusive arrangements or "single-option" contracting outcomes that undermine the competition and affordability goals of Part D. A more balanced approach would recognize shared accountability across plans, pharmacies, and LTC facilities, while preserving flexibility in situations where good faith contracting efforts are met with refusal or delay by the pharmacy side – provided that beneficiary access and continuity of care are maintained.

c. How do PBMs assess the impact of delayed or incomplete contracting on beneficiaries' ability to make informed plan choices during Medicare open enrollment?

PBMs and plans recognize that timely and accurate network information is critical for beneficiaries during Medicare open enrollment, particularly for LTC residents who rely on consistent pharmacy services. Plans monitor contracting status closely and work to minimize disruption by prioritizing beneficiary access, continuity-of-care protections, and compliance with CMS requirements.

However, in the LTC context, beneficiaries' practical pharmacy access is often shaped less by plan design than by facility level arrangements and exclusivity policies. Even when plans have broader LTC pharmacy networks, residents may be limited to a single pharmacy selected by the facility. As a result, delayed contracting between plans and exclusive LTC pharmacies can affect beneficiaries' pharmacy access regardless of the information available during open enrollment.

PBMs support clearer guidance and shared accountability across plans, pharmacies, and LTC facilities to reduce late-stage contracting disputes and improve the accuracy and usefulness of pharmacy access information available to beneficiaries during open enrollment. We are committed to working collaboratively to identify solutions that protect beneficiaries and preserve access.