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Causes of unaffordable prescription drugs: monopolies, rebates, and misaligned incentives

Testimony of:

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Committee on Ways and Means
Subcommittee on Health
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Summary of Major Points

- High prices for prescription drugs have resulted in many patients struggling to afford necessary medications. Medications do not work when patients cannot afford to take them.
- The main driver of high drug prices in the US is the fact that we allow brand-name drug makers to freely set and raise prices during periods of government-granted monopolies; prices are much lower in other advanced countries with more sensible drug pricing policies.
- Pharmacy benefit managers (PBMs) negotiate rebates from drug manufacturers in exchange for preferred formulary position and removal of utilization management tools.
- PBMs have negotiated increasing rebates that have partially offset the striking growth in manufacturer list prices, although rebates vary between drugs and health plans.
- Rebates negotiated by PBMs in aggregate can lower premiums, but rebates do not necessarily flow to patients; out-of-pocket costs for individual drugs are frequently based on list prices that exclude rebates.
- PBMs sometimes charge insurance plans and patients more than they pay pharmacies (i.e., spread pricing) and encourage patients to fill medications at their own pharmacies; these practices may be resulting in unnecessarily high prices, particularly for generic medications.

Summary of Policy Recommendations

- The most important policies Congress can enact to lower prescription drug costs are those that address high brand-name drug prices set by manufacturers and encourage timely generic competition.
- Enacting policies that place excessive restrictions on PBMs' abilities to manage formularies, such as out-of-pocket caps and restrictions on utilization management tools, will impede PBMs' abilities to negotiate rebates and result in higher net drug prices for some drugs. To avoid this, such policies should be paired with other policies that directly address the high prices set by manufacturers.
- In addition to addressing high prices set by manufacturers, Congress should take several actions related to PBMs to optimize medication affordability and accessibility, such as:
    - Prohibiting PBMs and plan sponsors from tying patient out-of-pocket costs to high manufacturer list prices that do not include rebates.
    - Requiring PBMs to pass 100% of rebates they negotiate to plan sponsors and requiring plans to use these rebates to lower premiums and offer more generous benefits.
    - Preventing PBMs from engaging in spread pricing or collecting fees that depend on the prices of medications.
    - Asking the Government Accountability Office to investigate the impact of vertical consolidation between PBMs and pharmacies.
    - Requiring disclosure of markups when medications are filled at a pharmacy that is owned by or affiliated with the PBM.

Chairman Buchanan, Ranking Member Doggett, and Members of the Committee,

My name is Benjamin Rome. I am a practicing primary care physician, an Instructor in Medicine at Harvard Medical School, and a health policy researcher in the Division of Pharmacoepidemiology and Pharmacoeconomics at Brigham and Women's Hospital in Boston. Within the Division, I am a faculty member of the Program On Regulation, Therapeutics, And Law (PORTAL), an interdisciplinary research group that studies the intersections between evidence-based use, regulation, and affordability of prescription medications. I am honored to be here today to talk with you about how Congress can make medications more affordable for patients.

Medications do not work when patients cannot afford them.

The high cost of prescription drugs harms patients. One in 4 US adults reports having difficulty affording their medications, and 3 in 10 report not picking up prescriptions or skipping doses due to high cost.[1]

Even among those with insurance, patients frequently owe high out-of-pocket costs that limit access to essential medications. Patients with higher out-of-pocket costs are less likely to pick up prescriptions for new medications[2] and are less likely to stay on medications for chronic diseases like diabetes and cardiovascular disease.[3] When patients cannot afford prescription medications to control symptoms or treat or prevent disease, their health suffers.

Origins of high drug prices.

In the US, new brand-name drugs are granted patents and other statutory protections that prevent direct competition during periods of market exclusivity. Often, companies add layers of additional extraneous patents that prevent competition for longer than anticipated. These periods of protection against competition typically last 12-17 years,[4] during which drug companies are free to set and raise prices as high as the market will bear. As a result of this dynamic, we have seen prices for brand-name drugs skyrocket. The average launch price for newly marketed brand-name drugs has been increasing by approximately 20% per year, from $2,000 per year in 2008 to $180,000 per year in 2021.[5] After drugs are introduced, manufacturers frequently hike prices each year above the rate of inflation, without any evidence that the drugs are becoming safer or more effective. These price increases averaged 4.5% per year from 2007 to 2018.[6] For example, the price of adalimumab (Humira), an anti-inflammatory medication used to treat rheumatoid arthritis and several other conditions, increased by 470% from 2003 to 2021.[7]

Compared with the US, other developed countries have far more sensible policies for regulating brand-name drug prices. Most countries systematically evaluate new drugs, negotiate fair prices that are aligned with drugs' benefits to patients, and have mechanisms to lower prices

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[1] Hamel L, Lopes L, Kirzinger A, Sparks G, Stokes M, Brodie M. Public Opinion on Prescription Drugs and Their Prices. KFF. Published October 20, 2022. https://www.kff.org/health-costs/poll-finding/public-opinion-on-prescription-drugs-and-their-prices/.

[2] Dusetzina SB, Huskamp HA, Rothman RL, et al. Many Medicare Beneficiaries Do Not Fill High-Price Specialty Drug Prescriptions. *Health Affairs*. 2022;41(4):487-496. doi:10.1377/hlthaff.2021.01742

[3] Rome BN, Gagne JJ, Avorn J, Kesselheim AS. Non-warfarin oral anticoagulant copayments and adherence in atrial fibrillation: A population-based cohort study. *American Heart Journal*. 2021;233. doi:10.1016/j.ahj.2020.12.010.

[4] Rome BN, Lee CC, Kesselheim AS. Market Exclusivity Length for Drugs with New Generic or Biosimilar Competition, 2012–2018. *Clinical Pharmacology and Therapeutics*. 2020;0(0):1-5. doi:10.1002/cpt.1983.

[5] Rome BN, Egilman AC, Kesselheim AS. Trends in Prescription Drug Launch Prices, 2008-2021. *JAMA*. 2022;327(21):2145-2147. doi:10.1001/jama.2022.5542.

[6] Hernandez I, San-Juan-Rodriguez A, Good CB, Gellad WF. Changes in List Prices, Net Prices, and Discounts for Branded Drugs in the US, 2007-2018. *JAMA*. 2020;323(9):854. doi:10.1001/jama.2020.1012

[7] Drug Pricing Investigation: AbbVie—Humira and Imbruvica. U.S. House of Representatives Committee on Oversight and Reform. May 2021.

over time.[8] As a result, average prices for brand-name drugs are twice as high in US, compared to peer countries.[9] For the first time, the Inflation Reduction Act of 2022 will allow Medicare to begin negotiating prices for certain high-cost drugs. This policy is a landmark achievement, although the scope is limited; manufacturers will still be free to set and raise prices for at least 9 years after FDA approval, and negotiated prices will only apply to Medicare, not the half of Americans with private insurance plans.[10]

Currently, the most important strategy for controlling high drug prices in the US is ensuring timely generic competition after market exclusivity periods expire. Effective generic competition can lower prices by 80% or more.[11] This direct competition is effective because states allow pharmacists to automatically substitute generics in place of the brand-name drug.[12] Generics account for 97% of prescriptions among drugs for which they are available.[13] Generic competition saved the US health care system an estimated $8.8 billion in 2017 alone.[14]

Brand-name manufacturers have developed numerous strategies to delay generic competition and extend their periods of monopoly protection.[15] For example, companies protect their drugs with thickets of patents related to the manufacturing, formulation, and use of the drug; generic drug makers must dispute these patents, and the resulting litigation can delay generic market entry. In other cases, brand-name drug makers introduce and heavily market new, only slightly modified versions of their drug with additional patent protection, just before the original drug nears the end of its exclusivity period; this strategy is known as "product hopping." In one example, the drug maker Teva introduced a new version of the multiple sclerosis medication glatiramer acetate (Copaxone) that could be injected 3 times weekly instead of once a day; this maneuver delayed effective generic competition by more than 2 years, costing $4-6 billion in unnecessary health care spending in the US.[16]

Summary and Policy Recommendations

- The main driver of high drug prices in the US is the fact that we allow brand-name drug makers to freely set and raise prices during periods of government-granted monopolies; prices are much lower in other advanced countries with more sensible drug pricing policies.
- The most important policies Congress can enact to lower prescription drug costs are those that address high brand-name drug prices set by manufacturers and encourage timely generic competition, such as:

[8] Emanuel EJ, Zhang C, Glickman A, Gudbranson E, Dimagno SSP, Urwin JW. Drug reimbursement regulation in 6 peer countries. *JAMA Internal Medicine*. 2020;180(11). doi:10.1001/jamainternmed.2020.4793.
[9] Mulcahy AW, Whaley C, Tebeka MG, Schwam D, Edenfield N, Becerra-ornelas AU. International Prescription Drug Price Comparisons: Current Empirical Estimates and Comparisons with Previous Studies. RAND Corporation; 2021. doi.org/10.7249/RR2956.
[10] Hwang TJ, Kesselheim AS, Rome BN. New Reforms to Prescription Drug Pricing in the US: Opportunities and Challenges. *JAMA*. 2022;328(11):1041-1042. doi:10.1001/jama.2022.15268.
[11] Dave CV, Hartzema A, Kesselheim AS. Prices of Generic Drugs Associated with Numbers of Manufacturers. *N Engl J Med*. 2017;377(26):2597-2598. doi:10.1056/NEJMc1711899.
[12] Rome BN, Sarpatwari A, Kesselheim AS. State Laws and Generic Substitution in the Year After New Generic Competition. *Value in Health*. 2022;25(10):1736-1742. doi:10.1016/j.jval.2022.03.012.
[13] Congressional Budget Office. Prescription Drugs: Spending, Use, and Prices.; 2022:222-229. https://www.cbo.gov/publication/57772#:~:text=The%20share%20of%20prescriptions%20for,to%2090%20percent%20in%202018.
[14] Conrad R, Liu W, Tillman Z, et al. Estimating Cost Savings from Generic Drug Approvals In 2017. US Food and Drug Administration; 2017. https://fda.report/media/113500/Estimating-Cost-Savings-From-Generic-Drug-Approvals-In-2017.pdf.
[15] Vokinger KN, Kesselheim AS, Avorn J, Sarpatwari A. Strategies That Delay Market Entry of Generic Drugs. *JAMA Intern Med*. 2017;177(11):1665-1669. doi:10.1001/jamainternmed.2017.4650.
[16] Rome BN, Tessema FA, Kesselheim AS. US Spending Associated with Transition from Daily to 3-Times-Weekly Glatiramer Acetate. *JAMA Internal Medicine*. 2020;180(9):1165-1172. doi:10.1001/jamainternmed.2020.2771.

- Promoting greater scrutiny of pharmaceutical patents by the US Patent and Trademark Office to prevent drug companies from obtaining dozens of irrelevant patents to extend their monopolies.
- Encouraging the Federal Trade Commission to investigate and prosecute anti-competitive behaviors such as product hopping that delay competition and result in higher prices for consumers.

Pharmacy benefit managers use formulary tools to negotiate lower drug costs.

To manage their prescription drug plans, most health insurers contract with pharmacy benefit managers (PBMs). To control spending, PBMs typically create a tiered formulary and impose utilization management rules to steer patients toward lower-cost medications and away from more expensive ones. Tiered formularies mean that patients pay lower out-of-pocket costs for drugs on preferred tiers. In 2022, 84% of workers with private insurance had pharmacy coverage with three or more tiers, and average copayments ranged from $11 in the lowest tier to $116 in the fourth tier.[17]

In addition to tiered formularies, another cost-containment strategy used by PBMs involves limiting access to expensive medications with utilization management tools. One such tool is prior authorization, which requires insurance approval before a medication can be covered. In a recent study, my colleagues found that 2 out of 3 new brand-name drugs had a prior authorization requirement by at least 1 of the 8 largest health insurers administering Medicare Part D plans, and 40% of these prior authorizations imposed requirements that were more strict than the FDA-approved labeling.[18] Another utilization management tool, called step therapy, requires patients to try a less expensive medication before a more expensive medication is covered.

Tiered formularies and utilization management tools can be frustrating for clinicians and patients, particularly when they prevent or delay the use of medications that are appropriate and aligned with evidence and standard clinical practice. Prior authorizations can be burdensome and time-consuming for busy clinical practices, and variations in these policies among plans can be confusing and difficult to navigate. By one estimate, physicians devote $27 billion worth of time each year navigating utilization management tools.[19]

Although these formulary management strategies are frustrating and costly, they are essential tools used by PBMs and health plans to negotiate lower prices from drug manufacturers. Brand-name drug manufacturers rely on formulary placement for patients to be able to access and use their expensive medications. As a result, PBMs can sometimes negotiate discounts from manufacturers in exchange for preferred formulary placement.

This negotiation process means that patients who need expensive medications sometimes face high out-of-pocket costs or restricted access to some medications. For policymakers, it can be tempting to enact rules that protect patients from this process, such as capping out-of-pocket costs or preventing step therapy restrictions. However, enacting such policies will impede PBMs' abilities to negotiate discounts, thereby resulting in higher net prices for some medications. As a

[17] 2022 Employer Health Benefits Survey. Section 9: Prescription Drug Benefits. *KFF*. https://www.kff.org/report-section/ehbs-2022-section-9-prescription-drug-benefits/.
[18] Naci H, Forrest R, Zhai M, Stofesky AR, Kesselheim AS. Characteristics of Prior Authorization Policies for New Drugs in Medicare Part D. *JAMA Health Forum*. 2023;4(2):e225610. doi:10.1001/jamahealthforum.2022.5610.
[19] Howell S, Yin PT, Robinson JC. Quantifying The Economic Burden of Drug Utilization Management on Payers, Manufacturers, Physicians, And Patients. *Health Aff (Millwood).* 2021;40(8):1206-1214. doi:10.1377/hlthaff.2021.00036.

result, any such policies must be accompanied by other policies that address the high prices set by drug manufacturers.

Summary and Policy Recommendations

- To control prescription drug spending, PBMs negotiate lower prices from drug manufacturers in exchange for preferred formulary position and removal of utilization management tools.
- Enacting policies that place excessive restrictions on PBMs' abilities to manage formularies, such as out-of-pocket caps and restrictions on utilization management tools, will impede PBMs' abilities to negotiate lower prices for some drugs. To avoid this, such policies should be paired with other policies that directly address the high prices set by manufacturers.

Rebates negotiated by PBMs vary and do not always reach patients.

Although negotiation by PBMs is an important strategy for combating the rising prices set by drug manufacturers, the negotiation process does not always ensure that medications are affordable for patients. Rather than directly negotiating for lower drug prices, PBMs traditionally negotiate rebates that are paid retrospectively by drug manufacturers after the point-of-sale.[20] Most of these rebates are passed on to the plan sponsor, and can be used to lower premiums or provide more generous pharmacy benefits. However, PBMs are not transparent about the size of these rebates and often keep a portion of the rebates they negotiate as their own profit.

Additionally, rebates do not directly lower the out-of-pocket costs for patients using expensive medications; these costs are based on the list prices set by manufacturers, even in cases when PBMs have negotiated substantial rebates. This is particularly true when plans require patients to pay deductibles (i.e., paying the full cost of medications up to a threshold) or coinsurance (i.e., a percentage of a drug's cost). In a recent study, my colleagues and I studied commercially insured patients using one of 79 brand-name drugs; we found that 58% paid coinsurance or deductibles; for these patients, their out-of-pocket costs increased each year when manufacturers raised drug prices.[21]

In recent years, increasing rebates negotiated by PBMs have partially offset the striking growth in manufacturer list prices. This has resulted in a widening gap between the list prices set by manufacturers and the net prices paid by health insurers after rebates. In Medicare Part D, for example, the share of brand-name drug spending offset by rebates and other discounts increased from 25% in 2014 to 37% in 2018.[22] The ability of PBMs to negotiate rebates varies widely by drug. For brand-name drugs for which there are multiple competitors in the same therapeutic class, PBMs can negotiate steep discounts by offering preferred formulary position to only one drug in the medication class. For example, many insulin products have average rebates exceeding 70%.[23]

In some cases, however, PBMs have limited leverage to negotiate rebates. This can occur either when a drug lacks competition from therapeutic alternatives, or when federal or state law

[20] Dusetzina SB, Bach PB. Prescription Drugs - List Price, Net Price, and the Rebate Caught in the Middle. *JAMA*. 2019;321(16):1563-1564. doi:10.1001/jama.2019.2445.
[21] Rome BN, Feldman WB, Desai RJ, Kesselheim AS. Correlation Between Changes in Brand-Name Drug Prices and Patient Out-of-Pocket Costs. *JAMA Network Open*. 2021;4(5):218816. doi:10.1001/jamanetworkopen.2021.8816.
[22] Feldman WB, Rome BN, Raimond VC, Gagne JJ, Kesselheim AS. Estimating Rebates and Other Discounts Received by Medicare Part D. *JAMA Health Forum.* 2021;2(6):e210626. doi:10.1001/jamahealthforum.2021.0626.
[23] United States Senate Finance Committee. Insulin: Examining the Factors Driving the Rising Cost of a Century Old Drug. January 2021. https://www.finance.senate.gov/chairmans-news/grassley-wyden-release-insulin-investigation-uncovering-business-practices-between-drug-companies-and-pbms-that-keep-prices-high.

requires insurance companies to cover a particular class of drug. For example, Medicare Part D plans are required to cover all medications that fall into six protected classes, which limits plans' ability to negotiate rebates for drugs in these protected classes.[24] One of the protected classes is cancer drugs, which had Medicare Part D rebates averaging 2% in 2016.[25]

There is also variation in the ability of PBMs to negotiate rebates. For example, in Colorado, average rebates for commercial insurers in 2018 ranged from 2% to 27%.[26] Presumably, this is because PBMs have greater leverage to negotiate rebates when they contract with larger insurers with greater market share.

Summary and Policy Recommendations

- PBMs have negotiated increasing rebates that have partially offset the striking growth in manufacturer list prices, although rebates vary between drugs and health plans.
- Rebates negotiated by PBMs in aggregate can lower premiums, but rebates do not necessarily flow to patients; out-of-pocket costs for individual drugs are frequently based on list prices that exclude rebates.
- Congress should prohibit PBMs and plan sponsors from tying patient out-of-pocket costs to high manufacturer list prices that do not include rebates.
- Congress should require PBMs to pass 100% of rebates they negotiate to plan sponsors and require plans to use these rebates lower premiums and offer more generous benefits.

Spread pricing and vertical integration between PBMs and pharmacies may be raising prices for generic drugs.

While there are dozens of PBMs, the three largest – Express Scripts, CVS Caremark, and Optum – control approximately 80% of the market.[27] This consolidation in the PBM market has raised concern among policymakers. However, PBMs argue that their large market share affords them greater leverage to negotiate lower drug prices from manufacturers. In other words, consolidation by PBMs is not inherently problematic, and, in fact, could help lower drug costs.

Beyond general concerns about consolidation, however, there two legitimate concerns have been raised about the way PBMs conduct business. The first centers around how PBMs contract with health plan sponsors. In some cases, PBMs use a strategy called spread pricing, in which they charge plan sponsors more than they pay pharmacies, allowing the PBM to pocket the difference. This pricing model misaligns financial incentives, allowing PBMs to profit from higher reimbursed prices. If the spread is large, patients may also end up overpaying for medications. In an infamous example, PBMs charged Ohio's Medicaid managed care organizations a "spread" of 31% for generic drugs, which amounted to $208 million of excess spending in 1 year.[28]

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[24] Hwang TJ, Dusetzina SB, Feng J, Maini L, Kesselheim AS. Price Increases of Protected-Class Drugs in Medicare Part D, Relative to Inflation, 2012-2017. *JAMA.* 2019;322(3):267-269. doi:10.1001/jama.2019.7521.
[25] US Government Accountability Office. Use of Pharmacy Benefit Managers and Efforts to Manage Drug Expenditures and Utilization. July 2019. https://www.gao.gov/products/gao-19-498.
[26] Center for Improving Value in Health Care. Colorado Prescription Drug Spending and the Impact of Drug Rebates. January 2021. https://civhc.org/wp-content/uploads/2021/01/CO-Drug-Rebate-Report_1.8.2020.pdf.
[27] Fein AJ. The Top Pharmacy Benefit Managers of 2021: The Big Get Even Bigger. Drug Channels. April 5, 2022. https://www.drugchannels.net/2022/04/the-top-pharmacy-benefit-managers-of.html.
[28] Yost D. Ohio's Medicaid Managed Care Pharmacy Services: Auditor of State Report. Auditor of State; August 16, 2018. https://ohioauditor.gov/auditsearch/Reports/2018/Medicaid_Pharmacy_Services_2018_Franklin.pdf.

The second problem is that PBMs have become more vertically consolidated. Each of the major PBMs has now merged with or is operated by a health insurance company.[29] Perhaps more concerningly, the major PBMs each own or are affiliated with their own mail-order and specialty pharmacies. Increasingly, PBMs are steering patients to purchase drugs at their own pharmacies. This practice raises serious concerns about conflict of interest; PBMs are supposed to negotiate the lowest prices possible for health plans and consumers, but PBM-owned pharmacies profit from high reimbursement by health insurers that exceeds the cost of acquiring medications. The problems with this vertical consolidation seem to be particularly pronounced among specialty pharmacies. In a recent analysis of Florida's Medicaid managed care plans, the five largest specialty pharmacies – all of which were owned by or affiliated with PBMs – accounted for 0.4% of dispensed claims but 28% of prescription drug profits in 2018.[30]

These two issues – spread pricing and vertical consolidation with pharmacies – may be leading PBMs to over-charge patients and health plans for some medications. The problem seems particularly prominent for generic drugs, for which competition by multiple generic manufacturers is supposed to result in lower prices for patients. Evidence for this has come from comparing average generic drug prices in Medicare Part D with prices for the same drugs at two pharmacies that sell generic medications directly to patients. My colleagues and I found that Medicare Part D plans could have saved more than $3 billion on 108 generic drugs by paying the prices available from the Mark Cuban Cost Plus Drug Company.[31] Similarly, Trish et al. found that Part D plans could have saved more than 20% on 184 common generics by purchasing these drugs at Costco pharmacy prices.[32] These two examples highlight the problem of overpayment for generics; however, it is unreasonable to expect patients to shop around at multiple retail pharmacies to find the best prices for generic medications; PBMs should be doing this work on patients' behalf.

One notorious example is the cancer medication imatinib (Gleevec), used to treat chronic lymphocytic leukemia. After Gleevec's market exclusivity ended in 2016, three generic competitors entered the market. By the end of 2017, however, the average prices paid by commercial insurers had only fallen 10%, far less than expected based on that degree of competition.[33] Medicare Part D plans paid an average of $2500 for a 90-day supply for a generic imatinib; in 2023, Mark Cuban's pharmacy began selling a generic version of imatinib for 20 times less, with a current price of under $100 per 90-day supply.[34]

This degree of overpayment for generic drugs is shocking and unacceptable. However, it is important to remember that even with these problems, generics account for just 10% of US prescription drug spending, despite representing more than 90% of filled prescriptions.[35] As a

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[29] Fein AJ. Mapping the Vertical Integration of Insurers, PBMs, Specialty Pharmacies, and Providers: A May 2023 Update. *Drug Channels*. https://www.drugchannels.net/2023/05/mapping-vertical-integration-of.html.

[30] Sunshine in the Black Box of Pharmacy Benefit Management: Florida Medicaid Pharmacy Claims Analysis. 3Axis Advisors; January 30, 2020. https://www.3axisadvisors.com/projects/2020/1/29/sunshine-in-the-black-box-of-pharmacy-benefits-management.

[31] Lalani HS, Kesselheim AS, Rome BN. Potential Medicare Part D Savings on Generic Drugs from the Mark Cuban Cost Plus Drug Company. *Ann Intern Med*. 2022;175(7):1053-1055. doi:10.7326/M22-0756.

[32] Trish E, Gascue L, Ribero R, Van Nuys K, Joyce G. Comparison of Spending on Common Generic Drugs by Medicare vs Costco Members. *JAMA Internal Medicine*. 2021;181(10):1414-1416. doi:10.1001/jamainternmed.2021.3366.

[33] Cole BAL, Dusetzina SB. Generic Price Competition for Specialty Drugs: Too Little, Too Late? *Health Affairs*. 2018;37(5):738-742. doi:10.1377/hlthaff.2017.1684.

[34] Lalani HS, Kesselheim AS, Rome BN. Potential Medicare Part D Savings on Generic Drugs from the Mark Cuban Cost Plus Drug Company. *Ann Intern Med*. 2022;175(7):1053-1055. doi:10.7326/M22-0756.

[35] Aitken M, Kleinrock M. Medicine Use and Spending in the U.S.: A Review of 2018 and Outlook to 2023. IQVIA Institute; May 9, 2019. https://www.iqvia.com/insights/the-iqvia-institute/reports/medicine-use-and-spending-in-the-us-a-review-of-2018-and-outlook-to-2023.

result, policies that target these PBM practices will not lower spending as much as policies that address high manufacturer prices for brand-name drugs.

Summary and Policy Recommendations

- PBMs sometimes charge insurance plans and patients more than they pay pharmacies (i.e., spread pricing) and encourage patients to fill medications at their own pharmacies; these practices may be resulting in unnecessarily high prices, particularly for generic medications.
- To address these concerns, Congress should:
  - Prevent PBMs from engaging in spread pricing or collecting fees that depend on the prices of medications.
  - Ask the Government Accountability Office to investigate the impact of vertical consolidation between PBMs and pharmacies.
  - Require disclosure of markups when medications are filled at a pharmacy that is owned by or affiliated with the PBM.