Worthy

Care over kickbacks: Making our pharmacy distribution system worthy

Introduction

In 2023, Blue Shield of California partnered with the non-profit organization CivicaScripts to get access to the generic drug used to treat prostate cancer, Abiraterone, for $160 per dose, a deep discount from the approximately $3,000 list price. This was an exciting breakthrough because generic drugs contain the same active ingredients at the same strength and purity as their brand counterparts, and so literally, the only difference between the drug we had sourced and others on the market was the price.

Eager to share the good news, we approached our Pharmacy Benefit Manager (PBM) and asked them to have their specialty pharmacy distribute the $160 version of Abiraterone instead of the $3,000 version.

Despite their frequent discussion of all the things they do to make drug costs more affordable for their customers, they said no.

At that moment, I was shocked but not surprised.

They kept repeating that answer for months while providing excuses, e.g., the PBM's contract with the specialty pharmacy didn't support offering the drug even though the same corporate parent owned both companies. After relentless engagement on the issue, we finally got our PBM to allow us to offer the $160 version through a different specialty pharmacy.

To an outsider, it may seem shamelessly brazen to try every way possible to circumvent obvious cost savings in pursuit of profit, but in the world of PBMs, it is a standard business practice. Revenue and profit are tied to the price of the drug. High volumes of more expensive drugs mean more profit — and that drives business decisions.

The distribution of pharmaceuticals is far from the only health care sector in which the payments can drive questionable behavior, but it is perhaps the most egregious. The concern about financial incentives driving unwanted behavior is one of the reasons Congress passed the "Stark Law" in 1989 which prohibits physicians from referring patients to others with whom they have a financial relationship. The idea being that you don't want physicians deciding whether and where to refer patients based on how much money they make. Such referrals are considered kickbacks and are illegal. (See the U.S. Department of Health and Human Services overview for context, and the Department of Justice cases; 05/06/25, 01/15/25, 07/01/24, and 06/28/22, for recent prosecutions resulting in custodial sentences for kickback violations.)

Unfortunately, kickbacks in the form of rebates and fees tied to the price of a drug are not only legal but the most common method to pay for the distribution of pharmaceuticals thereby creating a system full of incentives to sell and administer the most expensive drug possible as was the case with the Abiraterone example above.

It is clear this system requires not just alternatives, but industry-wide reform.

The following sections outline a clear path to meaningfully overhaul the pharmacy distribution system – one that reduces costs, improves the care provided to patients, and increases transparency and accountability.

Deep Dive: Want to better understand how the pharmacy distribution system works today? In 2019, The Wall Street Journal created a video explaining the flow of money, drugs and rebates and how this drives up the cost of prescription medicine for consumers.

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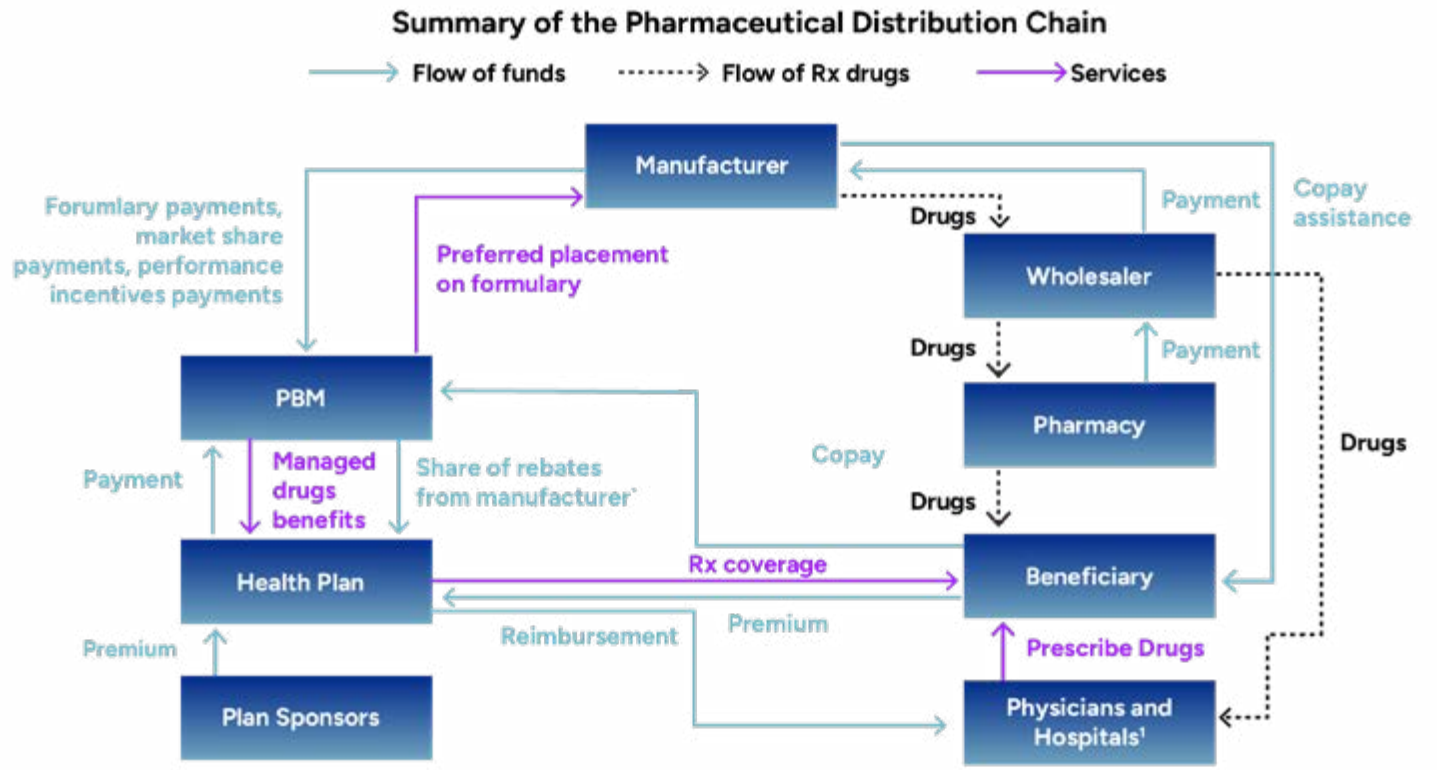


[1]Added to original chart from USC Schaeffer Source: USC Schaeffer

This segment is going to make references to the various participants in the complex pharmacy distribution chain. To help readers follow both how it works today and how it should in the future, I've provided a simple summary of the major participants involved in that system from the University of Southern California (see above) and a glossary of terms in the appendix.

As you look at the picture summary of the current system, there are three things worth noting:

1. It is complicated and includes a lot of different organizations/participants.
2. The PBMs have acquired or created their own companies to do a lot of these functions, e.g., pharmacies (including specialty pharmacies which deal with drugs that require special handling and administration).
3. Generally, the participants in the system get paid more when a higher volume of more expensive drugs are sold.

Drug pricing can influence health care decisions

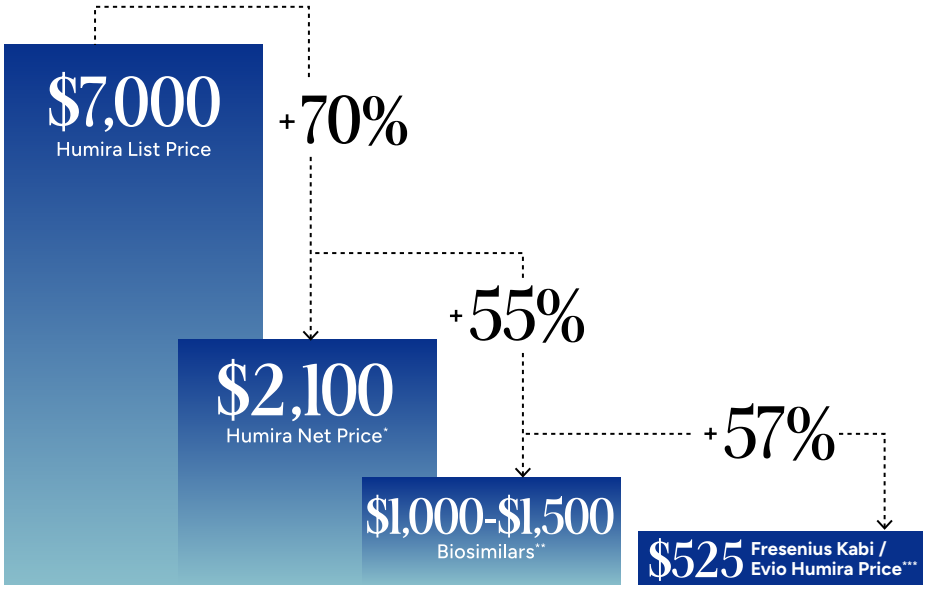
Let's look at another example of how this incentive system drives higher costs. AbbVie created Humira — a drug used to treat a variety of inflammatory conditions such as rheumatoid arthritis and was the best-selling drug of all time by total revenue – earning more than $21 billion of revenue in 2022 alone and more than $200 billion over the life of the patent. When the patent expired at the beginning of 2023, numerous other companies entered the market with the same kind of drug in a generic form, referred to as "biosimilars".

In short, the expiration of the patent resulted in a lot of lower-priced competition into a market previously dominated by Humira.

Blue Shield of California, the company with which I've been professionally affiliated for most of my career, wanted to take advantage of this increased competition at the same time it was launching its own alternative pharmacy distribution approach. So in the fall of 2024, Fresenius Kabi agreed to sell a Humira biosimilar to Blue Shield of California for $525 per monthly dose as compared to the nearly $7,000 monthly "list price," and the approximately $2,100 net price with "rebates and fees" for Humira.

In January of 2024, Humira had a 96% market share, and the drug maintained an over 70% market share for all of 2024

Average price for Humira v. Biosimilars



* Estimated but net price will depend on how much product needed, coupon savings, insurance coverage, and manufacturer savings

** Average for biosimilars to Humira reporting prices including Hxrimoz, Hadlima, Coherus, Adalimumab, and Amievita

*** Price to purchase monthly dose of Humira agreed upon by Blue Shield CA, Fresenius Kabi, and Evio Pharmacy Solutions

With competition like that, why would anyone buy Humira? But people did. In January of 2024, one year after biosimilars became available, Humira had a 96% market share, and the drug maintained an over 70% market share for all of 2024. Given that there have been such highly credible alternatives available for a fraction of the price for such a long time, how is this possible?

The "business model" for PBMs and their affiliates is to negotiate rebates and formulary placement fees from pharmacy manufacturers based on the list price of the drug. In the case of Humira, 2024 rebates and fees worth nearly $5,000 were kicked back each month to PBMs and their affiliates for each patient that used the drug. While a lot of that money was then passed back to others, including health plans and employers — and in the case of Blue Shield of California all of it was passed back to customers — much of that money was skimmed off the top by PBMs and their affiliates.

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A mark-up around every corner

We described how PBMs inflate the cost of prescription drugs but they are not alone. The same spread pricing practices also exists with some physician administered drugs (often called "buy and bill" practices). The spread is a markup on specialty drug acquisition and administration costs charged by providers who buy drugs directly from drug wholesalers and then bill payers for the drug at a higher price. The use of spread pricing is doubly problematic with the confluence of the substantial growth in specialty medications. A report by the Institute for Clinical and Economic Review (ICER) noted that markups charged to payers by hospitals for drugs administered in the hospital setting have been found to be as high as 200-300% of the base price of the drug. For high-cost specialty drugs, this markup can represent hundreds of thousands of dollars per patient, every year. The practice of buying and billing, as it is colloquially known, is not illegal, but it is another example where the costs are added to the system without any added value.

These same broken incentives can lead physicians to prescribe drugs that are sometimes unhelpful to patient health and/or to prescribe more costly drugs over clinically equivalent but less expensive alternatives. In a striking example, Medicare overpaid billions of dollars for a more expensive version of the same treatment. Genentech made both Lucentis and Avastin, but sold one for $2,000 a dose and the other for $50 a dose. The reimbursement structure set up by Medicare paid physicians a percent of the cost of the drug. As a result, physicians made $115 more per dose by administering the higher cost drug. Not all physicians administered the higher-cost drug, but the system failed all of us in creating an incentive structure in which driving up costs for patients and taxpayers became the default choice.

To be clear, physicians and the hospitals they work in should be appropriately compensated and paid for their value added to our healthcare system, which is their talent, judgement and professional expertise, not by marking up essential medications.

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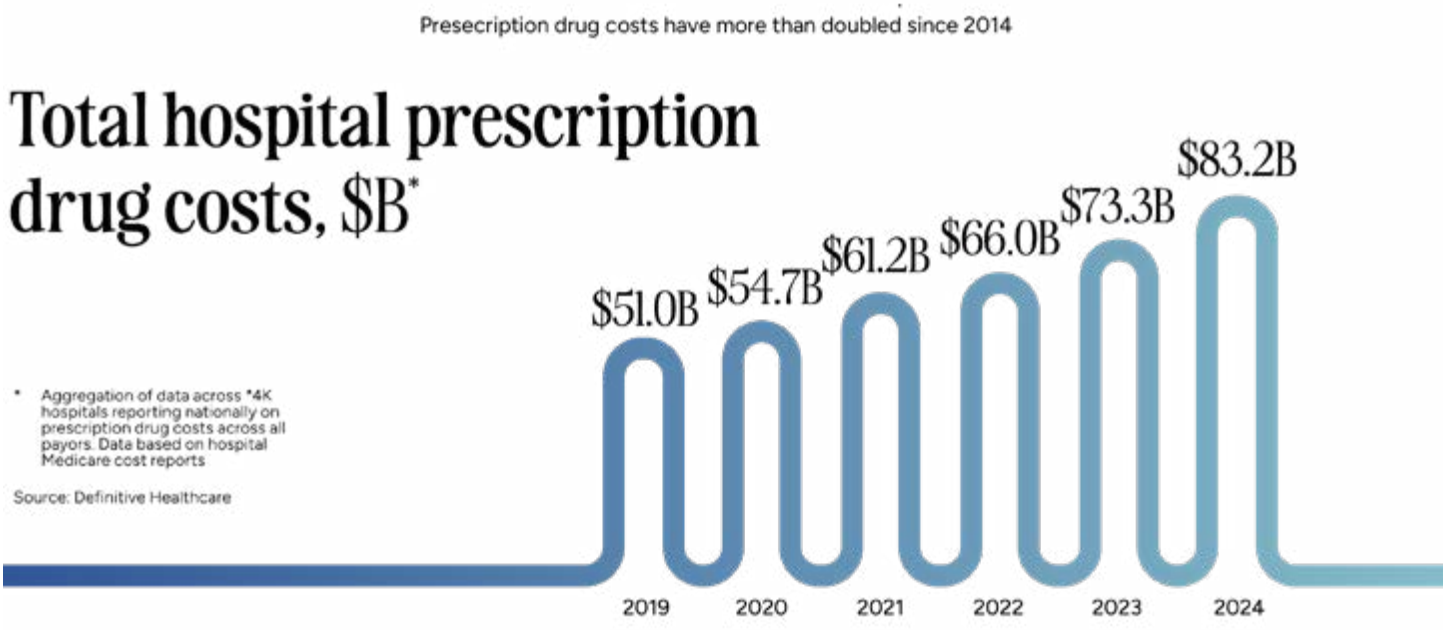
Hospitals: to 340B or not to 340B

If you've ever stayed overnight in a hospital, chances are that you've been given some drug(s) during your stay. That could be as simple as an over-the-counter pain reliever, such as Aspirin, or something far more complex and expensive, such as cell or gene therapy. A large and growing portion of the cost of visiting or staying in a hospital is associated with the cost of drugs.

Across all hospitals reporting nationally, prescription drug costs have more than doubled from $33.2B as of 2014, or 4.1% of total net patient revenue, to $83.2B as of 2024, or 5.7% of total net patient revenue. However, the profit growth for many hospitals has been much larger. One hospital recently privately shared that in 2025 they lost money collectively on all of their operations except for spread pricing on drugs where they earned all of their profit for that year.

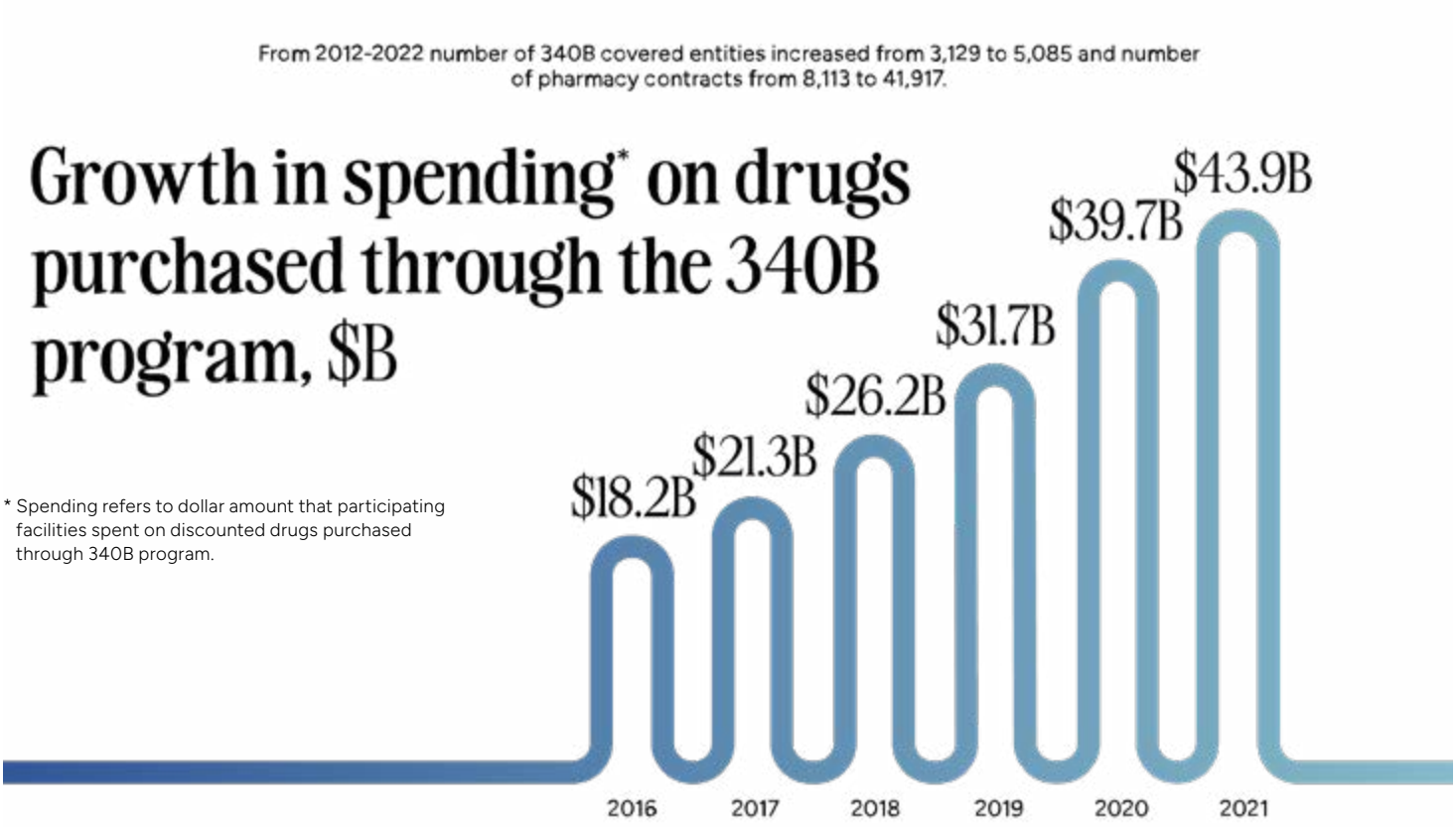


Hospitals commonly use the same "spread pricing" described earlier with physicians and as a result, make a lot of money when they are prescribing and administering drugs. "Spread pricing" has become a fast-growing source of profit for hospitals and the most dramatic example of it is with a program that was passed into law by Congress as part of the U.S. Public Health Service Act in 1992 that is referred to in the law: Section 340B (AAMC). For those of you interested in more background on 340B, there is an appendix explaining it in more detail. (For more information on 340B Commonwealth Fund, AAMC, HRSA). What is important to know is that it required drug manufacturers who participate in Medicaid to provide outpatient drugs at steeply discounted prices to certain safety-net health care providers as a way of improving Medicaid beneficiaries' access to medications and services. In short, it was very well intended.

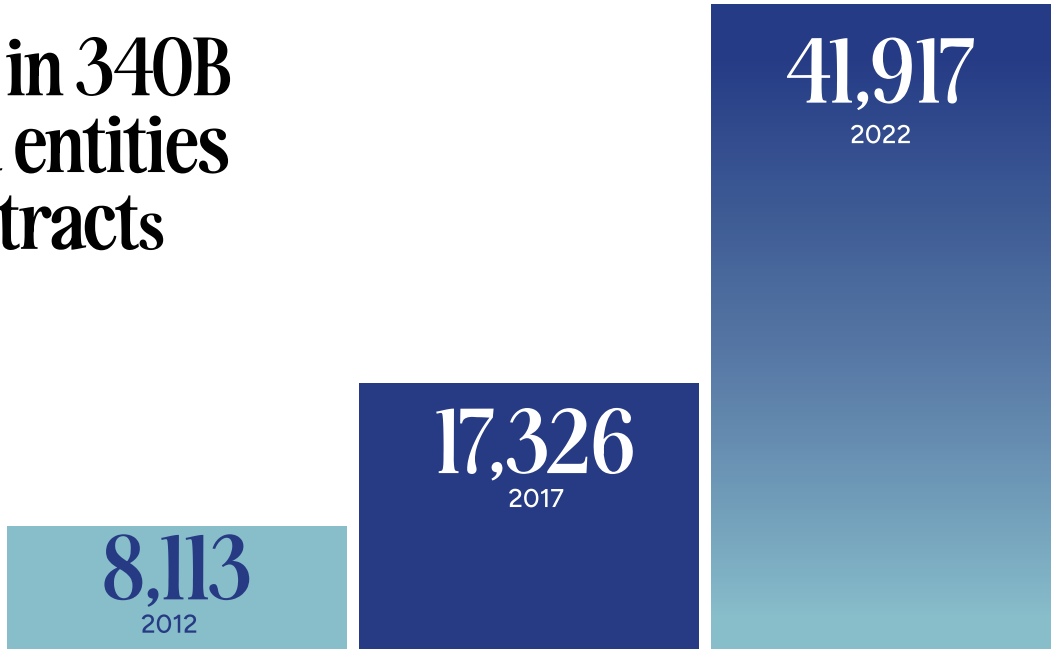
What has happened since then is that there are a lot of large, well-financed hospitals that cannot be described as "safety net" health care providers that now have access to the low-cost drugs under 340B but charge payors for those drugs way above their costs. In fact, hospital profit margins for 340B drugs average 72% compared to non-340B drugs at 22% (The Pharmaceutical Research and Manufacturers of America). Profitability of the 340B program for covered entities varies by payer mix as the chart here shows. In this example, a hospital purchases a drug at 340B price of $1,000 and when the drug is dispensed to a commercially insured patient, insurer reimburses for $3,000 while hospital retains $2,000 spread as profit. This exists too for Medicare and Medicaid at lower amounts.

So here is a program that was designed to reduce Medicaid costs, improve the access of Medicaid recipients to these drugs, and increase the financial capacity of safety-net hospitals and clinics to provide those services that has now turned into a major profit center for large, well-financed hospitals, particularly for patients that have commercial health insurance. In 2025, I was approached regularly by individuals and/or organizations offering to give our company the opportunity to profit from the 340B program. Our family of companies did not do so, however, as you can see from the charts showing the growth of the program below, many others have taken advantage of the opportunity.

From 2010 to 2021, spend on drugs purchased through the 340B program increased by 19% per year.



Growth in 340B covered entities and contracts



Number of pharmacy contracts

The bottom line is that this 340B program was designed for the purpose of improving Medicaid beneficiaries' access to high cost drugs and has now turned into a highly abused, rapidly escalating profit center that is adding costs but not demonstrating that it is doing anything to improve the quality of health care for patients.

Health care providers should not have large and growing financial incentives tied to a specific form of treatment.

Money matters to the participants in the healthcare system. As we have seen in examples of PBMs, physicians, and hospitals, it can drive behavior in ways that make it impossible to consistently deliver care that is worthy of our family and friends, and sustainably affordable for everyone.

The bottom line is that no matter what you call them – rebates, fees, or spread pricing – they are kickbacks. They are payments intended as compensation for preferential treatment and they change behavior of health care providers and others – sometimes at the expense of the quality of care for the patient.

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Domination of pharmacy distribution

One of the things that makes these kickbacks even worse is that there are now three, huge family of companies that dominate the pharmacy distribution chain. CVS (owned by CVS-Aetna), Express Scripts (owned by CIGNA), and OptumRx (owned by United Health Group) control 80% of the PBM market based on equivalent prescription drugs managed as of 2024 (Drug Channels). Each of them owns multiple, highly profitable companies in the distribution chain including Group Purchasing Organizations, PBMs, specialty pharmacies, and in the case of CVS a chain of retail drug stores. They did not create the rebate financing model, but by virtue of having so much market clout, they have taken full advantage of it. Given how much potential revenue and profit is at stake for a pharmacy manufacturer with each of the "Big 3," it can be absolutely critical to have key drugs favorably listed on a formulary. As a result, it makes it difficult if not practically impossible for an individual pharmacy manufacturer to negotiate a more favorable deal, push back on the fees being requested, or to embrace/support a direct competitor of the "Big 3" for fear of retribution. This tends to reinforce the current way of doing business as well as the market share and market power of the "Big 3." One of the consequences of this is to create serious competitive barriers to entry for anyone looking to move to a different system.

In August of 2023, while I was the CEO of Blue Shield of California, we announced that effective January 1, 2025 we were moving to a new system of drug distribution. We made it abundantly clear that the current system for distributing drugs was irretrievably flawed, even corrupt, and it needed to change. Our plan was to put together an alternative distribution system made of participants who were paid to ensure we got the right drug to the right patient at the right time as cost effectively as possible. In addition, we intended to negotiate contracts directly with manufacturers for a net price only. No fees, no rebates, no kickbacks. Just a straight price that we would pass on directly to our members.

After the announcement, I went out with a small group of team members to ask for these deals from pharmacy manufacturers. We had a lot of conversations with senior pharmacy leaders and while each company had its own point of view, they nearly all recognized that the current system was seriously flawed, what we were proposing made a lot more sense, and that moving to a new model would be complicated. Perhaps most importantly, nearly all of them were afraid of potential retribution from the "Big 3" especially if they were one of the first to sign a deal with us, e.g., having their biggest selling drugs being removed from the formularies of the "Big 3".

Since Blue Shield of California's announcement in August of 2023, the number of direct deals with pharmacy manufacturers can be counted using the fingers on two hands. There have been multiple reasons for the slow pace of these deals, but I firmly believe that the biggest barrier is the fear of retribution by the "Big 3".

The combination of market power and the ownership of other parts of the distribution chain, such as pharmacies, means that the "Big 3" can provide differential compensation and other favorable treatment to their affiliated companies as compared to others. And not surprisingly, they do just that.

Deep Dive: Understanding compensation to pharmacies and how it is impacting their profitability CNBC, Drug Channels.

This can have damaging impacts to the business models of pharmacies and specialty pharmacies that are not affiliated with one of the "Big 3" and there is growing evidence that this is happening. When there is so much market share and market power concentrated in a small number of companies, the questions we need to be asking should include: how is the power being used, is it being abused, and is it benefiting consumers? In the case of the "Big 3", the market power is being used to maximize profit, it is clearly being abused, and it is not benefiting consumers.

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Taking the air out of the inflated pricing model

PBMs, wholesalers, pharmacies, hospitals, and some physicians all benefit financially from the "spread" between the price listed or charged to the health plan and the net amount that is actually paid to the pharmaceutical company. PBMs also send a lot of those rebates back to employers and to health plans, which then use those funds in different ways, for example to make more profit, to fund different programs, and to subsidize richer benefits for Medicare Advantage products. (Blue Shield of California passes back all of the rebates to customers by crediting it to pricing).

Many participants in the system have been getting more money each year in this system, but there are serious problems with this. Chief amongst these is how much it costs. This system is like getting cash back on your credit card. The only way you receive more money is if we spend more money on health care. By definition, this is adding cost without improving quality or patient experience.

In addition, this can be grossly unfair to the patient receiving the care because some benefit designs determine the amount of money the customer owes (often referred to as their "co-payment" or "co-insurance") based on the list price, rather than the net price.

According to researchers at USC Schaeffer, consumers pay more in co-payments for a drug than the manufacturer receives in reimbursement for that drug up to 23% of the time (KFF).

In fact, before non-profit CivicaScripts announced in 2023 that it would produce insulin at a low net price, the list price for insulin for most of the companies making it was approximately $1,000 per vial. The net price was always much closer to $30—Eli Lilly announced a $35 per vial list price not long after CivicaScripts's announcement. But that meant for a long time there were some customers paying co-payments based on the $1,000 list price of insulin and some were **probably paying more in co-payments than the actual cost of the drug.**

Most recently, however, in California (10/16/25), Governor Gavin Newsom announced that the state would begin selling its own branded insulin, CalRx, starting January 1, 2026. Through a partnership with the non-profit drug manufacturer CivicaScripts, the low-cost insulin pens will be available for $11 each.

This is significant because it exposes the true cost of insulin and challenges the industry's inflated pricing model – which, historically, has influenced the decisions that healthcare organizations make when it comes to whether and which drugs to prescribe and administer. This is not always in the best interest of the patient and typically the payments and the conflict of interest that comes along with

them are completely invisible to the patient, the payor, and everyone else. This is driven by the fact that PBM affiliates — including offshore group purchasing organizations — collect fees that help ensure drugs receive favorable placement on the formulary. The PBM-affiliated specialty pharmacies also charge additional fees tied to the price of the drug for distributing and administering it. None of this is shared or understood and yet it can drive whether a consumer receives a drug and which drug they receive irrespective of what might be the best choice for them.

A good example of this is Flovent, an asthma drug for children. Noticing the trend for rapid increases in the list price of drugs that were largely going into rebates, Medicaid instituted a new rule that requires drug manufacturers to pay special rebates if they previously increased their prices faster than inflation. This was the case for Flovent and so its manufacturer, GSK (formerly, GlaxoSmithKline) removed Flovent as a branded drug and replaced it with an authorized generic version at a lower price. Since the generic version was now a new drug with no pricing history, GSK didn't have to pay the special rebates and since the generic version is the exact same drug with all the same compounds, this seems like a good example of federal policy that is working.

But generic drugs generally pay much lower rebates than brand drugs. As a result, some PBMs went from having Flovent on their formulary (and happily collecting fees and rebates to do so) to **not having the lower-priced generic version of Flovent on their formulary.** And many patients lost affordable access to a drug that is uniquely qualified to treat certain pediatric conditions. (Fox Business, CBS)

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Fixing high drug costs starts with smarter, patient-first delivery →

Fixing high drug costs starts with smarter, patient-first delivery

According to a June 2025 study published in Health Affairs, "delinking compensation from list prices for wholesalers, pharmacies, and PBMs could reduce drug spending by $95.4 billion or nearly 15% of net spending without adversely affecting manufacturers' incentive to innovate." (Health Affairs Scholar)

One of the dynamics cited in the study was that over five years, the average list price of drugs has grown by approximately 12% per year, while the average net price (what the pharmacy manufacturer actually receives for the drug) has grown by 3% per year, which means the rest of that inflation is revenue for PBMs. (Health Affairs Scholar). This dynamic certainly has helped PBMs to point out all the "value" they have been creating by increasing the amount of money that can go to fees, rebates, and profit. However, it has done nothing to improve patient care, nor to reward pharmacy manufacturers for their innovations.

In short, this study indicates that **we can reduce the cost of drugs by nearly $100 billion per year without changing any of the drugs people are taking today** nor how much we are paying pharmaceutical companies for those drugs. Sound like a good idea?

Turning this idea into a reality and making the delivery of drugs more efficient and patient-friendly is the first step to improving our system of prescription drugs. Naturally, we'll have to address the "kickback" payments currently in place, but we need to do more than just that.

There is hope.

All is not lost. There are some positive things happening that are starting to change the current pharmacy distribution system and we need to both recognize these efforts and take advantage of the momentum that they are creating.

Perhaps the only person more publicly frustrated than I am about the current pharmacy system, is Mark Cuban, who went to the trouble of investing in a company to try and disrupt the current distribution model, put his name on it (Mark Cuban Cost Plus), and frequently speaks out publicly about the evils of the current system. The company's approach is simple and powerful: They will search for the least expensive option for drugs and then add a fixed cost on top of that for their administration and make it available to consumers through multiple channels, including on-line and through pharmacies. As a result of his company's work, he has exposed some of the phenomena I described earlier such as sometimes being able to offer a cash price for drugs that is lower than the copayment a member might have to pay through their insurance. Perhaps as

importantly, his relentless, public criticism of the current system has drawn a lot of attention to a major health care problem.

Speaking of offering low cash prices for drugs to consumers, a new initiative called "Trump Rx" announced last year that the President's administration negotiated substantially lower prices for certain drugs such as the weight loss drugs Zepbound and Ozempic and made them available for purchase online. Some have been critical of the fact that consumers can only access the price by paying directly themselves as opposed to receiving some financial help from their health insurance coverage. But I think critics are missing how important this development is. The Trump Administration is showing us what is possible when you bypass the expensive, complicated "middlemen" and just get to a net price that everyone can understand. The entire industry, particularly health plans and self-funded employers/trusts, should take this as both an invitation and inspiration.

In the spring of 2025, the Arkansas legislature passed and the Governor Sarah Huckabee Sanders signed Act 624, also known as House Bill 1150, which prohibits PBMs from owning or operating retail pharmacies in the state. This law is designed to prevent anti-competitive practices and aims to increase the number of pharmacies. The ban took effect on January 1, 2026 and has faced legal challenges from PBMs, who claim it will force pharmacy closures and layoffs. Nonetheless, it is a good example of taking a proactive, bold step to try and address some of the challenges we've discussed in this segment.

The California legislature passed and Governor Gavin Newsom signed into law a PBMs reform bill in October 2025 (Senate Bill 41) that requires PBMs to send all rebates to the payer and consumers, de-links the fees they charge from the cost of the drug, thereby eliminating the incentive to place higher cost drugs on formularies, and eliminates their ability to mark-up generics. The bill passed the State Senate **unanimously** and had only two votes against it in the State Assembly, making it a truly bi-partisan effort.

Shortly after the California law passed, and perhaps not coincidentally, CIGNA's Evernorth division, which manages one of the "Big 3" PBMs (Express Scripts Inc. and its affiliates) made an announcement about a new "rebate-free" pharmacy model that will pass negotiated drug discounts directly to consumers at the point of sale, starting in 2027 for its fully insured plans and 2028 for its PBM clients. The company estimates this will lower brand-name drug costs by an average of 30% and increase transparency. The model will apply a "lowest of" pricing rule, meaning consumers will pay the lowest available price, whether it's the cash price, a direct-to-consumer price, or the discounted negotiated rate. While there are still a lot of details to be revealed about the model to understand how big this change really is, e.g., it is not being applied to all lines of business, the fact that one of the "Big 3" made a conscious decision to move in this direction has to be considered good news.

Even Congress is finally getting into the act. After repeated fits and starts, the Consolidated Appropriations Act of 2026 adopted several bipartisan reforms similar to what California passed. The law will require PBMs to pass through 100% of negotiated rebates for employer-sponsored plans—including rebates negotiated by off-shore Group Purchasing Organizations (GPOs). The bill also requires that PBM compensation be de-linked from the price of drugs in Medicare Part D. Finally, it would also require increased transparency about the nature of rebates, discounts, fees, and other sources of revenue generated by PBMs. These are important reforms that will likely spur further action as more pricing data is revealed to more payers and employers.

Finally, on February 4, 2026, the Federal Trade Commission announced a settlement with the same member of the "Big 3" mentioned above, Express Scripts, Inc. and its affiliates (collectively "ESI") in which ESI agreed that by 2027 or 2028 their standard benefit offering will include:

- Lower out-of-pocket costs for members, with drug cost based on net price (i.e. any discounts will be applied upfront)
- All plan sponsor fees will be de-linked from the list price of a drug
- No spread pricing, just administrative fees that are charged to plan sponsors
- Prohibition of rebate guarantees to plan sponsors
- Reimbursement to retail community pharmacies using a cost-plus methodology, and higher payment and increased support for pharmacies that provide clinical services
- Enhanced transparency reporting to both members and plan sponsors regarding their prescription drug cost

Additionally, ESI committed to move the manufacturer contracting activities (their Group Purchasing Organization) from Switzerland to the U.S.

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Delivering care, not kickbacks

While these are all positive developments that we can build upon, they are not enough to create a system Worthy of us all. We will need to pass new law(s) to do that. PBMs and their affiliated companies, physicians, hospitals, and others will need to be paid for their services but in a very different way.

How we transform the current system

We need to pass a federal law or laws with multiple parts. The first part should allow pharmacy companies to negotiate net prices for their drugs while **prohibiting** the participants in the distribution system from:

1. Charging for their services based on any drug's price
2. Receiving a differential payment for their services based on whether a drug is placed on the formulary or how much volume of a particular drug is sold, prescribed, or administered
3. "Spread pricing" or marking up the price of a drug beyond the charge for services rendered. As part of this step, the law would need to repeal or radically alter the 340B program to be compliant with this approach

In the case of PBMs and their affiliated companies this will likely result in a drop in compensation but that should not be the case for physicians and hospitals. That means payors will need to pay them differently – an approach Blue Shield of California has been proposing as it works with providers to transition to different payment models. Providers that predominantly serve Medicaid beneficiaries, such as federally qualified health clinics, should also be kept financially whole through different types of payments as some of them may be negatively impacted by the repeal of 340B.

This would need to be phased in over time as it is a major shift. That said, the effects of the current system are so insidious that we should give the industry no more than two years to complete the change.

The impact on this would be dramatic, and positive. The incentive to sell and administer a higher volume of more expensive drugs or particular kinds of drugs would disappear. The impact could be even more dramatic if we replace the current form of payment with payment models that reward higher quality, cost-effective care.

Pharmacy manufacturers should set/negotiate a price for their drugs. That price paid to the manufacturer can vary based on factors, such as volume, but the bottom line is that we should all be trying to create a healthcare system that is Worthy of us all. We cannot allow this insidious system that treats patients like cash machines to continue.

Require simple, transparent pricing to consumers

If we pass a law, making kickbacks illegal - but allowing the industry two years to adopt the change - then consumers will have to navigate this very complex pricing system (see chart below) and they could end up paying more in copays for a drug than the actual reimbursement to the manufacturer. As we saw earlier, according to researchers at USC Schaeffer, this happens up to 23% of the time (KFF).

Today's patients face eight different types of pharmacy "prices/costs." The result is confusion, frustration, and surprise bills. Health care shouldn't be this complicated.

Metric	Description
Average Manufacturer Price	Average price paid to the manufacturer by wholesalers and retail community pharmacies that purchase drugs directly from the manufacturer. Used to calculate drug rebates under Medicaid.
Average Wholesale Price	Published list price for a drug sold by wholesalers to retail pharmacies and nonretail providers. It is similar to a sticker price and used as a basis for negotiation for payments to retail pharmacies.
Net Price	Net amount of money a pharmaceutical manufacturer actually collects when all rebates, fees, and other payments to companies are counted.
Best Price	Lowest available price to any wholesaler, retailer, or provider, excluding certain government programs like 340B and programs for veterans.
National Average Drug Acquisition Cost	National average of prices at which pharmacies purchase prescription drugs from manufacturers or wholesalers, including some rebates.
Average Sales Price	A calculated value that all manufacturers must report to CMS for drugs that are covered under Medicare Part B (typically physician-administered drugs and injectables.) Weighted average of sales – net of all eligible discounts – to all customers exclusive of sales to government entities or non-U.S. entities.
Federal Upper Limit	Sets a reimbursement limit set for some generic drugs calculated as 175% Average Manufacturer Price.
Maximum Allowable Cost	Reimbursement limit set by states for prescription drugs in addition to the Federal Upper Limit.

Source KEE: Prescription Analytics Ins.

Therefore, as a part of the new law(s) making rebates, fees, and spread pricing illegal, we should also require the disclosure of "net price" to the consumer at the time of prescription and for all consumer copayments to be tied to the "net price". This would eliminate the scenario of consumers paying more than the cost of the drug and ensure they are receiving and understanding what the drug actually costs.

There will be modest administrative costs that need to be added to the net price (pharmacists and others do need to be paid for their services) but the laws should also require that these additional costs be fully disclosed and this transparency should help keep those fees reasonable.

In addition, the law should require all participants that are getting paid kickbacks/doing spread pricing during the two-year phase in period of the new system to disclose their conflict of interest to the patient. It should be made clear to the patient when PBMs and their affiliates, physicians, and hospitals are getting large payments to prescribe and administer certain drugs. This should also help convince all of these participants to move to the new payment model sooner rather than later to avoid having awkward conversations with patients.

Eliminate the preferential financial treatment of companies in the same family

The "Big 3" PBMs have not only grown their share of the PBM business largely via acquisitions, but have also created and acquired other businesses in the pharmacy distribution system - including pharmacies to whom they often make preferential payments. If we are going to make the delivery of prescription drugs efficient and patient-friendly, then the new law(s) should require PBMs to pay the same reimbursement to other companies that they pay to their affiliated companies. Otherwise, they can potentially reduce or eliminate competition by paying these other entities below their costs while reimbursing their affiliated companies in a manner that makes them highly profitable.

In order to ensure this is actually done, PBMs should be required to publish/post their reimbursement to their affiliates which should facilitate audits to ensure compliance and make it much easier for competitors to know what they should expect in terms of compensation.

Finally, PBMs should not be allowed to establish exclusive distribution relationships with an affiliated pharmacy or specialty pharmacy. They can do so if they are contracting with an independent entity but not if they have an ownership stake or financial interest in the company.

Prescription for Change: Ending the Incentives That Undermine Patient Care

By eliminating kickbacks, disclosing net prices, eliminating preferential treatment, and curtailing exclusivity with pharmacies, we can:

1. Save close to $100 billion per year without impacting the incentives for innovative drug discovery
2. Improve the quality of patient care by ensuring all incentives are aligned to ensure patients get access to the right drug at the right time
3. Make the pharmacy distribution system much more consumer-friendly, understandable, and personalized
4. Stop anti-competitive behavior by eliminating market abuses and facilitating transparency and competition

The fundamental problem with the current pharmacy distribution system is that nearly all of the participants in it view the selling and administering of prescription drugs as a way of making more money. In that situation, it is nearly impossible to do anything but see patients as potential cash machines. Instead, we need all of the participants in the distribution system to think about **what is best for the patient**. If we can change the system by eliminating "kickbacks" and the anti-competitive behavior of the three largest PBMs, as well as require simple, transparent pricing to consumers, then we can help ensure all patients receive the best possible care in the most efficient way possible. That would be care **worthy of us all**.

Appendix: Glossary of Terms

The current system of distributing pharmaceuticals is unnecessarily complicated, and this complexity allows it to remain shrouded in mystery for most of us, which makes the status quo easier to maintain. So let's try to demystify it by breaking it down to its basic elements here.

Payor: Entity providing health insurance coverage. This could be a health plan, an employer or trust, the federal government, or the state government.

Pharmacy Benefit Manager (PBM): As the title suggests, the organization that works with pharmaceutical companies, health insurers, and pharmacies to make medications accessible and set pricing for them, as well as to process claims for patients who are prescribed them.

Group Purchasing Organization: An entity that negotiates prices with pharmacy manufacturers. They are often owned by or closely affiliated with PBMs.

Retail pharmacy: The kind of pharmacy you are most familiar with and probably at some point have visited to either pick up a prescription or over the counter medications for allergies, a cold, or the flu, often placed within grocery or convenience stores.

Specialty pharmacy: A pharmacy that distributes and administers high-cost, high-complexity medications used to treat various illnesses including cancer, arthritis, multiple sclerosis, and autoimmune disorders. These drugs often need special handling, e.g., cold storage, complex dosing and monitoring, and/or require injection or infusion.

Formulary: A list of drugs established by the PBMs and/or the payor that they designate for preferential treatment, allowing consumers to access these select drugs at a much lower out of pocket cost.

Rebates: Money paid, usually every quarter, by pharmacy manufacturers to PBMs, based on the dollar volume of their drugs sold.

Fees: Money paid by pharmacy manufacturers to PBMs (or their affiliated companies, such as their wholly owned group purchasing organization), typically to help get their drug listed on a preferred formulary.

List Price: The full price for a drug, set by the pharmacy manufacturer.

Net Price: The actual amount of money a pharmacy manufacturer collects when all rebates, fees, and any other payments to other companies are counted.

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