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Unpacking the Financial Impacts of Medicare Drug Price Negotiation

Analysis on Pharmacy Cash Flows

Prepared for National Community Pharmacists Association

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Executive Summary

The introduction of Medicare's drug price negotiation program represents a shift in pharmacy reimbursement dynamics, fundamentally altering cash flow patterns for pharmacies for some of the most utilized brand drugs for one of the largest payers to pharmacy providers. This analysis evaluates the impact on outpatient pharmacy operations from the Maximum Fair Price (MFP) program for Medicare by focusing on its financial impacts via assessing changes in cash flows and profitability.

While MFP aims to reduce costs for Medicare beneficiaries, pharmacies will face liquidity challenges due to delayed manufacturer refunds. Pharmacies, which currently receive reimbursement from PBMs soon after dispensing medications, will now experience a delay for drug manufacturer refund payments, potentially resulting in a weekly cash flow shortfall of $10,838.25 compared to prior operations.

Profitability will also be affected, with an estimated annual revenue loss of $40,279.04 to $46,475.82 per pharmacy due to the elimination of estimated margins previously yielded on MFP medications relative to the MFP-based payments. Pharmacies dispensing higher volumes of MFP drugs may experience greater financial strain, requiring greater operational adjustments.

The results of this analysis are dependent upon several assumptions, as the details regarding the Medicare Transaction Facilitator (MTF) are unknown. We conduct a sensitivity analysis to contextualize the potential role of differing assumptions given the unknowns. Our model suggests a negative financial impact to pharmacies for the MFP drugs, with the net impact driven primarily by the proportional utilization of the 10 drugs selected for negotiation and the payment delay of the manufacturer refund.

Acknowledgements

The goal of this project was to provide perspective on drug pricing policy implications of Medicare Maximum Fair Price (MFP) to pharmacy providers. It goes without saying that we could not have devoted even a fraction of the time spent on this project had it not been for the financial support of the National Community Pharmacists Association (NCPA). We appreciate NCPA's desire to get a better understanding of the intersection of public policy and real-world impact.

Additionally, we would like to thank the many pharmacies across the country who have worked to provide transparency into pharmacy operations and education to the public on pharmacy financial performance.

We would also like to thank researchers, government agencies, and journalists, whose work provides much of the fundamental knowledge of the past. If not for their important collective work, much of this type of research would not have been possible.

Background

The Medicare Drug Price Negotiation Program is a policy initiative introduced as part of the Inflation Reduction Act (IRA) of 2022, designed to reduce the cost of prescription medications within the Medicare program.[1] This program grants Medicare the authority to directly negotiate prescription drug prices with drug manufacturers for a select number of high-cost drugs covered under Medicare Part D (outpatient drugs) and, later, Medicare Part B (physician-administered drugs). Initially, the focus of negotiation will be limited to brand-name drugs without generic or biosimilar competition. Medicare has already completed negotiation for the first ten medications whose price, known as the Maximum Fair Price (MFP), will take effect January 1st, 2026 (see **Table 1** for details).[2]

Table 1: First Ten Medications Selected for Medicare Price Negotiation

Medicare 2023	Total Medicare Reimbursement	Total Medicare Rx	Medicare Price 2026	List 2023
Eliquis	$16,482,621,000.00	3,706,000	$231.00	$521.00
Enbrel	$2,791,105,000.00	48,000	$2,355.00	$7,106.00
Entresto	$2,884,877,000.00	587,000	$295.00	$628.00
Farxiga	$3,268,329,000.00	799,000	$178.50	$556.00
Fiasp/Novolog	$261,271,900.00	78,500	$119.00	$495.00
Januvia	$4,087,081,000.00	869,000	$113.00	$527.00
Jardiance	$7,057,707,000.00	1,573,000	$197.00	$573.00
Stelara	$2,638,929,000.00	22,000	$4,695.00	$13,836.00
Xarelto	$6,031,393,000.00	1,337,000	$197.00	$517.00
Imbruvica	$2,663,560,000.00	20,000	$9,319.00	$14,394.00

Going forward, Medicare is to negotiate 15 additional drugs for 2027, 15 additional drugs for 2028 and 20 additional drugs per year in 2029 and beyond. While not included within this analysis, Medicare recently announced the 2027 drugs subject to negotiation which are as follows[3]:

- Ozempic; Rybelsus; Wegovy
- Trelegy Ellipta
- Xtandi
- Pomalyst
- Ibrance
- Ofev
- Linzess
- Calquence
- Austedo; Austedo XR
- Breo Ellipta
- Tradjenta
- Xifaxan
- Vraylar
- Janumet; Janumet XR
- Otezla

In order for drugs to be eligible for Medicare price negotiation, the drugs selected must be among the costliest drugs to Medicare and must have been on the market for at least nine years for small-molecule drugs and 13 years for biologic drugs. If a drug is selected for negotiation and a generic or biosimilar is later found to be "bona fide" marketed (e.g., not an authorized generic), the negotiation will not proceed or will be suspended. The drug remains on the selected list, but no maximum fair price will be set. To remove it from the list, CMS must confirm the availability of the generic or biosimilar. If a generic or biosimilar is approved and marketed after a fair price is established, the price will apply initially but will not continue in future years.[4]

The Medicare Drug Price Negotiation Program is expected to have far-reaching effects on multiple stakeholders. For Medicare beneficiaries, the program aims to reduce costs by lowering net drug prices, ostensibly leading to decreased premiums and out-of-pocket expenses, and potentially improving access to essential medications.[5] For drug manufacturers, the program could impact revenue by reducing profit margins on high-cost Medicare-covered drugs, particularly those without generic or biosimilar competition, while raising concerns about its potential effects on innovation and future investment in research and development.[6] Pharmacies, meanwhile, may face operational challenges as the program alters reimbursement structures and introduces new settlement timelines, potentially creating cash flow complexities.

Cash flow is an important consideration for any business, reflecting the movement of money in and out of the organization and determining its ability to sustain operations, invest in growth, and meet financial obligations. A positive cash flow ensures that a business can pay its suppliers, employees, and creditors on time, while also providing the flexibility to respond to unexpected expenses or opportunities. Along with the ebbs and flows in typical marketplace conditions, many federal policies within recent years have altered pharmacy cash flows. This includes requirements to reimburse pharmacies at actual acquisition cost (AAC) within Medicaid Fee-for-Service programs and requirements that Medicare reimbursement reflect the lowest possible negotiated rate at the point-of-sale (i.e., the removal of retrospective pharmacy DIR).[7] [8] To our knowledge, no formal research was conducted and publicized regarding possible impact of these changes to pharmacy finances at the time these policies were crafted or enacted. Given the potential for the MFP to alter a large portion of pharmacy expenses and revenues, we developed a model to analyze the potential impact to pharmacies with the changes in reimbursement practices associated with the retrospective refund delineated under the Inflation Reduction Act.

Medicare Transaction Facilitator (MTF)

To implement the maximum fair prices (MFPs) established under the IRA, the Centers for Medicare & Medicaid Services (CMS) has indicated that it plans to develop a Medicare Transaction Facilitator (MTF) system. This system will consist of two components: the MTF Data Module (MTF DM) and the MTF Payment Module (MTF PM).

The purpose of the MTF DM is to enable the seamless exchange of data among CMS, manufacturers, and dispensing entities (e.g. pharmacies) to ensure the efficient and timely application of the negotiated prices. The MTF PM, on the other hand, will provide *an optional service* for manufacturers to facilitate the distribution of MFP refunds to the appropriate dispensing entities.[9]

Dispensing entities will be required as part of their Medicare participation to enroll in the MTF DM. During enrollment, they will select their preferred method for receiving MFP refund payments: either an electronic funds transfer (the default option) or a paper check. Since participation in the MTF PM is voluntary for manufacturers, dispensing entities may receive MFP refunds either through the MTF PM or via an alternative process established by the manufacturer.[10] Details related to alternative processes led by manufacturers are not available, therefore, our model seeks to evaluate the MTF PM process.[11]

Under the MFP, dispensers of MFP medications paid for through Medicare are likely to be subject to a Maximum Fair Price Refund. This is because dispensers will continue to purchase inventory at typical rates (generally a slight discount to wholesale acquisition cost, or WAC, for brand name medications); however, a significant discount will be paid initially relative to dispensers' acquisition costs for the 10 MFP products (i.e., the MFP is approximately a 60% discount to WAC based upon the published MFP and the drugs' 2023 list price [see **Table 1**]).[12] [13] [14]

To support the implementation of the Maximum Fair Price (MFP), dispensers will require refunds aligned with their purchase prices. Requirements for effectuating the MFP are detailed in CMS's Medicare Drug Price Negotiation Program: Final Guidance, Implementation of Sections 1191–1198 of the Social Security Act for Initial Price Applicability Year 2027 and Manufacturer Effectuation of the Maximum Fair Price in 2026 and 2027 ("final guidance"). According to this guidance, manufacturers are responsible for ensuring the availability of the MFP to dispensing entities. This can be achieved through various methods, such as selling the selected drug to dispensing entities at the MFP or providing a retrospective MFP refund. The responsibility for effectuating the MFP lies solely with manufacturers, who must calculate the appropriate MFP refund amount for each qualifying claim to fulfill this obligation.[15]

CMS's final guidance allows manufacturers to provide refunds at the Standard Default Refund Amount (SDRA), defined as the difference between the WAC and the MFP. Alternatively, manufacturers may issue refunds at a different amount if they maintain adequate documentation to justify why the MFP refunds deviate from the SDRA. Additionally, total refund payments to dispensers are to be made within a 14-day prompt payment window based upon the claim-level payment elements provided to the MTF DM.[16]

$$\textbf{Standard Default Refund Amount (SDRA)} = \text{Wholesale Acquisition Cost (WAC)} - \text{Maximum Fair Price (MFP)}$$

Based upon the details regarding the manufacturer refund payment and the MTF PM that are available, we constructed a model to evaluate the potential financial impact of the program to pharmacies based upon the MTF PM details as currently available.

Cash Flow Model Framework

To evaluate the financial implications of the new reimbursement model for pharmacies as a result of Medicare MFP, we construct a baseline cash flow framework to represent the current reimbursement environment for these drugs and construct a new cash flow model to represent the new flow of monies, given the role of the MTF PM and the refund payment. For the baseline model, the traditional reimbursement is from the Medicare plan's pharmacy benefit manager (PBM), based upon the PBM's network reimbursement for the 10 Medicare negotiation drugs. For the New Model (post-negotiation framework), reimbursement the pharmacy will receive will be from the PBM, but also the drug manufacturer via a refund relative to their acquisition cost (see above).

The MTF will facilitate the exchange of data for the Medicare negotiated drugs between CMS, manufacturers, and dispensing entities to support the effective and timely effectuation of the negotiated prices. Pharmacies will move from a reality where cash flow is determined based upon their acquisition cost experiences from drug wholesalers and their reimbursement experiences from PBMs to one where cash flows depend upon acquisition, PBM reimbursement, and settlement (i.e., refund) from drug manufacturers (through the MTF).[a] The MFP introduces new reimbursement realities, whereas the settlement introduces new timelines into receivables. Three high-level scenarios are potential outcomes as a result of the changes in reimbursement patterns as a result of the MFP.

Scenario Overview

1. Best-Case Scenario for Pharmacies

In the best-case scenario, new settlement payments align with PBM reimbursement dates. In such a scenario, a financing impact related to new payment timelines is of little concern, as the settlement payment will align with PBM payment. It is additionally possible that pharmacies which may be experiencing losses on brand reimbursements from PBMs may see improved net reimbursements via MFP (as the drug manufacturer refund returns to the pharmacy an amount equal to or above their acquisition cost).[b]

2. Likely Scenario for Pharmacies

In the most likely scenario, in our estimation, settlement payments from manufacturers are delayed by a short window (i.e., one week) relative to the historic reimbursement window (i.e., pre-MFP settlement via MTF). This will result in a financing gap that must be addressed by pharmacies, creating additional financing costs and operational risks. Furthermore, if net reimbursement via the MFP falls below historic amounts (either through changes in PBM reimbursement practices or wholesaler pricing terms), pharmacies may face losses.

[a] It is possible that drug manufacturers lower their WAC in response to MFP; however, at the time of this report, no manufacturers have announced plans to lower their WAC to MFP. While some products have seen WAC price decreases at the start of 2025, their price remains higher than the MFP for 2026.

[b] If the pharmacy purchases drugs below WAC from their wholesaler, but the drug manufacturer uses the SDRA then the pharmacy may make new revenues (the difference between their acquisition cost discount relative to WAC and the SDRA).

3. Worst-Case Scenario for Pharmacies

In the worst-case scenario, settlement payments are significantly delayed, which will grow any financing needs and impact operational viability. Furthermore, if net reimbursement falls significantly below historic trends, pharmacies may face significant losses (this could be either due to changes associated with MFP or changes associated with acquisition costs).

The analysis conducted considers the following components:

Baseline Model[c]:

Acquisition Cost (HAC): Cost for pharmacy to acquire the drug.
Purchase Date (HPD): Date of pharmacy's drug purchase under wholesaler terms.
Reimbursement Amount (HRA): Amount pharmacy is reimbursed for the drug by the PBM.
Reimbursement Date (HRD): Date when reimbursement is received by pharmacy from the PBM.

Under the baseline model, cash outflow is the HAC at the HPD, and cash inflow is the HRA at the HRD. We can express the net cash flow at baseline and the cash gap duration with the following formulas:

Net Cash Flow (Baseline)

$$Net\ Cash\ Flow = HRA - HAC$$

Cash Gap Duration (Baseline)

$$Gap\ Duration = HRD - HPD$$

Post-Negotiation Model[d]:

Acquisition Cost (NAC): Cost for pharmacy to acquire the drug.
Purchase Date (NPD): Date of pharmacy's drug purchase under wholesaler terms.
PBM Reimbursement (NRA): Amount pharmacy is reimbursed for the drug by the PBM.
PBM Reimbursement Date (NRD): Date when partial reimbursement is received by pharmacy from the PBM.
Settlement Payment (NSP): Additional supplemental payment to pharmacy from the MTF PM or manufacturer.
Settlement Date (NSD): Date when settlement payment is received by pharmacy.

Under the post-negotiation model, cash outflow remains the acquisition cost (NAC) at the purchase date (NPD). Cash inflow is changed to reflect the amounts received from PBM reimbursement (NRA) and PBM reimbursement date (NRD) as well as the settlement payment from the manufacturer (NSP) at the settlement date (NSD). We can express the net cash flow and cash gap duration for the new model as follows:

Net Cash Flow (MFP)

$$Net\ Cash\ Flow = NRA + NSP - NAC$$

[c] We use H as a prefix to these terms to reflect the historic nature of reimbursement and acquisition costs within the model (i.e., current state, pre-MFP being in effect).
[d] We use N as a prefix to these terms to reflect the new nature of reimbursement and acquisition costs within the model (i.e., to reflect a time after MFP has been effectuated).

Cash Gap Duration (MFP)

$$Gap\ Duration = PBM\ Gap + Settlement\ Gap$$
$$PBM\ Gap = NRD - NPD$$
$$Settlement\ Gap = NSD - NPD$$

Assumptions

We make several assumptions for the model. First, we recognize that according to CMS data, 20% of all gross Medicare Part D expenditures in 2023 related to the 10 drugs selected for negotiation. Utilizing the Medicare Part D Drug Spending Dashboard, an outpatient pharmacy can anticipate filling between 14.4 prescriptions per week for these medications (for our base analysis, we assume 15).[e] [17] [18] [19] [20]

We assume that there will be no differences in the wholesaler terms for pharmacy acquisition costs pre- and post-MFP. This means that although the models may use different terms (HAC and NAC), we assume that these values are equivalent. Our model is attempting to measure the impact of the settlement and MFP only, not other market changes (whether related or not) and so this assumption appears appropriate. We estimate acquisition costs for these medications using National Average Drug Acquisition Cost (NADAC) and Wholesale Acquisition Cost (WAC) in 2023 (due to the fact that not all of the 10 MFP drugs have a published NADAC).[21] We estimate that pharmacies have an obligation to pay their wholesalers on an average days sales outstanding of 10 days.[22] In essence, this means that when the pharmacy acquires a drug, they will reimburse their wholesaler within 10 days of that purchase.[f] Similar to our assumption that acquisition cost does not change pre- or post-MFP, we are not changing the wholesaler payment due date pre- and post and so the impact of our decision on the day selection should not be material to our assessment.

For PBM reimbursement, we used the Medicare Part D Drug Spending Dashboard to estimate pharmacy revenues for these medications (i.e., HRA).[23] Because of the historic nature of the Part D Dashboard (most recent data is 2022), we roll forward the experience based upon the reported expenditures and utilizers in 2023. We roll forward the experience because pharmacy reimbursement in 2022 may be artificially inflated for these drugs due to pharmacy direct and indirect remuneration (DIR), which in essence resulted in pharmacies receiving inflated reimbursements for medicines from PBMs initially only to have large portions of the reimbursement clawed back at a later date.[24] We need an assessment of the current margin made on these medications to assess the role of MFP. The following example explains our process.

Eliquis – one of the 10 drugs selected for Medicare negotiation – had approximately $15 billion in gross Medicare expenditures across approximately 3.5 million patients in 2022.[25] According to CMS, Eliquis has $18 billion in gross Medicare expenditures across 3.9 million patients in 2023.[26] After accounting for the increased utilization (2022 vs 2023), the gross Medicare expenditures increased

[e] Approximately 45 million prescriptions for the 10 MFP drugs, divided by 52 weeks per year, divided by the estimated number of outpatient (i.e. retail and mail) pharmacies in Medicare networks (i.e., 60,000-66,000).

[f] There is no universal published average, although other research suggests potentially different experiences which could alter our model. See https://www.drugchannels.net/2021/06/how-cvs-health-drives-mckessons.html

by approximately 6% (or equivalent to the manufacturer WAC price increase from 2022 to 2023).[g] All medications appear to be closely aligned with their WAC price increase after accounting for changes in utilization, and therefore it appears appropriate to roll forward prices.

Next, we need pharmacy reimbursement information to compare historically-yielded pharmacy margin relative to predicted pharmacy margin going forward. We assume that NRA will equal the MFP. We make this assumption given the requirements of MFP and the historic low dispensing fees paid to pharmacies on prescription claims. Available public Medicare payment rates by plans suggest that dispensing fees are *de minimis* ($0 to $0.60).[27] [28] Our previous experience examining pharmacy reimbursement trends echo these public sources that in general, typical pharmacy dispensing fees track well below a dollar per claim. The MFP does not mandate a dispensing fee and none of the IRA Medicare MFP documents appear to provide specific guidance regarding dispensing fee amounts.[29] [h]

We assume that pharmacies receive payment from PBMs 14 days after the medication is "sold" (adjudicated for payment).[30] This assumed reimbursement window is the same in both models (HRD and NRD). For the MFP-model, we assume that PBMs will reimburse at the MFP value going forward. However, we note that by definition, a maximum fair price implies that it may be the case that pharmacies receive less than the MFP. Our model does not consider this, meaning risks to pharmacy financial realities under the IRA negotiation scheme could be understated.

For settlement payments from the drug manufacturer, details regarding MTF have not yet been finalized. Early indications seem to confirm that settlement payments will make up the difference between the HAC and the MFP price for the medications. This is our assumption for the model, but if wholesaler terms with pharmacies are different moving forward, then the impact may be altered beyond what our model assumes. We also assume that the settlement window will resolve 21 days after the sale of the medication (seven days beyond typical and assumed PBM reimbursement timelines). PBM reimbursement is generally not settled until 14-days after the sale of the medication (this meets PBMs' own incentives to retain cash flow over extended periods of time and also allows for the medication to be returned if not picked up by the patient after adjudicated). In essence, we assume that pharmacy payment can be settled seven days after finalized by the PBM to confirm the medication was dispensed by sending payment. The rule requires a 14-day prompt pay of the refund, but it is unclear when the 'clock' begins for that settlement to occur. Payment delays occur within the normal course of business, as claim adjudication does not signal that the medication has been dispensed 100% of the time. Oftentimes a patient may request a medication be filled but never pick it up (which results in the pharmacy returning the medication to stock and reversing the transaction). If there is no delay between transaction and settlement, the risk for refunds to be provided for claims never dispensed to patients would appear to exist (i.e., excess refunds provided by drug manufacturers to pharmacies). As the rules do not appear to consider the need to return drug manufacturer refunds from pharmacies to drug makers, it seems appropriate that there would

[g] We find this suggestive, but not conclusive that these medications are less subject to pharmacy DIR in the aggregate than other medications. Note, in checking current Medicare Plan Finder prices for these medications against their current NADAC or WAC price, we see similar levels of estimated margin for these drugs.

[h] "CMS is not establishing requirements for dispensing fees for selected drugs at this time but will monitor complaints and audits related to this issue" https://www.cms.gov/files/document/medicare-drug-price-negotiation-final-guidance-ipay-2027-and-manufacturer-effectuation-mfp-2026-2027.pdf

be a delay reasonably sufficient to ensure that such refunds of refunds would not be likely to occur (and a week gap between the two seems the minimum necessary to reasonably ensure this does not occur).[31]

Finally, we assume that prescriptions are of 30-day supplies with a 90% retail refill tolerance (i.e., three-day early fill allowance).[32] We assume that pharmacies will always have medication on-hand before the prescription is filled (i.e., purchase day is before sale day). We make this assumption for convenience, as we are not seeking to assess the role of inventory management on the MFP change – we simply want to ensure that inventory is on-hand before purchase. Inventory carrying costs can potentially play a role in the impact of MFP, but we do not believe that role is any more meaningfully different pre- and post-MFP (at least in a way directly related to MFP). Again, the earlier the purchase of a medicine is made before sale day of the medication, the greater the potential impact for a pharmacy. But given this impact is largely true within the historical (i.e., present) context as well, we do not consider the on-hand inventory meaningful to the construction of our model to analyze the impact of MFP on cash flow.

All told, our assumptions provide the following key figures for the model (see **Table 2**), on a weighted per-Rx basis for the 10 MFP medications (an appendix at the end of this report provides per-Rx details)[i]:

Table 2: Model Characteristics; Weighted per Rx Basis[33] [34] [35]

Baseline Model:	
Acquisition Cost (HAC)[j]:	$992.71
Purchase Date (HPD):	10
Reimbursement Amount (HRA)[k]:	$1,052.30
Reimbursement Date (HRD):	15
New Model:	
Acquisition Cost (NAC)[l]:	$992.71
Purchase Date (NPD):	10
PBM Reimbursement (NRA).	$270.17
PBM Reimbursement Date (NRD):	15
Settlement Payment (NSP):	$722.55
Settlement Date (NSD):	22

With drug purchase orders occurring on day 0 and the sale of the drug to the patient occurring on day 1, settlements would proceed over the year as follows, assuming the prescriptions are of 30-day supplies with a refill tolerance that allows the medication to be filled on day 27 of 30 (i.e., 90%). The cumulative impact in a year is that one payment falls outside of the year (**Table 3**). While the model already made plain that there would be a week delay in payment from the current status, the

[i] Weighting is based upon Medicare Part D utilization as published by CMS (see appendix)
[j] Not all medications have an available NADAC price point (Stelara and Imbruvica). We have to include WAC to address the lack of universal NADAC data. Given the relationship between NADAC and WAC for the drugs that have both prices, the inclusion of WAC may overestimate pharmacy acquisition cost and underestimate the amount of margin current made on these prescriptions.
[k] Weighted based upon Medicare reimbursement for 2022 rolled forward
[l] Equal to the weighted NADAC/WAC

difference is such that on an annual basis, the provider can anticipate having less income on their balance sheet than they otherwise would have but for the MFP:

Table 3: Annual Payment Windows

	Purchase Day Window	PBM Payment	Repayment Window
First Sale	10	15	22
Second Sale	37	42	49
Third Sale	64	69	76
Fourth Sale	91	96	103
Fifth Sale	117	122	129
Sixth Sale	144	149	156
Seventh Sale	171	176	183
Eighth Sale	198	203	210
Ninth Sale	225	230	237
Tenth Sale	252	257	264
Eleventh Sale	279	284	291
Twelfth Sale	305	310	317
Thirteenth Sale	332	337	344
Fourteenth Sale	359	364	371[m]

To be clear, this occurs because the manufacturer refund (which for MFP drugs represents an approximate 60% of anticipated acquisition costs) occurs after PBM reimbursement. Before MFP, the PBM reimbursement would cover both the drug's acquisition cost and any provider margin. After MFP takes effects, drug manufacturer refunds will pay for the majority of the provider's acquisition cost (since MFP is lower than WAC/NADAC).

Analysis

Medicare Drug Price Negotiation Within Outpatient Pharmacies

We focused on broad categories to determine the impact to pharmacies from the MFP program in Medicare. Specifically, we analyzed the liquidity and profitability gaps between the current baseline and the MFP.

Liquidity Impact

Liquidity measures the pharmacy's ability to manage cash flow timing without operational disruption. Under the current model, pharmacies acquire MFP drugs at a specific cost (Weighted Acquisition Cost per prescription: $992.71) and receive reimbursement from the PBM within 14 days (five days of purchase obligation). This timeline ensures that pharmacies maintain operational liquidity. It is important to note that based upon average gross pharmacy reimbursement ($1,052.30; based upon past reported Medicare reimbursement trends), these 10 medications are associated with positive margin of $59.58 per Rx in the aggregate (see **Table 2**). Relative to acquisition cost,

[m] Settlement occurs into the next year

this represents a 6% margin. Analysis of industry suggests the average gross pharmacy margin is approximately 20%.[36] Given that brands are more expensive, and that generics generally make up more margin opportunity to pharmacies relative to brand, the lower percentage for these products appears appropriate.[n]

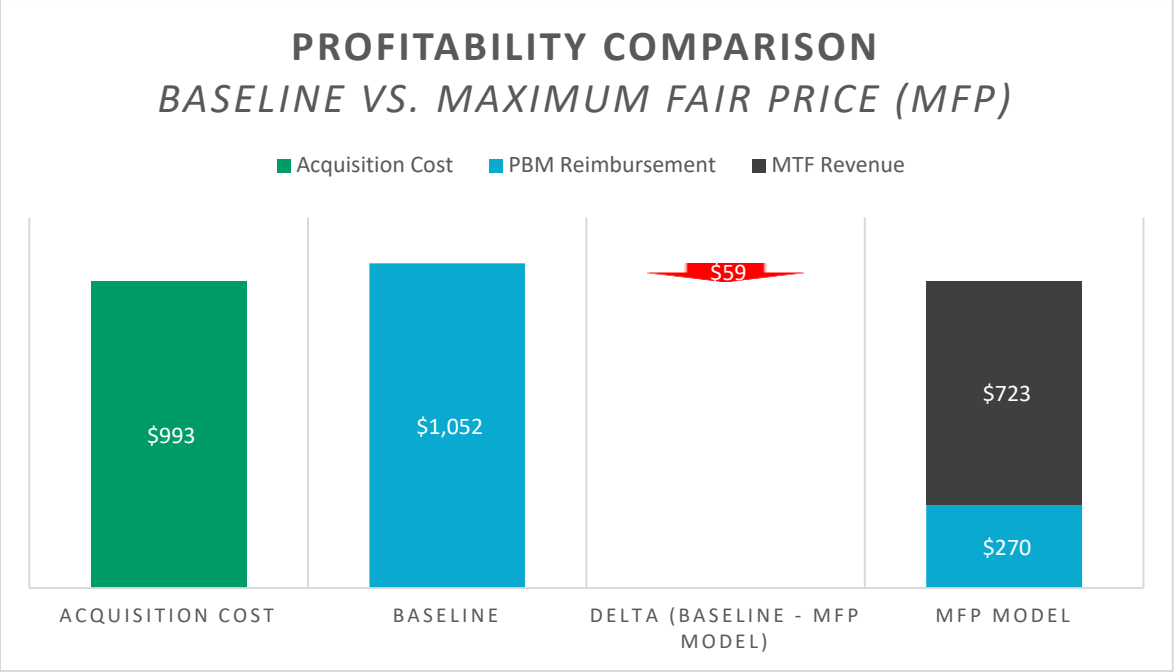
However, the new model introduces a change to this timeline, which can impact liquidity. While PBM reimbursement remains on the same five-day schedule post purchase price, it is only going to cover an estimated 38% of the pharmacy's acquisition cost based upon the Medicare negotiated MFP ($270.17 per transaction on a weighted basis). The remaining balance (i.e., $722.55 necessary to make pharmacies whole relative to their acquisition price) is settled by the manufacturer directly or third party – but only after an additional minimum seven-day delay from the historic settlement window. This delay creates a 12-day total cash gap, requiring pharmacies to bridge a temporary shortfall of $722.55 per MFP-impacted transaction (or an estimated $10,838.25 per week [based upon 15 MFP transactions per week] relative to the prior cash flows).

Profitability Impact

Profitability evaluates whether total reimbursements exceed acquisition costs. The new reimbursement framework devised through Medicare drug price negotiation offers a potential loss of revenue for pharmacies. Whereas previously, PBM reimbursement was creating an aggregate positive amount relative to pharmacy acquisition cost (i.e., $59.58 margin), the new model results in less revenue, as the refund payment only makes the pharmacy whole relative to their acquisition cost (i.e., does not reflect any payment above acquisition cost the pharmacy historically received). This is a profitability impact of roughly 6% per transaction from the pre-MFP situation (**Figure 1** on the next page). These medications represent 20% of Medicare expenditures collectively but also a significant portion of overall pharmacy operations (Medicare is at least 40% of total pharmacy retail operations).[37] In particular, many of these medications are more likely to be dispensed through Medicare than other payers, so the impact of these changes may be particularly outsized for outpatient pharmacies (e.g. Eliquis is generally a medication associated with older than younger individuals).[38] [39]

[n] We evaluate the role margin plays in our findings in the next section.

Figure 1: Pharmacy Profitability Impact Comparisons



Based upon the above, the annual impact to pharmacy via the MFP is estimated to be a reduction in profitability of approximately $40,279.04 to $46,475.82. This range is based upon an assumed volume of 13 to 15 MFP prescriptions per week over the year.

Sensitivity Analysis

There are three key variables within our model that warrant further consideration, particularly in regards to role they play regarding our conclusions. The introduction of MFP has an impact on pharmacy revenues and settlement windows, with the overall impact influenced by the total volume of claims impacted. Our assumptions regarding current reimbursement, drug manufacturer refund settlement date, and volume of claims per pharmacy are the key variables that impact our analyses above. In the next sections, we evaluate alternative assumptions for each of these key variables as a method of evaluating how changes in inputs affect the output of our model (i.e., sensitivity analysis).

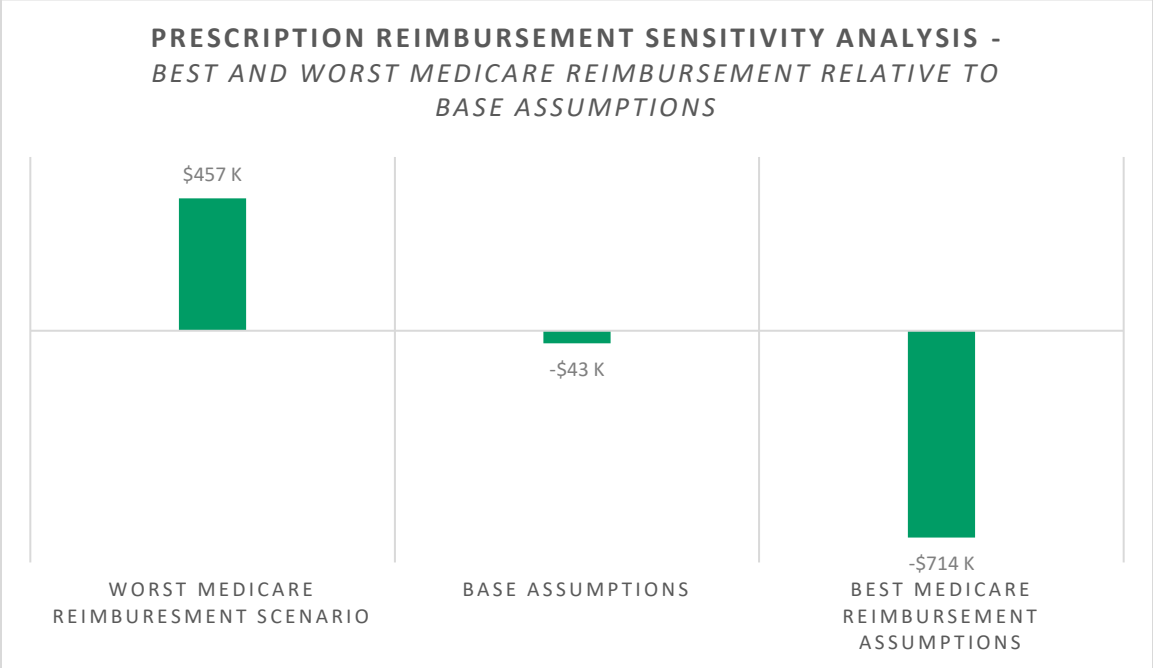
Prescription Reimbursement Evaluation

Our model identifies a profitability impact to pharmacy based upon an assumed net positive reimbursement on these drugs relative to acquisition cost pre-MFP and a net $0 margin experience after MFP is introduced. Pharmacies are a business, and it is reasonable to assume that as a business they receive positive margins for the drugs dispensed. However, recently many pharmacies have closed and others have reported margin pressures.[40] [41] Although our assumptions assume the 10 MFP drugs have relatively small gross margin percentages relative to industry analyses of overall pharmacy profits, it is nevertheless prudent to evaluate potential alternative reimbursement scenarios. This seems particularly important given the reports by some pharmacies of the current reimbursement challenges associated with stocking brand name medications.[42] [43] If our assumption on reimbursement (derived from CMS data) is inappropriate, then our estimated profitability impact may be over or understated.

To evaluate the potential role current reimbursement experience plays, we utilize the CMS Quarterly Prescription Drug Plan Formulary, Pharmacy Network and Pricing Information files to evaluate the minimum and maximum reported reimbursement per unit in Q4 2023 for each of the 10 MFP drugs.[44] By evaluating the worst and best reported reimbursement experience in Medicare, we can evaluate the potential impact to pharmacies on the basis of the various reimbursement realities they may experience within the many dozen plans likely operating within their market.[45]

Under the lowest price reimbursement assumption, pharmacies receive $856.19 in PBM reimbursement per weighted Rx relative to their $992.71 acquisition cost (or a loss of $136.53 per Rx; -16% margin). Under the best reimbursement scenario, pharmacies receive a weighted PBM reimbursement of $1,908.04 per Rx relative to the same $992.71 acquisition cost (or a margin of $915.33 per Rx; 48% margin). Note, it is unlikely that one pharmacy is universally experiencing 100% reimbursement at either the high or low end; however, the analysis of minimum and maximum prices provides for an assessment that evaluates the potential extreme impacts that may occur with the shift to MFP. Pharmacies currently experiencing the worst reported PBM reimbursement in Medicare for the 10 MFP drugs may experience positive cash flows of $457,094 annually from the movement to MFP whereas pharmacies experiencing the best current PBM reimbursement for these drugs may see a reduction of cash of $713,953 annually (**Figure 2**).

Figure 2: Prescription Reimbursement Sensitivity Analysis



The current disparate experience of PBM Medicare reimbursement for the 10 MFP drugs suggests that pharmacies may experience a benefit of pricing predictability from MFP not considered or assessed within our model. It is unreasonable, nor do we believe, that pharmacies in general are losing 16% on every brand claim. Similarly, we do not believe, nor does it seem reasonable, to assume that pharmacies are making 48% margins on every brand claim. The fact that industry analysis suggest pharmacies are making 20% gross margins seems to confirm the role that generic drugs play in pharmacy profitability relative to brands.[46] If pharmacies were making 20% margins on

brand drugs, the data suggest pharmacies would receive margins of approximately $200 for each MFP drug dispensed (given that the weighted average acquisition cost is approximately $1,000). Within our industry experience, we are not aware of pharmacies making such margins on brand medications. In general, pharmacies make single digit margins on brands in the aggregate.

Our model's assumption of a 6% margin for the 10 MFP drugs is likely to approximate the national average pharmacy experience (i.e., large and small chain as well as independent); however, the significant range in the sensitivity analysis suggests any individual pharmacy experience for these drugs may be highly variable. To the extent the pharmacies are currently experiencing negative margins on brands, MFP may represent a positive margin experience as it sets a reimbursement floor no worse than their acquisition cost (which they lack under the current reimbursement paradigm). Conversely, to the extent the pharmacies are currently experiencing positive margins on brands in Medicare, MFP may represent a lessened margin experience, as it sets a reimbursement ceiling no better than their acquisition cost.

As an alternative means of testing pricing sensitivity, we also modeled what it would potentially look like based upon different acquisition cost realities. Net reimbursement is a key variable in the model and is a function both of payments and the product acquisition cost. It is known that certain providers have significantly lower acquisition cost realities for brand medications. 340B Covered Entities, for example, can acquire brand medications 25% to 50% lower than other providers.[47] This means that pharmacies associated with Covered Entities (either directly owned or via contract relationships), may have higher historic margins on MFP drugs on the basis of lower acquisition costs (i.e., not necessarily differences related to variable PBM reimbursement). If we hold constant all other assumptions (e.g., acquisition costs at $1,052.30) but reduce acquisition costs by 25% (i.e., to $744.53) and 50% (i.e., to $496.36), then our model similarly shows varying impacts on cash flow. The shift to MFP, which is associated with no or minimal margin above acquisition costs for traditional pharmacies, suggests that 340B providers are more likely to experience the high-end of our reimbursement sensitivity analysis. Providers with a 25% acquisition cost discount would see a margin loss of $307.77 per MFP transaction ($1,052.30-$744.53) whereas providers with a 50% acquisition cost discount would see a margin loss of $555.94 per MFP transaction ($1,052.30-496.36). At 15 MFP transactions per week, the annual estimated impact to these providers on an annual basis range between $240,060.60 to $433,633.20.

Reduction in revenues, regardless of source, is likely to be associated with reductions in service offerings. For example, 340B Covered Entities may have less revenues available for charitable care or expanded healthcare services (i.e., dental care). Additionally, while contract pharmacies may receive a fixed amount per 340B prescription (e.g., a $25 dispensing fee), the reduction in revenues may result in reduced dispensing fee payments or carve outs (i.e., removal of MFP drugs from 340B relationships between Covered Entities and contract pharmacies).

Delayed Settlement Window

Our model identifies a potential liquidity impact based upon the drug manufacturer refund payment occurring after the PBM payment. Under current reimbursement practices, all revenues pharmacies receive for the drugs they dispense are based upon PBM reimbursement formulas. Under MFP, PBM reimbursement is to be no more than the MFP with any difference between MFP and acquisition

costs returned to pharmacies via a drug manufacturer refund payment. For the MFP drugs in the aggregate, the refund payment is anticipated to be greater than 60% of the total revenues pharmacies will receive. The refund to the pharmacy is to be returned to the pharmacy within a 14-day prompt pay window, although it is not clear when the prompt pay clock begins.

Our model assumes that there is a seven-day delay between PBM reimbursement and refund settlement. This appears reasonable given the need to ensure that the medication is filled and picked up by the Medicare member and not returned to stock. The delay in payment results in a per-week cash flow reduction of an estimated $10,838.25. However, to measure the potential impact of different time frames, we modify our model to assess the potential role alternative timelines play to pharmacies.

In **Table 3** previously, we demonstrated that the liquidity impact, on an annual basis, could be understood on the basis that the refund payment delay results in one payment falling outside the same year time frame as the typical acquisition cost and PBM reimbursement windows. Said differently, under our model assumption of a 30-day supply and 90% refill tolerance, 14 prescriptions can be filled per year. This results in 14 acquisition costs being incurred and 14 PBM reimbursements being paid relative to those prescription fills. However, the payment delay means that only 13 refund payments will be received per year (i.e., one less). In **Table 4**, we evaluate different drug manufacturer refund settlements (NSD). As can be seen below, until settlements reach beyond 42 days, there is no change in the anticipated number of settlement payments per year.

Table 4: Settlement Window Sensitivity Analysis

Repayment Window (NSD)	Number of Repayment Windows per 365 days
14 *(Same day as PBM Payment)*	14
21 *(Base Model Assumption)*	13
28	13
35	13
42	12

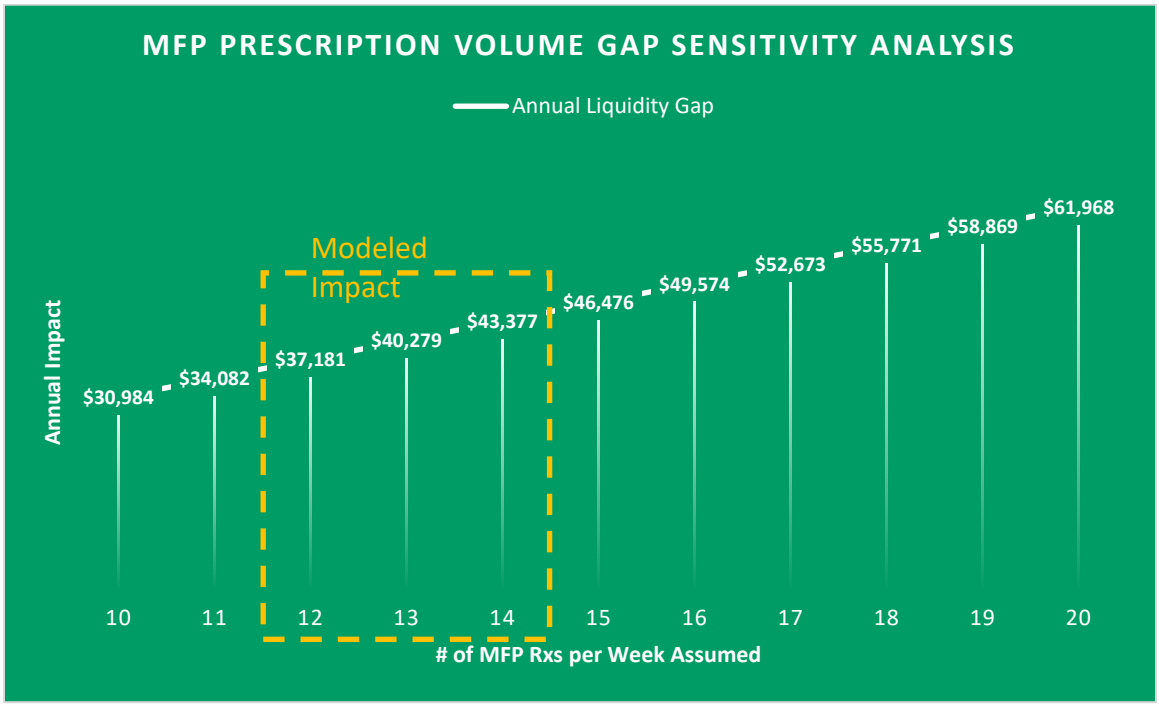
Although the 14-day prompt pay window has yet to be clearly established, it seems unlikely that it would reach a level where there would be a 42-day gap in payment (four weeks after PBM payment is finalized). This is suggestive that whatever the actual prompt pay settlement window clock looks like, the delay in settlement payment impact is most likely to be the one-week gap that our base model identifies in all likely scenarios.

Prescription Volume Evaluation

Our model identifies the scale of impact of MFP on the basis of the number of MFP prescriptions per pharmacy per week. However, not all pharmacies have the same volume of prescriptions. To evaluate the net impact of the changes for pharmacies, we need to evaluate different scenarios based upon varying amount of MFP prescriptions per week. The impact of varying transaction

volumes (from the assumed 13 to 15 to a 10 to 20 prescriptions per week range), has the following impact (**Figure 3**):

Figure 3: MFP Prescription Volume Sensitivity Analysis



The number of prescriptions subject to MFP plays an anticipated direct role on the overall impact to a given pharmacy. The more MFP prescriptions dispensed by a pharmacy, the risk to their cash flow is greater. Conversely, pharmacies that dispense fewer MFP medications will likely experience less risks to their operations associated with MFP induced changes.

To put the volume impact into perspective, the range of anticipated shortfall equates to half to one-and-a-half full-time equivalent (FTE) of a pharmacy technician (based upon an annual pharmacy technician salary of $43,000).[o] The base model assumes a net impact of approximately one pharmacy technician FTE. Given the current challenges related to pharmacy staffing, this level of impact represents a potentially significant operational challenge.[48]

0.5 to 1.5 Pharmacy Technician FTE

[o] Assuming a $43,000 annual salary for a pharmacy technician

Discussion

The implementation of Medicare's drug price negotiation program, particularly the introduction of the Maximum Fair Price (MFP), represents a potentially significant shift in pharmacy financial operations. Medicare is one of the largest purchasers of prescription drugs within the United States, which in turn means Medicare drug policy represents the potential to impact one of, if not the, largest customer to pharmacies. While the policy aims to alleviate prescription costs for Medicare beneficiaries, its impact on pharmacy cash flows introduces both opportunities and challenges that require careful consideration.

One of the most notable findings from our analysis is the anticipated liquidity strain on pharmacies due to the delayed settlement payments associated with MFP refunds. Under the current reimbursement structure (pre-MFP), pharmacies receive relatively timely payments from pharmacy benefit managers (PBMs) that on average align closely with their acquisition costs. However, with the introduction of the MFP model, pharmacies will experience a lag in reimbursement, as the majority of funds will now come from drug manufacturers through retrospective refunds processed via the Medicare Transaction Facilitator (MTF). Our model suggests that this delay – estimated at an average of seven days beyond the PBM payment window – could result in a shortfall of approximately $10,838.25 per week relative to the pre-MFP process.

Our analysis also highlights a reduction in profitability for pharmacies dispensing the MFP-listed medications. Historically, pharmacies achieved a modest approximated margin on these drugs, estimated at 6% based on acquisition costs. The transition to the MFP model, which aligns reimbursement with acquisition costs and eliminates margin potential, implies an annual revenue loss ranging from $40,279.04 to $46,475.82 per pharmacy. The long-term financial sustainability of pharmacies will depend on their ability to adapt to these cash flow changes.

While our model is developed based upon national averages, we recognize that not all pharmacies operate the same. Our sensitivity analyses underscores the variability in financial impact based on historic reimbursement and prescription volume trends as well as the timing of manufacturer refunds. Pharmacies dispensing a higher volume of MFP drugs will face proportionally greater liquidity pressures. Additionally, our scenario modeling indicates that if manufacturer refunds are further delayed beyond the assumed seven-day window, the liquidity burden may compound, potentially affecting pharmacy operations and staffing levels. Conversely, if refund timelines improve and align more closely with PBM reimbursements, the financial burden could be mitigated to some extent.

The introduction of the Medicare drug price negotiation program presents a double-edged sword for pharmacies. While it offers the potential for long-term cost containment within the Medicare program as well as greater predictability in business operations, the immediate financial ramifications – particularly in terms of liquidity and profitability – pose substantial challenges. Pharmacies will need to navigate these complexities through strategic financial planning and operational adjustments to maintain viability in the evolving healthcare landscape.

Policymakers should consider means to eliminate any delay between the typical PBM reimbursement window and drug manufacturer refund. Additionally, policymakers should monitor

and ensure that settlements are provided reliably without errors or unnecessary delays. As pharmacy providers may need to incur additional expenses to monitor drug manufacturer refunds, similar to costs currently incurred to monitor PBM remittances, oversight may help ease additional costs to operate not considered within this model. Finally, volume of MFP prescriptions should be routinely monitored. While CMS will appear to require participation in MTF as part of Medicare pharmacy networks, it is possible that preferred and non-preferred pharmacy networks as well as pharmacy ordering practices could potentially result in shifts of MFP prescriptions. Industry concerns have highlighted the potential role of pharmacy steering, and it is possible that network tools could be employed to shift typical MFP dispensing patterns, particularly if they are associated with sustainability and cash flow concerns.

Limitations

Our model and analysis are constructed using aggregate pharmacy data; however, it is possible that the aggregate data available for use in our model masks a heterogeneity to the data that cannot be determined based upon the available data sets. For example, several of the MFP drugs may meet the definition of specialty drugs. It is therefore possible that the distribution pattern of the MFP-selected drugs is not evenly distributed across the pharmacy channel and may be concentrated into select pharmacy provider types (i.e., specialty pharmacy). As specialty pharmaceuticals, the medications generally have low utilization which means they have a lower proportional impact on our modeling (see Appendix). However, specialty drugs are generally associated with higher margins, which means even a little utilization can be significant. Outside of the specialty pharmacy issue, a similar issue with unknown levels of heterogeneity may exist in regard to typical pharmacy reimbursements. As our sensitivity analysis demonstrates, the range of potential current reimbursements for the 10 MFP drugs can be significant. We believe limitations associated with aggregate pharmacy data are sufficiently controlled by the presentation of result impacts within our sensitivity analysis section and the low level of utilization for products likely to be of issue; however, it is important to recognize our model's presentation of an 'average' impact to pharmacy may over- or understate a typical pharmacy experience.

Our model does not consider several factors which may have a practical impact on pharmacy finances. First, our model does not consider any additional costs incurred to comply with the MTF. While the belief is that MTF services will be provided to pharmacies at no cost, most pharmacies typically incur a cost to oversee their remittances (i.e., accounts receivable). The introduction of a drug manufacturer refund will introduce a new payment source, which will require monitoring and accounting to ensure that all appropriate and applicable funds are received. The introduction of new costs associated with this is not considered within the model. Pharmacies today are already responsible for tracking and monitoring payments from various sources, and it therefore seems reasonable to assume that they can handle monitoring and tracking for one additional source if the MTF-PM is utilized. However, it should be noted that pharmacies are not generally used to receiving payments from drug manufacturers directly and therefore they may incur additional costs associated with working with drug manufacturers that they do not generally incur today (i.e., different preferences for data presentation, different means of handling disputes, etc.). Furthermore, it is unknown how many drug manufacturers will handle reimbursement outside of the MTF-PM. Drug manufacturers are required to participate in the MTF, but not required to participate in the MTF-PM. If a sufficient number of manufacturers develop their own means of handling payments, then it is possible higher costs for pharmacies may be incurred than otherwise considered within our model (i.e., one MTF-PM).

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3 Axis Advisors is an elite, highly specialized consultancy that partners with private and government sector organizations to solve complex, systemic problems and propel industry reform through data driven advocacy. With a primary focus on identifying and analyzing U.S. drug supply chain inefficiencies and cost drivers, 3 Axis Advisors offers unparalleled expertise in project design, data aggregation and analysis, investigative research, and public education. 3 Axis Advisors arms clients with independent data analysis needed to spur change and innovation within their respective industries. 3 Axis Advisors co-founders were instrumental in exposing the drug pricing distortions and supply chain inefficiencies embedded in Ohio's Medicaid managed care program that ultimately uncovered more than $244 million in secret prescription drug mark-ups and inspired a national reckoning on hidden cost drivers within the prescription drug supply chain. They are also the co-founders of 46brooklyn Research, a nonprofit organization dedicated to improving the transparency and accessibility of drug pricing data for the American public. To learn more about 3 Axis Advisors LLC, visit www.3axisadvisors.com.

Appendix

Model Per Drug Assumptions

Medicare 2023	Reimbursement per Rx	Acquisition Cost per Rx	Product Proportionality
Eliquis	$ 802.18	$ 760.31	43%
Enbrel	$ 7,234.07	$ 6,935.85	1%
Entresto	$ 984.96	$ 931.21	6%
Farxiga	$ 969.83	$ 917.95	6%
Fiasp/Novolog	$ 907.72	$ 707.61	7%
Januvia	$ 965.91	$ 917.02	10%
Jardiance	$ 1,035.11	$ 988.52	13%
Stelara	$ 24,120.72	$ 23,794.27	0%
Xarelto	$ 884.73	$ 879.78	15%
Imbruvica	$ 14,584.66	$ 13,069.92	0%

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