Why are price caps a bad solution for medicine affordability?

Americans need affordable access to medicines, but upper payment limits (UPLs) set by prescription drug affordability boards and Medicare Maximum Fair Prices (MFPs) are not viable solutions. In our complex drug supply chain, these price caps could bankrupt pharmacies and reduce patient access.

WHAT DOES THIS MEAN FOR PHARMACIES?

UNDER-REIMBURSEMENT

If UPLs are set too low, pharmacies may be reimbursed at rates below their acquisition costs. As PBMs respond to UPL impacts, they will likely use an old tactic to boost their own bottom lines—reducing reimbursements to pharmacies even further. In the past, PBMs have also cut dispensing fees, giving pharmacies pennies instead of the $12 or so needed to cover operating costs. These practices are contributing to an epidemic of pharmacy closures that will only increase when PBMs protect their profits by tightening reimbursements.

Pharmacy Benefit Managers (PBMs) are **drug supply chain middlemen** that make a fortune overcharging healthcare purchasers and underpaying pharmacies for the medications they dispense.

REIMBURSEMENT DELAYS

Medicare's MFP system was designed to require pharmacies float the difference between the list price and the reduced negotiated price while they wait for manufacturers to reimburse the difference.

The payment delay built into this flawed system will create an estimated weekly cash shortfall of $11,000 per week for each pharmacy that carries MFP-covered medicines.

WHAT DOES THIS MEAN FOR PATIENTS?

While the promise of medications that are more affordable to patients sounds good, the reality is that price caps are not the answer.

HIGHER COSTS

Over half (57%) of insurance executives who have studied Upper Payment Limits forecast bad outcomes for patients:

- Higher copays and premiums for plans that cover UPL medicines
- Changing tiers of access for plans that cover UPL medicines

LESS ACCESS TO MEDICINES AND PHARMACIES

A 2025 survey found that over 90% of independent pharmacies are considering or have already decided not to stock Medicare's price controlled drugs.

Over 48 million Americans already live in pharmacy deserts today. Patients can't get quality healthcare at any price from a closed pharmacy or from one that can't afford to stock their medicine because the pharmacy loses money on each prescription they dispense.

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How can states achieve savings and protect access to pharmacies?

Pharmacy Benefit Managers (PBM) tactics have increased costs for patients and healthcare purchasers all while driving community pharmacies out of business and failing to deliver on their promise to lower medication costs.

PBM reform can rein in drug costs while protecting pharmacies and patients. Here's what states are trying:

A single PBM for Medicaid: In 2022, **Ohio** chose one vendor to run its Medicaid drug plans so that it could curb PBM profiteering. The state **saved $140 million** in the first two years. Average dispensing fees rose from 73 cents to $9, and the rate of pharmacy closures fell for the first time in five years.

Virginia enacted SB875 to follow Ohio's example (2025).

State-operated prescription benefits: In 2018, **West Virginia** shifted its Medicaid prescription drug benefits from PBMs to a state-operated fee-for-service program. The move cut administrative costs by 85%, saving the state **almost $57 million**. A similar effort netted **North Dakota** $17 million in just one year. **California** estimated this approach would save at least $150 million a year; **New York's** 2024 budget anticipated nearly $1 billion of savings in a two-year transition.

Missouri, **Tennessee**, & **Wisconsin** also run their own fee-for-service programs.

Reimbursement regulation: In an attempt to stop the bleeding of pharmacy closures, about a dozen states require PBMs to match Medicaid reimbursements to rates established under their fee-for-service programs. Others prohibit PBMs from manipulating drug prices for their own profit.

California enacted SB41 to curb PBM practices (2025).

Dismantle PBM monopolies: In April 2025 **Arkansas** banned PBMs from operating pharmacies in the state to stop them from favoring affiliated pharmacies at the expense of others. A federal judge blocked the law in July 2025, so its impact remains to be seen.

FURTHER RESEARCH:

REPORTS

Understanding Drug Pricing from Divergent Perspectives: State of Washington Prescription Drug Pricing Analysis, 3 Axis Advisors, Jun 2024

Ohio SPBM Program Review/Experience Analysis, Milliman, Apr 2025

Understanding Pharmacy Reimbursement Trends In Oregon, 3 Axis Advisors, Oct 2022

Pharmacy Savings Report, West Virginia Medicaid, Navigant, Apr 2019

ON PRICE CAPS

Prescription Drug Affordability Boards: Potential Risks to Pharmacy Reimbursement, NASPA, Sept 2025

Unpacking the Financial Impacts of Medicare Drug Price Negotiation, 3 Axis Advisors, Jan 2025

ON LEGISLATION

Review California SB-41

Key Provisions: Comprehensive State PBM Regulation, NCPA

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