Reforming Pharmacy Benefit Managers to Unlock Generic Drug and Biosimilar Savings

Summary: *Generic and biosimilar medicines represent enormous value to the health care system. In 2024, these medicines generated $467 billion in savings in the U.S., including $142 billion in savings to Medicare and $202 billion across the commercial market.*[1]

Despite these significant benefits, patients, employers, and government programs continue to struggle with drug affordability of prescription medicines, even when lower-cost generic drugs (generics) and biosimilar biological products (biosimilars) are available. High spending on medicines is exacerbated by the practices of Pharmacy Benefit Managers (PBMs) – the intermediaries who oversee prescription medicine formularies, dispensing, and reimbursement. Without meaningful reform, PBMs will continue to restrict access to affordable generics and biosimilars.

The Problem: PBMs Prioritize Profits Over Affordability

PBMs hold considerable power over prescription medicine utilization. AAM's 2025 U.S. Generic & Biosimilar Medicines Savings Report, which highlights PBM business practices in the commercial and Part D payor segments, demonstrates how PBM preferences for costly reference products create challenges for payors and the manufacturers of generic and biosimilar medications, even when these medicines present lower net costs. These challenges include:

- **Hidden Price Concessions and Fees:** PBMs are incented to choose reference products with substantial price concessions and fees, frequently excluding generics and biosimilars from coverage or implementing barriers to dispensing when they are on the formularies.
- **Current PBM Revenue Models:** Administrative fees, data charges, and pharmacy spreads tied to high list-price products create incentives for dispensing higher-cost medicines. These manufacturer pricing schemes ultimately increase payer claim costs, despite PBMs' stated role of delivering value to payors.
- **Dispensing Barriers:** More than 25% of new generics face prior authorization requirements during the first two years after launch. In the biosimilars market, nine Humira biosimilars, despite having parity coverage with the originator, had less than 2% market share in January 2024, even with lower net costs per unit.[2]
- **Vertical Integration:** Unchecked PBM ownership of specialty, mail, and retail pharmacies, and demand for privately marketed prescription medicines are creating anticompetitive barriers to dispensing lower-cost products even when they are included on formularies.

Evidence of Harm

- **Delayed Coverage of Generics:** In 2025, only 24% of Medicare Part D plans covered first generics launched in 2024, compared to 78% of commercial plans. However, for those generics that were covered, plans frequently implemented various tiering and utilization management strategies, and formulary exceptions tactics, to limit access to them.[3]

- **Medicare Disadvantage:** Compared to those in commercial plans, Medicare Advantage and Part D enrollees continue to experience slower access to generics, despite federal efforts through the Inflation Reduction Act to promote access and affordability.
- **Concentrated Market Power:** Three PBMs control 80% of the market, giving them significant authority over coverage, access, and pharmacy network contract terms with insufficient oversight. A 2024 analysis from AAM and IQVIA highlights how vertically integrated PBMs limited adoption of lower-cost versions of branded Humira®, limiting health plan and employer savings by as much as $6B while protecting $2B in revenue through their commonly owned specialty pharmacies.

Policy Recommendations: A Call for PBM Reform

To realize the full savings potential of generic and biosimilar medicines and safeguard health budgets, policymakers should take decisive steps, including:

- **Reimagine the PBM Bidding Process:** Implement prospective bidding for Part D and ERISA plan sponsors that requires PBMs to compete based on their ability to provide the lowest net effective cost across the entire pharmacy benefit, inclusive of rebates, discounts and the entire range of concessions guaranteed to payors.
- **Limit Vertical Control:** Congress and the FTC should continue their work to provide additional guardrails on PBM utilization management, pharmacy sourcing, and network contracting practices that limit patient access to lower-cost medicines.
- **Legislative Action:** Pass bipartisan PBM reform measures, like those included in the 2024 omnibus bill, and additional reforms to curb anti-competitive behavior and promote accountability.

Conclusion

PBMs were established to manage the high costs of prescription medicines, but their current opaque practices often serve to increase them – at the pharmacy counter and the government's and taxpayers' expense. Reforming PBMs is a regulatory and ethical imperative—patients and taxpayers must receive the full value of generic and biosimilar medicines. Prescription medicine pricing and reimbursement processes must be governed by transparency, accountability, and healthy competition.

References

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