Fiscal Lab ON CAPITOL HILL

Fiscal Note H.R. _____

Net Effective Cost Transparency and Prescription Drug Affordability Act of 2026

The Fiscal Lab has examined the fiscal effects of the proposed legislation introduced in the 119th Congress by Representative Mackenzie. The legislation would improve the bidding process for Pharmacy Benefit Managers (PBMs), improve reporting of information, and impose transparency requirements. Following conversations with a representative from Representative Mackenzie's office and a representative from Fresenius Kabi, it is the opinion of the Fiscal Lab that the proposed legislation would help to reduce Medicare costs. However, as the data used is internal to Fresenius Kabi, the Fiscal Lab cannot independently confirm the proposed $70 billion in savings as stated.

The proposed legislation works to incorporate reforms through three main channels. First, it reforms the bidding process by using a Net Effective Cost (NEC) that removes potential rebates and discounts that may benefit the PBM and private insurers. Second, it imposes a rating system for Medicare Advantage PBM requirements to measure how prices align to bid projections to avoid providers whose true costs far exceed their bid projections. Third, and finally, it ensures that commercial health plans have access to the NEC so individual companies can better estimate healthcare prices.

Based upon the research and data reviewed by the Fiscal Lab, it is believed that this legislation will save the federal government money through transparency and avoiding providers that typically have significant cost overruns. However, at this time, the Fiscal Lab is unable to access the data necessary to provide an independent score.

To amend Title XVIII of the Social Security Act, and the Employee Retirement Income Security Act of 1974, to create certain requirements with respect to pharmacy benefit managers.

It is belief of the Fiscal Lab that this legislation will lower costs. However, at this time, we are unable to provide a detailed score.

The proposed legislation focuses on three key changes:

1. Require the use of a Net Effective Cost (NEC) that better reflects the true cost of the drug for consumers by stripping out any manufacture benefits offered and adding in any PBM fees.
2. Improve the reporting of information by incorporating a rating scale that would allow Medicare Advantage Prescription Drug plans to identify manufacturers whose costs align to their bid projected costs, establishing manufacturers who routinely have cost overruns.
3. Require transparency for Commercial Health Plans to examine the NEC, allowing for a better estimate of individual costs for the Employee Retirement Income Security Act (ERISA), which defines standards for private sector retirement plans.

Net Effective Cost

The application of a standardized Net Effective Cost would evaluate prices based on total costs after rebates, discounts, price concessions, and PBM fees rather than relying on list prices or individual rebates.

$$Net\ Effective\ Cost = Gross\ Drug\ Costs - Rebates - Discounts - Other\ Concessions + PBM\ Fees$$

In principle, this should direct plans toward the drug with the true lowest net cost.

For Medicare Part D, lower NEC should bring down plan spending, reducing federal subsidies and risk-sharing payments. Potential savings would depend upon how often the current formula favors PBM rebates or other favorable arrangements that are not the lowest cost after all rebates and fees are included. For beneficiaries, NEC could produce savings if it shifts utilization away from high list prices with high rebates toward lower-priced generics or biosimilars.

The Congressional Budget Office (CBO) previously scored H.R. 7148 (Consolidated Appropriations Act of 2026) that included some major PBM reforms focusing on transparency, rebate pass-through, and delinking PBM compensation from drug price and rebate amounts. The results from CBO that may overlap with the legislation here is that delinking PBM compensation from rebates and transparent pricing would save $444 million over 10 years and employer plan PBM oversight/transparency would save $1.865 billion, for a total value of $2.309 billion over the 10-year window. The largest savings are generated through reducing costs for employer plans and not Medicare Part D. CBO also notes that lower premiums can translate into higher wages and therefore higher federal revenues.

Rating System

The proposed legislation incorporates a rating system to indicate when a manufacturer's bid projected price aligns to the actual costs in the following manner:

- 5 Stars: Price is within 2 percent of bid projection.
- 4 Stars: Price is within 5 percent of bid projection, with timely and effective corrective actions.
- 3 Stars: Price is within 10 percent of bid projection, with adequate corrective actions.
- 2 Stars: Price exceeds 10 percent of bid projection or has inadequate corrective actions.
- 1 Star: Price exceeds 15 percent of bid projection, fails to submit corrective actions, or demonstrates repeated noncompliance.

The details of the corrective actions are to be determined by the Health and Human Services (HHS) secretary with the requirement for public reporting of the data. So manufacturers that routinely align the bid projected price with the true cost would receive higher ratings.

While Centers for Medicare & Medicaid Services (CMS) would not mandate what manufacturer may be required through Part D, it could consider the ratings when evaluating Part D bids. It would give health insurance plans an incentive to select manufacturers that provide predictable net costs, potentially improving bid accuracy and reducing unexpected federal spending. This concept would fit within the existing Part D system because plans must use rebates and other price concessions in their bids, but CMS reconciles payments using actual costs.

This would interact with existing methodology called "risk corridors" where Medicare pays overage from projected actual costs. Currently, costs 5 percent above target are fully covered by Medicare, costs between 5 and 10 percent are half covered by Medicare, and costs above 10 percent trigger Medicare picking up 80 percent of the additional expense. While these cost overruns help mitigate losses, they do not cause a manufacturer to lose a significant portion as Medicare closes the gap on losses. Selecting a manufacturer that typically has their costs within bid projections would prevent Medicare from covering these cost overruns and likely reduce spending.

This rating system would also be useful outside of Medicare as employers could require their PBMs to consider manufacturer price reliability ratings when constructing their plan for evaluating drugs. Rather than selecting the drug offering the largest rebate, they could evaluate the NEC and the price reliability rating. This would prevent selecting a drug with a lower projected net cost but a history of substantial cost overruns that may make it less attractive, relative to a slightly higher-priced drug but with a high degree of pricing predictability.

From a federal budget perspective, the primary savings mechanism would not be the lower drug prices themselves but the reduced variance between the projected and actual drug costs. There could be secondary savings as well, if plans select manufacturers that offer lower and more predictable prices. The objective would then be to make pricing reliability a component of prescription drug competition along with prices, rebates, access, and effectiveness. Manufacturers that accurately price their products would gain a competitive advantage over other manufacturers.

Transparency of NEC

Transparency offered by this legislation would require PBMs to report the NEC in a uniform format for each bid received, which would allow the actual expected cost of competing drugs to be visible through an apples-to-apples basis, rather than through obscure pricing structures.

For Medicare Part D, CMS could require plan sponsors to report the NEC, allowing the identification of higher list price drugs with a higher rebate compared to other drugs with that may have a lower true net cost, improving overall bid accuracy and potentially reducing federal subsidies.

For ERISA-covered plans, employers could evaluate the same uniform NEC information from the PBMs allowing them to compare competing drugs on their accurate price rather than rebate versus list-price. The employer can then select the plan that provides the best economic advantage.

The transparency offered would not require CMS or ERISA plans to select the lowest NEC drug automatically but would provide a better understanding of the pricing structures through a uniform process. The principal benefit is that CMS and ERISA plans would be able to see the true expected cost of comparable drug options.

Conclusion

A uniform NEC framework could lower prescription drug prices by allowing CMS and ERISA plans to compare the true cost of drugs after various price concessions rather than relying upon list-price and rebates. For Medicare Part D, better visibility into NEC could encourage the selection of lower drug prices and improve the accuracy of plan bids, reducing potential cost overruns, and higher government subsidies. For ERISA plans, NEC could improve the formula selection by identifying where large rebates actually produce a lower overall cost.

Combining the NEC with a manufacture price reliability measure could generate additional savings by identifying manufacturers whose actual prices consistently align to projected costs. Plans could favor lower-cost, more predictable products that would reduce exposure to unexpected price increases.

So the possible cost savings from the proposed legislation could be generated through the lower drug prices from uniform NEC pricing structure, accurate reporting, and lower cost overruns.

Additional Notes: None

Modeling Used: None

Source(s):

Congressional Budget Office, "H.R. 7148, Consolidated Appropriations Act, 2026," cost estimate, January 21, 2026. Useful for the enacted PBM reform baseline and federal budget effects.

Centers for Medicare & Medicaid Services, "2026 Medicare Part D Bid Information and Part D Premium Stabilization Demonstration Parameters," July 28, 2025. Useful for Part D bidding, premium stabilization, and the return to standard risk-corridor parameters in 2026.

Centers for Medicare & Medicaid Services, "Advance Notice of Methodological Changes for Calendar Year 2026 for Medicare Advantage and Part D Payment Policies," July 10, 2025. Establishes the standard Part D risk corridors: plans bear the first 5 percent of overruns, CMS shares 50 percent from 5–10 percent, and CMS bears 80 percent above 10 percent.

US Department of Labor, Employee Benefits Security Administration, "Proposed Pharmacy Benefit Manager Fee Disclosure Rule," January 2026. Useful for ERISA plan access to PBM fee, compensation, and financial arrangement information.

Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies (Federal Trade Commission, July 2024). Useful for PBM concentration, vertical integration, affiliated pharmacies, rebates, and competition concerns.

Ensuring Access to Lower-Cost Medicines for Seniors Act, S. 4323, 119th Cong. (2026). Useful for the proposal to improve Medicare Part D access and tiering for lower-cost generics and biosimilars.

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