TPG Chief Pharmacy Officer Summit - 2026

Executive Summary

The TPG Chief Pharmacy Officer Summit brought together healthcare leaders from health plans, health systems, pharmacy organizations, academia, and technology sectors to discuss the future of pharmacy care management and the evolving healthcare ecosystem. Discussions focused on healthcare consumerism, pharmacy practice transformation, PBM transformation, artificial intelligence, value-based pharmaceutical pricing, integrated data sharing, prior authorization reform, biosimilars, and patient affordability. Participants consistently emphasized that while technology and AI offer significant opportunities to improve operational efficiency, patient engagement, and care coordination, the healthcare industry's greatest challenges remain rooted in fragmented and misaligned incentives, reimbursement complexity, operational silos, and limited alignment among stakeholders. The meeting reinforced the expanding role of pharmacists within value-based and patient-centered care models, highlighting the need for reimbursement reform, broader provider status recognition, integrated care coordination, and greater patient education. Across all sessions, participants stressed the importance of transparency, collaboration, affordability, and trust in improving patient outcomes and creating a more sustainable healthcare system. The proceedings concluded with agreement that meaningful healthcare transformation will require stronger collaboration between health systems, health plans, pharmacies, pharmaceutical manufacturers, and regulators to align incentives, modernize care delivery, and better meet the evolving needs of patients.

Background

Eleven Chief Pharmacy Officers representing health plans and health systems across nine states convened for a collaborative healthcare leadership forum focused on the future of pharmacy care management, healthcare delivery, and the evolving pharmacy ecosystem over the next five years. The meeting brought together leaders from payer organizations, integrated delivery systems, Health benefit manager, academia, and the technology sector to discuss both strategic challenges and opportunities shaping the healthcare industry.

The event was highly interactive, encouraging open dialogue and cross-sector collaboration around some of the most pressing issues in healthcare, including healthcare consumerism, pharmacy practice transformation, drug pricing reform, biosimilars, prior authorization modernization, integrated data sharing, artificial intelligence, and patient affordability. Throughout the proceedings, participants repeatedly emphasized that while technological innovation is advancing rapidly, the most significant barriers to healthcare improvement remain rooted in fragmented business models, misaligned incentives, regulatory complexity, and insufficient coordination between healthcare stakeholders.

The Current Healthcare Landscape

Opening discussions focused on the transformation of the healthcare delivery model where consumers are becoming the drivers of the delivery system. Participants examined how healthcare financing, reimbursement systems, pharmacy benefit management, and provider relationships are shifting in response to rising healthcare costs, workforce shortages, changing consumer expectations, and rapid technological advancement. Integral to this transition is the evolving role of the pharmacist as care becomes more patient-centered and the system become more value-driven.

In the traditional healthcare model, patients are merely the receivers of the care, where financial resources primarily flow from employers and government programs such as Medicare and Medicaid into delivery systems that include hospitals, physicians, pharmacies, and specialists to provide the care. Health plans, PBMs, and specialty benefit organizations are identified as the financial intermediaries, controlling contractual relationships and reimbursement flow.

The evolution of patients and consumers becoming the drivers of the healthcare system, can be seen as a reverse movement back towards the delivery side, demanding more convenience, transparency, personalization, and digital access. This evolution highlights the transition away from traditional facility-driven and provider-centric healthcare models toward more patient-centered, technology-enabled care delivery. Participants identified telehealth, patient centered home-based care, mobile healthcare access, precision medicine, and direct-to-consumer pharmacy services as rapidly expanding areas of disruption. Companies often cited as traditional health system disruptors in this new era of health care are Amazon Pharmacy, Lilly Direct, Mark Cuban's Cost Plus Drugs, and other digital healthcare entrants, as they are examples of how convenience-oriented healthcare models are reshaping patient expectations and bypassing the traditional healthcare infrastructure.

What is the Role of the Pharmacist in this Evolutionary State?

The was strong agreement that pharmacists will play a more significant role in direct patient care over the next three to five years. Key drivers identified included advances in technology reducing task-related pharmacy work, ongoing shortages in primary care physicians, value-based care initiatives, rural healthcare access challenges, and expanding provider status legislation. Participants emphasized the expanding role of pharmacists in chronic disease management, medication optimization, specialty care coordination, immunizations, and preventive care delivery, while also recognizing an important unmet need for greater consumer-focused education. A key priority identified was improving patients' understanding of their care and treatment plans so they can become more engaged, informed, and empowered participants in managing their own healthcare.

However, the group also identified major barriers preventing pharmacists from fully expanding into broader clinical roles. The primary barrier identified was the inability of the pharmacy profession to achieve broader recognition and advancement toward provider status, as well as the recognition of the expansion of clinical responsibilities and the ability to be reimbursed for services. Barriers to reimbursement include the complex reimbursement process and fragmented billing systems. Reimbursement for pharmacy services must evolve away from the

current transactional model that reimburses primarily for dispensing prescriptions towards a model that compensates pharmacists for the professional clinical services they provide. In other words, pharmacy reimbursement must shift from a transaction-based payment structures to outcomes-driven care models focused on improving patient health and overall care quality.

It was noted that across Europe there is a growing trend toward integrating pharmacists into provider practices to conduct medication reviews and support patient care interventions aimed at optimizing outcomes, particularly within value-based care models. In the United States, Kaiser Permanente has been advancing a similar approach by positioning pharmacists as physician extenders; however, participants noted that this model is largely enabled by Kaiser's unique reimbursement and care delivery structure. From a health system perspective, partnerships that embed pharmacists within provider practice settings have the potential to benefit a much broader patient population rather than focusing solely on narrow or specific patient groups.

Closing this portion of the discussion, participants noted that employers and healthcare purchasers often do not fully recognize the value pharmacists can contribute to broader healthcare delivery and cost management strategies. The group emphasized the need for greater employer and payer education regarding the clinical and economic value of pharmacy services, along with expanded patient education initiatives to help optimize care, improve engagement, and drive better health outcomes.

Pharmacy Benefit Management and the PBM Evolution

The discussion then shifted to the evolving role of PBMs, formulary management challenges, and the impact of emerging technologies such as artificial intelligence on healthcare operations. Participants discussed the increasing complexity created by multiple payer formularies, rebate structures, and fragmented coverage policies, all of which complicate patient care and provider decision-making. Health systems managing numerous payer formularies frequently encounter operational inefficiencies, patient confusion, and medication switching during transitions of care. Additionally, as health systems increasingly move beyond traditional care delivery and assume financial risk for patient outcomes, many have begun developing internal formularies tailored to the patient populations for which they are financially and clinically accountable.

The complexity created by multiple payer formularies, rebate structures, and fragmented coverage policies prompted broader discussion around the underlying root causes driving these challenges. Participants noted that this complexity is fueled by multiple competing financial and operational incentives within the healthcare system. One example cited was the pressure on PBMs to maintain strong rebate-driven business models to remain competitive with health benefit consultants, who often evaluate prescription benefit performance primarily through rebate metrics and guaranteed rebate levels for their clients. As a result, organizations evaluating formulary and pharmacy benefit strategies are frequently forced to determine their primary objective: minimizing patient out-of-pocket costs, maximizing traditional rebate revenue to the organization, or optimizing financial returns from alternative revenue streams such as 340B-related margins.

Participants explored opportunities for stronger collaboration between health systems and health plans in areas such as biosimilar adoption, prior authorization simplification, and the

development of shared care pathways. However, the group acknowledged that rebate-driven incentives, PBM contracting arrangements, consultant recommendations, and 340B program considerations continue to create significant challenges in aligning formularies with patient-centered care strategies.

The discussion also examined the evolving PBM marketplace. While the "big three" PBMs have historically maintained dominant market positions, participants noted increasing momentum among mid-sized, technology-enabled PBMs that emphasize greater pricing transparency and value-based contracting approaches. At the same time, anticipated regulatory changes involving point-of-sale pricing transparency, increased FTC scrutiny, and potential Most Favored Nation pricing initiatives are expected to place additional pressure on traditional rebate-based PBM business models and further accelerate market disruption.

AI Integration

Artificial intelligence emerged as a major theme throughout the meeting. Nearly all participating organizations reported actively evaluating or implementing AI-driven solutions in areas such as prior authorization processing, clinical decision support, administrative workflow automation, and medication management. Most organizations expressed a preference for partnering with external AI vendors rather than developing internal platforms, citing the rapid pace and complexity of technological advancement. While participants agreed that AI has the potential to become a significant operational enabler across the healthcare ecosystem, they also emphasized that technology alone will not resolve the industry's deeper structural, financial, and business model challenges.

One of the most immediate opportunities identified for AI adoption was the automation of lower-level administrative and operational tasks to free up resources for greater patient interaction and engagement. Participants highlighted several use cases for AI, including customer service call support, 340B transaction management, documentation improvement, extraction and analysis of information from medical records, and use as a virtual assistant for tasks such as retrieving drug information from clinical databases. AI can be used to access and assess workflows where gaps in workflows are identified, and the use if AI to fill those gaps.

From a clinical perspective, AI is already being integrated into areas such as imaging interpretation, clinical documentation support, and health plan care management programs. Participants also discussed how AI can help streamline prior authorization workflows, improve communication processes, and support more efficient care coordination. Future opportunities identified included integrating AI into claims processing systems to improve coding accuracy, optimize claims submissions, and reduce administrative inefficiencies across the healthcare ecosystem.

More specifically within pharmacy practice, participants discussed how AI can be leveraged to enhance the documentation of pharmacy services, thereby strengthening the ability to demonstrate clinical value and support reimbursement for professional services. AI also presents opportunities to support the medication consultation process through proactive predictive

models capable of identifying individual patient risk factors and helping demonstrate improved clinical outcomes.

It was noted that in the United Kingdom, AI is already being utilized to triage patients and prioritize those requiring more immediate clinical attention. Participants also discussed the potential for AI-enabled discharge medication reconciliation tools that would allow patients to access medication information independently while providing seamless escalation to a pharmacist when more detailed counseling or intervention is needed.

Overall, participants agreed that one of the greatest benefits of incorporating AI into pharmacy practice is its ability to reduce administrative burden and automate lower-level tasks, allowing pharmacists to redirect their time and expertise toward practicing at the top of their license and delivering higher-value patient care services.

From a patient perspective, participants identified several opportunities for incorporating AI to support patient advocacy and engagement. AI has the potential to assist in identifying gaps in care and prompting providers to address issues such as behavioral health concerns or situations where patients are not responding adequately to current treatment plans. Participants also discussed the ability of AI to evaluate patient risk and project potential outcomes by analyzing multiple clinical and non-clinical factors.

These predictive capabilities could be used to identify patients at higher risk for critical events such as hospitalization, disease progression, medication non-adherence, or adverse drug reactions. By enabling earlier intervention and more personalized care planning, AI may help improve patient outcomes, enhance care coordination, and support more proactive healthcare management.

A New Paradigm for Valuing Innovative Medicines

This session focused on the evolving global pharmaceutical pricing landscape and the growing shift toward value-based approaches for assessing innovative medicines. A comparison was made between the traditional market-driven U.S. pharmaceutical pricing model with European frameworks that place greater emphasis on cost-effectiveness, affordability, and uncertainty as the primary drivers used to determine the net value and pricing of medications.

Cost-effectiveness was described as the balance between clinical benefit and economic impact, specifically evaluating whether the incremental health benefit provided by a therapy justifies its additional cost compared to existing standards of care. Affordability was viewed from a broader population health perspective, recognizing healthcare as a zero-sum financial environment in which sustained cost trend increases are difficult to absorb. Uncertainty was identified as another major consideration, particularly as accelerated approval pathways create challenges in fully understanding a medication's long-term clinical effectiveness, durability of response, and impact upon real-world outcomes at the time of launch.

In contrast, the U.S. pricing model was characterized as largely market-driven, where pricing is determined primarily by what the market is willing to bear. In short, the fundamental philosophical distinction between the two systems is made with a simple observation: in the

United States, healthcare is often viewed as a business, whereas in Europe, healthcare is generally managed as a societal expense requiring tighter cost control and value justification.

Global pharmaceutical pricing is increasingly operating within a more disciplined value-based framework that emphasizes measurable clinical benefit, affordability, and long-term sustainability rather than relying solely on traditional market-driven pricing dynamics. European health technology assessment (HTA) processes are placing growing pressure on manufacturers to demonstrate the specific incremental value a new therapy provides compared to existing standards of care, rather than simply marketing products as "best in class."

Evaluations typically assess therapies across multiple domains, including clinical evidence, available treatment alternatives, the competitive landscape, and historical pricing or reimbursement precedents. Incremental benefit assessments are increasingly driven by head-to-head clinical studies, the quality and magnitude of clinical improvement relative to standard therapy, the projected impact across patient populations, the identification of appropriate comparator treatments, and the generation of real-world evidence following product launch. The discussion highlighted the growing importance of population-level outcomes, quality-adjusted life years (QALYs), and real-world evidence within both European HTA evaluations and the evolving U.S. CMS pricing negotiation framework. In summary, the European payer evaluation model is becoming increasingly comprehensive, incorporating assessments of clinical differentiation, cost-effectiveness, budget impact, commercial market dynamics, access considerations, and overall patient affordability when determining the value and reimbursement positioning of innovative therapies.

The discussion then shifted to the implications of Most Favored Nation (MFN) and International Reference Pricing (IRP) policies. The original U.S. MFN proposal identified 15 international markets that would be used as reference points for pricing comparisons, though the list has since been narrowed to eight markets. Under the proposed framework, the second-lowest price among the referenced countries would serve as the benchmark for establishing the reference price.

While the publicly communicated objective of MFN was to lower U.S. drug prices and create greater international pricing alignment, it was suggested that a broader underlying objective is that this is an attempt by the United States to incorporate elements of the more rigorous European health technology assessment (HTA) evaluation process while still maintaining its fundamentally free-market healthcare structure.

European representatives explained that these policies could creating unintended market consequences. European healthcare systems are generally unwilling to accept significant price increases, which may result in delayed, restricted, or abandoned pharmaceutical launches in European markets as manufacturers seek to avoid establishing lower international reference prices that could negatively impact future U.S. pricing negotiations. Additionally, if manufacturers abandon launches in Europe, the basis for the MFN program is also abandoned. There is also a question of whether the United States would ultimately realize meaningful net cost reductions under such policies, noting that lower reference pricing may further discourage manufacturers from offering confidential discounts and negotiated pricing arrangements due to increasing transparency requirements surrounding global pharmaceutical pricing.

Breakout Sessions

Participants rotated through three breakout sessions focused on Integrated Data Collection and Sharing, Patient Affordability and the Impact of Benefit Design, and Prior Authorization. Attendees were encouraged to evaluate each topic through the lens of the patient experience and consider how these operational, financial, and clinical challenges directly impact patient care, access, affordability, and trust within the healthcare system.

Breakout A – Integrated Data Collection and Sharing

This breakout session focused on real-time healthcare analytics and the role of integrated data systems in improving patient outcomes and supporting value-based care delivery. Highlighted was the need to move beyond traditional retrospective analytics toward continuous patient journey surveillance capable of supporting real-time clinical interventions and more proactive care management.

A central theme of the discussion was the evolution of "value" in healthcare from being viewed as a static outcome to being understood as an ongoing process. It was emphasized that "value in healthcare should be a verb," meaning that healthcare value is continuously created through coordinated actions, interventions, and decision-making throughout the patient journey rather than being measured only after outcomes have occurred. The group explored how AI interoperability standards and the integration of clinical, claims, pharmacy, and patient-generated data could improve care coordination, clinical decision-making, and operational efficiency.

Several challenges were identified, including fragmented data systems, inconsistent adoption of interoperability standards, operational silos, and legal or regulatory barriers that limit effective healthcare data sharing. Participants also highlighted the underutilized role pharmacists could play in value-based care models if they were provided broader access to integrated patient information, laboratory data, and care coordination systems that would allow them to intervene more effectively throughout the patient care continuum.

Breakout B – Patient Affordability

This session examined affordability barriers within specialty pharmacy and the impact of current pharmacy benefit design models. The discussion began with a central question: Is it possible to create a model in which patients experience the lowest possible out-of-pocket costs, health plans achieve the lowest net cost, and pharmacy providers maintain sustainable and favorable margins simultaneously?

Participants identified several major barriers to patient affordability, including rebate-driven revenue structures, high-deductible benefit designs, and inflated drug list prices, all of which can expose patients to unaffordable out-of-pocket expenses despite substantial negotiated discounts existing elsewhere within the pharmaceutical supply chain.

The group reviewed multiple contracting and reimbursement scenarios demonstrating how direct manufacturer agreements and biosimilar strategies may reduce both patient costs and overall payer spending while also improving pharmacy provider economics.

Participants generally agreed that current PBM rebate models often prioritize rebate guarantees and revenue optimization over true net-cost reduction and patient affordability, creating financial misalignment across the healthcare ecosystem.

Upcoming regulatory reforms under the Consolidated Appropriations Act were discussed extensively, particularly requirements expected in 2028 that may require rebates and negotiated discounts to be passed directly to patients at the point of sale. Participants anticipated that these changes could accelerate the transition toward direct contracting and more transparent pricing models.

Breakout C – Prior Authorization

The Prior Authorization breakout session addressed growing frustration with outdated prior authorization infrastructure and administrative inefficiencies. The foundational premise is the payer's desire to ensure that the "Right Patient, receives the Right Drug, at the Right time." Participants discussed the lack of standardization across insurers, fragmented EMR systems, and inconsistent clinical criteria that create confusion and delays for providers and patients.

AI and automation were discussed as potential tools to improve prior authorization workflows, streamline routine approvals, and enhance communication transparency across the healthcare ecosystem. Participants noted that AI could play an important role by conducting initial EMR reviews to identify pertinent clinical information relevant to established authorization criteria. If the required clinical criteria are clearly met, the traditional prior authorization process could potentially be bypassed or expedited. Conversely, if the necessary criteria are not satisfied, the request would proceed through the standard prior authorization review process.

However, participants also acknowledged that regulatory requirements for human oversight and individualized clinical decision-making continue to limit the ability to fully automate prior authorization workflows. The group agreed that future prior authorization systems must strike an appropriate balance between operational efficiency, transparency, clinical oversight, and patient trust while simultaneously reducing unnecessary administrative burden for providers, payers, and patients.

Breakout Summary

Across all breakout sessions, participants repeatedly returned to the central importance of patient trust within the healthcare system. The group agreed that patients must feel confident that the healthcare system is acting transparently, fairly, and in their best interests. Building that trust will require greater honesty and transparency, clearer communication, and improved patient education regarding the financial, clinical, and operational pressures influencing healthcare decisions.

Participants emphasized that helping patients understand the complexities and pressure points within the healthcare system is essential to creating long-term value. Without transparency and trust, efforts to improve affordability, streamline care delivery, or implement new technologies will face significant resistance and limited success. Ultimately, the discussions reinforced the idea that meaningful healthcare transformation must remain grounded in patient-centered value, collaboration, and transparency across all aspects of care delivery.

Panel Discussion: Consumerism and Healthcare Transformation

The panel discussion focused on the accelerating rise of healthcare consumerism and the resulting transformation of healthcare delivery models. Participants discussed how patients increasingly expect healthcare experiences similar to those found in other consumer industries, including digital convenience, transparent pricing, app-based services, and rapid access to care. However, participants acknowledged that the current healthcare system remains poorly positioned to meet these evolving expectations. The existing model was described as outdated, burdened by long wait times, limited patient interaction, and fragmented communication. A recurring theme throughout the discussion was the need for healthcare delivery to shift toward bringing care directly to the patient, rather than requiring patients to navigate complex healthcare systems on their own.

Community pharmacies were identified as having a significant opportunity to demonstrate greater "value" within this evolving environment. Participants emphasized that pharmacies must continue moving away from a dispensing-focused model toward a more patient-centered and clinically integrated approach that emphasizes direct patient engagement, education, and care coordination. This transition was also closely tied to broader discussions around reimbursement reform, with participants noting the need to move beyond product-based payment models and toward reimbursement structures that recognize and compensate pharmacists for professional clinical services and improved patient outcomes.

At the same time, participants expressed concern that the increasing consumer-driven healthcare models could unintentionally disadvantage vulnerable populations, including elderly patients, children, and individuals with limited health literacy who often require greater professional guidance and coordinated support. Panelists observed that the patients who need healthcare support the most are frequently those least equipped to make informed healthcare decisions independently due to social, educational, behavioral, or economic factors. As a result, the discussion emphasized the importance of balancing patient choice and convenience with strong clinical oversight, coordinated care, and regulatory protections. Participants highlighted the need for stronger FDA oversight processes, more comprehensive insurance coverage, and expanded patient education efforts to help patients better understand their treatment options and navigate the healthcare system more effectively.

The panel explored the growing expansion of direct-to-patient pharmaceutical distribution models and the potential consequences these models may have on coordinated patient care. Participants expressed concern that direct-to-patient distribution could further fragment care delivery by bypassing traditional healthcare touchpoints, particularly pharmacists. Panelists noted that reducing pharmacist involvement in medication management may limit opportunities for pharmaceutical care interventions, medication oversight, adherence monitoring, and overall care coordination, ultimately diminishing the ability to positively influence patient outcomes and maintain comprehensive visibility into the patient's treatment journey.

Another area of discussion focused on biosimilar adoption and the need for better alignment of incentives across all healthcare stakeholders. Participants agreed that existing rebate-driven reimbursement structures often create barriers to biosimilar utilization and contribute to formulary variability between health systems and payers. Panelists expressed concern that

current rebate models frequently prioritize financial incentives over achieving the lowest true net cost for the healthcare system and patients. The group emphasized the importance of aligning incentives in ways that support reduced hospitalization rates, broader biosimilar adoption, and more sustainable long-term management of healthcare cost trends.

Finally, participants agreed that legislative reform of the current 340B program is necessary. Discussions focused on the need for greater accountability and transparency regarding how 340B-generated margins are utilized, along with the need to define and establish standardize minimum levels of care and patient support that participating organizations must provide. At the same time, participants acknowledged that many healthcare institutions serving vulnerable populations have become highly dependent on 340B-related financial margins to sustain operations and continue providing care, making thoughtful and balanced reform critically important.

Participants agreed that while technology and AI offer significant opportunities to improve efficiency and patient engagement, meaningful transformation will require deeper alignment between health systems, health plans, pharmacies, manufacturers, and regulators.

Closing Discussion and Next Steps

The closing session reflected on the major themes and insights that emerged throughout the meeting. Participants agreed that the healthcare industry's most significant challenges are not primarily technological in nature, but rather stem from fragmented and misaligned incentives, operational silos, reimbursement complexity, and insufficient coordination among stakeholders across the healthcare ecosystem.

Attendees emphasized the critical importance of stronger collaboration between health systems, health plans, providers, pharmacies, and pharmaceutical organizations to improve patient outcomes, affordability, transparency, and overall trust in the healthcare system. The discussions also reinforced the expanding role pharmacists are expected to play within future healthcare delivery models, highlighting the need for continued evolution of reimbursement structures, broader recognition of pharmacist provider status, and more integrated care coordination frameworks to support patient-centered care delivery.

Participants agreed on the importance of creating actionable plans to advance areas of the discussions prior to the 2027 Summit. Accordingly, participants have started work on biosimilar utilization, AI applications, prior authorizations, and medication use evaluation.