Statement for the Record: The National Community Pharmacists Association (NCPA)

United States House of Representatives Energy and Commerce Committee Subcommittee on Health

Hearing: "*Lowering Health Care Costs for All Americans: An Examination of the Prescription Drug Supply Chain*"

February 11, 2026

Chairman Griffith, Ranking Member DeGette, Chairman Guthrie, Ranking Member Pallone and Members of the Subcommittee:

Thank you for conducting this hearing on the pharmaceutical supply chain and how our current system contributes to the costs of prescription medications. My name is Douglas Hoey, I am a pharmacist as well as the CEO of the National Community Pharmacists Association (NCPA). I greatly appreciate the opportunity to share independent pharmacy owners' experience and insight on the prescription supply chain. In this statement, I present NCPA's thoughts on the drug supply chain and identify opportunities that Congress should be prioritizing as you look to improve affordability and accessibility for American patients.

Specifically, I want to touch on how vertical and horizontal consolidation continues to increase costs while lowering patient access and quality of care. If Congress wants to help foster affordability in our health care system, the supply chain needs to shift drastically to create true competition in the marketplace. NCPA recommends that Congress prioritize ways to halt and dissolve the horizontal and vertical consolidation that has overtaken health care, and specifically, the prescription drug supply chain. Consolidation creates opacity and fosters sham organizations like pharmacy benefit manager (PBM) offshore Group Purchasing Organizations (GPOs). Consolidation has also led to market giants exploiting their dominant market share, resulting in anticompetitive practices such as patient steering, opaque pricing games, punitive audits and formulary manipulation. When three health care giants control step-by-step the patient's journey through the healthcare system, they are able to manipulate it to force competition out. Practices such as PBM's offering contracts to their pharmacy network that are neither reasonable

nor relevant result in inadequate reimbursement for pharmacy competitors, which stifles healthy competition, reduced consumer access to pharmacies, and increases health care costs.

Before moving into the challenges within the system and areas that we think need your attention, I want to thank both Congress as a whole, and the members of this Subcommittee in particular, for passing significant PBM reforms last week. This was an important first step, but there is more work to be done to reverse the trend of growing pharmacy deserts, improve access to independent community pharmacies and lower drug prices.

The Roles of Pharmacy and Pharmacy Services in the Drug Supply Chain

As CEO of NCPA, I come to you speaking on behalf of America's community pharmacists, including the owners of nearly 19,000 independent community pharmacies. More than half of all community pharmacies provide long-term care services which is of growing importance as our populations ages. They play a critical role in ensuring patients have immediate access to medications in both community and long-term care (LTC) settings. They are the front line of American healthcare unofficially triaging care for millions of patients who walk into their pharmacies every day. They are also important to the economies of the communities in which they operate. Together they represent a $103 billion health care marketplace and employ more than 235,000 individuals on a full or part-time basis who provide an expanding set of health care services to millions of patients every day.[1] Our members are small business owners who are among America's most accessible health care providers, and I myself am a pharmacist that is licensed in Oklahoma, Virginia, and Texas and practiced in a variety of community pharmacy settings including my own family's pharmacy before coming to NCPA.

More than any other segment of the pharmacy industry, independent pharmacies are often located in the underserved and rural areas that are home to many Medicare and Medicaid beneficiaries. In fact, nearly two-thirds of independent pharmacies collectively serve areas with a population of less than 50,000. Pharmacists have more medication-related education and training than any other health care professional. Pharmacists can and do assist patients in

[1] 2025 NCPA Digest; 2024 NCPA Digest

optimizing the impact of medications and decreasing patients' costs by providing essential services, including medication therapy management, immunizations, chronic disease management, and preventive care screenings, helping patients manage their health conditions and avoid costly hospitalizations.

Pharmacists are the most accessible health care professional but unfortunately, patients do not always have access to pharmacies that are closest to them due to patient steering to affiliate pharmacies owned by pharmacy benefit managers (PBMs) or other entities. Research from the University of Southern California-NCPA Pharmacy Access Initiative shows that across the country, *roughly one in eight neighborhoods are pharmacy shortage areas*. PBMs are systematically eradicating their competition through forced economic duress and burying them in red tape. Pharmacies in the United States are closing at an unprecedented rate. Just in the last four years, consumers have over 4,100 *fewer* pharmacies from which to choose — a more than 7 percent decrease in pharmacy choice for patients across the nation — and that pattern of pharmacy deserts is *increasing*.[2] The closures of these pharmacies harm patients, many of whom rely on their local pharmacy for first-line medical care.

The Ugly Side of Vertical Integration

The primary driver of pharmacy deserts are pharmacy reimbursements from PBMs that are below the pharmacy's cost to buy the drug and operate its business. Pharmacy deserts are areas in the country where pharmacies have disappeared and patients are stranded without a local pharmacist, who often serves as the only health care provider. Adequate reimbursements ensure healthy competition and, therefore, more choices for patients. However, in many states, the PBM market is highly concentrated both in commercial coverage but also in public programs (Medicaid managed care and Medicare Part D). A February 2026 study evaluated market concentration of PBMs using the Herfindahl-Hirschman Index (HHI), a measure of market concentration used by the U.S. Department of Justice merger guidelines. This study showed that 46 out of 50 states were highly concentrated in their PBM markets in Medicaid managed care and Medicare Part D. In many cases, one of the top 3 PBMs accounted for at least 50% of the market. For example,

[2] 2022 NCPA Digest, 2023 NCPA Digest, 2024 NCPA Digest, 2025 NCPA Digest

Caremark accounted for 83.1% of the Medicaid managed care market in Hawaii and 71.8% of the Medicaid managed care market in Illinois. In several other states, the total number of prescription fills through the top 3 PBMs in Part D was almost 90%.

Market shares like that make it impossible for an independent pharmacy not to be in network. Who can give up somewhere between half to over three quarters of their customers and stay in business? These concentrations result in outsized leverage, giving the PBM-insurers the ability to under-reimburse pharmacies who they often compete with. That outsized market power also enables the PBMs to steer patients to their own pharmacies, force unconscionable contract terms, conduct unfair and punitive audits, charge excessive fees, manipulate pharmacy-generated data for their own benefit, use coercive marketing tactics, and exploit undisclosed conflicts of interest. PBMs exploit their market dominance and the complexity of the payment model by releasing data only under their terms or just flat out refusing to provide it. In its first interim staff report on PBMs, the FTC stated, "The failure of certain respondents to timely produce data and documents has hindered the ability of the Commission to perform its statutory mission and noted that the FTC would pursue a court order if needed to get that data."[3]

In 2023, the United States spent over $722 billion on prescription drugs.[4] Today, many Americans are financially strained and unable to afford the soaring costs of lifesaving medications. This affordability crisis is, in part, a result of the largest, most powerful health insurance conglomerates' takeover of the health care system. The conglomerates I speak of are CVS Health with a Fortune 500 rank of 5, UnitedHealth Group with a Fortune 500 rank of 3, and Cigna with a Fortune 500 rank of 13.[5] They have leveraged their marketplace dominance to stifle competition from independent pharmacies, harming American consumers through exorbitant prescription drug prices and reducing access to healthcare. These three companies processed nearly 80

3 See Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies, July 2024.

4 H. COMM. ON OVERSIGHT AND ACCOUNTABILITY, THE ROLE OF PHARMACY BENEFIT MANAGERS IN PRESCRIPTION DRUG MARKETS, 3 (Jul. 2024).

5 Full List of Fortune 500 Companies (2026)

percent[6] of the approximately 7.1 billion prescriptions[7] dispensed by U.S. pharmacies in 2024. As of 2024, the combined revenue of the parent conglomerates owning the four largest PBMs (UnitedHealth Group, CVS Health, Cigna, and Humana) exceeded $1 trillion and equaled 22 percent of national health expenditures.[8]

The last time I sat before this committee in 2017 to talk about challenges in the drug supply chain, I raised concerns about large PBMs, their role in the supply chain, and the largely unregulated impact they had on patients. To be clear, Congress and the states have taken some action. However, PBM power in the supply chain has only grown due to increased vertical and horizontal consolidation. As seen in our Appendix, since 2017, CVSHealth acquired Aetna, Cigna acquired Express Scripts, UnitedHealth Group's OptumRX acquired Change Healthcare and UnitedHealth Group is now the largest employer of physicians in the country. Meanwhile, there are more than 4,100 fewer pharmacies today than four years ago[9] Horizontal and vertical consolidation in health care has not produced the efficiencies and consumer price reductions Americans were promised. Instead, it has created worse outcomes, higher costs, and rationing access for patients, employers, and taxpayers. It has created an uneven playing field for competitors and has directly harmed access to independent pharmacies.

Since their inception, PBMs have morphed from claims adjudicators into corporate giants that exploit their strategic position at the "middle" of nearly all drug transactions in the U.S. to extract profits from the upstream and downstream participants in the drug supply chain while providing questionable value to the ultimate consumer. They leverage the number of beneficiaries in a particular plan to negotiate lucrative rebates and fees from pharmaceutical manufacturers, creating unbalanced formularies and driving up the cost of drugs. The cold, calculated process of auctioning off placement on patient drug formularies to the highest

[6] Drug Channels: The Top Pharmacy Benefit Managers of 2024: Market Share and Key Industry Developments

[7] Understanding the Use of Medicines in the U.S. 2025 | IQVIA

[8] FTC Report: Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies

[9] IndependentsClosing_2025FlyerEdit.pdf

bidder in exchange for rebates, discounts and other fees results in over $350 billion between the list price of brand prescriptions and the net price. Some of those dollars may find their way back to payers, it is unclear because of PBM opacity, but only after the PBMs (or their GPOs or other subsidiaries) have taken their healthy cut off the top.[10]

Additionally, many of these practices have shifted from PBMs to their affiliated GPOs, some of which are purposefully offshored, ostensibly to avoid the scrutiny of regulators and employers. These GPOs then generate revenues for their PBM owners by extracting some of those discounts, fees or rebates before payments are made to payers.

PBMs have recently claimed that they pass along "nearly 100 percent" of these manufacturer rebates to plan sponsors.[11] However, this hinges on what is considered a "rebate." PBM GPOs instead levy a variety of fees in addition to or instead of the rebates that are collected from manufactures, and since rebate and fee arrangements between PBMs, their GPOs, and manufacturers are considered "proprietary," they are not shared with plan sponsors. It is only once the GPO collects their cut that the money then flows back to the PBM and then down to the plan sponsor. A recent investigation found that these GPOs operate on skeleton crews while bringing in "tens of millions, if not close to $100, million, per employee."[12] Additionally, Kent Rogers, one of the creators of Emisar, the GPO tied to UnitedHealth, told the New York Times that, "The intention of the G.P.O. is to create a fee structure that can be retained and not passed on to a client."[13] Recent moves by the FTC have highlighted their concerns of the impact that GPOs have on the industry, with the settlement last week requiring Cigna's GPO, Ascent to relocate from Switzerland to the US, and to submit to FTC monitoring for 10 years.[14]

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[10] **Drug Channels Institute.**Fein, A. J. *Gross-to-Net Bubble Hits $356B in 2024—But Growth Slows to 10-Year Low.* Drug Channels, July 15, 2025.

[11] Reminder: Small Businesses Prefer Flexibility and Options for Their Pharmacy Benefit Contracts | PCMA, March 4, 2025.

[12] "Bullshit" — The New Way Health Giants Hide Billions - HUNTERBROOK

[13] How PBMs Are Driving Up Prescription Drug Costs - The New York Times

[14] FTC Secures Landmark Settlement with Express Scripts to Lower Drug Costs for American Patients | Federal Trade Commission

Vertical integration, such as can be seen in the Insurance-PBM-GPO relationship, creates limited visibility into contract terms and performance, enabling these vertically and horizontally consolidated companies to capture larger shares of revenues.

When a PBM-insurer both owns its own pharmacy and is also responsible for building a retail pharmacy network, that PBM negotiates contracts with their own competitors. Not surprisingly, this conflict of interest incentivizes the PBM-insurers to find ways to steer patients to their own pharmacies, such as designing formularies to maximize their own rebates and foreclosing competition from smaller, independent PBMs.[15] Maximizing profits through formulary manipulation often happens in the case of name brand medications. These developments have reduced competition from rival pharmacies and led to higher drug prices for consumers.

Congress recently passed PBM reform that includes a requirement that contracts between PBMs and pharmacies in the Medicare Part D program must be "reasonable and relevant." NCPA and its members applaud this action and are grateful that Congress has heard its concerns voiced over many years. However, the legislation says "reasonable and relevant" contract enforcement must be implemented by no later than 2029. In the meantime, pharmacies will continue to be forced to accept one-sided, take it or leave it contracts or risk losing large swaths of their business. NCPA recommends that CMS accelerate the implementation of the reasonable and relevant contracts to January 1, 2028. This still allows nearly two years for this policy to be configured and implemented and will help stem the growth of pharmacy deserts impacting patient access.

How Patient Steering Leads to Increased Costs and Waste

PBM-insurers have perfected crafting and implementing anticompetitive practices, opaque reimbursement models, and restrictive pharmacy network contract terms. Due to these practices, they have created an environment in which they can use their overwhelming market power to steer patients away from their competitors to their own pharmacies and pay themselves more. They have the power to determine which drugs patients may have and which

[15] FTC First Interim Report, at 10, 66-67.

pharmacies patients may use, and through their affiliations with or ownership of pharmacies, they control how much their competitors can be reimbursed for prescription drugs and other pharmacy services. And while they do not set the list price, they do determine the drug price patients pay at the counter. They use this influence to increase their outlandish profits at the expense of taxpayers, patients, and local, independently-run pharmacies.

Specifically, you can see this market power when they steer patients to their own affiliate pharmacies, including mail-order and specialty pharmacies. They also manipulate the more profitable patients, often shifting them to their own pharmacies through coercion and plan design – often unbeknownst to the payor. Mail-order pharmacy also leads to excessive waste because expensive drugs are auto shipped – even when patients don't need them, as can be seen in a recent Wall Street Journal article which found that between 2021 and 2023 mail-order pharmacies shipped prescriptions excessively early causing $3 billion of waste in the Medicare program alone.[16]

While it is common practice for PBM-insurers to steer towards their affiliated pharmacies, the most lucrative prescriptions are filled at "specialty" pharmacies that provide expensive, brand-name pharmaceuticals.[17] From 2016 to 2023, the total specialty medication dispensing revenue at all U.S. pharmacies increased at a compound growth rate of 11.2 percent, nearly three times faster than dispensing revenue for traditional medications.[18] During that same period, the largest PBM-affiliated pharmacies increased their share of specialty dispensing revenue by 25 percent.[19] Due to the lack of an industry standard or regulatory definition for a "specialty drug," PBMs have broad discretion to make specialty classification decisions.[20] Specialty drugs can include common brand name drugs, but also generics. Accordingly, PBMs have been able to expand the designation of specialty drugs to include medications previously classified as non-specialty that have been on the market for many years. For example, many branded HIV drugs are included on specialty drug lists, though they have been dispensed for decades by retail pharmacists. The

[16] Pharmacies Flood Medicare Patients With $3 Billion of Extra Drugs - WSJ
[17] FTC First Interim Report, at 21
[18] Id., at 30.
[19] Id., at 31.
[20] Id., at 36.

generic versions are not included on the specialty drug lists, suggesting the deciding factor is profitability to the PBM. Similarly, hepatitis, infertility, and immunosuppressant products have also been dispensed by retail pharmacists historically, though now are turning up on specialty drug lists. Once a drug is added to a PBM's specialty drug list, it can trigger exclusivity provisions in contracts with certain payers that require the use of the PBM's affiliated specialty [21] These reclassifications of drugs do not seem to have been made for therapeutic reasoning, but instead economic.

The idea that PBMs use patient drug formularies and their own definition of what constitutes a "specialty" medication is further supported by the fact that nearly 70% of all specialty prescriptions in the U.S. are dispensed by one of the "big 3" PBMs specialty pharmacies which account for over $180 billion in revenue. The vertical integration of the Big Insurance owned PBMs provides a ripe environment for steering the prescription from other pharmacies the patient may prefer to their own mail order pharmacy through the use of prior authorizations, differential copays, plan designs that prefer the PBM owned pharmacies, or simply blocking competitors from being allowed to fill the prescription.[22]

The classification of a common brand name drug as specialty can also trigger extractive profiteering by PBMs. A Florida report found that PBMs steer patients to PBM-affiliated pharmacies, and "when it comes to dispensing brand name drugs, … PBM-affiliated pharmacies are making 18x to 109x more profit over the cost of the drugs than the typical community pharmacy."[23] Similarly, the FTC found that PBM-affiliated pharmacies distributed 45% of prescriptions overall, but 72% of prescriptions marked up over $1000, indicating that the Big 3 PBMs may be steering these high-cost prescriptions to their own affiliated pharmacies and away from unaffiliated pharmacies.[24] In 2023, specialty medications accounted for less than 3 percent of the total number of prescriptions dispensed in the U.S. but for more than 50 percent of drug spend—doubling from $133 billion in 2016 to $237 billion in 2023.[25]

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[21] Id., at 32.

[22] https://www.drugchannels.net/2025/04/the-top-15-specialty-pharmacies-of-2024.html

[23] 3ΔXIS Advisors, Sunshine in the Black Box of Pharmacy Benefits Management: Florida Medicaid Pharmacy Claims Analysis, 126 (Jan. 30, 2020).

[24] FTC Second Interim Report, at 2, 15-17.

[25] Ibid.; FTC Second Interim Report, at 1

Recent reports from the Federal Trade Commission (FTC) found PBM-insurers are steering patients to use *generic* specialty drugs at their affiliated pharmacies, allowing the PBM-insurers to generate more than $7.3 billion in revenue above their estimated acquisition cost.

While there remains a need for a deep look into specialty drug classification and steering thankfully, the FTC has begun to take some action against the unfair market power of the PBMs. Just last week, it settled with ESI, requiring ESI to, among other things:

- Stop preferring on its standard formularies high wholesale acquisition cost versions of a drug over identical low wholesale acquisition cost versions;
- Provide a standard offering to its plan sponsors that ensures that members' out-of-pocket expenses will be based on the drug's net cost, rather than its artificially inflated list price; and
- Provide a standard offering to all plan sponsors that allows the plan sponsor to transition off rebate guarantees and spread pricing.[26]

Oversight and enforcement of these settlement terms remain to be seen as PBMs have historically adapted their corporate structures and shifted operational activities (including overseas entities) in ways that reduce transparency and frustrate oversight/reform efforts.[27]

Conclusion

The prescription drug marketplace continues to vertically and horizontally consolidate at an alarming pace. Vertically integrated companies continue to find ways to increase costs at the expense of patients. The current business climate seems to be one in which market power is increasingly concentrated in an ever-shrinking number of corporate entities. The past and continued consolidation will only lead to more games and higher costs for the government, patients, employers, and taxpayers.

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[26] See FTC Secures Landmark Settlement with Express Scripts to Lower Drug Costs for American Patients | Federal Trade Commission. FTC February 3, 2026.

[27] **U.S. House of Representatives, Committee on Oversight and Accountability.** *The Role of Pharmacy Benefit Managers in Prescription Drug Markets* (Staff Report, Final with Redactions). July 2024.

Therefore, NCPA urges Congress to consider action to break up these vertically and horizontally consolidated companies, protecting consumers and fostering competition in the marketplace. This could be done in several different ways. Last April, the National Association of Attorneys General submitted a letter signed by 39 Attorneys General urging Congress to pass a law prohibiting PBMs, or any part of their health care conglomerate network, from owning or operating pharmacies.[28]

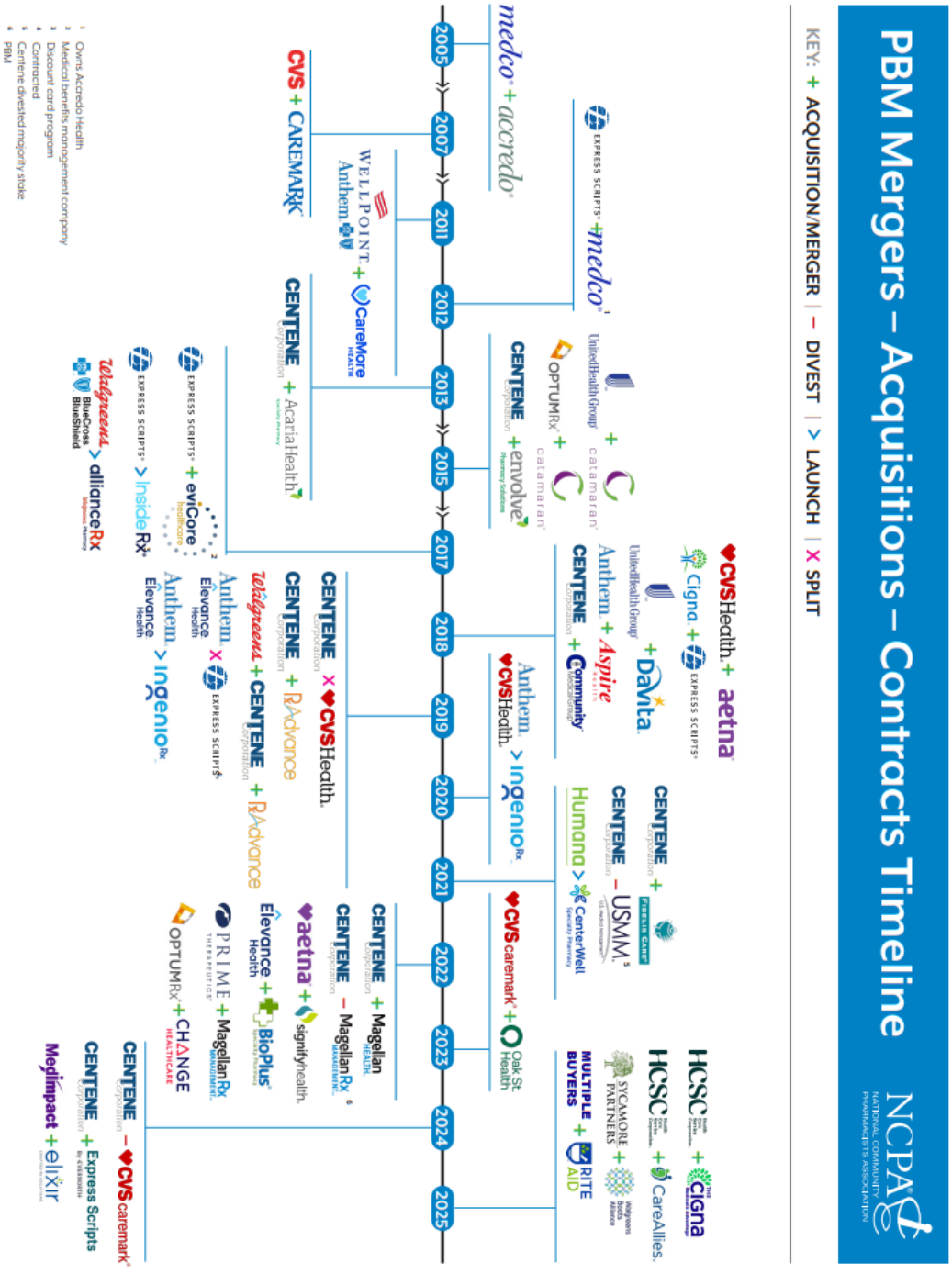
Congress should address below-cost pharmacy reimbursements by requiring a transparent pharmacy reimbursement model in all public health programs, focusing on the acquisition cost of the drug, a commensurate professional dispensing fee to cover operational costs and a payment related to pharmacy related services that support patient adherence to their medications and which keeps them healthy and out of more expensive care settings, such as hospitals and nursing facilities. Congress should also ban spread pricing in state Medicaid managed care programs and require fair and transparent reimbursement and prohibit steering to PBM affiliated pharmacies.

NCPA also recommends that CMS accelerate its implementation of "reasonable and relevant" contract provisions to January 1, 2028 instead of 2029. The need for restoring a competitive playing field to Medicare Part D is great and cannot wait an additional year.

We appreciate your attention to this ever-changing landscape. The recommendations that we have provided are not to advantage community pharmacy, but to level the playing field, promote competition, and prioritize patient access to affordable health care. I look forward to working with the committee moving forward and welcome any questions.

[28] 4-14-Pharmacy-Benefit-Managers- -FINAL-e.pdf

Appendix


PBM Mergers – Acquisitions – Contracts Timeline
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3 Discount card program
4 Contracted
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6 PBM