Statement for the Record: The National Community Pharmacists Association

United States Senate Committee on Finance

Hearing: "Pharmacy Benefit Managers and the Prescription Drug Supply Chain: Impact on Patients and Taxpayers"

March 30, 2023

Chairman Wyden, Ranking Member Crapo, and members of the committee:

Thank you for conducting this hearing on pharmacy benefit manager practices and their impact on patients and taxpayers. In this statement, the National Community Pharmacists Association will offer support and suggestions on several policy considerations that would lower out-of-pocket costs for patients' prescription drugs, provide certainty for pharmacies, and protect taxpayers by bringing more transparency to prescription drug spending.

NCPA represents America's community pharmacists, including the owners of more than 19,400 independent community pharmacies. Almost half of all community pharmacies provide long-term care services and play a critical role in ensuring patients have immediate access to medications in both community and long-term care settings. Together, our members represent a $78.5 billion health care marketplace, employ 240,000 individuals, and provide an expanding set of health care services to millions of patients every day. Our members are small business owners who are among America's most accessible health care providers.

Our pharmacies and the patients they serve have long had concerns about pharmacy benefit managers (PBMs), their anticompetitive practices, and the role they play in ever-increasing drug costs. These concerns have been further exacerbated because of the COVID-19 pandemic's effects on small businesses. Independently owned pharmacies have served as lifelines as essential businesses during the pandemic. However, PBM practices are causing these small businesses to struggle to remain viable and keep doors open to provide continued access and care.

NCPA and the University of Southern California School of Pharmacy and Leonard D. Schaeffer Center for Health Policy and Economics have collaborated to develop a web tool that shows pharmacy shortage areas at the neighborhood level and generates information on pharmacy closures and populations affected. High-level findings include:

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- 25 percent of the U.S. population (81,203,948) lived in pharmacy shortage areas across urban, suburban, and rural areas in 2020.
- Only one-third of pharmacy shortage areas calculated within the web tool carry the Health Resources and Services Administration designation of Medically Underserved Areas, or MUAs. This means that two-thirds of pharmacy shortage areas are unaccounted for when considering low access to health care in geographical areas under the MUA definition.
- Populations with the highest pharmacy shortage area population were Black (37.1 percent), Medicaid (33.2 percent), and low-income (36.7 percent).
- States with the highest percentage of census tracts calculated as pharmacy shortage areas are Alaska, Mississippi, Montana, New Mexico, North Dakota, South Dakota, and Wyoming.
- Independent pharmacies were the most dynamic factor in terms of creating and closing pharmacy shortage areas.

Pharmacies have also faced significant closures in recent years:

- From 2012 to 2019, over 1,000 independent pharmacies closed, going from approximately 23,000 to less than 22,000.[1]
- Both chain and independent pharmacies closing contribute to creating pharmacy shortage areas, but in most states, independent pharmacies closing contribute far more gaps than chains.[2]
- Independent pharmacies are at greater risk of closure than chains in urban and non-urban areas. Additionally, pharmacies serving disproportionately low-income and uninsured populations are at greater risk of closure.[3]
- *Kaiser Heath News* cited a Rural Policy Research Institute study showing that due to over 1,000 pharmacy closures since 2003, 630 communities are now without a pharmacy.[4]

We appreciate the efforts of the chair and ranking member to discuss PBM practices and their effect on drug prices for patients.

PBMs are not transparent about the rebate process and their profit margins. Moreover, we often do not know how much the PBMs make on administrative service fees and spread pricing (the difference between how much they reimburse the pharmacy and the higher price they charge the plan for the same prescription). More accurate reporting is needed to provide this transparency. To get a complete picture of PBM financials, we also need greater clarity on:

- Complicated and opaque methods to determine pharmacy reimbursement.
- Methods to steer patients towards PBM-owned or affiliated pharmacies.
- Fees and clawbacks charged to pharmacies.
- Potentially unfair audits of independent pharmacies.

[1] From historic NCPA Digest data.
[2] Data from 2018 to 2020, from University of Southern California School of Pharmacy and Leonard D. Schaeffer Center for Health Policy and Economics.
[3] Assessment of Pharmacy Closures in the United States From 2009 Through 2015 | Clinical Pharmacy and Pharmacology | JAMA Internal Medicine | JAMA Network.
[4] How Rural Communities Are Losing Their Pharmacies | Kaiser Health News (khn.org)

- The prevalence of prior authorizations and other administrative restrictions.
- The use of PBM-defined specialty drug lists and associated specialty drug policies.
- The effect of rebates and fees from drug manufacturers on formulary design and the costs of prescription drugs to payers and patients.

Bring transparency to the Medicaid program and prevent the use of spread pricing by PBMs

H.R. 1613, the *Drug Price Transparency in Medicaid Act,* was introduced by Reps. Buddy Carter (R-Ga.), Vicente Gonzalez (D-Texas), Rick Allen (R-Ga.), Jake Auchincloss (D-Mass.), Elise Stefanik (R-N.Y.), and Deborah Ross (D-N.C.). It would bring transparency to the Medicaid program by:

- Prohibiting spread pricing/requiring a full pass-through in all Medicaid managed care programs.
- Requiring that pharmacy reimbursements in all state Medicaid managed care programs be at a rate of pharmacy's average acquisition costs and the state's Medicaid fee-for-service dispensing fee.
- Limiting payments to PBMs to solely administrative fees.
- Mandating National Average Drug Acquisition Costs reporting to the Centers for Medicare & Medicaid Services by all pharmacies participating in state Medicaid programs. This provision would provide much needed transparency in drug pricing and allow reimbursements to reflect the true acquisition costs of prescription drugs in Medicaid.

Bring transparency for employers and consumers and greater enforcement authorities

S. 127, the *Pharmacy Benefit Manager Transparency Act of 2023*, introduced by Sens. Maria Cantwell (D-Wash.) and Chuck Grassley (R-Iowa), would increase drug pricing transparency for employers and plan sponsors and hold PBMs accountable for unfair and deceptive practices that drive up the costs of prescription drugs at the expense of consumers. The bill:

- Prohibits deceptive, unfair pricing schemes, including spread pricing and arbitrary clawbacks of payments made to pharmacies.
- Incentivizes transparent PBM practices by making clear that a PBM would not be in violation of the law if it:
    - Passes along 100 percent of rebates to the health plan sponsor; AND
    - Provides the full disclosure of cost, price, reimbursement and all charged fees, mark-ups, and discounts to the plan sponsor and pharmacy; OR
    - Provides the aggregate remuneration fees it receives from drug makers to health plans, payers, and any federal agency.
- Mandates transparency by requiring that PBMs file an annual report with the Federal Trade Commission, including the total amount they pocket through spread pricing and pharmacy fees.
- Clarifies the enforcement authority of the FTC and state attorneys general to prohibit unfair or deceptive business practices PBM-insurers use in commercial health insurance.

On March 22, 2023, the Senate Committee on Commerce, Science, and Transportation marked up the legislation in an executive session. An amendment by Sens. Jon Tester (D-Mont.) and Shelley Moore Capito (R-W.Va.) was adopted that closes a loophole which could have allowed PBMs to continue to engage in the abusive practice of clawbacks and protects the CMS direct and indirect remuneration final rule regarding post-adjudication clawbacks. S. 127, as amended, advanced out of the committee on a bipartisan 18-9 vote.

NCPA hopes the full Senate will promptly take up this legislation to ensure PBM business practices that impact employers, patients, and pharmacies are fair and transparent.

Ensure patient access to pharmacies and pharmacy market competition

Opaque and convoluted PBM and insurance plan pricing structures prevent pharmacies from being able to plan their business operations, as they are currently unable to understand what they will be reimbursed for a given drug or the services they provide for dispensing a given drug. Pharmacy performance/quality measures are being abused by plans/PBMs to secure fees from pharmacies rather than to fairly assess pharmacy performance.

Draft legislation in development by Reps. Morgan Griffith (R-Va.), Vicente Gonzalez (D-Texas), Buddy Carter (R-Ga.), Lisa Blunt Rochester (D-Del.), and others would improve patient access to pharmacies and pharmacy market competition. This bill requires:

- The secretary of the Department of Health and Human Services to promulgate regulations to ensure Medicare Part D prescription drug plans (PDPs) and Medicare Advantage prescription drug plans (MA-PDs) reasonably reimburse pharmacies.
    - This regulatory effort would help to ensure total reimbursement paid – net of all price concessions, fees, incentive payments, and any other form of remuneration is reasonable for a pharmacy to acquire and dispense drugs and provide necessary pharmacy services.
- PDP sponsors and MA-PD plans, beginning on Jan. 1, 2024, to only use standardized measures established by the secretary and relevant to the performance of a pharmacy based on the drugs a pharmacy dispenses.
- PDP sponsors and MA-PD plans to promptly furnish all pricing components to pharmacies, so that a pharmacy understands its final reimbursement and the purpose of any adjustments in reimbursement.

We are grateful CMS has finalized its rulemaking which applies all pharmacy price concessions at the point of sale after years of congressional efforts in support of DIR fee reform. However, while the final rule is a good start, additional statutory authority and clarity is needed that would allow CMS to address other issues, such as adequate pharmacy reimbursement. We hope Congress will work with us to ensure that more comprehensive pharmacy DIR fee reform can be implemented in 2024.

More on PBM practices

PBMs protect profits at the expense of competition and consumer welfare. Our additional comments below demonstrate the staggering scope of such practices. NCPA believes Congress and CMS could correct many of these harms by focusing immediate attention on adhesion contracts between PBMs and independent community pharmacies, patient steering to PBM-affiliated pharmacies, and discriminatory reimbursement.

<u>The effect of PBM rebates and fees on net drug prices to patients, employers, and other payers</u>

NCPA has sought reforms on rebates and fees for more than 10 years to address ballooning expenses for patients. NCPA is hopeful that CMS' attempt to bring transparency to pharmacy DIR fees through the

recently issued final rule[5] is a step in the right direction. With vertical integration both upstream and downstream, there is a need to level the playing field between independent pharmacies and PBM-affiliated pharmacies to protect patients from paying too much at the counter. NCPA believes it is incumbent on Congress to engage with CMS to address PBM market power exacerbated by rebates and clawback fees. The vertical integration of PBMs into monoliths with an affiliated upstream insurance provider and downstream pharmacies has only increased the incentives for PBMs to disfavor independent pharmacies. The current CMS fee and rebate structure creates incentives for PBMs to disfavor competing independent pharmacies, resulting in pharmacy deserts and increased patient costs. The final CMS rulemaking, however, also illustrates that CMS is not equipped to address the issues without the assistance of Congress.

Utilization management, other "cost controls," and the effect on patients and independent pharmacy

Due to contractual obligations with PBMs, NCPA members frequently must explain to their patients that due to "utilization management" (e.g., prior authorization and step therapy) and formulary exclusions, patients are unable to get access to their prescribed medication. While described as "payer controls," used to "control costs," PBMs, through their offshore group purchasing organizations (GPOs) Ascent Health Services (Cigna/Express Scripts), Zinc Health Services (Aetna/CVS Caremark) and Emisar Pharma Services (United Healthcare/Optum), use these cost controls to direct utilization to the drug with the best manufacturer rebate, which is often not the best drug for the patient, while also using the GPOs to hide rebates from plan sponsors.[6] PBMs also use these "cost controls" to control manufacturer access to the market, creating a "pay-to-play" game to get new drugs to the marketplace. In a recent analysis by IQVIA, two-thirds of patients who want to start a new prescribed drug were unable to do so because of these controls, with the largest PBMs blocking about 450 products.[7]

On Monday, March 27, 2023, Ohio Attorney General Dave Yost filed a lawsuit against Cigna/Express Scripts, Prime Therapeutics, and Ascent. In the complaint, Yost accuses PBMs Express Scripts and Prime Therapeutics of colluding with Ascent, based in Switzerland, to illegally drive up drug prices which resulted in higher out-of-pocket costs for patients. Additionally, the state of Ohio argues, "PBMs also use their market power to hurt competing pharmacies, and particularly independent pharmacies."

Ascent is one of the new contracting entities, or GPOs, that Cigna/Express Scripts has added to their vertically integrated corporate structure, adding another layer of confusion and deception to drug pricing. The three largest PBMs (Caremark, Optum, and Express Scripts) have all created their own contracting entities or GPOs. Two of these entities are located in Ireland and Switzerland. Many believe these GPOs are corporate shells created for the purpose of hiding the actual amount of rebates PBMs receive from pharmaceutical manufacturers.

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[5] Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency, CMS 4192-F, May 9, 2022, 2022-09375.pdf (govinfo.gov).

[6] PBMs claim that they no longer retain rebates but that is because the rebates have shifted to their offshore GPOs.

[7] Greenwalt, L. (2022). Payer Controls: Goodbye, Old Assumptions for Access and Uptake. Iqvia.com. Retrieved 26 March 2023, from https://www.iqvia.com/locations/united-states/blogs/2021/09/payer-controls-assumptions-for-access-and-uptake.

PBM drug substitutions and their effect on patient costs

PBMs operating in the commercial, Medicare Part D, and Medicaid spaces alike contribute to artificially inflating drug costs using expensive name brand medications when less expensive generic alternatives are available. For example, PBMs continue to require the use of the more expensive brand asthma inhaler Symbicort over the generic budesonide; Symbicort costs over $150 per month more. One PBM mandated that a state Medicaid program use Lamictal, at over $16.50 a tablet, which is significantly more expensive than its generic counterpart that costs less than $0.10 a tablet. PBMs similarly give wasteful, preferential treatment to other brand medications like Advair, Concerta, Colcrys, Ventolin, Adderall XR, and Focalin XR. Common sense would dictate that where you have a choice between two equivalents, you take the less expensive one, unless there is a compelling reason not to.

In these cases, PBMs claim that they secure large rebates from the manufacturer to bring the net cost of the product down to below the cost of the generic. Even if this were true (which would require complete transparency and a 100 percent pass-through of all monies that flow from a pharmaceutical manufacturer to a PBM), it does not negate the consumer harm that exists to patients when they are in the deductible phase and paying more out of pocket for their medication costs. PBMs will also blame these formulary placements on plan sponsors, but plan sponsors like others in this industry are at the mercy of PBMs and their constant threats of rate hikes.

PBMs' use of potentially unfair, deceptive, or anticompetitive contract terms and all related practices when calculating pharmacy reimbursements and disbursements

NCPA members have received Medicare Part D contract amendments that appear predatory. One PBM offered an anticompetitive contract amendment that would compensate independent pharmacies 10 percent below their wholesale acquisition cost, provide no dispensing fee,[8] and assess a per-transaction performance pool fee. The intended effect of such an amendment and discriminatory pricing can only be to force independent pharmacies to opt out of the Medicare Part D networks or stay in them only to face financial ruin. The end result is the strengthening of PBM-affiliated mail-order, specialty, and retail pharmacies at the expense of independent pharmacies.

It is important to understand the lengths to which PBMs go to obfuscate how they price and reimburse drugs. Such distortion begins with terminology: an average wholesale price (AWP) is generally a mark-up (typically 20 percent) of the wholesale acquisition cost (WAC) and can be thought of as the manufacturer's list price.[9] It is generally accepted that WAC is the amount paid by the wholesaler to the manufacturer.

The maximum allowable cost (MAC) is the amount set by the PBM and is the amount the PBM will reimburse a pharmacy for generic drugs (pharmacy MAC). MAC is also the amount the PBM will charge a plan sponsor for a drug (plan sponsor MAC). The pharmacy MACs and plan sponsor MACs can change by the hour or even minute. The price difference between the pharmacy MAC and the plan sponsor MAC is the "spread." Many understand that the spread is a revenue stream retained by the PBMs. As an example

[8] Stoller, M. (2022). The Red Wedding for Rural Pharmacies. Mattstoller.substack.com. Retrieved 5 May 2022, from https://mattstoller.substack.com/p/the-red-wedding-for-rural-pharmacies?s=r.

[9] Anderson, L. (2022). Average Wholesale Price (AWP) as a Pricing Benchmark. www.drugs.com. Retrieved 5 May 2022, from https://www.drugs.com/article/average-wholesale-price-awp.html.

of the amount of money generated by this arbitrage, spread pricing cost the state of Ohio $225 million in 2018.[10]

A generic effective rate (GER) represents a reimbursement baseline calculated as a percentage discount (e.g., 86 percent) off the average wholesale price (AWP) of a generic drug. A PBM will calculate across all generic drugs dispensed for a specified period (e.g., 1 year) either at an individual pharmacy level or often across all the pharmacies represented by a pharmacy services administrative organization (PSAO). However, PBMs reimburse generic claims at varying MAC, WAC or discounts off AWP, not at the GER. Accordingly, at the end of the specified evaluation period, PBMs reduce the AWP of all the individual generic drugs dispensed by the GER discount (e.g., 86 percent) and that number is compared to the actual reimbursement originally paid to a pharmacy. The PBM will then reconcile the total dollar difference. If, after the PBM completes the calculations and determines a pharmacy has received excess reimbursement, the PBM will claw back the money. Given the vast differences between generic reimbursements based on MAC, WAC, and discounts of AWP, it is particularly difficult for pharmacies to know where they stand in comparison to the contracted GERs. Notably, PBMs do not refund clawbacks to patients; the PBMs retain the clawbacks for themselves. Brand effective rates (BERs) work the same, except the PBMs use them for brand drugs.

This effective rate contracting/payment method allows PBMs to play games with individual drug reimbursements to the detriment of patients, pharmacies, and employers. Effective rate contracts allow a PBM, at its sole discretion, to reimburse a pharmacy artificially high or low knowing the PBM will reconcile the pharmacy reimbursement dollars at the end of the evaluation period to the contracted effective rate, as described above. For patients who have a percentage-based cost share, when a pharmacy dispenses a drug at a higher price artificially inflated by the PBM, based on the point-of-sale adjudication, the patient will pay a higher copayment. The patient will not receive the benefit of the end of the year reconciliation – the PBM will keep that money.

<u>PBMs' use of unconscionable contract terms</u>

PBMs control market access, and they use that control to force unconscionable contract terms. PBM adhesion contracts include random basis audits, aberrant drug list compliance, inventory management limitations, specialty drug limitations, complicated performance metrics, complex pricing schemes, "flexible contracting" (which means unilateral, no-notice contract changes), and other such provisions. The PBM can base an audit off any of those unconscionable contract terms. A PBM audit is an existential threat to an independent pharmacy's business. Nevertheless, it is common for a single pharmacy to face several PBM audits a month. One of the most common audits is an invoice audit. Invoice audits require the pharmacy to prove that it bought the drugs it billed to the PBM. While that sounds reasonable, it is the frequency with which the PBM conducts such audits and the penalties that are not reasonable. If a PBM finds even a minor discrepancy, the pharmacy faces substantial financial penalties, and potentially even termination of the network agreement.

Termination of the network agreement can be fatal. In 92 percent of metropolitan statistical areas (MSAs), at least one insurer with a PBM has a 30 percent market share. In 50 percent of MSAs, one insurer has at

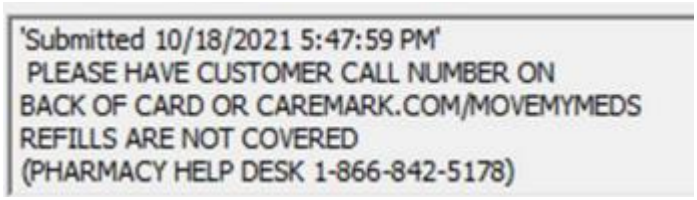
[10] Ohio Auditor of State. Ohioauditor.gov. (2022). Retrieved 26 March 2023, from https://ohioauditor.gov/news/pressreleases/Details/5042.

least 50 percent market share.[11] With PBMs controlling access to the upstream insurer networks, they are able to control the downstream pharmacy market, and conflicts of interest abound.

PBMs steering patients away from unaffiliated pharmacies and toward PBM-affiliated specialty, mail-order, and retail pharmacies

PBMs use a variety of methods to steer patients away from unaffiliated pharmacies. PBMs create arbitrary lists, such as specialty and aberrant drug lists, to limit independent pharmacies' access to patients. These lists require patients to obtain certain drugs from a PBM-affiliated pharmacy.[12] The PBMs use contract provisions that require independent pharmacies to "walk" their patients to "specialty pharmacies," a term PBMs arbitrarily define. Any independent pharmacy can potentially be a specialty pharmacy, however, the PBMs make the sole determination of who meets the opaque "criteria." If the PBMs do not determine the independent pharmacy meets PBM-established specialty pharmacy accreditation requirements, the pharmacy cannot be part of the specialty pharmacy network. Such a process begs the question: when would a PBM with a downstream affiliated specialty pharmacy ever determine an independent pharmacy is worthy of such designation?

Other methods include refill walk requirements. Below is a screenshot from an independent pharmacy's pharmacy management system. As you will see, the PBM requires the independent pharmacy to inform its patient that the patient must seek an alternative way of getting their refills. The alternative way is through the PBM-affiliated pharmacy.



Failure to follow these exclusionary procedures often leads to audits and threats of termination of the pharmacy's network agreement. At the very least, PBMs force pharmacies to choose between filling the refill free of charge (real-time claims adjudication would prevent the independent pharmacy from submitting a claim) or letting the patient go untreated until they find a PBM-affiliated alternative.

PBMs' policies and practices related to specialty drugs and pharmacies

On behalf of PBMs, sPCMA, a division of the Pharmaceutical Care Management Association representing the specialty pharmacy industry, released a white paper to defend PBM specialty drug practices.[13] In it, sPCMA admits that the definition of specialty drug continues to evolve. It lists a number of attributes that on the one hand apply to many non-specialty drugs, and on the other hand begs the question: if specialty drugs are used to treat complex or chronic medical conditions that require lab monitoring; additional patient education, adherence and support; and administration technique training beyond traditional

[11] COMPETITION in HEALTH INSURANCE A comprehensive study of U.S. markets. Ama-assn.org. (2022). Retrieved 26 March 2023, from https://www.ama-assn.org/system/files/2020-10/competition-health-insurance-us-markets.pdf.

[12] Fein, A. (2022). Insurers + PBMs + Specialty Pharmacies + Providers: Will Vertical Consolidation Disrupt Drug Channels in 2020?. Drugchannels.net. Retrieved 26 March 2023, from https://www.drugchannels.net/2019/12/insurers-pbms-specialty-pharmacies.html.

[13] https://www.spcma.org/wp-content/uploads/2016/06/sPCMA_The_Management_of_Specialty_Drugs.pdf.

dispensing activities, why would a PBM want to send specialty drugs through its affiliated mail-order pharmacy? sPCMA provides the answer – money –[14] and "[i[15]

Other criteria cited in this document reveal the lack of differentiation between most designated specialty drugs and more widely used drugs. In fact, sPCMA notes that patients use specialty drugs for a wide range of conditions. When addressing why specialty drugs have limited distribution, sPCMA cites criteria that is relevant with all non-specialty designated drugs too: drug inventory tracking, supply chain integrity, and dosing and lab monitoring. Therefore, the criteria PBMs use is nebulous at best.

The impact on patients is clear. PBMs cut off patients who often have complex or chronic medical conditions from specialty options and force them into mail order at significant risk to their health.[16] The PBM practices prevent patients from accessing prompt care, education, injection training, adherence, and related support that only an in-person pharmacist can provide. Additionally, this practice is hurting consumers because when a mail-order drug fails to arrive at a patient's home, patients are forced to fill their specialty drugs at a pharmacy that is out of network, or not authorized to distribute specialty drugs.

Potential conflicts of interest and anticompetitive effects arising from horizontal and vertical consolidation of PBMs with insurance companies, specialty pharmacies, and providers

In 2018, the auditor of the state of Ohio produced a State Report on Ohio's Medicaid Managed Care Pharmacy Services that spoke to PBM conflicts of interest.[17] In it, the auditor found discriminatory reimbursement because PBMs compensated their affiliated pharmacies at a higher rate than independent pharmacies. This discriminatory reimbursement occurs nationwide, based on evidence reviewed from Arkansas, Florida,[18] and Oklahoma. In fact, in February 2018, the Arkansas Pharmacists Association, joined by Arkansas Lieutenant Governor Tim Griffin and almost half of the General Assembly, held a press conference unveiling data demonstrating that PBMs pay their own affiliate pharmacies more than independent pharmacies.[19] The Arkansas data contained over 200 examples of discriminatory reimbursement. Of the top generic drug prescriptions, Arkansas found that the PBMs were paying themselves, on average, over $60 more per prescription than they were paying independent pharmacies. The PBM was steering patients to its wholly owned affiliate so that it could pay itself more. Such anticompetitive behavior results in increased costs and harm to patients.

Conclusion

Prescription drug prices continue to grow at an alarming rate, while transparency and competition are decreasing. As we have shown above, there are many factors in the pharmaceutical supply chain and delivery system that may contribute to these negative factors, including PBM "middlemen." NCPA stands ready to work with Congress and the administration to implement policies that will lower drug prices at the pharmacy counter for our patients.

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[14] *Id* at 3.
[15] *Id* at 4.
[16] https://www.npr.org/sections/health-shots/2019/01/07/673806506/extreme-temperatures-may-pose-risks-to-some-mail-order-meds.
[17] https://audits.ohioauditor.gov/Reports/AuditReports/2018/Medicaid_Pharmacy_Services_2018_Franklin.pdf.
[18] Milliman, Florida Agency for Health Care Administration: Pharmacy Benefit Manager Pricing Practices in Statewide Medicaid Managed Care Program (Dec. 2020).
[19] https://m.youtube.com/watch?v=CDnFSOMAazA.