Submitted electronically to drugs@finance.senate.gov

August 17, 2026

Sen. Ron Wyden (D-OR), Ranking Member, Senate Finance Committee
Sen. Catherine Cortez Masto (D-NV)
Sen. Peter Welch (D-VT)

Re: Request for Information: Commonsense Policy Options to Lower Drug Prices for Patients

Ranking Member Wyden, Senator Cortez Masto, Senator Welch, and members of the Senate Finance Committee Minority Staff,

The National Community Pharmacists Association (NCPA) appreciates the opportunity to provide feedback on Senate Finance's *Request for Information: Commonsense Policy Options to Lower Drug Prices for Patients.*

NCPA represents America's community pharmacists, including 18,900 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 (LTC) settings. Together, our members employ 235,000 individuals, and provide an expanding set of healthcare services to millions of patients every day. Our members are small business owners who are among America's most accessible healthcare providers. NCPA submits these comments on behalf of both independently-owned community and long-term care pharmacies.

Senate Democrats are interested in proposals that will lower out-of-pocket drug costs for patients. Among other things, Senate Democrats requested feedback on the following specific policy options and questions:

Generic Drug Price Markups

- *Moving to a cost-plus/NADAC-based reimbursement model for generic medicine ingredient costs. Senate Democrats are interested in policy ideas that would bring "cost-plus" style pricing into Medicare Part D for generic medicines.*

Both reimbursement for ingredient costs and dispensing fees for pharmacies must be required and economically viable. For contracts to be reasonable and relevant, pharmacies must be compensated with a fair ingredient cost and a commensurate professional dispensing fee. The "cost-plus" models touted by the PBMs do not adequately reflect the costs of acquiring and dispensing the medications. Costs that should be counted by plans when determining professional dispensing fees are defined in the

Medicare regulations at 42 CFR 423.100.[1] **We are currently reviewing recent state cost of dispensing surveys to ensure that the current components of recent cost to dispense surveys are included in this regulatory definition. For example, beneficiary counseling is included in the professional dispensing fee definition in 42 CFR 447.502, while it is not included in 42 CFR 423.100.[2]**

Payment of nominal dispensing fees to pharmacies may be included in some Part D contracts but are not adequate to cover the cost of dispensing for the pharmacy. Furthermore, Medicare Part D contracts are take-it-or-leave it to the pharmacy, leaving the pharmacy little choice but to accept unfair dispensing fees. Such unfair dispensing fees may result in pharmacies not stocking the drugs and therefore reducing access. Dispensing fees should be adequate as in fee-for-service Medicaid programs to cover the pharmacy's business operation costs.

In the Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs final rule, CMS noted that many commenters requested that CMS establish safeguards to guarantee that pharmacies participating in Medicare Part D receive a "reasonable rate of reimbursement."[3] CMS noted that these commenters urged the administration to ensure that the negotiated price at a minimum cover the pharmacy's costs of purchasing and dispensing covered items and providing covered services. In addition, some commenters requested that CMS establish a flat dispensing fee or an alternative such as pharmacy reimbursement based on a public drug pricing benchmark such as national average drug acquisition costs (NADAC) plus a fair dispensing fee in line with those in state Medicaid fee-for-service programs. In response, CMS stated that it would consider these suggestions for future rulemaking. **NCPA is very supportive of this approach to Medicare Part D pharmacy payment and appreciates this RFI focusing on commonsense policy solutions such as a cost-plus reimbursement model.**

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[1] 42 CFR 423.100. Dispensing fees means costs that-
(1) Are incurred at the point of sale and pay for costs in excess of the ingredient cost of a covered Part D drug each time a covered Part D drug is dispensed;
(2) Include only pharmacy costs associated with ensuring that possession of the appropriate covered Part D drug is transferred to a Part D enrollee. Pharmacy costs include, but are not limited to, any reasonable costs associated with a pharmacist's time in checking the computer for information about an individual's coverage, performing quality assurance activities consistent with § 423.153(c)(2), measurement or mixing of the covered Part D drug, filling the container, physically providing the completed prescription to the Part D enrollee, delivery, special packaging, and salaries of pharmacists and other pharmacy workers as well as the costs associated with maintaining the pharmacy facility and acquiring and maintaining technology and equipment necessary to operate the pharmacy. Dispensing fees should take into consideration the number of dispensing events in a billing cycle, the incremental costs associated with the type of dispensing methodology, and with respect to Part D drugs dispensed in LTC facilities, the techniques to minimize the dispensing of unused drugs. Dispensing fees may also take into account costs associated with data collection on unused Part D drugs and restocking fees associated with return for credit and reuse in long-term care pharmacies, when return for credit and reuse is permitted under the State in law and is allowed under the contract between the Part D sponsor and the pharmacy.
(3) Do not include administrative costs incurred by the Part D plan in the operation of the Part D benefit, including systems costs for interfacing with pharmacies. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-C/section-423.100.

[2] See 42 CFR 447.502.

[3] See 2022-09375.pdf (govinfo.gov) at 27845.

A study by 3 Axis Advisors found that moving to a NADAC plus professional dispensing fee model in Part D would result in:

- Savings to Medicare beneficiaries of 8.4% ($499.78 million to $457.86 million) on 8,553,375 Part D transactions dispensed in 2021 at over 1,000 community pharmacies;
- Reductions in average beneficiary cost at the pharmacy counter for brand prescriptions by $43.74 (487,507 transactions), and $2.56 (8,065,868 transactions) per generic prescription.[4]

Games & Abuses Due To Vertical Integration

- *Addressing potential Medicare program abuses that occur through vertical integration. Senate Democrats request feedback on whether Congress should require CMS to develop a new standard for how margin is considered for vertically integrated sponsors in the Part D bidding process in order to prevent program abuses and put downward pressure on drug costs.*

NCPA cannot answer the specific question on margin and find that this information is difficult if not impossible to ascertain.

The PBMs do not operate in a competitive environment and do not seek to attract pharmacies into their networks by offering competitive contract terms. Because PBMs control access to beneficiaries, PBMs instead impose non-negotiable terms on pharmacies that include below cost reimbursement, junk fees, unattainable dispute resolution, and unilateral one-sided no notice contract changes. These terms are driving independent pharmacies out of business – and their customers are steered to the PBM-affiliated pharmacies, further consolidating market power into the vertical entity. Importantly, consumers do not receive any benefits from these terms that squeeze independent pharmacies.

A May 2026 OIG report[5] reveals several key takeaways, including that patients covered by vertically integrated health plans pay substantially higher drug out of pocket costs. In comments to the Federal Trade Commission, NCPA has highlighted the unholy trinity of health plans, PBMs and affiliated pharmacies under one ownership, making health care less affordable due to the conflicts of interest inherent in common ownership. Another key takeaway is that vertically integrated health insurance corporations continue to, at best, make it difficult to analyze the full cost impact on purchasers of health care. The OIG highlighted "data limitations pertaining to pharmacy payments" that made the full impacts of vertical integration on pharmacies unknown. What is known is that the vertically integrated health plans/PBMs make it difficult even for the FTC to investigate their impact on consumers and competition.

[4] "Deserving of better: How American seniors are paying for misaligned incentives within Medicare Part D." March 7, 2022. 3 Axis Advisors. Available at: https://www.3axisadvisors.com/projects/2022/3/7/deserving-of-better-how-american-seniors-are-paying-for-misaligned-incentives-within-medicare-part-d-3aa.

[5] Impacts of Vertical Integration in Medicare Part D on Sponsors' Drug Costs, Pharmacy Reimbursement, and Enrollee Cost Sharing. OIG HHS May 2026.

The FTC has indicated that PBM practices remain highly opaque, requiring required multiple rounds of compulsory data requests in their efforts to investigate the impact of PBMs.

The OIG study also noted that just six health plans account for over 80 percent of all of the gross Part D spending in 2023. That level of market concentration is consistent with findings from previous reports by the FTC, the House Oversight Committee, and several news investigations, all of which determined that PBMs increase the cost of drugs and limit patient choice.

We urge Congress to address vertical integration and affiliated-pharmacy steering, including differential reimbursement that pays PBM-owned pharmacies more than independents.

Pharmacy Dispensing Fees in Part D

- *Helping pharmacies become less reliant on drug margin as a form of compensation by ensuring reasonable dispensing fees in Medicare Part D. Senate Democrats therefore request feedback on how best to structure minimum pharmacy dispensing fee requirements in Medicare Part D. For example, Part D could leverage minimum dispensing fees already established by State Medicaid programs based on cost of dispensing surveys. Alternatively, Part D could develop its own minimum dispensing fees based on new or existing cost of dispensing surveys. Senate Democrats also request feedback on whether and how best to distinguish between pharmacy types when setting minimum dispensing fees (e.g., retail, essential retail, specialty, mail order, long-term care).*

NCPA supports that PBMs reimburse pharmacies based on acquisition cost plus a commensurate professional dispensing fee, in line with Medicaid fee-for-service. A January 2020 cost of dispensing study[6] commissioned by NCPA, National Association of Chain Drug Stores (NACDS), and National Association of Specialty Pharmacy (NASP) found that the mean overall cost of dispensing per prescription was $12.40, and that the mean cost of dispensing for drugs covered by Medicaid FFS was $12.45. A comprehensive list of ingredient costs and professional dispensing fees in state Medicaid programs can be found in the footnote below.[7]

In contemplating Part D dispensing fees, NCPA recommends leaning on the best practices from the states. There is no one-size-fits-all solution, as states have different circumstances that inform the calculation of their dispensing fee. For example, Alaska bases its dispensing fee on terrain, divided into on-road, off-road and tribal categories. Tennessee tiers its dispensing fee by both pharmacy type and prescription volume. In general, NCPA supports tiering dispensing fees based on pharmacy location and patient population characteristics versus volume. NCPA is happy to discuss in further detail with the Committee.

[6] Cost of Dispensing Study. Abt Associates January 2020.

[7] See Medicaid Covered Outpatient Prescription Drug Reimbursement Information by State: Quarter Ending March 2026. CMS.

NCPA supports recognition of pharmacies in rural or highly impoverished areas when accounting for commensurate dispensing fees. NCPA points to Oregon and Washington's Medicaid FFS structure in regard to its "critical access" designation generally but would recommend the need to also take into consideration "coverage per capita," which could help ensure more independent pharmacies in metro and urban areas are included to combat the strain caused by chain closures.

NCPA also advises Congress to require CMS to investigate how states should incorporate the impact of professional pharmacy staffing shortages into cost of dispensing surveys. Often low staffing creates a vicious cycle where low staffing generates poor reimbursement.

NCPA advises Congress to require CMS mandate that states regularly update their dispensing fees and provide a mechanism for doing so which reflects updated COD surveys. This should be done at least every 2-3 years. CMS should also be required to consider a CPI dispensing fee adjustment annually given the different cadence of state cost of dispensing survey publications, and that the state cost of dispensing surveys account for the variability in cost of living.

For specialty drugs, NCPA recommends that the cost of dispense be tied to the drug itself, and that reimbursement should be linked to the drug itself and not the type of pharmacy.

Long-term care pharmacy

Average cost to dispense in long-term care pharmacy is a product of many factors, including base cost, LTC fulfillment and total logistics, delivery, LTC orders, consulting, billing and bad debt related to prescriptions. Missouri, Rhode Island, Tennessee, and Maryland have a specific tier for LTC pharmacy, while Washington state captures unit dose systems, which hints at LTC pharmacy. In general, the additional costs to dispense to patients incurred by long-term care pharmacies much be addressed and taken into consideration in any move to cost-plus reimbursement models or minimum dispensing fees.

NCPA also asks that Congress ensure that LTC pharmacy reimbursement applies regardless of care setting. We ask that Congress prohibit PBMs from limiting LTC reimbursement to skilled nursing or intermediate care facilities, consistent with CMS recognition that LTC pharmacy services are furnished across a broader continuum of care, including assisted living communities and beneficiaries' homes.

NCPA would ask Congress to distinguish LTC pharmacy services by pointing to those required by C.F.R. § 483.45. Also, we would recommend recognizing a long-term care pharmacy as one with a national provider identifier associated with taxonomy code 3336L0003X (or a successor code), as maintained by the National Uniform Claim Committee. This definition is included in Preserving Patient Access to Long-Term Care Pharmacies Act (S. 3159 / H.R. 5031).

This approach recognizes that LTC pharmacy reimbursement must reflect the full cost of furnishing federally required pharmacy services.[8]

Additionally, NCPA asks Congress to recognize the full spectrum of LTC pharmacy services. A reasonable dispensing fee in long-term care pharmacy should incorporate 24/7 emergency access, consultant pharmacist support, unit-dose packaging, short-cycle dispensing, medication regimen support, delivery logistics, and regulatory compliance, and should be included regardless of LTC setting.

Lastly, NCPA stresses that NADAC-based reimbursement alone is inappropriate for LTC pharmacy. NADAC surveys are not sent to LTC pharmacies, so LTC costs are not incorporated into the surveys. NCPA again stresses the importance of a reasonable dispensing fee in long-term care pharmacy to represent the above-mentioned distinct set of services.

NCPA thanks the Minority Staff of the Senate Finance Committee for the opportunity to provide feedback, and we stand ready to work with the Committee to offer possible solutions and ideas. Should you have any questions or concerns, please feel free to contact me at anne.cassity@ncpa.org or (703) 838-2682.

Sincerely,

Anne Cassity, JD
Senior Vice President, Government Affairs
National Community Pharmacists Association

[8] Recent long-term care pharmacy cost to dispense studies review the full cost to dispense. In 2024, it was found that the average cost to dispense long-term care pharmacy was $17.65. See *Long-Term Care Pharmacy Cost Analysis https://seniorcarepharmacies.org/wp-content/uploads/CLA_Long-Term_Care_Pharmacy_Cost_Analysis.pdf, 2024.*