Pennsylvania
Insurance Department

1311 Strawberry Square
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Pennsylvania Insurance Department Act 77 of 2024 Impact Study

May 21, 2026

Note

This report is prepared by the Pennsylvania Insurance Department pursuant to its authority under 40 P.S. § 4551(b.1)(1)(ii) and is based on data submitted by the five largest pharmacy benefit managers operating in the Commonwealth for the fully-insured commercial market only.

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Scope

This study is limited to the fully-funded health insurance commercial market in Pennsylvania: individual health benefit plans and large or small group employer plans that are insured where a licensed insurance company bears the risk. Employer-based self-funded plans, which are regulated under federal law (even if administered by a licensed insurance company), government programs for health care coverage (including Medicare, Medicaid, CHIP, and Tricare), and limited benefit policies are outside of the scope of this study.

Executive Summary

Act 77 of 2024, known as the "Pharmacy Benefit Reform Act," directs the Pennsylvania Insurance Department (PID) to conduct an analysis of pharmacy benefit managers' (PBM) business practices, including a review of the impact of steering and spread pricing on pharmacy access, the cost of prescription drugs to consumers, and the potential impact of reimbursement based on the national average drug acquisition cost plus a $10.49 professional dispensing fee.

In this report, PID presents key findings across PBMs, dispensing channels, retail pharmacy types, and insurance markets. Supported by Freedman Healthcare, LLC, PID collected pharmacy data including information on prescription drug utilization, pharmacy reimbursement, dispensing fees, and costs borne by health plans and members in the fully-insured market for calendar years 2022 through 2024. The fully-insured market accounts for approximately 24% of the overall healthcare market. The analysis is based on data from five PBMs (Caremark, Express Scripts, Navitus, OptumRx, and Prime Therapeutics), which together represent 100 percent of the fully-insured individual and small group insurance markets and approximately 84 percent of the total fully-insured large group commercial insurance market in Pennsylvania.

The findings show:

- Limited evidence of steering having a broad effect on prescription drug costs or pharmacy access.
- Spread pricing exists but appears relatively limited in the context of overall drug spending, which is occurring alongside a broader trend of declining spread amounts (i.e., a 64% reduction in overall spend from 2022 to 2024).
- Requiring reimbursement based on the national average drug acquisition cost (NADAC) plus a $10.49 dispensing fee would have the most meaningful impact on retail pharmacies, particularly non-affiliated retail pharmacies and independent[1] pharmacies, increasing their revenue. Adopting NADAC plus a $10.49 dispensing fee for non-affiliated retail pharmacies and independent pharmacies only would likely increase the overall cost of prescription drugs in the Commonwealth's insurance market by approximately $36.8 million, which is less than 0.8 percent of the of the total prescription drug costs. If passed on to the consumer or employer

[1]Independent pharmacies are pharmacies that operate on a standalone basis and are not part of a national or regional chain such as CVS, Target, Walgreens, or Walmart. This definition is distinct from 'affiliated' versus 'non-affiliated'.

health benefit plan, this will have a minimal effect on rates.

- Using 2024 data as the comparator, requiring reimbursement based on the NADAC plus a $10.49 dispensing fee solely for independent retail pharmacies would result in an additional $14.0 million in annual revenue for independent retail pharmacies, which is approximately 0.3 percent of the total prescription drug costs.

Below is a summary of the main findings from the analysis:

Policy Question 1 - What is the impact of steering on prescription drug costs to consumers in the Commonwealth and pharmacy access*?*

- Steering occurs when financial incentives or other structural components drive increased participation among PBM affiliated pharmacies. In Pennsylvania, steering does not appear to be impacting whether consumers choose to patronize pharmacies affiliated with PBMs..
    - Generally across all pharmacy types, from 2022 to 2024, utilization patterns were stable, with non-affiliated providers accounting for roughly 90 percent of all prescriptions distributed and affiliated providers making up the remaining 10 percent.
    - The data suggests that some steering may be occurring with respect to affiliated mail order pharmacies (i.e., there was higher utilization of affiliated mail order pharmacies compared to non-affiliated mail order pharmacies), and it appears to help drive down the overall cost per prescription (e.g., greater rebate amounts per script, see Table 1). The data does not show whether the PBM has passed additional savings along to the health benefit plan.
    - Throughout the period, member cost sharing, or what members pay through deductibles, co-pays and co-insurance, when using affiliated pharmacies was 52 percent higher on average than member expenses when using non-affiliated pharmacies, which includes affiliated mail order pharmacies and affiliated retail pharmacies. It is important to note that, with the exception of CVS when acting as an affiliate pharmacy to Caremark, which represents a very small fraction of the affiliated retail pharmacy data, all other affiliated retail pharmacies are specialty pharmacies (i.e., dispensing specialty drugs). Affiliated mail order and affiliated retail pharmacies tend to dispense higher-cost drugs associated with higher rebates and generally higher member cost sharing.
- Overall, the findings suggest that PBMs and health benefit plans do not appear to be steering members through the use of member financial incentives. However, PBMs may deploy non-financial program designs such as auto-enrollment, marketing or other conveniences that prompt member use of affiliated mail order pharmacies or affiliated retail pharmacies.
- Concentrations in the market based on steering would be a marker of member access being impacted, that is, increased utilization among affiliated pharmacies and decreased utilization among non-affiliated pharmacies. There are no major trends in drug usage year-over-year between affiliated and non-affiliated pharmacies that would indicate reduced access for members.
- While the data collected cannot fully determine whether members experienced reduced choice,

delayed access, or high switching costs, it does provide information on the use of drugs and the associated costs.

Policy Question 2 - What is the impact of spread pricing on the cost of prescription drugs to consumers in the Commonwealth and pharmacy access?

- Spread pricing is the difference between what the health benefit plan pays for a drug and what the pharmacy is paid, with the difference being retained by the PBM. Spread pricing appears in the data, but its impact is relatively limited when compared with total drug spending in the commercial market: less than 1 percent of the sampled drugs for 2024. The estimated total mean spread declined from about $42 million in 2022 to $23 million in 2023 and $15 million in 2024.
- While spread can add plan-side cost and may affect premiums, the overall size is modest relative to multi-billion dollar annual drug spending.
- Spread pricing may impact access through increased member costs or reduced payments to the pharmacy. While there is limited evidence of a relationship between spread pricing and pharmacy reimbursement, the data does show that member costs increase as spread pricing increases. This may reflect the fact that higher-cost drugs are more likely to be prioritized for spread pricing, which would also result in higher member cost sharing.
- The spread varies across PBMs, affiliations, and retail types. Refining PBM data collection in future years and comparing trends over time would be helpful in determining long-term impacts on different pharmacy types and on member access, such as reductions in payment or reduced access.
- Declining spreads likely reflect growing state and federal scrutiny of spread pricing, which is pressuring PBMs to reduce visible per-prescription spreads.

Policy Question 3 - What is the impact to consumers and pharmacies in the Commonwealth of requiring reimbursement to a pharmacy based on NADAC plus a $10.49 professional dispensing fee?

- Reimbursement based on the NADAC plus a $10.49 dispensing fee would likely have the greatest impact on retail pharmacies, particularly non-affiliated retail pharmacies, which appear to be reimbursed below that level under the current system.
- For all three years, non-affiliated retail reimbursement under the current system is less than NADAC pricing plus a $10.49 dispensing fee. The difference between current reimbursement and NADAC pricing plus a $10.49 dispensing fee was about $36.8 million in 2024, meaning that those pharmacies would receive more under this new reimbursement approach.
- The overall effect on total system spending in the commercial market would appear to be modest. Total costs under NADAC plus a $10.49 dispensing fee would remain relatively close to current spending levels overall, less than a 0.5% spending increase, suggesting the main effect would be redistribution of reimbursement rather than a major change in total cost.

Policy Considerations

- **In response to steering:**
  The data does not suggest steering is occurring through direct financial incentives to members. However, plan design features, such as auto-enrolling members into affiliated mail order pharmacy services, may result in increased utilization of these pharmacies because of the effort required to choose another pharmacy. Given Act 77's limits on auto-enrollment, post-implementation evaluation would help assess its effects on member choice and pharmacy access.

- **In response to spread pricing:**
  The analysis suggests PBMs retain a margin between what the health benefit plan pays and what the pharmacy receives. Continued standardized reporting would help clarify over time who bears these costs and better inform future regulation. This could include expanded data collection to provide greater insight into how pharmacies are reimbursed.

- **In response to NADAC pricing plus a $10.49 dispensing fee:**
  A NADAC plus $10.49 dispensing fee approach would likely result in a modest increase in spending because that approach would likely redistribute payments rather than increase total spending significantly. It may improve transparency and support non-affiliated retail and independent pharmacies without materially increasing overall system costs. Application of a dispensing fee requirement for independent pharmacies only would have even less of an impact on overall system costs.

- **Continued Monitoring and Oversight:**
  Continued data collection, reporting, and oversight would help policymakers track reimbursement practices, spread pricing, pharmacy access, and member cost sharing over time. Other states have adopted similar reporting and oversight frameworks, reflecting a broader trend toward PBM reform.

Introduction

The Pharmacy Benefit Reform Act of 2024 (Act 77 of 2024) requires the PID to analyze PBMs' business practices to better understand the impacts of steering and spread pricing on pharmacy access and prescription drugs costs for Pennsylvania commercial health insurance consumers. The act also requires the PID to analyze the impact of requiring payers to reimburse pharmacies using a hypothetical "cost plus" approach equal to the national average drug acquisition cost (NADAC) and a professional dispensing fee of $10.49.

In this report, PID summarizes key findings from these analyses, including how results vary across PBMs, by dispensing channel (e.g., retail or mail order), types of retail pharmacy (e.g., those affiliated with a PBM versus those who are not), and markets (e.g., large group, small group, or individual). It also provides insight into overall prescription drug spending for Pennsylvania payers and consumers including and excluding rebates.[2] PID retained Freedman Healthcare, LLC (FHC) to support this work.

PID used a standardized template to collect data from PBMs on prescription drug utilization and costs, including dispensing fees paid to pharmacies and costs paid by health insurers (health benefit plans) and members. PBMs also provided information on how costs and utilization varied by dispensing channel, affiliation, and retail type. PID collected pharmacy spending information for the fully-insured market for calendar years 2022 through 2024. Five PBMs provided data for this report:

- CaremarkPCS Health LLC (Caremark)
- Express Scripts Inc. (Express Scripts)
- Navitus Health Solutions (Navitus)
- OptumRx Inc. (OptumRx)
- Prime Therapeutics LLC (Prime Therapeutics)

These PBMs represent approximately 87 percent of the total fully-insured Pennsylvania market and provided detailed information on pharmaceutical pricing and payments. The data provided here are based on collected information for the Pennsylvania fully-insured commercial market.

Background and Overview

Nationally, prescription drug costs have increased nearly 73 percent since 2018. They comprised about 8.8 percent of total U.S. health spending in 2024, the most recent year available.[3] Over the last several decades, PBMs have emerged as key intermediaries. PBMs were meant, at least in part, to help manage pharmaceutical costs by negotiating drug prices and organizing drug benefits on behalf of health benefit plans. The same relationships that give PBMs leverage to perform these functions also give them the

[2] Pharmacy rebates are payments that drug manufacturers provide to PBMs.. They are commonly used as part of negotiated agreements related to formulary placement and overall prescription drug pricing.
[3] Peterson-KFF Health System Tracker. (n.d.). National spending on services and prescriptions. https://www.healthsystemtracker.org/indicator/spending/national-spending-services/

ability to impact what drugs are covered, pharmacy relationships and reimbursement, and how health benefit plans are paid across the system.

PBM Operations and Considerations of Steering and Spread Pricing

PBMs operate between health benefit plans, drug manufacturers, pharmacies, and patients. They contract with health benefit plans, employers, and other health benefit plan sponsors to administer pharmacy benefits. They build and maintain pharmacy networks, develop formularies, process drug authorizations and pharmacy claims, and negotiate reimbursement and rebates with pharmacies and manufacturers. A formulary is a health benefit plan's list of prescription drugs that it covers. Drugs on the formulary are often grouped into tiers, which affect how much a patient pays as their cost-share. PBMs also influence prescription drug benefit design, access and payment.

Funds flow across these entities in several ways. Typically, the health benefit plan pays the PBM to administer the pharmacy benefit. This can be through administrative fees, per-prescription charges, or other pricing terms. Manufacturers may pay rebates or other incentives tied to formulary placement, preferred status, or achieving utilization targets. Pharmacies are reimbursed by or through the PBM for dispensing the drug. Commonly, this is through an ingredient payment plus some form of dispensing payment. Patients pay cost sharing through copayments, coinsurance, or deductibles. Those amounts can vary depending on the drug, the pharmacy, the dispensing channel, and the patient's health benefit plan design. For these reasons, PBMs do not simply process transactions, they help determine how the pharmacy benefits are designed, how money flows through the system, and how incentives are structured.

The three largest PBMs are affiliated with a major insurer and each has an affiliated mail order, specialty, or retail pharmacy businesses. OptumRx is part of UnitedHealth Group, Express Scripts is part of Evernorth, which also owns Cigna, and Caremark is part of Aetna, which also operates CVS retail pharmacies. This integrated structure can create efficiencies, but it also may create incentives to use financial levers to direct prescription volume toward affiliated entities. In practice, steering tends to work through strategies such as lower copays, preferred network placement, or other benefits that make one channel financially more attractive to the consumer than another. These strategies can shape where members fill prescriptions and can shift utilization in ways that benefit the PBM. Volume can be directed toward affiliated pharmacies and distribution channels, reimbursement can be managed in ways that affect dispensing margins, and the difference between what the plan pays and what the pharmacy receives may create additional retained value for the PBM.

Act 77 focuses on two aspects of these complex relationships – spread pricing and pharmacy dispensing fees. Spread pricing occurs when the PBM charges the health benefit plan more for a prescription drug than it pays the manufacturer and the dispensing pharmacy and keeps the difference as revenue. Spread pricing may raise costs to plans, and those costs are typically passed on to consumers, including employers offering insurance coverage to their employees. It is also a concern that pharmacies not affiliated with the PBM have less negotiating power related to the fees they receive from the PBM for filling and dispensing the drugs. These dispensing fees are separate from the ingredient cost of the drug.

This is an important consideration as margins also can be built into the ingredient reimbursement, making it harder to tell whether pharmacies are fairly reimbursed and whether plans are paying more than necessary.

State Responses to Existing Dynamics

Some states are showing interest in reimbursement models based on the National Average Drug Acquisition Cost (NADAC) or similar approaches tied to the wholesale price of drugs plus a professional dispensing fee.[4] The basic idea is to reimburse pharmacies for the ingredient cost of the drug using a standardized and transparent benchmark and then add a separate dispensing fee to pay the pharmacy for the service of dispensing those drugs.[5,6]

Alabama recently passed Senate Bill 252, which ties commercial reimbursement for independent pharmacies to the state Medicaid reimbursement methodology, using a state-based average acquisition cost benchmark plus a $10.64 professional dispensing fee. The same law also prohibits mandatory mail order, addresses steering, requires spread-pricing reporting, and allows a pharmacist to decline to dispense a drug when reimbursement falls below cost. In Iowa, Senate File 383, passed in 2025, requires reimbursement in the commercial market at no less than NADAC plus a $10.68 professional dispensing fee, while also requiring pass-through pricing approaches. Also in 2025, Montana passed House Bill 740, which requires independent pharmacies in the commercial market to be reimbursed at NADAC plus a $15 dispensing fee, with annual inflation adjustments beginning each January. West Virginia, through Senate Bill 453, required PBMs serving state employees to reimburse in-state pharmacies at no less than the NADAC plus a dispensing fee at least equal to the West Virginia Medicaid outpatient dispensing fee.[7]

In addition to these efforts, many states have begun requiring regular reporting of PBM specific pharmaceutical data. West Virginia's law also imposed expanded transparency requirements around reimbursement, networks, rebates, and fees. As another example, the Delaware Office of Value-Based Health Care Delivery requires PBMs to submit annual pharmacy spend information, including drug utilization, costs, and rebate data.[8] These data are used to evaluate policy issues related to pharmacy spend and impacts on Delaware residents.

These examples show that states are progressively exploring similar policy actions to address increasing costs and provide transparent approaches to oversight and regulation. Following the state trend of moving toward NADAC or drug cost benchmarks paired with a dispensing fee, states are trying to make pharmacy payment more transparent, reduce reliance on hidden spending practices, and create clearer

[4] National Community Pharmacists Association. (2026, January). 2025 state wins for community pharmacy. https://ncpa.org/sites/default/files/2026-01/2025-state-wins-for-comm-pharmacy.pdf
[5] Centers for Medicare & Medicaid Services. (2024, December). Methodology for calculating the National Average Drug Acquisition Cost (NADAC) for Medicaid covered outpatient drugs. U.S. Department of Health and Human Services.
[6] Centers for Medicare & Medicaid Services. Retail price survey. U.S. Department of Health and Human Services.
[7] West Virginia Legislature. (2024). Senate Bill 453 (Regular Session, 2024). https://www.wvlegislature.gov/Bill_Text_HTML/2024_SESSIONS/RS/bills/sb453%20sub2.pdf
[8] Delaware Department of Insurance. (n.d.). Office of Value Based Health Care Delivery (OVBHCD). https://insurance.delaware.gov/divisions/consumerhp/ovbhcd/

pricing and payment systems.

Overall Market Trends

This section provides a brief overview of recent trends in prescription drug costs, utilization, market composition. This background is important because it provides the context for the later analysis of steering, spread pricing, and the potential impact on consumers and pharmacies of a reimbursement model based on NADAC plus a $10.49 dispensing fee. The data provided reflect the Pennsylvania fully-insured commercial market.

Key Findings:

- Rising prices are driving higher costs. Total prescription spending and costs per script increased from 2022 to 2024 (see Figure 1). Accounting for rebates, costs increased by 14 percent on a per prescription basis and 20 percent on a PMPM basis (see Figure 2).[9] Utilization increased only 6 percent from 2022 to 2024.
- PBM market share is concentrated but shifting. In 2024, Express Scripts accounted for the largest share of membership at 56 percent and OptumRx accounted for 24 percent. Express Scripts saw a 27 percent decrease in membership in the large group market from 2022 to 2023 (see Figure 3). This shift in market composition may have reduced overall costs during the period.
- On a per-member per-month basis, Express Scripts had the highest member cost share, and the largest rebates (see Figure 4). Navitus does not negotiate rebates in Pennsylvania and was the most expensive overall. However, they had the lowest member cost share. Caremark had the lowest costs overall, and the second lowest member cost share. These trends remain consistent on a per-prescription basis (see Figure 5).
- Although CVS is a major retail pharmacy chain and represents a substantial share of retail pharmacies, Caremark accounts for only a small share of the overall reported data. As a result, CVS is represented in this dataset as non-affiliated retail. Caremark represents approximately 1 to 2 percent of the market in any given year. In 2024, Caremark accounted for 1.4 percent of the overall market. In that same year, Caremark's affiliated retail business accounted for less than 0.5 percent of all prescriptions and 0.3 percent of overall drug spend. This explains why affiliated retail is such a small portion of the overall data. As a result, CVS is mostly represented in this data set through relationships with the other reporting PBMs, as a non-affiliated, chain, retail pharmacy.

The Impacts of Steering

> ***Policy Question 1 - Steering***
> What is the impact of steering on prescription drug costs and pharmacy access to consumers in the Commonwealth?

This section examines whether the data suggests PBMs are directing members to affiliated pharmacies – those owned by a PBM – through lower member cost share and other direct financial, such as lowering the

[9] PMPM stands for Per Member Per Month and represents the average monthly cost of prescription drugs for a single member in a health plan. It is calculated by dividing the total pharmacy costs (drug spend plus administrative fees) by the total number of members in a given period.

cost of drugs through rebates. If steering were occurring through direct financial incentives, one would expect lower member cost share for affiliated channels along with higher utilization or increasing utilization in those channels over time. This section also analyzes where prescriptions are being filled, how utilization is distributed across retail and mail order pharmacies, and whether affiliated retail and mail order pharmacies appear to be associated with different cost patterns than non-affiliated pharmacies.

Key Findings:

- Steering does not appear to be occurring through financial incentives. Member cost share is higher at affiliated pharmacies and utilization among affiliated pharmacies does not appear to be increasing over time. If steering were occurring, member cost share would presumably be lower at affiliated pharmacies and in turn, utilization would be increasing.
- Mail order utilization is steady, ranging from 9 to 12 percent of all prescriptions in any given year. PBMs may be steering members towards mail order – which is typically more likely to be affiliated with the PBM than a retail pharmacy. The data show higher utilization of affiliated mail order pharmacies than non-affiliated mail order pharmacies, accounting for 10 percent of all prescriptions compared with 0.5 percent.
- The affiliated mail order and affiliated retail channels, especially for Express Scripts and OptumRx, consist of higher cost claims and higher rebates.
- Caremark represented 1 percent of the market overall in 2024, with their affiliated retail business providing less than 0.5 percent of all scripts and representing 0.3 percent of overall drug spend in the commercial market.

From 2022 to 2024, prescriptions filled by pharmacies affiliated with PBMs had higher member cost share per prescription than those filled by non-affiliated pharmacies. Further, the overall distribution remained at about 90 percent of drugs filled at non-affiliated pharmacies and 10 percent of drugs filled at affiliated pharmacies across the period (see Figure 6).

Nearly all mail order pharmacies are affiliated with a PBM. Non-affiliated mail order pharmacies represented only 0.4 to 0.5 percent of an average 44 million scripts between 2022 and 2024. For retail pharmacies, the opposite is true. Affiliated retail pharmacies account for only 0.6 percent to 1.0 percent of prescriptions.

Of the 0.6 percent of scripts filled at an affiliated retail pharmacy in 2024, Caremark accounted for almost all of them, 0.5 percent. CVS/Caremark is the only PBM-affiliated retail pharmacy operating in Pennsylvania. All other PBM affiliations involve mail order or specialty pharmacies only. For reporting purposes, CVS is generally treated as non-affiliated because CVS is only classified as affiliated for Caremark and Caremark accounts for 1 percent of the total market. Caremark data does not suggest meaningful steering through financial incentives to the member. Through their affiliated retail channel, Caremark's member cost share per-prescription remained low year-over-year ($9.32 in 2022, $13.27 in 2023, and $10.05 in 2024), and its utilization decreased from 2022 to 2024. For these reasons, the most meaningful comparisons remain affiliated mail order and non-affiliated retail, which account for most utilization in their respective channels.

Express Scripts accounted for most affiliated mail order scripts at about 9 percent of scripts overall. OptumRx accounted for about 1 percent of affiliated mail order prescription volume. For Express Scripts, non-affiliated retail volume exceeded affiliated mail order volume by about 6 to 1.

Looking specifically at affiliated mail order compared with non-affiliated retail, higher affiliated utilization tends to coincide with higher drug cost per prescription and higher rebates per prescription, but not with lower member cost share (see Figures 7 and 8). In contrast, non-affiliated utilization, which is largely non-affiliated retail, tends to coincide with lower drug cost per prescription, lower rebates, and lower member cost share.

It may also be the case that affiliated mail order pharmacy usage may be out of convenience, or to facilitate access to drugs that are not readily available through retail pharmacies.

The Impacts of Spread Pricing

> ***Policy Question 2 –***
> What is the impact of spread pricing on prescription drug costs and pharmacy access to consumers in the Commonwealth?

This section focuses on the second policy question, examining spread pricing, how it appears in the market, how it varies across the market, and how costs and access are affected. The "spread" is defined as the difference between what the health benefit plan pays to the PBM and what the PBM pays to the pharmacy, with the difference being retained by the PBM. A positive spread reflects additional cost to the health benefit plan. This is important, as it can increase premiums and costs over time.

For the spread pricing analysis, PID collected information on a market basket of prescription drugs intended to be broadly representative of the overall Pennsylvania commercial health insurance market from a pricing perspective. In total, the market basket included 185 drugs. The market basket excluded most generic drugs and focused instead on higher cost drugs, including drugs used to treat conditions such as cardiovascular disease, diabetes, autoimmune conditions, and other common conditions. The selection of drugs included in the market basket represent those drugs most commonly associated with higher spread. The market basket was reviewed by clinical and policy experts to confirm the prescription drugs included were appropriate for this analysis. For each prescription drug included in the market basket, PID gathered information on spread at the 25th percentile, 50th percentile, 75th percentile, and the mean, allowing for the analyses to assess the average spread and the distribution of spread across the market.[10] The market basket includes only brand name drugs because they are the category with the largest spread and where spread has the greatest financial impact.

[10] These data were collected for each drug included in the market basket, for all combinations of affiliated and non-affiliated, retail and mail, and chain and independent pharmacies. These ranges were collected for plan paid amounts, pharmacy reimbursement, and dispensing fees. This allowed for multiple comparisons across different dimensions and allowed for analysis of variability in payment to these different pharmacy types.

Key Findings:

- **Spread pricing may be increasing prescription drug costs**. The total spread exceeded $15 million in 2024: this effectively resulted in health benefit plans paying more per prescription than pharmacies received and the PBMs retaining the difference as the spread. This in turn may result in health benefit plan spending - and potentially premiums - higher than they would have been in the absence of spread pricing.
- **Impacts are uneven across PBMs.** Some PBMs appear to generate large positive retained margins, while others appear to be operating with negative spread on large parts of their business. Positive spread pricing could impact such things as premiums, employer contributions, taxpayer funding, or benefit design changes.
- **Independent pharmacies are associated with negative average spread.** Chain pharmacies remain modestly positive, meaning that PBMs retain more from chain pharmacies than from independent ones. This could be the result of several different dynamics, including but not limited to: chain pharmacies may provide a more spread favorable mix of drugs; the data may not include reconciliations or fees; chain pharmacies may accept lower reimbursement in exchange for preferred network volume; or PBMs may tolerate negative spread from independent pharmacies to maintain access and satisfy network adequacy requirements.

Spread pricing appears across the observation period, even though the median and mean spread per prescription declined over time (see Table 2). The total mean spread by PBM also declined over time. In total, the estimated spread decreased from $42 million in 2022 to $23 million in 2023 to $15 million in 2024. The observed decline in median and mean spread pricing per prescription could reflect changes in how PBMs structure their revenue, with less margin taken through per-script spread and more generated through other mechanisms such as fees, specialty pharmacy margins, or rebate arrangements. Increased scrutiny and oversight of spread pricing in recent years may have led PBMs to reduce the visible spread per prescription and distribute margin through other channels, including pharmacy direct and indirect remuneration (DIR) fees, clawbacks, rebate retention, higher plan fees, or specialty-pharmacy markups. Evolving contract designs may also contribute to narrowing spread amounts over time.[11,12,13,14]

Each year, the 50th percentile spread is well above the mean spread, $12.70 versus $7.72 in 2022, $11.78 versus $6.13 in 2023, and $7.91 versus $3.43 in 2024. This indicates that a significant portion of scripts have positive spread, but some scripts have a large negative spread that pulls the mean down.

OptumRx has consistently large positive spread, with mean spread per prescription of about $119.89 in 2022, $110.67 in 2023, and $139.23 in 2024 (see Table 2). In contrast, Express Scripts is consistently

[11] Federal Trade Commission. (2024, July). *Pharmacy benefit managers: The powerful middlemen inflating drug costs and squeezing Main Street pharmacies* (Interim Staff Report). https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf
[12] Mattingly, T. J. II, Ben-Umeh, K. C., Bai, G., & Anderson, G. F. (2023). Pharmacy benefit manager pricing and spread pricing for high-utilization generic drugs. *JAMA Health Forum, 4*(10), e233588. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2810783
[13] U.S. Government Accountability Office. (2024, March). *Prescription drugs: Selected states' regulation of pharmacy benefit managers* (GAO-24-106898). https://www.gao.gov/assets/gao-24-106898.pdf
[14] Mulligan, K., & Lakdawalla, D. (2026, January). *Hidden profits? How accounting conventions and vertical consolidation can obscure PBM profit* (White Paper Series). Leonard D. Schaeffer Center for Health Policy & Economics, University of Southern California. https://schaeffer.usc.edu/wp-content/uploads/2026/01/2026-01-pbm-profitability.pdf (DOI: 10.25549/W413-NF29)

negative, with mean spread per prescription of about -$18.75, -$17.67, and -$12.17 across those same years, and given OptumRx account for a large share of the overall prescription volume, this impact is significant. Some PBMs appear to generate large positive retained margins, while others appear to be operating with negative spread across large parts of their business.

This negative spread could suggest several different issues. One possibility is that the market basket is not fully representative of each PBM's broader book of business.[15] Another is that there may be differences in how PBMs interpreted the data request and reported these data, which could affect how spread pricing appears in the results. It is also possible that the data collected do not capture all of the payments or adjustments necessary to fully explain negative spread. In addition, some of the differences may reflect real differences in PBM operating models. For example, Navitus describes itself as a pass-through PBM that returns rebates, discounts, and fees to clients rather than relying on spread-based revenues, which could affect how pricing and reimbursement are represented in the data. As noted above in this report, while Navitus' overall costs are higher than the costs for some other PBMs, its member costs are lower than other PBMs operating in this market.

Affiliated pharmacies show higher average spread per prescription than non-affiliated pharmacies in every year (see Table 3). In 2022, mean spread per prescription was about $15.87 for affiliated pharmacies versus $7.47 for non-affiliated pharmacies. In 2023, it is $9.69 versus $5.92. In 2024, it is $6.68 versus $3.19. It is worth noting that affiliated volume is much smaller than non-affiliated volume, especially in 2022 and 2023, so most of the total spread dollars are still generated in the non-affiliated pharmacies

Chain pharmacies show a mean spread per prescription of about -$0.10 in 2022, $2.29 in 2023, and $1.18 in 2024. Independent pharmacies show $1.56 in 2022, -$3.55 in 2023 and -$4.44 in 2024. This means in more recent years, independent pharmacies are associated with negative average spread while chain pharmacies remain modestly positive. A negative PBM spread does not automatically imply generous reimbursement; it only means that on the measured definition, the PBM is not retaining a positive margin on average from these transactions.

The core takeaway is that spread pricing appears to add real costs to drug benefits, even if those costs are not always visible to members. Since the average spread remained positive and the total spread exceeded $15 million in 2024, the practice effectively resulted in health benefit plans paying more per prescription than pharmacies received, with PBMs retaining the spread. Among other things, those dollars could increase premiums, employer contributions, taxpayer funding, or benefit designs.

From a consumer perspective, with greater spread pricing, there could be higher premiums that are borne by the member or the employer. For pharmacies, the main concerns are the differences across independent versus chain pharmacies, and the differences across affiliated pharmacies versus non-affiliated pharmacies. How pharmacies are treated depends on channel, retail type, and, potentially, affiliation.

[15] The commercial health insurance market represents approximately 24% of the overall health insurance market in Pennsylvania.

The Impact of adopting NADAC Pricing and a Professional Dispensing Fee of $10.49

Policy Question 3 –
What is the impact of requiring reimbursement based on NADAC plus a professional dispensing fee of $10.49?

The third policy question relates to the impact on consumers and pharmacies of requiring PBMs to reimburse a pharmacy using the NADAC plus a professional dispensing fee of $10.49. This analysis provides insight into the impact of this reimbursement approach on members, pharmacies and the Commonwealth.

As background, the NADAC is a national drug pricing benchmark developed for Medicaid drug reimbursement. It shows the average invoice price that chain and independent retail pharmacies pay to manufacturers for a targeted list of drugs, based on a national survey by Centers for Medicare and Medicaid Services (CMS) of invoice purchase prices reported by pharmacies. The NADAC is updated weekly by CMS. CMS also posts monthly files that include the prior month's findings. The NADAC excludes drugs that are dispensed in long-term care settings and certain specialty drugs distributed through other channels.[16]

For this analysis, the NADAC was calculated on a price per unit basis. NADAC data was collected for each full reporting year and used to develop an overall average price per unit. The unit price was then applied to the reported utilization data for each matched drug to estimate total NADAC drug costs for all drugs across each reporting year. The analysis compares these estimated NADAC costs, and NADAC plus the proposed $10.49 dispensing fee, to the actual reported drug costs.[17]

Key Findings:

- **The overall cost impact in the commercial health insurance market of applying NADAC pricing plus a $10.49 dispensing fee is limited.** It would have added about 1 percent over current costs in 2022, reduced current costs by about 1 percent in 2023, and added about 0.5 percent in 2024.
- **This approach would redistribute money across the system.** Non-affiliated retail pharmacies, and in particular independent pharmacies, would be the biggest beneficiaries under this pricing approach. Affiliated retail and mail order pharmacies would receive less in this approach.
- **Average dispensing fees are small today.** PBMs indicated that there may be other payments or reimbursement arrangements that are not captured in this data collection.
- **Chain and independent retail pharmacies would benefit from a $10.49 dispensing fee.** Under this approach, chain retail pharmacies would have received an additional estimated $14.7 million in 2024, while independent retail pharmacies would have received an estimated $14 million.

[16] Centers for Medicare & Medicaid Services. (2024, December). Methodology for calculating the National Average Drug Acquisition Cost (NADAC) for Medicaid covered outpatient drugs. U.S. Department of Health and Human Services.
[17] The NADAC does not include all available drugs in the pricing lists. Rather, this analysis addresses all drugs where NADAC price drugs were matched to PBM reported data: 81 percent of all drugs were matched in 2022, 84 percent in 2023, and 88 percent in 2024. Matched drugs from the PBM to the NADAC list accounted for 77 percent to 81% of overall spend.

Assuming there are no other changes, this increase in costs would go to directly go to the benefit of the pharmacies. This would result in a 0.6 percent increase to the overall cost of prescription drugs in the Commonwealth's insurance market.

- **If a $10.49 dispensing fee were required for independent retail pharmacies only,** this would likely increase the overall cost of prescription drugs in the Commonwealth's insurance market by approximately $14 million, which is approximately 0.3 percent of the total prescription drug costs.

Assessing NADAC pricing alone, total PBM reported drug cost exceeded total NADAC costs by about $340.5 million in 2022, $267.7 million in 2023, and $301.3 million in 2024 (see Table 4). However, once the $10.49 dispensing fee is added, the comparison tightens to about $5.0 million above current cost in 2022, about $4.8 million below current cost in 2023, and about $23.0 million above current cost in 2024. The total system drug cost for NADAC-matched drugs in Pennsylvania for 2024 was approximately $4.7 billion. This means that the current system lands slightly below NADAC pricing plus a dispensing fee at an increase of $23 million, or a 0.5 percent increase.

From the NADAC pricing comparison, absent a $10.49 dispensing fee, the overall PBM cost per unit is modestly above NADAC per unit at about $0.42 in 2022, $0.41 in 2023, and $0.63 in 2024 (see Table 5). Except for Prime Therapeutics, PBMs generally show positive differences, meaning current PBM costs per unit are above NADAC. Prime Therapeutics is negative in every year shown, meaning its costs are already below NADAC. These differences become more meaningful due to the volume of drugs, particularly once a hypothetical $10.49 dispensing fee is added.

Across all three years, non-affiliated retail shows the largest negative value relative to NADAC plus a $10.49 dispensing fee, at about $14.2 million in 2022, $4.7 million in 2023, and $36.8 million in 2024 in the Pennsylvania commercial health insurance market (see Figure 9). Because this compares current drug costs to NADAC plus a $10.49 dispensing fee, a negative value reflects current reimbursement lower than reimbursement under NADAC plus a $10.49 dispensing fee. Therefore, non-affiliated retail pharmacies would be the biggest beneficiaries under this pricing approach. In 2024, they would have received about $36.8 million more under NADAC plus a dispensing fee, which is different from the affiliated channels. Affiliated retail and mail channels are currently paid more, and shifting to NADAC plus a dispensing fee would result in them receiving about $13.1 million less in 2024. It is worth noting that is for both affiliated and non-affiliated depending on the PBM reporting, i.e., CVS is affiliated retail when Caremark is the reporting PBM, and non-affiliated for all other PBMs. Since Caremark represents such a small portion of the overall data, retail affiliated is also small, 0.6 percent of all prescriptions in 2024.

Current prices at chain pharmacies are higher than and consistently much closer to NADAC than prices at independent pharmacies (see Table 6). For the overall market, reimbursement appears lower for independent pharmacies, who likely have less bargaining power. The mean chain pharmacy reimbursement per-prescription is $1.84 vs. NADAC's $1.98 in 2022, $1.89 vs. $1.98 in 2023, and $1.82 vs. $1.85 in 2024. Independent pharmacies are much further below NADAC pricing in 2022 and 2023, $1.30 vs. NADAC's $1.40 in 2022, $1.13 vs. $1.20 in 2023, and then equal in 2024 at $1.14 vs. $1.14.

Based on the number of prescriptions in the market basket for chain and independent pharmacies, we can estimate the overall cost impact, or new spending on these pharmacies, by applying NADAC pricing plus a $10.49 professional dispensing fee to all drugs (see Table 7). Using a ratio of the number of prescriptions distributed in 2024, chain pharmacies would have received an additional $12.1 million overall, while independent pharmacies would have received an additional $9.9 million overall. Looking just at retail pharmacies, this would be an additional $14.7 million for chain retail pharmacies and $14.0 million for independent retail pharmacies in new spending in 2024.

Tracing these data points across the various breakdowns, the 2024 impact would have been $23 million in additional spending, calculated as $32.5 million in net new retail spend offset by $8.6 million in mail order savings. The $32.5 million retail impact is driven by $36.8 million in added costs from non-affiliated retail pharmacies, partially offset by $4.3 million in savings from affiliated retail pharmacies. Of the $36.8 million in non-affiliated retail costs, $14.7 million is attributed to chain pharmacies and $14.0 million to independent pharmacies, while the remaining $8.1 million reflects spend that cannot be assigned to either category because the data is listed as “unknown” or “N/A.”

Across the period, the current average dispensing fee remained around one dollar or less per prescription (see Table 8). PBMs indicated that the dispensing fee amounts appeared broadly consistent with their own data and seemed accurate. PBMs also indicated that there may be other payments or reimbursement arrangements that are not captured in these fields. In addition to a dispensing fee, pharmacies may be reimbursed for drug ingredient costs, their contracts may also include preferred network terms, performance adjustments, or items such as audit recoveries, and payments for specialty pharmacy services. The final amount paid to a pharmacy may differ from the pharmacy’s final drug reimbursement after these contractual adjustments applied. From discussions with the PBMs, the dispensing fees shown here should not be treated as a complete picture of overall pharmacy reimbursement, which also includes other incentives, payment adjustments, or reimbursement structures not visible in this data.

A requirement to reimburse pharmacies using NADAC plus a $10.49 professional dispensing fee would likely have a modest effect on pharmacy reimbursement, reducing payments for affiliated retail and mail order pharmacies and increasing them for retail non-affiliated pharmacies.

Overall Conclusions and Policy Considerations

Steering Policy Considerations

The data does not suggest steering is occurring through financial incentives to the member. However, steering may be occurring through other structural components or plan designs. For example, PBMs may employ program design elements such as member auto-enrollment into affiliated mail. Considering Act 77 limits immediate auto-enrollment into mail order pharmacies or pharmacies owned or controlled by the PBM, post-implementation evaluation of the effects would be advisable.

Spread Pricing Policy Considerations

The spread pricing analysis suggests that PBMs tend to retain a margin between what the health benefit plan pays and what the pharmacy receives. Given the scale of the spread, these costs may not be visible to members or employers. However, these costs are still present in the system and are either absorbed by the pharmacy through lower payments, by the health benefit plan through higher costs, or by members through increased premiums, deductibles, co-insurance or co-pays. Formalizing reporting through a standardized approach would help to clarify who is bearing the cost and inform if and how PBMs should be regulated.

NADAC Pricing Plus a Dispensing Fee

The NADAC plus $10.49 dispensing fee approach would likely redistribute payments rather than change total spending overall. Costs under this approach remain relatively close to current spending when considering the scale of overall pharmacy spend. Non-affiliated retail pharmacies and independent pharmacies appear to benefit the most under a NADAC plus dispensing fee approach, while affiliated channels that are currently reimbursed at higher levels under the current system would likely receive less. This suggests this type of policy could improve transparency and support pharmacy access without materially increasing total costs to the system; however, without addressing other contract provisions, entities negatively impacted by the use of a drug cost benchmark and higher state-set dispensing fee may attempt to recoup those costs through other reimbursement mechanisms or contractual adjustments. These potential dynamics would need to be considered and possibly addressed in any future legislation.

Continued Monitoring and Oversight

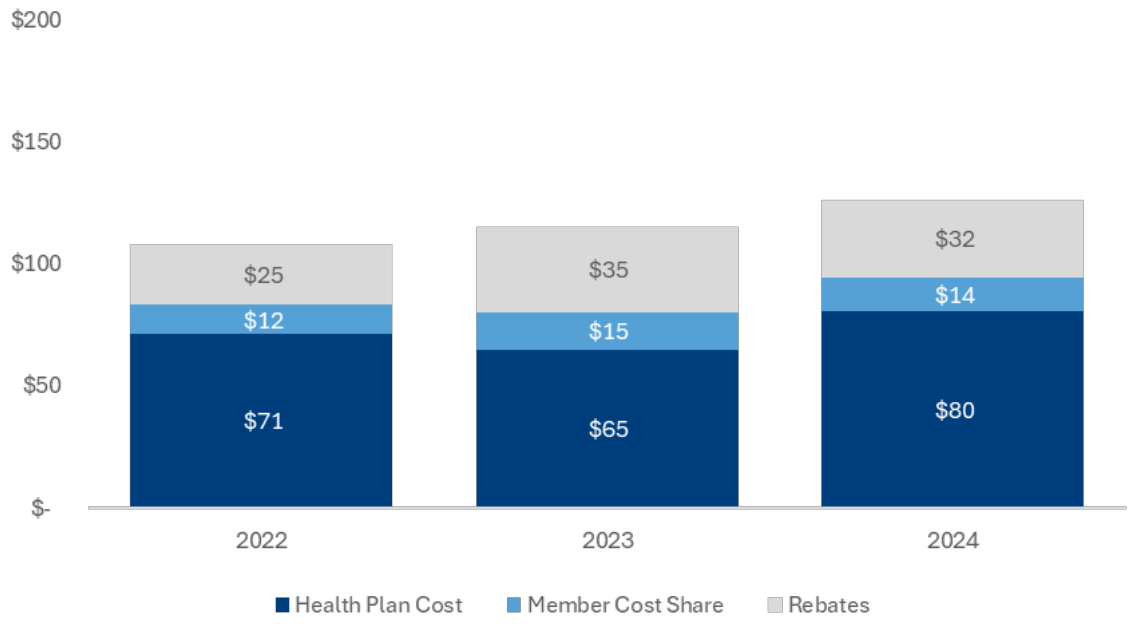
From a policy perspective, these findings support continued oversight and greater transparency around spread pricing and pharmacy reimbursement, particularly if policy makers consider a more standardized reimbursement approach tied to NADAC pricing plus a professional dispensing fee or similar approaches. Continued data collection and regular reporting would help policy makers monitor how reimbursement practices, spread pricing, pharmacy access, and member cost sharing change over time, and would help inform additional reforms. Other states have taken similar approaches by requiring ongoing PBM reporting and oversight, reflecting a broader national trend toward PBM reform around spread pricing and reimbursement practices. Such an approach would move payment closer to a more transparent benchmark and may better align reimbursement with the goal of maintaining access to pharmacy services across the Commonwealth.

Appendix

Figures and Graphs

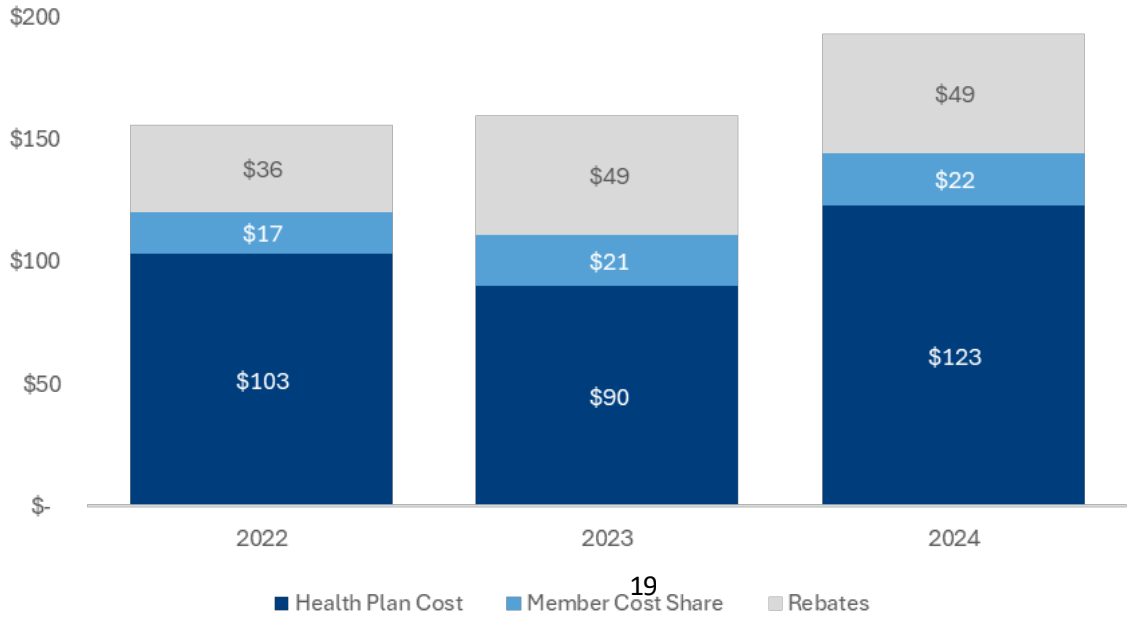
The data provided here are based on collected information for the Pennsylvania fully-insured commercial market and show Pennsylvania data only.

Figure 1. Overall Market Trends – Cost per Prescription



**Note: Health Plan Costs are adjusted for Rebates, e.g., rebates are passed on to the health plan, to show rebates here rebates are subtracted from health plan costs.*

Figure 2. Overall Market Trends - PMPM



**Note: Health Plan Costs are adjusted for Rebates, e.g., rebates are passed on to the health plan, to show rebates here rebates are subtracted from health plan costs.*

Figure 3. Total Scripts per 1,000 Member Months

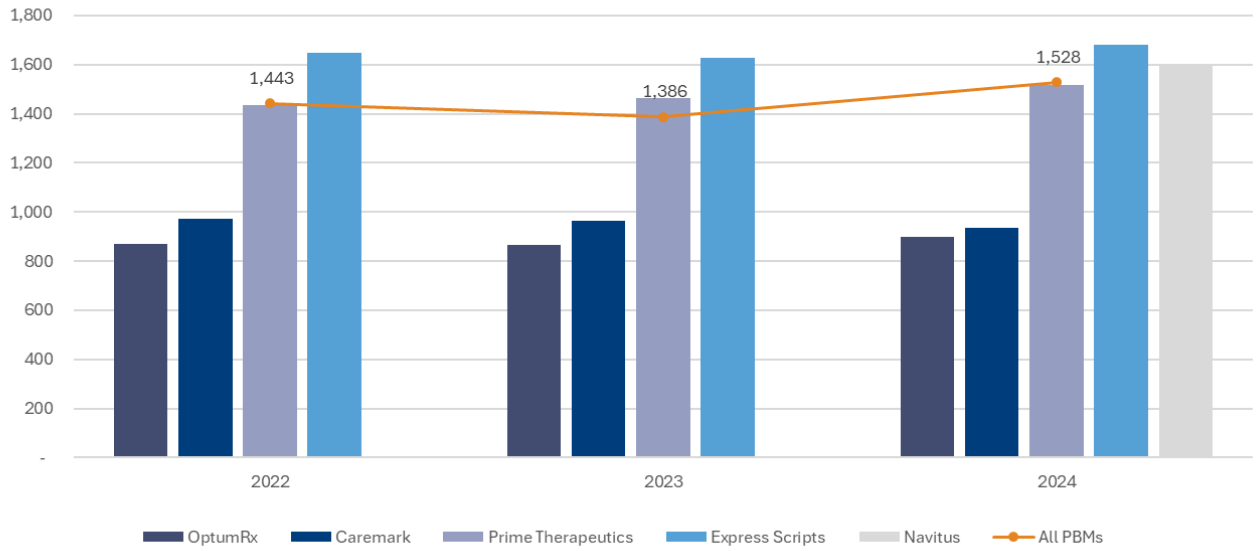
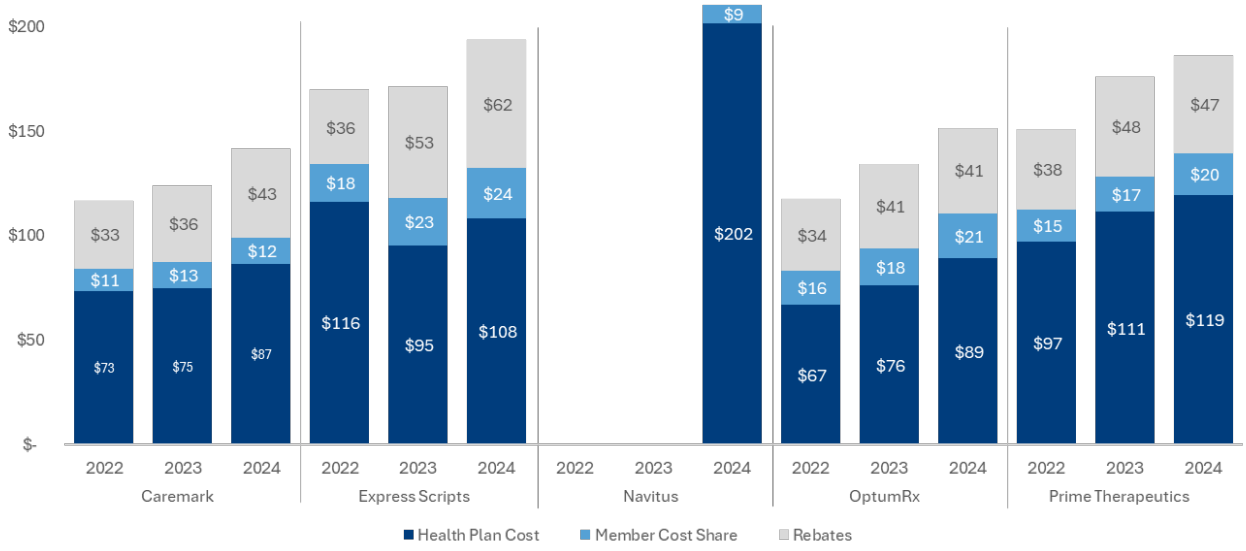
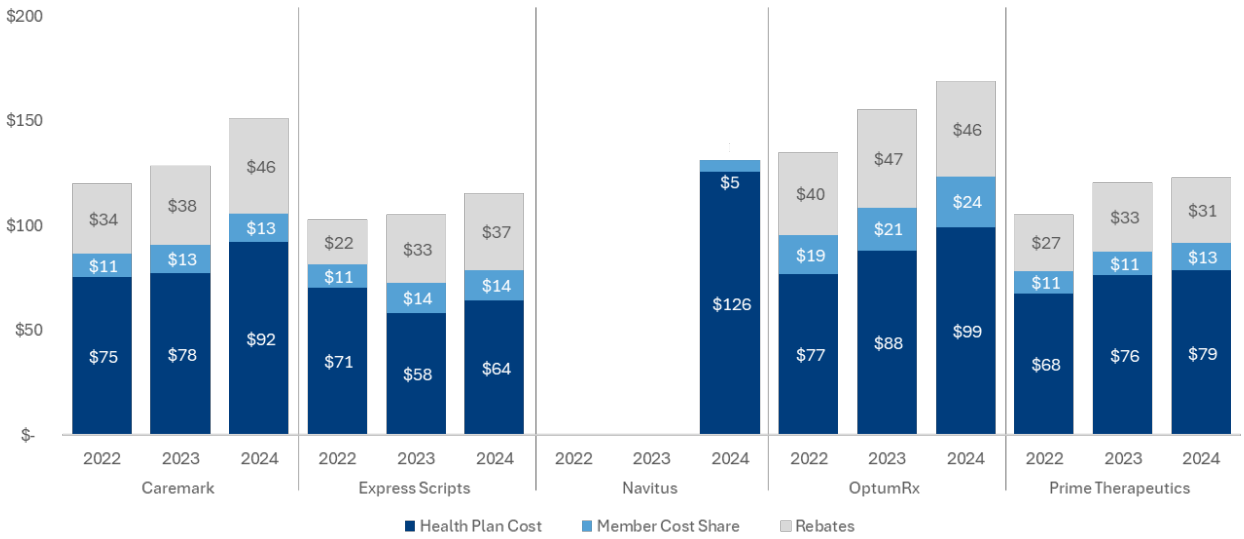


Figure 2. Total Cost PMPM by PBM



**Note: Health Plan Costs are adjusted for Rebates, e.g., rebates are passed on to the health plan, to show rebates here rebates are subtracted from health plan costs.*

Figure 5. Total Cost per Prescription by PBM



**Note: Health Plan Costs are adjusted for Rebates, e.g., rebates are passed on to the health plan, to show rebates here rebates are subtracted from health plan costs.*

Figure 6. PBM Steering Based on Affiliation and Member Cost Share

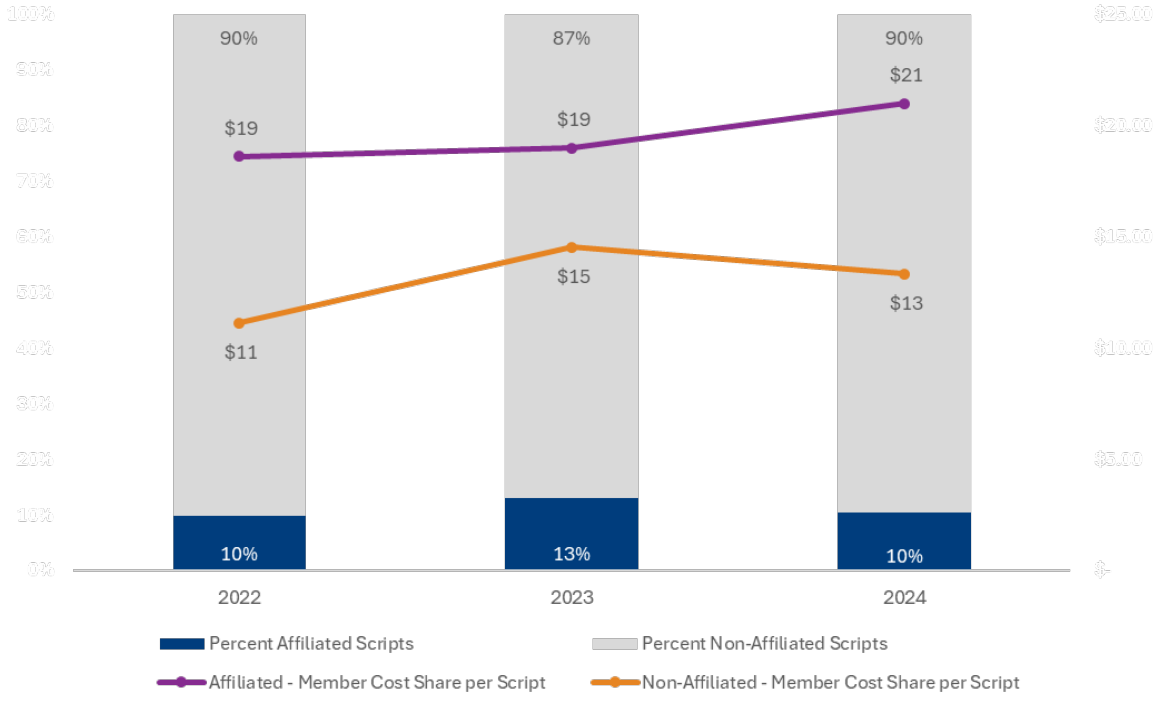


Figure 7. Pharmacy Specific Steering Based on Affiliation and Total Cost

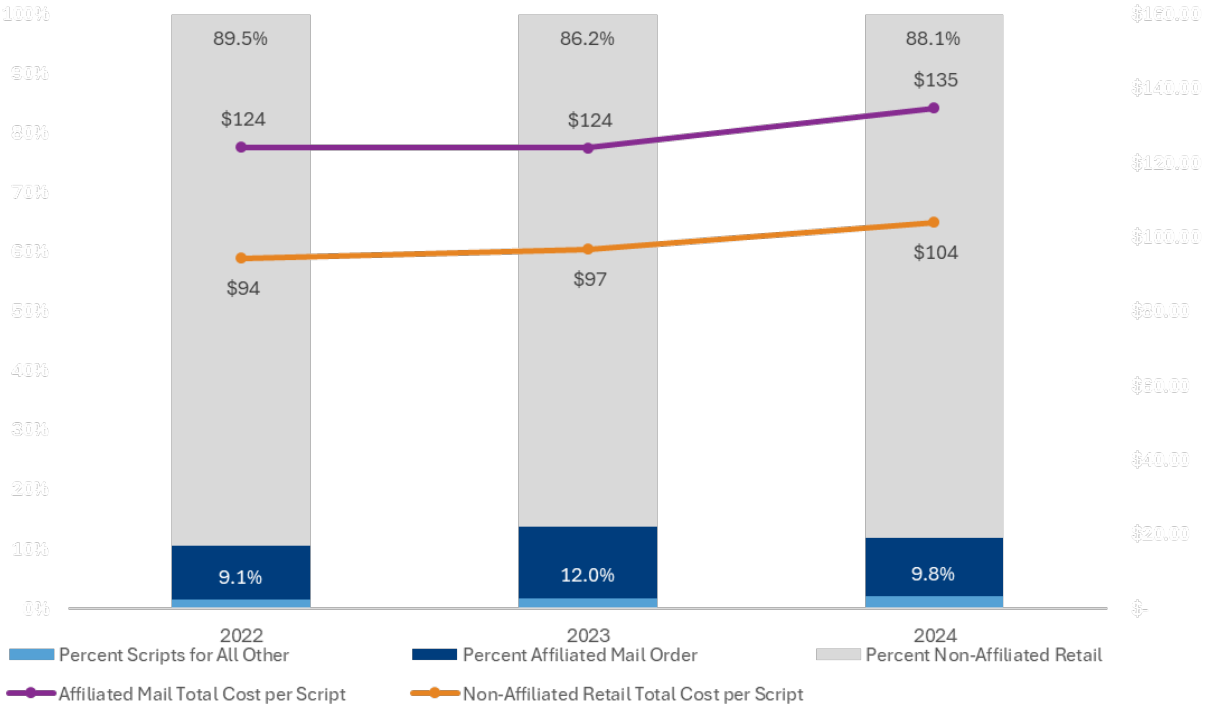


Figure 8. Pharmacy Specific Steering Based on Affiliation and Rebates

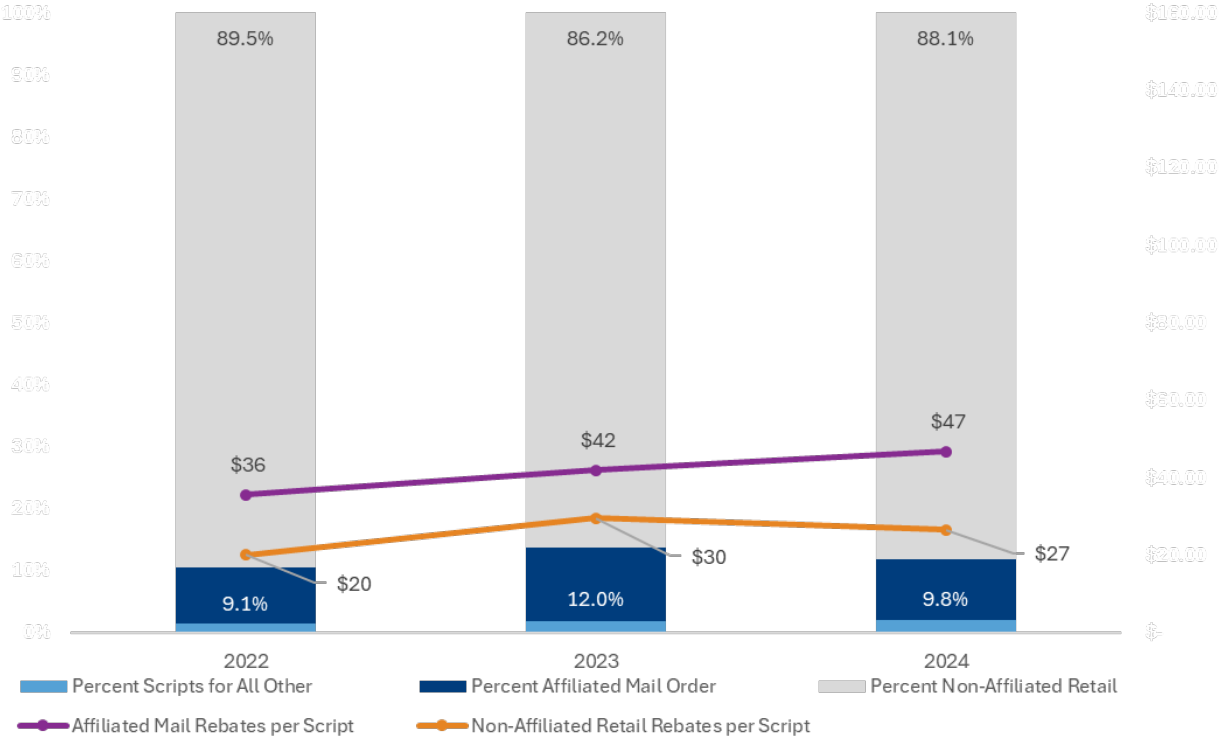


Figure 9. NADAC Pricing and Dispensing Fees by Pharmacy Type

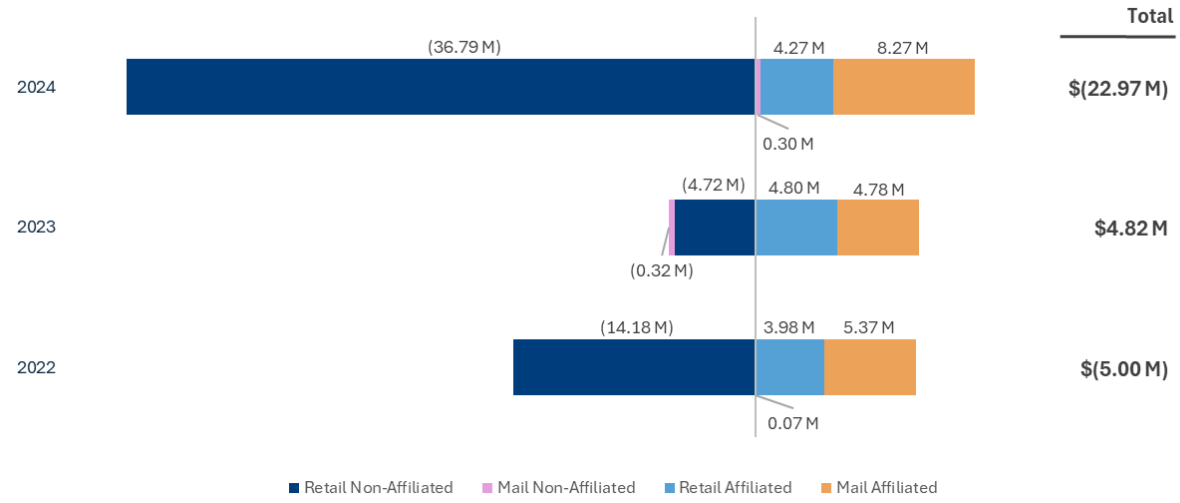


Table 1. Pharmacy Type and Affiliation Per-Prescription Costs

Year, Distribution Channel & Affiliation	Member Cost Share per Prescription	Total Cost per Prescription	Rebates per Prescription	Percent Total Scripts
2022	**$ 11.86**	**$ 107.92**	**$ 24.63**	**100%**
Mail	$ 12.85	$ 125.27	$ 35.49	9.5%
Affiliated	$ 12.94	$ 124.26	$ 35.62	9.1%
Non-Affiliated	$ 10.54	$ 149.45	$ 32.37	0.4%
Retail	$ 11.54	$ 101.16	$ 22.36	90.2%
Affiliated	$ 83.60	$ 915.97	$ 288.87	0.7%
Non-Affiliated	$ 10.94	$ 94.37	$ 20.14	89.5%
2023	**$ 15.12**	**$ 115.39**	**$ 35.34**	**100%**
Mail	$ 13.77	$ 125.10	$ 41.66	12.4%
Affiliated	$ 13.86	$ 124.00	$ 41.92	12.0%
Non-Affiliated	$ 11.29	$ 156.30	$ 34.18	0.4%
Retail	$ 14.94	$ 106.92	$ 32.86	87.2%
Affiliated	$ 79.03	$ 1,032.57	$ 334.77	1.0%
Non-Affiliated	$ 14.24	$ 96.68	$ 29.52	86.2%
2024	**$ 14.13**	**$ 126.43**	**$ 31.85**	**100%**
Mail	$ 14.39	$ 136.52	$ 45.55	10.3%
Affiliated	$ 14.52	$ 134.79	$ 46.74	9.8%
Non-Affiliated	$ 12.06	$ 169.70	$ 22.80	0.5%
Retail	$ 13.46	$ 112.76	$ 29.16	88.7%
Affiliated	$ 120.25	$ 1,418.54	$ 424.27	0.6%
Non-Affiliated	$ 12.75	$ 103.98	$ 26.51	88.1%

Note: Unknown or other distribution channel is excluded from this table as it accounted for less than 1 percent of overall scripts for all years.

Table 2. Spread Per-Prescription and Estimated Totals

Year & PBM	Spread Per Prescription at the 25th Percentile	Spread Per Prescription at the 50th Percentile	Spread Per Prescription at the 75th Percentile	Mean Spread Per Prescription	Total Mean Spread (Estimated)
2022	**$ 2.57**	**$ 12.70**	**$ 16.37**	**$ 7.72**	**$ 42,518,622**
Caremark	$ 196.76	$ 194.60	$ 197.14	$ 199.82	$ 13,212,610
Express Scripts	$ (25.39)	$ (14.86)	$ (9.39)	$ (18.75)	$ (76,473,646)
OptumRx	$ 122.18	$ 121.73	$ 119.08	$ 119.89	$ 138,150,424
Prime Therapeutics	$ (7.78)	$ 48.81	$ 44.90	$ 2.32	$ 496,521
2023	**$ 4.86**	**$ 11.78**	**$ 9.50**	**$ 6.13**	**$ 23,342,234**
Caremark	$ 228.60	$ 221.38	$ 220.96	$ 226.72	$ 10,255,670
Express Scripts	$ (19.63)	$ (11.95)	$ (15.14)	$ (17.67)	$ (46,760,783)
OptumRx	$ 110.62	$ 110.62	$ 110.74	$ 110.67	$ 106,104,062
Prime Therapeutics	$ 17.13	$ 50.27	$ 60.26	$ 5.19	$ 808,602
2024	**$ 2.45**	**$ 7.91**	**$ 6.49**	**$ 3.43**	**$ 15,438,147**
Caremark	$ 207.37	$ 203.17	$ 204.59	$ 207.31	$ 5,402,219
Express Scripts	$ (14.03)	$ (8.77)	$ (11.63)	$ (12.17)	$ (32,594,908)
Navitus	$ (18.87)	$ (16.20)	$ (2.04)	$ (26.56)	$ (19,199,786)
OptumRx	$ 39.22	$ 139.22	$ 139.22	$ 139.23	$ 128,830,770
Prime Therapeutics	$ 9.59	$ 74.66	$ 77.99	$ 5.33	$ 757,805

Table 3. Spread Pricing per Prescription by Affiliation and by Retail Type

Year, Affiliation & Retail Type & PBM	Spread Per Prescription at the 25th Percentile	Spread Per Prescription at the 50th Percentile	Spread Per Prescription at the 75th Percentile	Mean Spread Per Prescription
2022	**$ 2.57**	**$ 12.70**	**$ 16.37**	**$ 7.72**
Affiliated	**$ 15.57**	**$ 16.09**	**$ 15.92**	**$ 15.87**
Chain Pharmacy	$ 3.20	$ 3.60	$ 2.95	$ 3.10
Non-Affiliated	**$ 2.18**	**$ 12.59**	**$ 16.38**	**$ 7.47**
Chain Pharmacy	$ (1.00)	$ 6.10	$ 7.29	$ (0.30)
Independent Pharmacy	$ (8.91)	$ 5.67	$ 12.71	$ 1.56
2023	**$ 4.86**	**$ 11.78**	**$ 9.50**	**$ 6.13**
Affiliated	**$ 6.29**	**$ 6.63**	**$ 18.53**	**$ 9.69**
Chain Pharmacy	$ 0.86	$ 1.17	$ 13.28	$ 4.21
Non-Affiliated	**$ 4.78**	**$ 12.09**	**$ 8.96**	**$ 5.92**
Chain Pharmacy	$ 3.91	$ 8.39	$ 2.75	$ 2.06
Independent Pharmacy	$ (7.94)	$ 3.17	$ 2.03	$ (3.55)
2024	**$ 2.45**	**$ 7.91**	**$ 6.49**	**$ 3.43**
Affiliated	**$ 4.83**	**$ 3.82**	**$ 10.12**	**$ 6.68**
Chain Pharmacy	$ 3.15	$ 2.10	$ 8.41	$ 4.98
Non-Affiliated	**$ 2.27**	**$ 8.22**	**$ 6.22**	**$ 3.19**
Chain Pharmacy	$ 2.29	$ 6.69	$ 3.82	$ 0.60
Independent Pharmacy	$ (7.93)	$(0.37)	$(1.72)	$ (4.44)

Note: Affiliated chain pharmacies and unknown retail types are excluded from this data table.

Table 4. Cost Estimates of Implementing NADAC and $10.49 Dispensing Fee

	A	B	C	A - B	A - C
Year & PBM	**Total Drug Cost**	**Total NADAC Cost**	**Total NADAC Cost + $10.49 Dispensing Fee**	**Total Drug Cost less NADAC Cost**	**Total Drug Cost less NADAC Cost + $10.49 Dispensing Fee**
2022	**$ 4,061.4 M**	**$ 3,720.9 M**	**$ 4,066.4 M**	**$ 340.5 M**	**$ (5.0 M)**
Caremark	$ 56.1 M	$ 50.8 M	$ 53.7 M	$ 5.3 M	$ 2.4 M
Express Scripts	$ 3,186.2 M	$ 2,903.6 M	$ 3,172.6 M	$ 282.6 M	$ 13.5 M
OptumRx	$ 647.9 M	$ 592.9 M	$ 653.3 M	$ 55.0 M	$ (5.4 M)
Prime Therapeutics	$ 171.2 M	$ 173.7 M	$ 186.8 M	$ (2.4 M)	$ (15.6 M)
2023	**$ 3,416.1 M**	**$ 3,148.4 M**	**$ 3,411.3 M**	**$ 267.7 M**	**$ 4.8 M**
Caremark	$ 61.6 M	$ 55.8 M	$ 58.8 M	$ 5.8 M	$ 2.8 M
Express Scripts	$ 2,450.4 M	$ 2,255.0 M	$ 2,443.8 M	$ 195.4 M	$ 6.6 M
OptumRx	$ 740.5 M	$ 672.5 M	$ 732.4 M	$ 68.1 M	$ 8.2 M
Prime Therapeutics	$ 163.6 M	$ 165.1 M	$ 176.3 M	$ (1.5 M)	$ (12.7 M)
2024	**$ 4,735.1 M**	**$ 4,433.8 M**	**$ 4,758.1 M**	**$ 301.3 M**	**$ (23.0 M)**
Caremark	$ 46.7 M	$ 43.3 M	$ 45.3 M	$ 3.5 M	$ 1.5 M
Express Scripts	$ 2,883.3 M	$ 2,692.2 M	$ 2,890.2 M	$ 191.0 M	$ (6.9 M)
Navitus	$ 766.1 M	$ 727.0 M	$ 779.1 M	$ 39.2 M	$ (13.0 M)
OptumRx	$ 867.0 M	$ 798.5 M	$ 859.4 M	$ 68.5 M	$ 7.6 M
Prime Therapeutics	$ 172.0 M	$ 172.9 M	$ 184.2 M	$ (0.9 M)	$ (12.2 M)

Note: Total Drug Cost is for the market basket only.

Table 5. NADAC and Drug Cost Price Per Unit (PPU) Comparison

	A	B	A-B
Year & PBM	**NADAC PPU**	**Total Drug Cost per Unit**	**Total Drug Cost per Unit Less NADAC PPU**
2022	**$ 27.75**	$ **28.17**	$ **0.42**
Caremark	$ 33.37	$ 33.81	$ 0.44
Express Scripts	$ 21.06	$ 22.06	$ 1.01
OptumRx	$ 28.92	$ 29.65	$ 0.73
Prime Therapeutics	$ 29.31	$ 28.75	$ (0.56)
2023	$ **34.19**	$ **34.60**	$ **0.41**
Caremark	$ 40.03	$ 40.44	$ 0.41
Express Scripts	$ 28.17	$ 29.02	$ 0.85
OptumRx	$ 33.68	$ 34.51	$ 0.83
Prime Therapeutics	$ 37.63	$ 36.99	$ (0.64)
2024	$ **49.03**	$ **49.66**	$ **0.63**
Caremark	$ 58.93	$ 59.72	$ 0.80
Express Scripts	$ 43.04	$ 44.16	$ 1.12
Navitus	$ 46.41	$ 47.13	$ 0.71
OptumRx	$ 50.82	$ 51.91	$ 1.10
Prime Therapeutics	$ 50.72	$ 49.97	$ (0.75)

Table 6. Chain vs Independent Pharmacy Reimbursement Comparison

Year & Retail Type	Average Pharmacy Reimbursement per Prescription - 25th Percentile	Average Pharmacy Reimbursement per Prescription - 50th Percentile	Average Pharmacy Reimbursement per Prescription - 75th Percentile	Average Pharmacy Reimbursement per Prescription - Mean	Total NADAC Price per Prescription
2022	**$ 1.70**	**$ 1.84**	**$ 1.98**	**$ 1.86**	**$ 2.27**
Chain Pharmacy	$ 1.65	$ 1.81	$ 1.98	$ 1.84	$ 1.98
Independent Pharmacy	$ 1.21	$ 1.29	$ 1.38	$ 1.30	$ 1.40
2023	**$ 1.58**	**$ 1.73**	**$ 1.89**	**$ 1.76**	**$ 2.13**
Chain Pharmacy	$ 1.67	$ 1.85	$ 2.05	$ 1.89	$ 1.98
Independent Pharmacy	$ 1.03	$ 1.11	$ 1.20	$ 1.13	$ 1.20
2024	**$ 1.49**	**$ 1.61**	**$ 1.76**	**$ 1.65**	**$ 1.84**
Chain Pharmacy	$ 1.63	$ 1.76	$ 1.94	$ 1.82	$ 1.85
Independent Pharmacy	$ 1.02	$ 1.11	$ 1.23	$ 1.14	$ 1.14

Table 7. Estimated Impact of NADAC plus a Dispensing Fee on Chain and Independent Pharmacies

Year & Distribution Channel	New Pharmacy Spend Under NADAC Cost + $10.49 Dispensing	Percent Prescriptions Chain Pharmacy	Percent Prescriptions Independent Pharmacy	Estimated Additional Spend Chain Pharmacy	Estimated Additional Spend Independent Pharmacy
2022	**5.0 M**	**48%**	**46%**	**2.4 M**	**2.3 M**
Mail	(5.4 M)	3%	0%	(0.1 M)	(0.0 M)
Retail	10.2 M	45%	45%	4.6 M	4.6 M
2023	**(4.8 M)**	**50%**	**43%**	**(2.4 M)**	**(2.1 M)**
Mail	(4.5 M)	6%	0%	(0.3 M)	(0.0 M)
Retail	(0.1 M)	44%	43%	(0.0 M)	(0.0 M)
2024	**23.0 M**	**53%**	**43%**	**12.1 M**	**9.9 M**
Mail	(8.6 M)	7%	0%	(0.6 M)	(0.0 M)
Retail	32.5 M	45%	43%	14.7 M	14.0 M

Note: This table excludes unknown or not identified pharmacies and distribution channels.

Table 8. Current Average Dispensing Fees

Year & PBM	Dispensing Fee 25th Percentile Average per Script	Dispensing Fee 50th Percentile Average per Script	Dispensing Fee 75th Percentile Average per Script	Dispensing Fee Mean per Script
2022	**$ 0.47**	**$ 0.74**	**$ 1.01**	**$ 0.74**
Caremark	$ 0.02	$ 0.03	$ 0.06	$ 0.04
Express Scripts	$ 0.49	$ 0.82	$ 1.15	$ 0.82
OptumRx	$ 0.48	$ 0.54	$ 0.59	$ 0.54
Prime Therapeutics	$ 0.03	$ 0.06	$ 0.10	$ 0.07
2023	**$ 0.54**	**$ 0.73**	**$ 1.78**	**$ 1.05**
Caremark	$ 0.05	$ 0.07	$ 0.11	$ 0.08
Express Scripts	$ 0.36	$ 0.59	$ 1.90	$ 1.00
OptumRx	$ 1.45	$ 1.46	$ 1.46	$ 1.45
Prime Therapeutics	$ 0.02	$ 0.05	$ 0.09	$ 0.07
2024	**$ 0.78**	**$ 0.92**	**$ 1.11**	**$ 0.93**
Caremark	$ 0.04	$ 0.05	$ 0.08	$ 0.06
Express Scripts	$ 0.83	$ 0.98	$ 1.20	$ 1.00
Navitus	$ 0.17	$ 0.34	$ 0.47	$ 0.34
OptumRx	$ 0.87	$ 0.89	$ 0.90	$ 0.86
Prime Therapeutics	$ 0.02	$ 0.04	$ 0.08	$ 0.06

Glossary

Affiliated Pharmacy is a pharmacy that directly or indirectly shares ownership, management, or control with a pharmacy benefits manager (PBM), insurer, or another pharmacy entity. These pharmacies are often part of a PBM's pharmacy network.

Brand Drugs are prescription or over-the-counter medications sold by a pharmaceutical manufacturer under a specific proprietary name or trademark. They are typically protected by patents or other exclusivity periods for a limited time, during which the manufacturer has exclusive rights to market the drug.

Chain Pharmacy is a pharmacy that is part of a national or regional retail chain operating multiple pharmacy locations under common ownership or branding (such as CVS, Target, Walgreens, or Walmart).

Cost Per Prescription (or script) is a pharmacy metric representing the total allowable cost of a dispensed medication, typically calculated as the sum of the drug's ingredient cost plus the pharmacy's professional dispensing fee. It may be used to measure average, annualized spending per prescription, defined as the total allowed dollars divided by the number of scripts over a given period.

Dispensing Fee, typically a fixed charge, is a fee applied to each prescription to cover the professional services, operational costs, and overhead associated with preparing and dispensing medication. It covers pharmacist expertise, packaging, and safety checks, separate from the drug's ingredient cost.

Distribution Channel refers to the method by which a member accesses their prescription drug, through either mail order or retail (brick-and-mortar) pharmacies.

Drug Acquisition Cost refers to the actual net price a pharmacy pays to obtain a medication from a manufacturer or wholesaler, including discounts, rebates, and price concessions but excluding dispensing fees. It serves as a key benchmark for reimbursement.

Generic Drug is a medication that contains the same active ingredient as a brand-name drug and is designed to be equivalent in dosage form, strength, route of administration, quality, safety, and effectiveness. A generic drug generally becomes available after applicable patent or exclusivity protections for the brand-name drug expire and usually cost less than the brand-name drug.

Independent Pharmacy is a pharmacy that operates on a standalone basis and is not part of a national or regional chain. This term is distinct from 'affiliated' versus 'non-affiliated'.

Member Cost Share is the share of a prescription drug or other healthcare cost paid by patients. This term generally includes deductibles, coinsurance, and copayments, or similar charges; it does not include premiums or the cost of non-covered drugs.

Member Months represent the total number of individuals enrolled in an insurance plan multiplied by the number of months they are covered. This metric measures the equivalent of one covered life for one month,

serving as the denominator to calculate , e.g., PMPM. They can also serve as a baseline for comparison across populations.

Per Member Per Month (PMPM) is a key metric representing the average monthly cost of prescription drugs for a single member in a health benefit plan. It is calculated by dividing the total pharmacy costs (drug spend plus administrative fees) by the total number of members in a given period.

Pharmacy Benefit Managers (PBMs) are entities that function, inter alia, as intermediaries between insurers or health benefit plans and pharmaceutical manufacturers. PBMs may create formularies, negotiate rebates with manufacturers, process claims, create pharmacy networks, review drug utilization, and manage mail order specialty pharmacies.

Rebates are a form of price concession paid by a pharmaceutical manufacturer to a health benefit plan sponsor or pharmacy benefit manager working on an insurer's or health benefit plan's behalf.

Scripts per 1,000 Member Months is a standard pharmacy utilization metric measuring the average number of prescription fills per 1,000 members over a specific period, normalized by member months.

Specialty Drug is defined under PA Act 77 of 2024 as either of the following:

(1) "A prescription drug prescribed to a covered individual with a cost that meets or exceeds the cost of a drug on the specialty tier of Medicare Part D under 42 CFR 423.104(d)(2)(iv) (relating to requirements related to qualified prescription drug coverage) and meets three or more of the following criteria:
(i) The drug requires specialized product handling or administration by the dispensing pharmacy.
(ii) The drug requires specialized clinical care, including, but not limited to, frequent dosing adjustments to the prescription drug, clinical monitoring or expanded patient service, intensive patient counseling and ongoing clinical support, such as individualized disease or therapy management to support patient outcomes for a covered individual.
(iii) The drug is prescribed for a covered individual with a rare medical condition, complex or chronic medical condition or life-threatening medical condition.
(iv) The prescription drug has a limited or exclusive distribution and is not typically stocked or dispensed by a retail pharmacy.

(2) A prescription drug that is prescribed to a covered individual and that is listed as a specialty drug on the medical assistance fee-for-service specialty pharmacy drug list."[18]

Spread Pricing is a model of prescription drug pricing in which the PBM charges a health benefit plan or health insurer (in the context of this report, an insurer or health benefit plan) a contracted price for prescription drugs and the contracted price for the prescription drugs differs from the amount the PBM directly or indirectly pays the pharmacist or pharmacy for prescription drugs and related pharmacist services.

[18] Act 77, Section 103 ("Definitions"), defining "specialty drug", https://www.palegis.us/statutes/unconsolidated/law-information/view-statute?SESSYR=2024&SESSIND=0&ACTNUM=0077.&CHPT=000.&SCTN=002.&SUBSCTN=000; 40 P.S. § 4503.

Steering is a practice where PBMs or insurers create plan design to direct patients toward using their owned or affiliated pharmacies.

Data Collection and Analytic Methodology

Data Collection

PID and FHC released a data call in November 2025. The data collected included requests for utilization and cost information for 2022, 2023, and 2024. There were two main spreadsheets used for the data collection.

The first spreadsheet collected information on market segment, dispensing channel (affiliation vs non-affiliation, retail vs mail order), utilization, drug costs, and rebate information. The second spreadsheet was used to support the analysis of dispensing fees and spread pricing through a market basket approach. The market basket approach collected information across dispensing channels and retail type (independent vs chain), including dispensing fee information, reimbursement amounts made to the pharmacy, charges to the carrier or plan sponsor at the 25th, 50th and 75th percentiles, as well as the mean for all drugs in the market basket. This means for each drug included in the market basket, for every combination of pharmacy, distribution channel and their affiliation to a PBM, data was collected across a range to determine high and low payments and skewness of the data. The market basket included 185 drugs. A larger list of drugs were reviewed and scoped down based on costs and utilization in other markets, policy needs for this analysis and subject matter expert guidance to identify the most ideal candidates for this report and analysis. These data make it possible to compare the distribution of spread pricing across those different measures and to assess how spread varied across the market.

All submitted data were reviewed for completeness and reasonableness on both a per prescription and PMPM basis. The data was also compared across years to identify any specific issues in the underlying submissions and to address questions related to dispensing fees and spread pricing. After this review, the data was aggregated into combined files used for this analysis and for comparison across all NDCs.

Analysis Methodology

The steering analysis used prescription volume along with per prescription costs to members, total drug cost per prescription, and rebates per prescription to identify patterns and relationships across affiliated and non-affiliated pharmacies and across dispensing channels. This approach was used to assess whether differences in utilization appeared to coincide with differences in member cost share that suggest steering toward particular channels.

For the spread pricing analysis, market basket data was used to calculate the difference between what was charged to the health benefit plan and what was reimbursed to the pharmacy. This analysis also used utilization information, including the number of prescriptions, and member cost share information to calculate totals and per-prescription spending. Given that the member cost share was included in the reimbursement field but not in the charge to the carrier or plan sponsor, the member cost share was deducted from the reimbursement made to the pharmacy by Caremark, Navitus, OptumRx, and Prime Therapeutics. Express Scripts indicated the member cost share was not included their data with respect to reimbursement made to the pharmacy.

For the analysis comparing the submitted data to the NADAC, monthly NADAC pricing files were pulled for each year. These files provide the National Drug Code (NDC) and the corresponding NADAC price per unit. Those data were mapped by NDC to the submitted data and the number of units reported in the data collection was used to calculate a total NADAC cost for each year by multiplying the NADAC price per unit by the number of units dispensed.

In order to calculate an overall NADAC price plus a $10.49 dispensing fee, a dispensing fee was added based on the number of prescriptions. This made it possible to compare both the total NADAC cost and the total NADAC cost plus a dispensing fee to the submitted amounts in the data. The total NADAC cost was converted to a per prescription basis by dividing the total NADAC cost by the number of prescriptions, which allowed for comparison of NADAC costs per prescription.