

Department of Health and Human Services
Office of Inspector General



Office of Evaluation and Inspections

DATA SNAPSHOT

May 2026 | OEI-BL-24-00240

**Impacts of Vertical Integration in
Medicare Part D on Sponsors' Drug
Costs, Pharmacy Reimbursement,
and Enrollee Cost Sharing**



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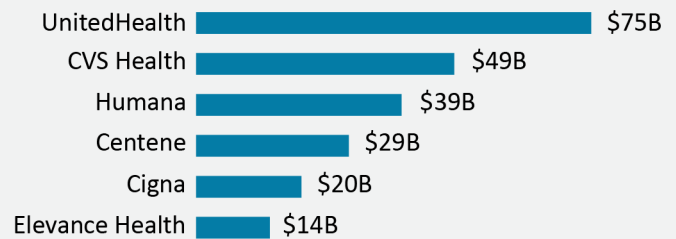
DATA SNAPSHOT

Impacts of Vertical Integration in Medicare Part D on Sponsors' Drug Costs, Pharmacy Reimbursement, and Enrollee Cost Sharing

Why OIG Did This Review

- Stakeholders have raised concerns about the potential effects of vertical integration, including higher drug costs and anticompetitive behavior that negatively affects independent pharmacies. The Part D market is heavily concentrated among a small number of vertically integrated organizations and their associated sponsors (i.e., VI sponsors). In 2023, 6 of 11 vertically integrated organizations we identified accounted for about 82 percent of the \$275.9 billion in Part D spending that year.
- In order to understand the impact of vertical integration on Medicare and enrollee costs, OIG initiated this evaluation and [audit](#) work.
- For the purpose of this study, vertical integration refers to the consolidation of Part D sponsors with pharmacy benefit managers (PBMs). Pharmacies can also be affiliated with sponsors or PBMs. For example, a single entity may own a Part D sponsor, a PBM, and pharmacies.

These 6 VI sponsors accounted for 82% of gross Part D spending in 2023.



Source: OIG analysis of 2023 Part D sponsor data and Prescription Drug Event data.

What OIG Found

- Overall, the **net cost of drugs was similar for vertically integrated Part D sponsors and other Part D sponsors for select drugs.** However, **the approaches used by Part D sponsors to reach the net costs of drugs differed.** For most drugs, vertically integrated sponsors paid pharmacies more upfront, but then took back more money later through rebates and fees. In contrast, other sponsors paid less upfront and got less back later for most drugs.
- Vertically integrated sponsors paid their own pharmacies a little less than they paid other pharmacies. Because of data constraints, we **couldn't account for later payment adjustments to pharmacies** that usually reduce what they ultimately receive.
- In general, **enrollees** in plans offered by vertically integrated Part D sponsors **paid lower monthly premiums but substantially higher drug out-of-pocket costs.**

Due to (1) data limitations pertaining to Part D sponsors' adjustments to pharmacy payments, and (2) recent dynamic shifts in the Part D market, the full impacts of vertical integration—particularly on pharmacies—remain unknown.

Recent changes to the Part D market and PBM requirements could increase transparency of payment models and facilitate more comprehensive assessments of vertical integration.

Primer

Part D Prescription Drug Plans. Private insurance companies, called Part D sponsors, contract with the [Centers for Medicare & Medicaid Services \(CMS\)](#) to offer prescription drug coverage to eligible enrollees. Enrollees in traditional Medicare receive their Part D prescription drug coverage from stand-alone prescription drug plans, while Medicare Advantage includes prescription drug coverage for their enrollees through Medicare Advantage prescription drug plans.

Pharmacy Benefit Managers (PBMs). PBMs manage prescription drug benefits on behalf of health insurers, including Part D sponsors. They act as intermediaries between sponsors, pharmacies, drug manufacturers, and other actors in the drug supply chain. Sponsors use PBMs to develop formularies, create pharmacy networks, and negotiate the amount that plan sponsors reimburse pharmacies for drugs at the point of sale. PBMs also negotiate payment adjustments applied after the point of sale with manufacturers and pharmacies. These payment adjustments are called direct and indirect remuneration (DIR).¹

DIR. DIR changes the final Part D costs incurred by Medicare and sponsors. Manufacturer rebates to sponsors comprise a substantial share of all DIR. DIR also includes sponsors' adjustments to pharmacy payments (i.e., pharmacy DIR). Money that sponsors recoup from pharmacies after the point of sale (e.g., price concessions and fees) accounts for most pharmacy DIR. Sponsors may also pay pharmacies bonuses or other incentive payment adjustments after the point of sale. Sponsors must submit DIR data to CMS annually so that they can be factored into the agency's calculation of final Medicare payments to plans.

Vertical Integration in Part D. In general, vertical integration is an arrangement in which a single company owns multiple parts of a supply chain process. For the purpose of this study, vertical integration in Part D refers to the consolidation of sponsors with PBMs. Pharmacies can also be affiliated with sponsors or PBMs. For example, a single organization may own a sponsor, PBM, and pharmacies (mail-order, specialty, and/or retail pharmacies). Vertically integrated organizations may also engage in transactions with external entities, such as a PBM negotiating reimbursement rates on behalf of an independent sponsor.

Potential Impact of Vertical Integration on Part D. Proponents of vertical integration state that these arrangements allow health care entities to lower costs.² For example, experts have noted that vertically integrated plans generally receive larger rebates from manufacturers due to their substantial market share, giving them leverage in negotiation. Because rebates in turn decrease the costs incurred under Part D plans, plans offered by vertically integrated entities may have lower premiums.

Other stakeholders have expressed concerns about potential for anticompetitive behavior.³ For example:

- A vertically integrated entity could use inflated prices and fees to raise operational costs of rivals that use the PBM or the pharmacies owned by the entity. Inflated prices and fees could in turn raise costs for Medicare and its enrollees.
- Vertically integrated sponsors could also steer enrollees with high drug costs to their own pharmacies and away from unaffiliated pharmacies. In a letter to sponsors and PBMs, CMS stated it is aware that vertical integration "has the potential to result in anticompetitive behavior and place independent pharmacies at a disadvantage." The agency urged sponsors and PBMs to engage in sustainable and fair practices with *all* pharmacies. CMS also warned that it monitors plan compliance with network adequacy standards and other requirements.⁴

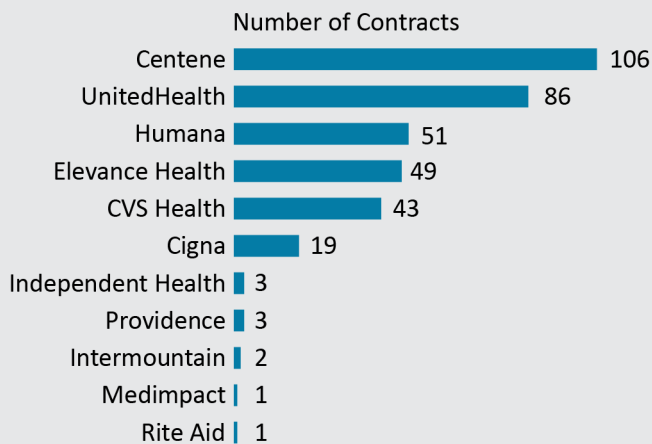
Changes to the Part D Program. Several changes to the Part D payment structure and PBM requirements occurred after this study's period of review, potentially realigning incentives in the Part D market. For example, as of 2024, sponsors are required to apply pharmacy price concessions to the negotiated price at the point of sale, which in turn could lower the price enrollees pay out of pocket for drugs and increase transparency of payment models.⁵ In addition, as of 2025, enrollees' out-of-pocket costs are capped and sponsors' liability for spending above the out-of-pocket cap has increased.⁶ Finally, beginning in 2028, PBMs will no longer be permitted to receive compensation based on drug list prices or rebate/discount amounts. Instead, they may only receive flat payments tied to services.⁷

Quick Facts: Vertical Integration in Part D

Vertically integrated organizations were responsible for 35 percent of Part D benefit contracts

In 2023, 300 organizations offered Part D plans. We determined that 11 of the 300 organizations also owned a PBM and thus are considered to be vertically integrated (VI).

These 11 VI organizations are associated with 364 of the 1,035 total contracts that offered Part D plans in 2023.



Source: OIG analysis of 2023 Part D sponsor data.

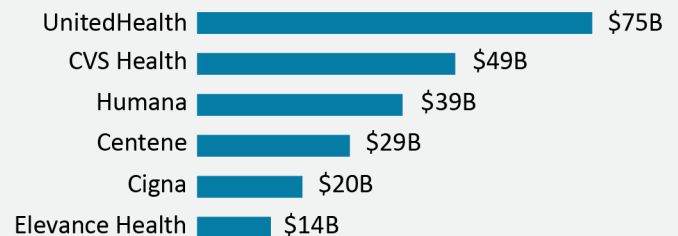
Vertically integrated organizations managed the prescription drug benefits for four out of every five enrollees

Of the 54.6 million individuals enrolled in Part D, 79 percent were in a plan offered by one of the 11 vertically integrated organizations. Just three vertically integrated organizations—UnitedHealth, CVS Health, and Humana—together provided Part D coverage to 57 percent of enrollees. UnitedHealth alone provided coverage to 24 percent of enrollees, demonstrating the extensive reach of the organization.

Just six vertically integrated sponsors accounted for 82 percent of Part D spending

Gross spending is heavily concentrated among six vertically integrated sponsors, which accounted for \$225.9 billion (82 percent) of the total \$275.9 billion spent in Part D.

These 6 VI sponsors accounted for 82% of gross Part D spending in 2023.

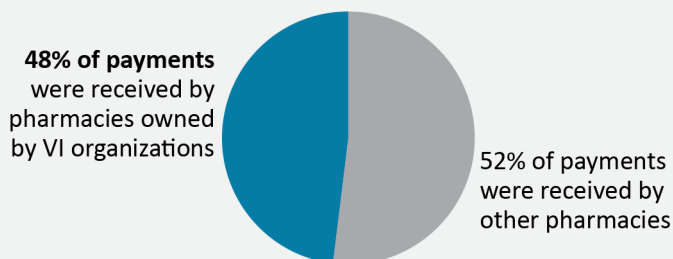


Source: OIG analysis of 2023 Part D sponsor data and Prescription Drug Event data.

Pharmacies owned by vertically integrated organizations received 48 percent of total payments from Part D

The 11 vertically integrated organizations also owned 13,297 (33 percent) of the 40,475 pharmacies for which we could determine ownership, and received 48 percent of the total payments from Part D.

Pharmacies owned by VI organizations received 48% of all Part D prescription payments in 2023.



Source: OIG analysis of 2023 Part D sponsor, National Council for Prescription Drug programs, and Prescription Drug Event data.

85 percent of total DIR went to vertically integrated sponsors

Overall, 85 percent of DIR (i.e., manufacturer rebates, pharmacy price concessions, and other DIR) went to vertically integrated organizations. DIR allowed vertically integrated sponsors to recoup 34 percent of gross spending on Part D drugs. For comparison, DIR allowed non-vertically integrated sponsors (hereinafter referred to as "other sponsors") to recoup 29 percent of gross spending.

Overall, the net cost was similar for vertically integrated sponsors and other sponsors for select drugs

Overall, the difference in the total net cost of drugs between vertically integrated sponsors and other sponsors was negligible (less than 1 percent) for the 60 drugs in our sample. For brand-only drugs, vertically integrated sponsors paid virtually the same (0.3 percent less) as other sponsors after accounting for DIR (i.e., the manufacturer rebates, pharmacy price concessions, and other fees that sponsors collect on the back end, as well as additional amounts sponsors pay after the point of sale). For multiple-source drugs, vertically integrated sponsors paid 2 percent less than other sponsors after accounting for DIR.

OIG selected a purposive sample of 60 high-cost and high-use drugs (see methodology section). We grouped drugs together on the basis of drug ingredient and drug name, which means that several versions of the same drug were often grouped together.

The term “brand-only drugs” refers to groupings that contain brand-name drugs with no generic versions available for the drug, whereas **the term “multiple-source drugs”** refers to groups that contain generic drugs only, or a combination of brand-name drugs and their generic versions.

Brand-only drugs are typically more expensive than multiple-source drugs. They are also generally subject to higher rebates.

On a drug-by-drug basis, the difference in net costs between vertically integrated sponsors and other sponsors was relatively minimal for most drugs in our sample. For 36 of the 60 drugs, the per unit post-DIR difference was within 5 percent in either direction. Only 4 of the 60 drugs had post-DIR differences that were greater than 25 percent. Exhibit 1 shows this distribution of differences in net costs across the 60 drugs.

However, vertically integrated sponsors and other sponsors arrived at these similar net costs in different ways

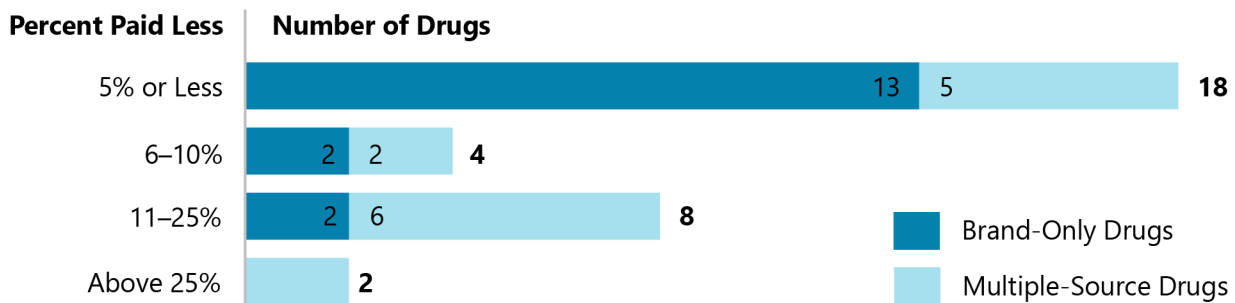
When net costs are broken down into their two components—(1) sponsors' point-of-sale reimbursement to pharmacies, and (2) the DIR sponsors collect or pay after the point of sale—differences between vertically integrated sponsors and other sponsors become apparent. For most drugs in our sample (41 of 60), vertically integrated sponsors reimbursed more at the point of sale than other sponsors. At the same time, vertically integrated sponsors recouped higher amounts of DIR on the back end (i.e., from manufacturers and pharmacies) than other sponsors did for most drugs in our sample (36 of 60).

It is important to note that changes in the Part D market after the period covered by this study may have altered this dynamic. Sponsors are now required to apply pharmacy price concessions at the point of sale, which could in turn lower these payments.⁸ PBMs will be required to pass all rebates and discounts to sponsors as of January 2028, which could further lower costs.⁹ In addition, sponsors' liability for spending above the out-of-pocket cap has increased, which may discourage high point-of-sale payments.

Exhibit 1 shows the “before DIR” (i.e., point-of-sale) reimbursement and “after DIR” (i.e., net) payment amounts for vertically integrated sponsors compared to other sponsors for several drugs in our sample.

Exhibit 1: Distribution of differences in net costs with examples

Drugs for which **VI sponsors spent less per unit compared to other sponsors** (after DIR).



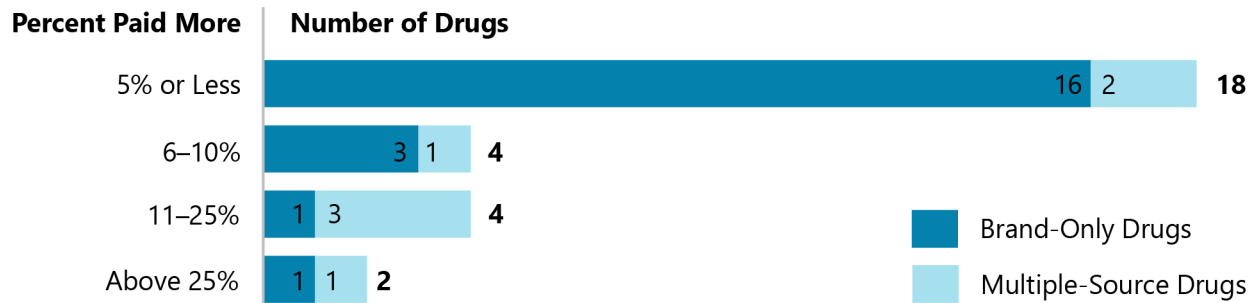
Drug’s Primary Condition	Before DIR Price Per Unit			After DIR Price Per Unit		
	VI	Other	Difference	VI	Other	Difference
Autoimmune*	\$9,333.56	\$8,756.90	6.59%	\$7,762.31	\$8,126.96	-4.49%
Autoimmune*	\$1,850.31	\$1,653.24	11.92%	\$1,069.21	\$1,091.40	-2.03%
Autoimmune*	\$3,795.74	\$3,502.63	8.37%	\$2,069.55	\$2,254.99	-8.22%
Overactive Bladder	\$0.45	\$0.42	5.13%	\$0.14	\$0.17	-14.75%
Type 2 Diabetes	\$489.23	\$455.64	7.37%	\$215.86	\$216.32	-0.21%
Prostate Cancer*	\$148.63	\$136.25	9.09%	\$114.55	\$117.36	-2.39%
Type 2 Diabetes	\$20.84	\$18.44	13.04%	\$7.98	\$8.36	-4.57%
Asthma ⁺	\$2.69	\$3.40	-20.80%	\$2.26	\$3.04	-25.62%
High Cholesterol ⁺	\$0.20	\$0.30	-32.67%	\$0.24	\$0.25	-4.43%

*These drugs are specialty drugs.

⁺These drugs are multiple-source drugs. All other drugs are brand-only drugs.

Exhibit 1 (continued)

Drugs for which **VI sponsors spent more per unit compared to other sponsors** (after DIR).



Drug's Primary Condition	Before DIR Price Per Unit			After DIR Price Per Unit		
	VI	Other	Difference	VI	Other	Difference
Heart disease*	\$182.65	\$178.01	2.61%	\$173.52	\$172.93	0.34%
Autoimmune*	\$7,232.55	\$6,801.09	6.34%	\$6,672.41	\$6,524.78	2.26%
Hereditary Angioedema*	\$12,920.63	\$12,643.31	2.19%	\$12,749.56	\$12,461.74	2.31%
Cancer**	\$823.27	\$747.75	10.10%	\$747.69	\$721.03	3.70%
Cancer*	\$1.61	\$1.51	6.92%	\$1.51	\$1.45	4.19%
Type 2 Diabetes	\$19.12	\$17.90	6.80%	\$6.37	\$5.91	7.64%
Autoimmune*	\$27,317.06	\$24,737.43	10.43%	\$20,735.83	\$18,680.68	11.00%
Types 1 & 2 Diabetes	\$30.87	\$27.83	10.93%	\$9.45	\$5.17	82.66%
Acid Reflux [†]	\$0.22	\$0.23	-7.45%	\$0.25	\$0.18	36.85%

*These drugs are specialty drugs.

[†]These drugs are multiple-source drugs. All other drugs are brand-only drugs.

Source: OIG analysis of 2023 PDE, DIR, and Part D sponsor data.

Note: The drug costs in the charts represent pre-DIR and post-DIR volume-weighted cost per unit. In addition, drug costs presented in the charts are rounded figures. Percent differences were calculated using the underlying unrounded values.

Price concessions, fees, and other payment adjustments charged to pharmacies by PBMs or sponsors after a prescription has been dispensed comprise the vast majority of pharmacy DIR. As such, pharmacy DIR generally raises the overall cost of drugs for pharmacies.

Due to data constraints, our pharmacy payment analysis of a sample of drugs includes only reimbursements for transactions at the point of sale.

Sponsors submit both summary DIR data and drug-level DIR data to CMS annually. Neither summary nor drug-level DIR data are detailed enough to trace the flow of DIR from specific pharmacies, as sponsors do not include pharmacy information in their reports. For drug-level DIR data, sponsors do not report pharmacy DIR separately from other DIR. For this reason, we could not determine net payments to pharmacies for the drugs in our sample.

From an aggregate perspective, vertically integrated sponsors, overall, received more pharmacy DIR than other sponsors in 2023. That year, pharmacy DIR accounted for 24 percent (\$18.7 billion) of the total DIR that vertically integrated sponsors received. For other sponsors, pharmacy DIR accounted for 19 percent (\$2.6 billion) of the total DIR that these sponsors received.

At the point of sale, vertically integrated sponsors reimbursed pharmacies at higher amounts above their acquisition costs than other sponsors; however, this does not account for sponsors' subsequent adjustments to pharmacy payments

At the point of sale, vertically integrated sponsors reimbursed pharmacies at an average of 15 percent above their acquisition costs for the 37 drugs in our sample with available National Average Drug Acquisition Cost (NADAC) data, whereas other sponsors reimbursed an average of 8 percent above cost. For the brand-only drugs in our sample, vertically integrated sponsors reimbursed pharmacies at 10 percent above their acquisition cost compared to 1 percent above cost by other sponsors. For the multiple-source drugs in our sample, both vertically integrated sponsors and other sponsors reimbursed pharmacies at double the acquisition cost, on average.

Among the individual drugs in our sample, vertically integrated sponsors reimbursed pharmacies above their acquisition cost for all 37 drugs at the point of sale. Other sponsors reimbursed for 32 of the 37 drugs above acquisition cost at the point of sale.

National Average Drug Acquisition Cost (NADAC) represents the average drug invoice price that retail community pharmacies pay to acquire drugs. For this reason, **we used NADAC as a proxy for pharmacy acquisition cost.**

It is important to note that NADAC does not include discounts, such as price concessions that pharmacies might receive after the initial invoice. In addition, drugs that are not available in retail pharmacies, such as specialty drugs, typically do not have NADAC data. Of the 60 drugs in our sample, 37 had a NADAC.

Given that sponsors collect billions in DIR from pharmacies, it is important to note that data limitations prevented us from drawing conclusions about the effects of payment models on pharmacies, including whether or how much sponsors' net payments to pharmacies may have exceeded pharmacy acquisition costs for these drugs. Similarly, given that vertically integrated sponsors collected more in pharmacy DIR, data limitations prevented us from determining whether these sponsors paid higher, lower, or similar net amounts to pharmacies compared to other sponsors.

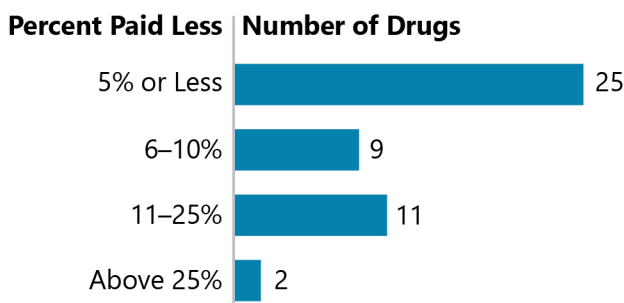
At the point of sale, vertically integrated sponsors reimbursed their own pharmacies slightly less than unaffiliated pharmacies; however, this does not account for sponsors' subsequent adjustments to pharmacy payments

Of the 60 drugs in our sample, 57 had reimbursements from vertically integrated sponsors to both their own pharmacies and unaffiliated pharmacies. Overall, vertically integrated sponsors reimbursed their own pharmacies 4 percent less at the point of sale than they reimbursed unaffiliated pharmacies for the same drugs. For brand-only drugs, vertically integrated sponsors reimbursed 3 percent less to their own pharmacies than to unaffiliated pharmacies. For multiple-source drugs, vertically integrated sponsors reimbursed 8 percent less to their own pharmacies than to unaffiliated pharmacies.

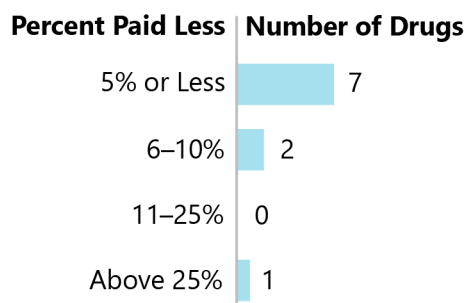
The difference between point-of-sale reimbursements from vertically integrated sponsors to their own pharmacies versus reimbursements to unaffiliated pharmacies was minimal for most drugs in our sample. For 32 of the 57 drugs, the difference was 5 percent or below in either direction. For 43 of the 57 drugs, the difference was within 10 percent in either direction. See Exhibit 2.

Exhibit 2: Comparison of point-of-sale payments from vertically integrated sponsors to their own versus unaffiliated pharmacies

Drugs that VI sponsors **paid less to their own pharmacies** for, and percent VI sponsors paid less.



Drugs that VI sponsors **paid less to unaffiliated pharmacies** for, and percent VI sponsors paid less.



Source: OIG analysis of 2023 PDE, NCPDP, and Part D sponsor data.

Note: This analysis does not take into account pharmacy DIR data, which were unavailable for the study period at the required level. Three of the 60 drugs in our sample did not have both transaction types.

Overall, vertically integrated sponsors reimbursed both affiliated and unaffiliated pharmacies at amounts above drug acquisition cost

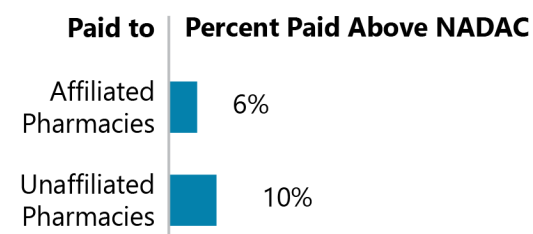
Vertically integrated sponsors reimbursed their own pharmacies above acquisition cost (i.e., NADAC) for 36 of the 37 drugs in our sample for which pricing data were available. Similarly, they reimbursed unaffiliated pharmacies above NADAC for all 37 drugs.

Gross reimbursements from vertically integrated sponsors to unaffiliated pharmacies had a larger spread above NADAC compared to reimbursements made to affiliated pharmacies. Vertically integrated sponsors reimbursed their own pharmacies 11 percent above acquisition cost for drugs in our sample and reimbursed unaffiliated pharmacies 16 percent above acquisition cost. For brand-only drugs specifically, vertically integrated sponsors reimbursed their own pharmacies 6 percent above acquisition cost and reimbursed unaffiliated pharmacies 10 percent above acquisition cost. For multiple-source drugs, vertically integrated sponsors reimbursed their own pharmacies 79 percent above acquisition cost and reimbursed unaffiliated pharmacies 96 percent above acquisition cost.

Exhibit 3: Payments from vertically integrated sponsors compared to NADAC

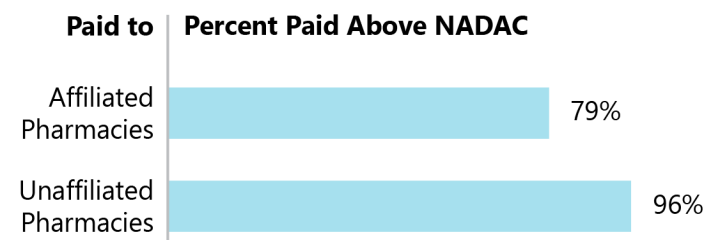
Brand-Only Drugs:

Percent above NADAC that VI sponsors paid pharmacies.



Multiple-Source Drugs:

Percent above NADAC that VI sponsors paid pharmacies.



Source: OIG analysis of 2023 PDE, NCPDP, NADAC, and Part D sponsor data.

Note: This analysis does not take into account pharmacy DIR data, which were unavailable for the study period at the required level. This analysis includes 37 of the 60 drugs in our sample for which NADAC data were available.

A lack of detailed DIR data limited OIG’s ability to address stakeholder concerns about the effects of vertical integration on net payments to unaffiliated pharmacies

Stakeholders have raised concerns about payments from vertically integrated entities to unaffiliated pharmacies and have called for restricting PBMs’ ownership of pharmacies. For example, the National Association of Attorneys General wrote to Congress in April 2025 stating, “PBMs’ use of affiliated pharmacies—pharmacies owned by either the PBM itself or the PBM’s parent company—has exacerbated the problem of manipulated prices and unavailability of certain prescription medications.” The Association explains that PBMs’ ownership of pharmacies causes them to engage in tactics (e.g., less favorable contract terms) that disadvantage unaffiliated pharmacies.¹⁰ The National Community Pharmacists Association has also cited “opaque reimbursement models” and “restrictive contract terms”

as areas of concern.¹¹ Similarly, The Federal Trade Commission (FTC) has mentioned concerns regarding preferential rates paid to pharmacies affiliated with vertically integrated entities, and that these entities have bargaining leverage that overpowers independent pharmacies.¹² The agency has attributed such practices to independent pharmacies closing, thereby limiting patient access to drugs. FTC states that between 2013 and 2022, approximately 10 percent of independent retail pharmacies in rural areas went out of business.¹³

Recent statutory changes aim to address these concerns. For example, by April 2028, CMS must finalize standards defining “reasonable and relevant” contract terms for sponsor-pharmacy agreements, including fair reimbursement rates and performance metrics.¹⁴ Beginning January 2029, Part D sponsors must implement these standards for all network pharmacies, and CMS will launch a formal complaint process allowing pharmacies to report violations under anti-retaliation protections.¹⁵

The DIR data for the period under review were not detailed enough to trace the flow of DIR from specific pharmacies to sponsors, as sponsors reported DIR without including pharmacy information. Therefore, we were unable to account for pharmacy DIR from affiliated versus unaffiliated pharmacies to vertically integrated sponsors and, as a result, could not assess the impact, if any, vertical integration has on net payments to these pharmacies.

Recent changes to the Part D program may lead to increased transparency into the effects of vertical integration on pharmacies. As of January 2024, pharmacy DIR must be reflected at the point of sale;¹⁶ however, due to lags in data availability, these data were not available for OIG to analyze. In addition, beginning in 2027, each sponsor will report to CMS all incentive payments and other fees paid to pharmacies.¹⁷ Beginning in 2028, sponsors will also be required to disclose to CMS any pharmacies affiliated with the sponsor or with PBMs acting on its behalf.¹⁸

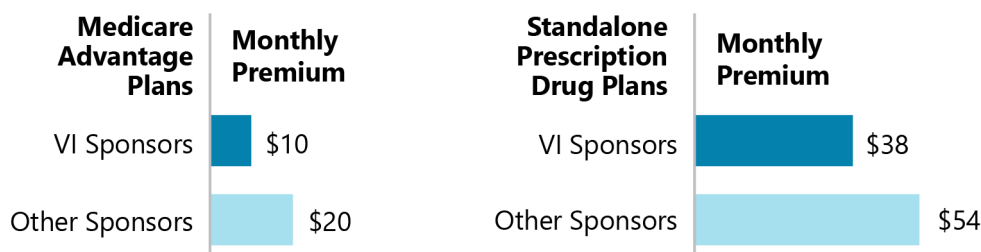
In general, enrollees in plans offered by vertically integrated sponsors paid lower monthly premiums but, for select drugs, higher drug out-of-pocket costs in 2023

Enrollees in plans offered by vertically integrated sponsors overall paid lower monthly premiums

Monthly premiums for plans offered by vertically integrated organizations were substantially lower than premiums for plans offered by other sponsors. For Medicare Advantage, the monthly premiums (i.e., the prescription drug benefit portion) for plans offered by vertically integrated sponsors were half the cost of plans offered by other sponsors. For Standalone Prescription Drug plans, monthly premiums for plans offered by vertically integrated sponsors were 30 percent less than the cost of plans offered by other sponsors.

Exhibit 4: Comparison of monthly premiums

Monthly premiums were lower for plans offered by VI sponsors.



Source: OIG analysis of 2023 Part D sponsor and plan data.

Note: We analyzed only the prescription drug benefit portion of Medicare Advantage Plan premiums.

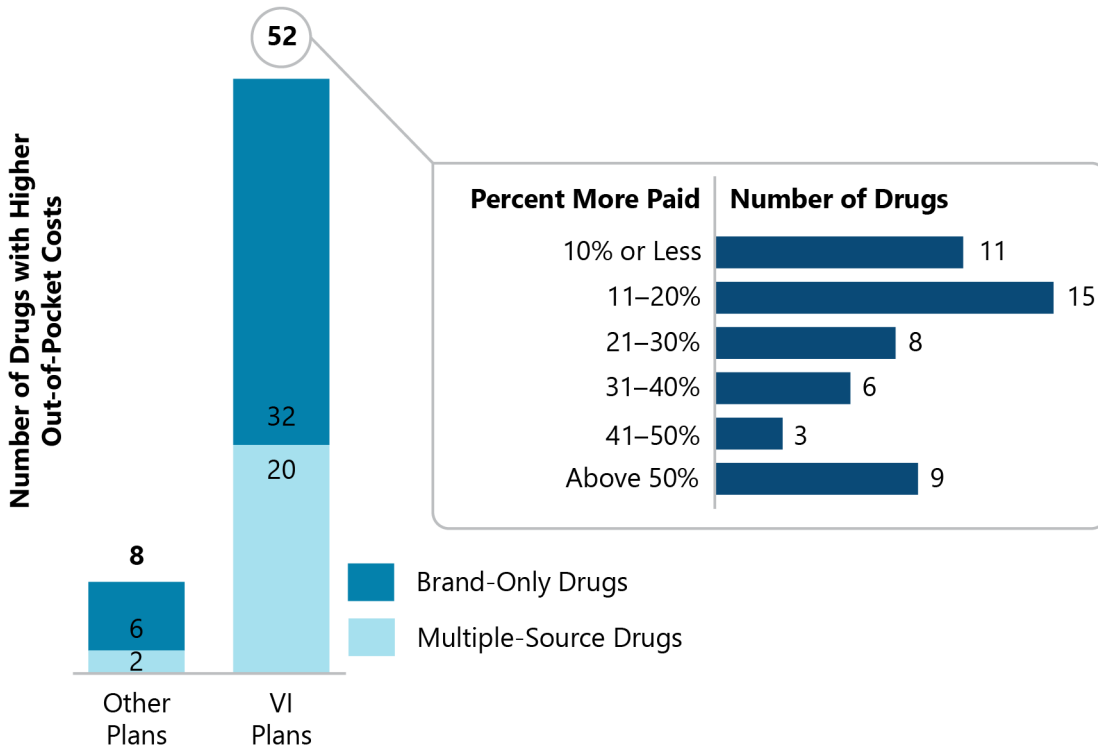
Large DIR amounts may account for lower premiums for plans offered by vertically integrated sponsors. Rebates and other DIR reduce Part D expenses, which in turn reduce premiums for consumers. As previously stated, vertically integrated sponsors receive more DIR than other sponsors, which results in lower premiums.

Enrollees in plans offered by vertically integrated sponsors tended to pay more in out-of-pocket costs for the drugs in our sample

Enrollees who did not receive any financial assistance (e.g., low-income subsidy, support from State pharmaceutical assistance programs, charities, group health plans, etc.) paid substantially more in out-of-pocket costs for the drugs in our sample when enrolled in plans offered by vertically integrated sponsors. These enrollees paid nearly 40 percent more in drug out-of-pocket costs, overall, compared to enrollees in plans offered by other sponsors. Enrollees without financial assistance in vertically integrated plans paid more in out-of-pocket costs for 52 of the 60 drugs in our sample than enrollees in other plans.

Exhibit 5: Comparison of out-of-pocket costs for sampled drugs

In VI plans, 52 of 60 drugs had higher out-of-pocket costs for enrollees who did not have financial assistance.



Source: OIG analysis of 2023 PDE and Part D sponsor data.

Forty-one percent of enrollees in our study received financial support. These enrollees paid slightly more (5 percent) for the drugs in our sample when enrolled in a plan provided by a vertically integrated sponsor.

It is important to note that changes to the Part D benefit will likely shift enrollees' cost sharing obligations. As of 2024, pharmacy DIR must be reflected at the point of sale.¹⁹ Because enrollees' out-of-pocket costs are calculated on the basis of the point-of-sale price, this change might lower out-of-pocket costs for enrollees. In addition, as of January 2025, enrollees' out-of-pocket drug costs are capped at \$2,000 annually.²⁰ Therefore, once an enrollee meets the cap, they no longer pay out-of-pocket costs.

What OIG Concludes

Due to data limitations, the full impacts of vertical integration in Part D remain unknown. Our point-in-time analysis uncovered similarities between vertically integrated and other sponsors—such as sponsor net drug cost. However, we could not draw overall conclusions about whether or how much vertically integrated sponsors and other sponsors differ in their net payments to pharmacies. Nor could we determine whether vertically integrated sponsors pay different net amounts to affiliated versus unaffiliated pharmacies. This is because there were not yet drug- and pharmacy-specific program data on the payment adjustments (e.g., fees and price concessions collected from pharmacies) that sponsors or PBMs make after the point of sale.

Recent dynamic shifts in the Part D market and changes to PBM requirements also prevented OIG from drawing definitive conclusions about the impacts of vertical integration. Significant changes to Part D could cause a realignment of incentives within the program and result in different financial impacts on Part D costs, pharmacies, and enrollee cost sharing. For example, as of 2024, plan sponsors are required to apply pharmacy price concessions to the negotiated price at the point of sale, which in turn could lower the price enrollees pay out of pocket for drugs and increase transparency of payment models.²¹ In addition, as of January 2025, enrollees' out-of-pocket costs are capped and sponsors' liability for spending above the out-of-pocket cap has increased.²² PBMs will be required to pass all rebates and discounts to sponsors as of January 2028, which could further lower costs.²³ Nonetheless, our work provides a valuable point-in-time baseline that can inform future assessments of how these changes reshape the Part D market.

Proponents of vertical integration state that it allows health care entities to lower costs. However, other stakeholders have raised concerns about the effects of vertical integration, including higher drug costs, limited access to medications, anticompetitive behavior that negatively affects independent pharmacies, and lack of pricing transparency. CMS has stated that the agency is aware that the increasing level of vertical integration has the potential to result in anticompetitive behavior and place independent pharmacies at a disadvantage.²⁴ The agency has urged sponsors and PBMs to engage in sustainable and fair practices with all pharmacies. CMS has also stated that it is closely monitoring plan compliance with requirements. Recent statutory changes may address concerns about anticompetitive behavior. For example, by April 2028, CMS must finalize standards defining "reasonable and relevant" contract terms for sponsor-pharmacy agreements and by January 2029, sponsors must implement these standards for all network pharmacies.²⁵

OIG is currently conducting additional work examining the effects of vertical integration on Part D. An audit is underway that will examine the contract arrangements between several vertically integrated entities and pharmacies in 2023 and 2024, and the potential effects of those contracts on prices for Part D drugs. When taken together, OIG's evaluation and audit work will provide a fuller picture that can inform ongoing discussions on the effects of vertical integration in the pharmaceutical marketplace.

Methodology

Identifying vertically integrated entities. Using 2023 DIR submission data from sponsors and contract information, we identified the parent company of each (1) Part D sponsor that offered drug benefits, and (2) PBM that provided services to at least one Part D sponsor. If the same parent company was associated with a sponsor and a PBM, we categorized the parent company as a vertically integrated organization. We also categorized every sponsor owned by the parent company as a vertically integrated sponsor. We used financial reporting documentation and sponsor bid submissions to validate our categorizations.

Identifying pharmacy affiliation. Due to data constraints, we identified ownership relationships for pharmacies that accounted for 73 percent of total expenditures.²⁶ Using National Council for Prescription Drug Programs (NCPDP) data, financial reporting documentation, and pharmacy websites, we determined the ownership relationships of pharmacies that received reimbursement from Part D in 2023 (please see explanation in the limitations section about pharmacy ownership data). If the parent company of a pharmacy matched the name of a vertically integrated organization, we categorized the pharmacy as being affiliated with a vertically integrated organization.

Summarizing vertically integrated entities' presence in the Part D market. Using 2023 data from Part D sponsors, we summarized the number of contracts associated with each vertically integrated organization. Using Part D plan enrollment data, we summarized the number and percentage of enrollees in a plan offered by vertically integrated sponsors. We used DIR data to summarize the total DIR received by vertically integrated entities for all drugs (i.e., not limited to our sample). Using PDE data, for all drugs, we summarized the total pre-DIR spending associated with vertically integrated entities. In addition, we used PDE and NCPDP data to summarize the total number of pharmacies associated with vertically integrated organizations.

Selecting the drug sample. We used First DataBank data to group individual drug products (i.e., National Drug Codes) based on drug ingredient and drug name, which meant that several versions of the same drug were often grouped together. We then selected the top drugs on the basis of each of the following criteria:

- Highest expenditures;
- Largest number of enrollees; and
- Highest average cost per enrollee; we limited selection on the basis of this criterion to drugs associated with at least 100 enrollees and at least 100 sponsors.

This resulted in 3 lists of 20 drugs each (60 drugs total) in our sample.

We then categorized drugs as being “brand-only” or “multiple-source.” The term “brand-only drugs” refers to groupings that contain brand-name drugs with no generic versions available for the drug. The term “multiple-source drugs” refers to groups that contain generic drugs only, or a combination of brand-name drugs and their generic versions.

Our comparison of sponsors' costs, point-of-sale payments to pharmacies, and enrollee out-of-pocket drug costs pertain only to our sample of 60 drugs and are not generalizable to other drugs.

Comparing gross sponsor costs. For each NDC associated with the 60 drugs in our sample, we calculated gross cost per unit for vertically integrated sponsors by summing the amount vertically integrated sponsors paid and dividing the total by the sum of units for which these sponsors paid (after converting units, as necessary, to ensure that unit calculations for all NDCs within a drug group were based on the same unit type). To calculate gross cost per unit for each drug group, we then aggregated the NDC-level cost per unit figures to the drug group level by weighting each NDC's gross cost per unit by the proportion of the drug group's claims associated with the NDC. We repeated this analysis for other sponsors and then compared the gross cost per unit between vertically integrated sponsors and other sponsors for each drug group.

We also calculated a total gross cost (i.e., overall gross cost) associated with vertically integrated sponsors by multiplying each drug group's gross volume-weighted cost per unit (as described above) by the sum of the drug group's utilization, and then summing the resulting figures. We repeated this analysis for other sponsors, and then compared the overall gross cost between vertically integrated sponsors and other sponsors.

Comparing net sponsor costs. For each NDC associated with the 60 drugs in our sample, we calculated net cost per unit for vertically integrated sponsors by summing the amount vertically integrated sponsors paid, subtracting the total DIR amount associated with the vertically integrated sponsors for the NDC, and dividing the result by the sum of units for which these sponsors paid (after converting units, as necessary, to ensure that unit calculations for all NDCs within a drug group were based on the same unit type). To calculate net cost per unit for each drug group, we then aggregated the NDC-level cost per unit figures to the drug group level by weighting each NDC's net cost per unit by the proportion of the drug group's claims associated with the NDC. We repeated this analysis for other sponsors, and then compared the net cost per unit between vertically integrated sponsors and other sponsors for each drug group.

We also calculated a total net cost (i.e., overall net cost) associated with vertically integrated sponsors by multiplying each drug group's volume-weighted net cost per unit (as described above) by the sum of the drug group's utilization, and summing the resulting figures. We repeated this analysis for other sponsors, and then compared the overall net cost between vertically integrated sponsors and other sponsors.

Comparing pharmacy reimbursement at the point of sale. For each NDC associated with the 60 drugs in our sample, we calculated National Drug Acquisition Cost (NADAC) cost per unit (after converting units, as necessary, to ensure that unit calculations for all NDCs within a drug group were based on the same unit type). To calculate NADAC for each drug group, we then aggregated the NDC-level NADAC per unit figures to the drug group level by weighting each NDC's NADAC per unit by the proportion of the drug group's claims associated with the NDC. We then summed the result by drug group.

We also calculated a total NADAC-based cost (i.e., overall NADAC cost) by multiplying each drug group's volume-weighted NADAC cost per unit (as described above) by the sum of the drug group's utilization, and summing the resulting figures.

We compared both drug-level NADAC and overall NADAC cost to gross cost associated with vertically integrated sponsors. We repeated this analysis for other sponsors. We were unable to analyze net payments because sponsors do not report pharmacy DIR separately from other DIR at the drug level.

Comparing vertically integrated sponsors reimbursements to affiliated versus unaffiliated pharmacies at the point of sale. For the drugs in our sample, we determined whether each PDE associated with vertically integrated sponsors represented reimbursements to affiliated pharmacies or unaffiliated pharmacies (please see explanation in the limitations section about pharmacy ownership data). We aggregated reimbursements by pharmacy affiliation and then compared the results.

We also compared aggregate reimbursements at the point of sale to NADAC to determine the extent to which vertically integrated sponsors reimbursed affiliated and unaffiliated pharmacies above pharmacies' drug acquisition costs.

It is important to note that we could not compare payments made after the point of sale due to data constraints. The DIR data for the period under review were not detailed enough to trace the flow of DIR from/to specific pharmacies, as sponsors reported DIR at the drug level without including pharmacy information.

Comparing premiums. We used 2023 Part D plan data to aggregate monthly premiums by plan type (Medicare Advantage and Standalone Prescription Drug Plans) and by whether the plan was offered by a vertically integrated sponsor. We then compared premiums between vertically integrated sponsors and other sponsors for each plan type. When comparing Medicare Advantage plan premiums, we included only the prescription drug benefit portion.

Comparing drug out-of-pocket costs. We used 2023 PDE data to aggregate out-of-pocket costs for the drugs in our sample by whether the enrollee received financial assistance and by whether they were in a plan offered by a vertically integrated sponsor. For enrollees without financial assistance, we compared drug out-of-pocket costs between enrollees in plans offered by vertically integrated sponsors versus other sponsors. We repeated this analysis for enrollees with financial assistance.

Limitations

Due to data constraints, we could not compare net payments made to pharmacies (i.e., could not account for fees or price concessions after the point of sale). Sponsors submit both summary DIR data and drug-level DIR data to CMS annually. Neither summary nor drug-level DIR data are detailed enough to trace the flow of DIR from/to specific pharmacies, as sponsors do not include pharmacy information in their reports. For drug-level DIR data, sponsors do not report pharmacy DIR separately from other DIR. We also did not review contracts between sponsors and pharmacies to further compare payments to affiliated versus unaffiliated pharmacies.

In addition, due to data constraints, we did not identify ownership relationships for all pharmacies that received reimbursement from Part D in 2023. Instead, we identified the parent company of pharmacies

that accounted for 73 percent of total expenditures. We excluded the remaining pharmacies from our analysis of vertically integrated sponsors' point-of-sale reimbursements to affiliated versus unaffiliated pharmacies, and the presence of affiliated pharmacies in the Part D market.

Also, our comparisons of sponsors' costs, point-of-sale payments to pharmacies, and enrollee out-of-pocket drug costs pertain only to our sample of 60 drugs and are not generalizable to other drugs.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued in 2020 by the Council of the Inspectors General on Integrity and Efficiency.

Endnotes

¹ Per CMS regulations and guidance, DIR is any form of price concession, received either by the Part D sponsor or by an intermediary contracting organization (e.g., a PBM) with which the sponsor has contracted, from any source (including manufacturers, pharmacies, enrollees, or any other person or entity) that serves to decrease the costs incurred under the Part D plan by the Part D sponsor, either directly or indirectly. Thus, DIR includes discounts, chargebacks, rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-price services, grants, legal judgment amounts, settlement amounts from lawsuits or other legal action, and other price concessions or similar benefits. DIR also includes price concessions from and additional contingent payments to network pharmacies that cannot reasonably be determined at the point of sale. See 42 C.F.R. § 423.308; CMS Final Medicare Part D DIR Reporting Guidance for 2023. Manufacturer rebates to sponsors comprise a substantial share of all DIR.

² For example, see Congressional Testimony of Craig L. Garthwaite on June 12, 2019, at <https://www.judiciary.senate.gov/download/garthwaite-testimony>. Accessed on November 21, 2025.

³ For example, see Letter from the National Association of Attorneys General to Representative Mike Johnson, Senator John Thune, Senator Charles Schumer, and Representative Hakeem Jeffries dated April 14, 2025. Accessed at <https://www.naag.org/wp-content/uploads/2025/04/4-14-Pharmacy-Benefit-Managers--FINAL-e.pdf> on August 13, 2025.

⁴ Centers for Medicare & Medicaid Services, “CMS Letter to Plans and Pharmacy Benefit Managers,” December 14, 2023. Accessed at www.cms.gov/newsroom/fact-sheets/cms-letter-plans-and-pharmacy-benefit-managers on August 14, 2025.

⁵ The negotiated price must reflect the lowest possible reimbursement a network pharmacy will receive for a drug and include pharmacy price concessions. To implement the requirement, CMS added the “Pharmacy Price Concessions at POS” field to the PDE file layout. Sponsors are required to use this field beginning January 1, 2025. See 87 Fed. Reg. 27704, 27707-27708, 27835-27840 (May 9, 2022). See also “New 2025 Prescription Drug Event (PDE) File Layouts (FINAL),” April 2023.

⁶ Sections 1860D–2(b) and 1860D–15(b) of the Social Security Act (42 U.S.C. § 1395w–102(b) and 42 U.S.C. § 1395w–115(b)) as amended by the Inflation Reduction Act of 2022 (P.L. 117-169).

⁷ Section 1860D–12(h) of the Social Security Act (42 U.S.C. § 1395w–112) as amended by the Consolidated Appropriations Act, 2026 (P.L. 119-75).

⁸ 87 Fed. Reg. 27704, 27707-27708, and 27835 (May 5, 2022). See also “negotiated price” at 42 C.F.R. §§ 423.100 & 423.2305.

⁹ Section 1860D–12(h)(1) of the Social Security Act (42 U.S.C. § 1395w–112(h)(1)) as amended by Section 6224 of the Consolidated Appropriations Act, 2026 (P.L. 119-75).

¹⁰ Letter from the National Association of Attorneys General to Representative Mike Johnson, Senator John Thune, Senator Charles Schumer, and Representative Hakeem Jeffries dated April 14, 2025. Accessed at <https://www.naag.org/wp-content/uploads/2025/04/4-14-Pharmacy-Benefit-Managers--FINAL-e.pdf> on August 13, 2025.

¹¹ Letter from the National Community Pharmacists Association to William McGinley dated December 19, 2024. Accessed at <https://ncpa.org/sites/default/files/2024-12/12.19.2024-NCPArecommendations-DOGE.pdf> on August 13, 2025.

¹² Federal Trade Commission, *Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies*, July 2024. Accessed at https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf on August 13, 2025.

¹³ Ibid.

¹⁴ Section 1860D–4(b)(1)(A) of the Social Security Act (42 U.S.C. § 1395w–104(b)(1)(A)) as amended by Section 6223 of the Consolidated Appropriations Act, 2026 (P.L. 119-75).

¹⁵ Section 1860D–4(b)(1)(A) & (F) of the Social Security Act (42 U.S.C. § 1395w–104(b)(1)(A) & (F)) as amended by Section 6223 of the Consolidated Appropriations Act, 2026 (P.L. 119-75).

¹⁶ Effective January 1, 2024, sponsors are required to apply pharmacy price concessions to the negotiated price. The negotiated price must reflect the lowest possible reimbursement a network pharmacy will receive for a drug and include all pharmacy price concessions. To implement the requirement, CMS added the “Pharmacy Price Concessions at POS” field to the PDE file layout. Sponsors are required to use this field beginning January 1, 2025. See 87 Fed. Reg. 27704, 27707-27708, 27835-27840 (May 9, 2022). See also “New 2025 Prescription Drug Event (PDE) File Layouts (FINAL),” April 2023.

¹⁷ Section 1860D-42(e)(3)(C) of the Social Security Act (42 U.S.C. § 1395w-152(e)(3)(C)) as amended by Section 6223 of the Consolidated Appropriations Act, 2026 (P.L. 119-75).

¹⁸ Section 1860D-42(e)(3)(B) of the Social Security Act (42 U.S.C. § 1395w-152(e)(3)(B)) as amended by Section 6223 of the Consolidated Appropriations Act, 2026 (P.L. 119-75).

¹⁹ Effective January 1, 2024, sponsors are required to apply pharmacy price concessions to the negotiated price. The negotiated price must reflect the lowest possible reimbursement a network pharmacy will receive for a drug and include all pharmacy price concessions. To implement the requirement, CMS added the “Pharmacy Price Concessions at POS” field to the PDE file layout. Sponsors are required to use this field beginning January 1, 2025. See 87 Fed. Reg. 27704, 27707-27708, 27835-27840 (May 9, 2022). See also “New 2025 Prescription Drug Event (PDE) File Layouts (FINAL),” April 2023.

²⁰ For 2025, enrollees’ maximum out-of-pocket cost is set at \$2,000. This limit will be adjusted annually on the basis of the growth in per capita Part D costs.

²¹ The negotiated price must reflect the lowest possible reimbursement a network pharmacy will receive for a drug and include pharmacy price concessions. To implement the requirement, CMS added the “Pharmacy Price Concessions at POS” field to the PDE file layout. Sponsors are required to use this field beginning January 1, 2025. See 87 Fed. Reg. 27704, 27707-27708, 27835-27840 (May 9, 2022). See also “New 2025 Prescription Drug Event (PDE) File Layouts (FINAL),” April 2023.

²² Sections 1860D–2(b) and 1860D–15(b) of the Social Security Act (42 U.S.C. § 1395w–102(b) and 42 U.S.C. § 1395w–115(b)) as amended by the Inflation Reduction Act of 2022 (P.L. 117-169).

²³ Section 1860D–12(h)(1) of the Social Security Act (42 U.S.C. § 1395w–112(h)(1)) as amended by Section 6224 of the Consolidated Appropriations Act, 2026 (P.L. 119-75).

²⁴ Centers for Medicare & Medicaid Services, “CMS Letter to Plans and Pharmacy Benefit Managers,” December 14, 2023. Accessed at www.cms.gov/newsroom/fact-sheets/cms-letter-plans-and-pharmacy-benefit-managers on August 14, 2025.

²⁵ Section 1860D–4(b)(1)(A) of the Social Security Act (42 U.S.C. § 1395w–104(b)(1)(A)) as amended by Section 6223 of the Consolidated Appropriations Act, 2026 (P.L. 119-75).

²⁶ Because we could not determine whether the remaining pharmacies were affiliated with vertically integrated sponsors, we excluded them from our analysis of vertically integrated sponsors’ point-of-sale reimbursements to affiliated versus unaffiliated pharmacies, and the presence of affiliated pharmacies in the Part D market.

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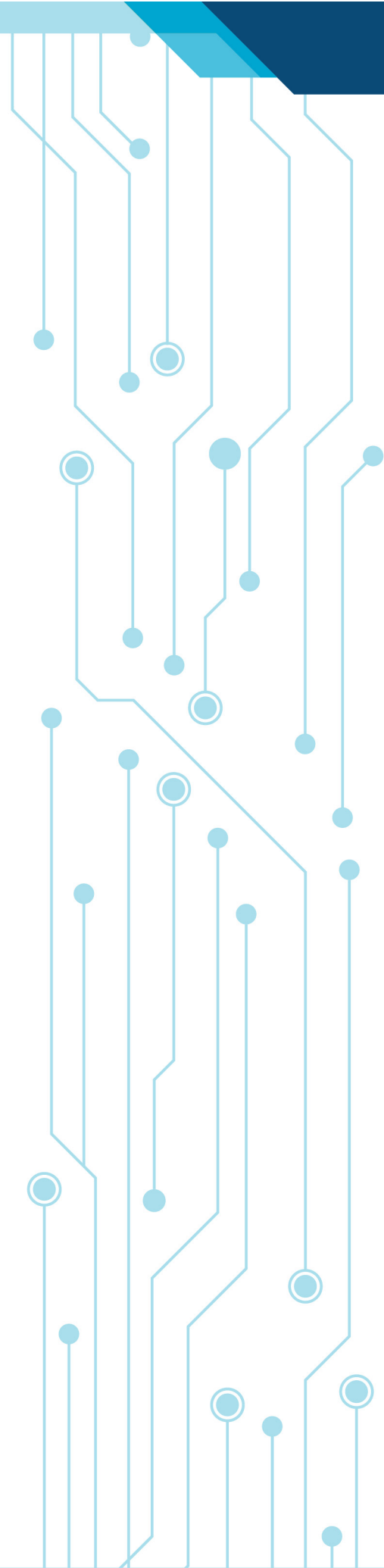
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