REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (A-26)
Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts

EXECUTIVE SUMMARY

At the 2025 Annual Meeting, the House of Delegates referred Resolution 113-A-25, which asks that the American Medical Association (AMA) support efforts to expand telepharmacy, advocate for equitable pharmacy reimbursement, and study the impact of preferred pharmacy networks with the goal of mitigating access issues for patients in pharmacy deserts.

The Council on Medical Service reviewed information on the current state of pharmacies across the United States and the elements involved in their ability to succeed. Currently, pharmacies are facing a closure crisis, leading to many communities being deemed "pharmacy deserts," or areas in which residents do not have adequate access to a pharmacy. Pharmacies face a number of issues in remaining financially viable. Low reimbursement rates from payers are often driven by pharmacy benefit manager (PBM) negotiations resulting in rates that do not cover the full acquisition and operating costs associated with a drug. Further, many PBMs are vertically integrated with payers and/or large chain pharmacies leading to a highly concentrated market and, often, resulting in anticompetitive practices or PBMs excluding small/community pharmacies from preferred pharmacy networks. The Council reviewed the literature and considered a variety of information on a number of potential solutions to support pharmacies and reduce pharmacy deserts. First, the Council reviewed alternative dispensing methods, such as telepharmacy, remote dispensing, and mail order dispensing. Both telepharmacy and remote dispensing allow patients who cannot access a full-service pharmacy to access pharmacist services via the internet. Further, mail order pharmacy services allow patients, especially those with managed chronic conditions, to receive a convenient supply of medication delivered to their home. Although these types of prescription dispensing have been shown to be beneficial to patients and pharmacies, challenges remain when there is not reliable access to broadband, patients lack safe mail delivery methods, and the prescription is not shelf-stable or is needed urgently. Second, the Council explored legislative and regulatory solutions, including PBM regulation and boosted reimbursement rates. These types of regulations have shown promise, especially at the state level, in ensuring pharmacies receive reimbursement adequate for operations and limiting untoward PBM practices. Finally, the Council reviewed federal, state and non-governmental incentive-based solutions. Similar to programs designed to attract physicians to underserved areas, these programs are designed to make operating a pharmacy in an underserved area more possible and, in some cases, advantageous for pharmacists.

Based on its review of the issue, the Council recommends the adoption of new AMA policy that supports efforts to ensure that pharmacy reimbursement rates are adequate to cover the actual costs related to obtaining and dispensing medications. The Council also recommends policy that supports the establishment of a minimum preferred pharmacy network adequacy standard and recognizes and encourages payer coverage of telepharmacy and remote dispensing when specific criteria are met. Furthermore, the Council recommends new policy that supports payer and PBM practices that promote fair market competition, patient choice, and support the financial viability of independent and community pharmacies. In addition to new policies, the Council recommends the reaffirmation of Policy H-120.989, which outlines appropriate mail order pharmacy practices and recognizes it as a legitimate drug dispensing method, and Policy D-110.987, which outlines advocacy efforts related to PBM regulation towards increased transparency.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-A-26

Subject: Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee A

Resolution 113, "Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts," was introduced by the Ohio delegation at the 2025 Annual Meeting and was referred. It asks the following:

> RESOLVED, that our American Medical Association (AMA) support efforts to expand telepharmacy as a potential solution to pharmacy deserts; and be it further;
>
> RESOLVED, that our AMA advocate for equitable reimbursement rates for pharmaceuticals between Medicare, Medicaid, and private insurers to ensure sustainable pharmacy operations in rural and underserved areas; and be it further;
>
> RESOLVED, that our AMA study and address the impact of preferred pharmacy networks on patient access to pharmacy services, particularly in pharmacy deserts, with attention to supporting independent pharmacies.

This report reviews the state of pharmacies and pharmacy access in the United States, economic issues faced by pharmacies, and solutions to improve pharmacy access. Additionally, it provides an overview of related AMA policies and offers a number of recommendations.

BACKGROUND

Pharmacies are key to ensuring that patients have access to the medications prescribed by their physicians. For many people, pharmacies are their most frequent contact with the health care system, as evidence shows that patients visit pharmacies 1.5-2 times more frequently than other health care providers.[1] However, over the last 15 years, pharmacies have been closing at an alarming rate. Between 2010 and 2021, 29 percent of all pharmacies across America closed.[2] In 2024, 2,200 pharmacies closed, meaning an average of six pharmacies closed each day.[3] As an example of the magnitude of the issue, in 2025, Rite Aid, a major pharmacy retailer across the United States, filed its second bankruptcy in two years and ceased all operations. This resulted in approximately 2,200 Rite Aid pharmacies closing between the initial bankruptcy filing in May 2023 and October 2025.[4]

These closures highlight an overarching trend among not only chain pharmacies, but also local/independent pharmacies. Estimates show that independent pharmacies make up about 35 percent of all pharmacies nationally and meet the needs of over 15 million Americans.[5] These pharmacies are also closing rapidly, approximately one per day.[5] Historically, independent community pharmacies have closed at a higher net rate than chain pharmacies. However, in recent years more independent pharmacies have also been opening, which has lowered their net closure

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rate. This more recent trend may indicate that independent pharmacies have a higher "churn rate," meaning that while they may open more frequently, they are unable to stay in business and end up closing or selling to a chain. Notably, while there is an increase in independent pharmacies opening, they do not seem to be opening in communities that are low-income or which currently lack access to pharmacies.[6,7] This is particularly important as research demonstrates that individuals who live in rural areas, are 65 years or older, or live in a low-income household are more likely to rely on independent pharmacies for access to prescriptions.[8] As these pharmacies often lack the bargaining power that bigger chain pharmacies have, they may struggle to stay open, exacerbating the access problems within vulnerable communities.[7]

As a result of these closures, pharmacy deserts have been growing. While there is no single universally accepted definition of a pharmacy desert, the term generally refers to communities that do not have easy access to a pharmacy. The term was originally coined in 2014 and relied on census tracts to identify communities that had a "high poverty rate" and no pharmacies within one mile in urban areas or 10 miles in rural areas.[9] In 2025, researchers expanded on this definition by introducing a pharmacy vulnerability index. This index takes a slightly different approach in identifying deserts, defining them as areas where the travel time to the nearest pharmacy is longer than the travel time to the nearest supermarket, accounting for the region and urbanicity levels.[10] Importantly, geographic distance is not the only issue that many patients face in accessing pharmacies, as lack of public transportation and limited pharmacy hours can greatly exacerbate access issues.[3,9] This vulnerability index led to the concept of "keystone pharmacies," or pharmacies that if closed would create a pharmacy desert. Based on this definition, nearly 18 percent of the United States population currently lives in pharmacy deserts and another nearly nine percent live in areas served by a keystone pharmacy.[10] Individuals who reside in rural communities are disproportionately represented when assessing communities served by keystone pharmacies, while pharmacy deserts seem to be equally distributed across urbanicity when incorporating national population statistics.[9,10] Thus, while more rural communities are at risk to become pharmacy deserts, the problem also exists in some urban and suburban communities.

In both suburban and urban settings, individuals living in pharmacy deserts are more likely to be a part of a racial and/or ethnic minority.[8,9] When controlling for setting (urban vs rural), predominately Black and Hispanic communities faced the largest decline in pharmacies, with nearly five percent fewer pharmacies than non-predominately Black/Hispanic communities.[11] However, in rural settings, White individuals are more likely to reside in a pharmacy desert or in areas served by a keystone pharmacy. This is likely explained by the fact that more White individuals live in rural areas. Regardless of the racial makeup of the community, pharmacies in communities with poverty rates higher than 20 percent had significantly higher risks of pharmacy closure.[10,11] Further, many communities considered pharmacy deserts are also considered medically underserved, meaning they do not have adequate access to physicians or non-physician practitioners, which exacerbates the issue.[10,11] Pharmacy deserts are not just an issue of convenience, as patients living in them are less likely to be able to access their medications and as a result, unable to access their treatments.[9,10] While not driven solely by pharmacy access issues, they likely contribute to medication nonadherence which results in avoidable health care spending, including millions of dollars due to unnecessary hospitalizations each year.[12] Further, disparities among racial and ethnic communities are prevalent across both access and utilization of prescription medications. Since these disparities are not entirely explained by access to medical professionals, health insurance coverage, or medication cost, researchers posit that this additional driving factor to this disparity may be pharmacy deserts.[13,14]

PHARMACY ECONOMICS

Prior to the modern insurance paradigm, pharmacy economics were straightforward, as pharmacists acquired the goods and set prices based on supply and demand. Pharmacies buy a drug at a price set by the drug manufacturer and the consumer purchases it with the markup determined by the pharmacy. However, with the advent of prescription drug insurance, the patient-pharmacist connection became less direct as payers were inserted in the middle, shifting pharmacist focus to volume to keep pharmacies economically viable.[15] The inception of the Medicare Modernization Act in 2003, which created Medicare Part D and the contemporary business model used by pharmacy benefit managers (PBMs), further complicated pharmacy reimbursement and what was necessary to stay in business.[15] Payment paradigms become increasingly complicated when payers, PBMs, and discount programs are involved in the transaction.[16,17] If a patient is utilizing insurance, the plan typically pays for the bulk of a covered drug at the set reimbursement rate with the pharmacy, usually negotiated by a PBM. Often the patient is responsible for some out-of-pocket (OOP) payment that is paid directly to the pharmacy. In theory, the combination of the patient OOP payment and the payer reimbursement should cover the drug and dispensing costs for the pharmacy. However, in practice, pharmacy reimbursement does not fully cover acquisition and operating costs.[17] Moreover, another concerning issue arises when a non-integrated pharmacy deals with a PBM that is vertically integrated as it can result in anticompetitive practices.[18,19] Several mergers and acquisitions across the pharmacy and PBM/payer markets, as well as insurers creating their own PBMs, have led to large vertically integrated firms operating across these three product markets.[20] Estimates show that five of the six largest PBMs are vertically integrated with both insurers and pharmacies, indicating high concentration in PBM markets.[19,21] Research shows that nearly 80 percent of prescription claims are processed by the three largest PBMs.[17,18]

Furthermore, not only are the largest PBMs vertically integrated with insurers, but these firms also often either own or have preferred network agreements with a significant number of pharmacies.[17,18,19] Preferred pharmacy networks are similar to “in-network providers” in concept. PBMs negotiate an agreement with a pharmacy or pharmacy chain on behalf of insurers for discounted rates for beneficiaries.[21] This can be beneficial for patients if they have access to pharmacies that are within the preferred network. Patients who utilize these pharmacies can save money on their prescription costs. For example, among Medicare Part D plans, preferred pharmacies can reduce patient spending by two percent.[21] However, preferred pharmacy networks can limit patient choice and, in cases when patients are unable to access a preferred pharmacy, lead to higher OOP costs.[21] Since PBMs have a large share of market power, downward pressure is put on non-integrated pharmacies, lowering reimbursement rates. Often exacerbating the closures of small, independent pharmacies as they cannot sustain the reduction in reimbursement or patients when they are redirected to preferred network pharmacies.[19,22]

Even pharmacies in preferred networks can experience financial strain emanating from inadequate reimbursement rates. In many cases, on behalf of insurers, PBMs have significantly reduced pharmacy reimbursement rates, sometimes resulting in pharmacies dispensing medications at a deficit.[23,24] Additionally, pharmacies are often hit with Direct and Indirect Renumeration (DIR) fees.[23] These fees are retroactive and result from a payer attempting to recoup a portion of their payment after a transaction is completed. This can be harmful for any pharmacy, but it is particularly problematic for small or independent pharmacies that do not have the same funding or volume as larger retail chains. While there have been some recent reform efforts from the Centers for Medicare & Medicaid Services (CMS) related to DIR fees, the solutions presented have not been comprehensive and do not address all payer types.[24] Further, programs like 340B, intended to make drugs more affordable for patients, can make it difficult for non-340B pharmacies to compete. Specifically, 340B program hospital and clinic pharmacies can purchase medication for a

price much lower than most other pharmacies can offer, which they can then sell at rates significantly lower than non-340B pharmacies or at more favorable markups.[21]

While the process of reimbursement does not dramatically differ between a vertically integrated pharmacy and an independent pharmacy, the results vary greatly. Smaller, independent pharmacies are generally not vertically integrated with PBMs and/or payers, and thus lack the bargaining power to negotiate and are often excluded from preferred pharmacy networks.[23,25] As a result, independent pharmacies often receive worse reimbursement rates and/or a loss of patients as PBMs and payers steer patients towards vertically integrated and preferred pharmacy networks.[23,25] These issues have led to significant losses in gross margins for pharmacies.[23] Gross margins are the total revenue of a business minus the cost of the goods that are sold. These margins fund business growth and innovation. Research shows that even though pharmacies are dispensing more prescriptions toward increasing revenue, gross margins are decreasing.[23] For example, Walgreens experienced a 33 percent decrease between 2015 and 2024 in gross margins per 30-day prescription. Additionally, non-prescription drug purchases, which can bolster margins, also decreased seven percent. This drop in gross margins is a direct result of PBM and payer reimbursement rates becoming increasingly tighter.[23] As a result, it has become increasingly difficult to run a financially successful pharmacy. For more information on drug pricing and PBMs, please reference CMS Report 5-A-19: The Impact of Pharmacy Benefit Managers on Patients and Physicians; CMS Report 4-I-19: Additional Mechanisms to Address High and Escalating Pharmaceutical Prices; CMS Report 6-A-25: Prescription Medication Price Negotiation; and CMS Report 6-A-24: Economics of Prescription Medication Prior Authorization.

POTENTIAL SOLUTIONS

Pharmacy-Based Solutions

There are a number of potential pharmacy-based solutions that could work towards improving pharmacy access and, since no solution will independently fix the entirety of the problem, it is important to explore them together. One such potential solution, particularly in existing pharmacy deserts, is the expansion of telepharmacy, which generally consists of a remote pharmacist providing traditional services, such as prescription review, prescription verification, and patient consultation, via the internet.[26] Individuals who do not have convenient access to a pharmacy or may not be able to travel to a pharmacy could benefit most from telepharmacy services. In practice, telepharmacy has shown promise in addressing access issues and reducing operating costs, as they operate with increased efficiency.[27] This has shown improved patient outcomes and medication adherence while reducing unnecessary medical visits and hospitalizations.[28]

To better address the needs for more emergent prescriptions, some settings have begun to implement remote dispensing. This type of dispensing is often included as a method of telepharmacy but is unique in that there is an immediacy in dispensing.[29] In remote dispensing set ups, a pharmacist at a central location will supervise dispensing at a number of remote sites. Patients have the ability to speak with the pharmacist to verify the prescription, review drug utilization, and complete any necessary drug counseling. Pharmacy technicians will typically be on-site and manage the physical portions of dispensing. This means that patients have access to medications immediately, which can be crucial if a patient has acute care needs.[29] Some providers or payers have even recently begun to implement prescription kiosks or “drug vending machines,” that are enabled by remote dispensing.[30,31] These kiosks allow clinicians to send prescriptions for shelf-stable medications for both acute and chronic care needs and, upon dispensing, patients have the ability to engage pharmacists via videoconferencing built into the kiosk.[30,31]

Further, mail order pharmacy services are another potential part of the solution. While similar to telepharmacy and remote dispensing, mail order pharmacy services do not always entail real-time interaction between the patient and pharmacists.[32] These services are typically operated through a patient's PBM and mail prescriptions directly to the patient's home. While there can be variety in medications provided, the vast majority of mail order prescriptions are sent as a 90-day supply, thus making this method of delivery most appropriate for well-managed chronic conditions and/or maintenance medications and not as useful for acute prescription needs, like an antibiotic.[32] While there are clear potential benefits to the expansion of telepharmacy, remote dispensing, and mail-order pharmacy services, there are also significant barriers. Communities that are more likely to be in a pharmacy desert are also less likely to have access to reliable broadband as there are significant disparities in access to broadband in rural communities and in majority Black and Hispanic neighborhoods.[33,34] Additionally, the necessary technological investment, both initially and ongoing, can be overwhelming for many pharmacies. Telepharmacy services require significant technological infrastructure and security which is complex and can be prohibitively expensive.[28] Of note, while not a required aspect, many of these solutions include an enhanced clinical role for pharmacists.[27] The AMA has long opposed scope of practice expansions that would allow pharmacists to practice medicine—which includes making a diagnosis or prescribing medications—without appropriate physician supervision.[35]

In both mail order and telepharmacy services, there can be issues with both communication and promptness of medication delivery. Specifically, a patient may not be able to fill some prescriptions via telepharmacy or mail order. If the pharmacies are not accurately communicating, the dispensing pharmacist may not have adequate information to do a full medication utilization review.[34,36] This could lead to missing patient education on potential drug interactions or adverse drug interactions that could have been prevented had full information been available.[34,36] Further, there can be complications with patients receiving the medication in a timely manner. Research shows that in a significant number of cases; patients have to wait several days between the telepharmacy consultation and receipt of the medication and mail order prescriptions typically take about a week to be delivered. This could be a significant issue if a patient needs medication to treat an acute condition. For example, patients prescribed antibiotics are often unable to wait days or a week for the prescription without significant consequences to their health. Likewise, delivery delays can impact medication adherence when chronic medications are delayed to the point where patients run out of their medications. Importantly, some newer delivery models are able to deliver medications in one to two days, so it is possible that this delivery window will continue to be reduced.[36] Pharmacists surveyed also voiced significant concern that not only could this delay result in incorrect medication usage, but medications could be damaged or inaccurate when delivered via mail or should a patient not have a secure location to receive mail. Further, this delivery method is significantly more complicated for medications that are temperature or light sensitive.[36] This could be partially addressed by the aforementioned medication kiosks that allow for immediate dispensing, but this would only be an option for shelf-stable medications. Due to these issues, telepharmacy and mail order pharmacy services may not be a safe or viable solution for situations when a drug has specific instructions and/or need to be accessed rapidly, but could serve communities struggling to access non-emergent pharmacy services.[34,36]

Legislative & Regulatory Solutions

At a minimum, pharmacies must be reimbursed in a manner that allows them to remain open and accessible in communities across the United States. It is essential that payers reimburse pharmacies in a manner that is fair and covers the actual costs of obtaining and dispensing the medication. Similar to physician practices that dispense medications, it is not possible for pharmacies to provide medications at a deficit and remain financially viable.[23] To ensure that reimbursement is

fair and equitable, it will be important to address the role of PBMs and vertical integration between payers, PBMs, and pharmacies/pharmacy chains. While the dissolution of existing integration is exceptionally challenging, it may be beneficial to work towards the prevention of further integration. A January 2026 Congressional hearing highlighted the importance of this issue and came with assurances from Congress that oversight on this issue would continue. The Consolidated Appropriations Act of 2026, signed into law in early February 2026, includes provisions that will work to regulate PBMs and promote a more sustainable environment for pharmacies.[37] Further, at the end of January 2026, the Department of Labor proposed a new rule that would require increased transparency in PBM practices. Specifically, the new rule, if implemented, would require that PBMs disclose rebates and payments from drug manufacturers, any compensation received when the drug cost paid by the insurer exceeds the pharmacy reimbursement, and any payments recouped from pharmacies connected to drugs dispensed in the PBM managed plan.[38] Along with this rule, a February 2026 Federal Trade Commission (FTC) settlement with vertically integrated PBMs, demonstrated additional commitments to not only transparency, but also providing more reasonable reimbursement to pharmacies.

While PBM regulation is essential to improving pharmacy reimbursement, and as a result improving pharmacy access, some states have begun to implement innovative new payment methods. For example, in 2022, Ohio Medicaid worked to revamp the system all together. After an investigation showed that two major PBMs charged patients $224 million more than they paid the pharmacies, the state ended its working relationship between Medicaid and multiple PBMs.[39] Instead, Ohio Medicaid contracted its own PBM, Ohio Medicaid's Single Pharmacy Benefit Manager (SPBM).[40] As a part of this program the state mandates dispensing fees based on surveys sent to pharmacists that are designed to determine the actual cost of dispensing and ensure reimbursement covers the full cost. Additionally, the implementation of the Ohio SPBM has allowed the state to better oversee the PBM and prevent untoward business practices that may occur.[39,40] In the first two years of its implementation, the SPBM overhaul has boosted pharmacy dispensing fees by over 1,200 percent and has reportedly saved $140 million.[41] While this model does seem to hold promise, it has not been without opposition. PBMs and associated groups have tied up many of the most promising aspects of the Ohio legislation and regulation in extensive legal battles that were ongoing at the time this report was written. Further, some state legislators and regulators have called the initial results of this program into question and voiced potential concern with data privacy in the SPBM.[41,42] Additionally, the feasibility to implement a similar program on a national level is complicated by the fact that Medicaid programs vary greatly between states.[42] Further, implementation in the Medicare or commercial markets would likely face significantly greater legal challenges. While the SPBM as implemented in Ohio may not be the perfect solution, most agree that it has seemed to make significant improvements and should be considered as a model option.[42] Other states have begun to implement legislation that works to mitigate some of the issues that are faced by pharmacies. For example, Alabama SB 252 increased Medicaid reimbursement rates and set a standard per-prescription dispensing fee. Further, Illinois HB 1697 and California SB 41 work to eliminate spread pricing and practices designed to steer patients towards PBM affiliated pharmacies.

Incentive Based Solutions

In addition to regulatory or legislative solutions, some states have worked to provide pharmacies serving underserved communities with monetary support via grants. For example, Illinois offers the Pharmacy Support Program to pharmacies serving underserved areas in an effort to improve access to pharmacies and pharmacy services. Further, private organizations and associations have stepped in to provide support and funds for pharmacies operating in pharmacy deserts. For example, the National Community Pharmacists Association announced the Rural Pharmacy Ownership

Accelerator, which is a program designed to prepare pharmacy owners to open and operate pharmacies in rural areas.[43] The American Pharmacist Association has offered a variety of grants that have, among other things, offered seed money for pharmacists to open or expand practice in underserved communities.[44] Additionally, some PBMs have begun to offer programs to support independent pharmacies operating in underserved areas. For example, the Sustaining Pharmacy Access and Rural Care (SPARC) Program was recently launched by LucyRx, an independent PBM that boasts increased transparency from competitors. The SPARC program works to increase reimbursement rates, expand community services, and advocate for legislative reforms.[45] While this program could be beneficial for pharmacies in that it provides enhanced reimbursement rates, core tenants of the program work to expand pharmacist scope of practice to both prescribe and to provide preventive care. Although these tenants of the program conflict with AMA policy, the program's increased reimbursement to independent pharmacies serving underserved communities demonstrates a potential solution coming from the private sector.[45]

It also may be advantageous to implement incentive programs to support pharmacies in pharmacy deserts. Similar to programs designed to attract physicians to practice in medically underserved communities, these programs could provide some kind of supplemental payment for pharmacies operating in these areas.[2] While this would require a substantial investment from state and/or federal governments, it could be transformative for pharmacies serving these communities. Grants or programs that provide financial support have the potential to assist pharmacies in remaining open, however it is important to qualify that these types of solutions will not remedy the issue in the long-term.

Across all potential solutions, it is important to remember that no single solution will be successful in isolation. To make significant improvements in pharmacy access, it will be essential to ensure that solutions are designed and implemented holistically and in tandem. Additionally, it is important to ensure that pharmacy and pharmacist organizations and associations lead efforts to improve pharmacy access. While the AMA should continue to offer support, these organizations are experts in pharmacy and pharmacy practice and AMA efforts should be integrated with their solutions.

AMA POLICY AND ADVOCACY

To support alternative dispensing methods, Policy H-120.989 outlines AMA support for mail service pharmacies as a legitimate alternative and outlines the criteria that should be met to ensure that these pharmacies remain beneficial for patients. Policy H-120.936 supports the establishment of national guidelines that work towards safe and timely delivery of medications via the mail. Policy H-120.962 expands these guidelines to ensure that mail order pharmacies remain accessible and affordable for patients and do not charge egregious additional fees. Policy H-120.940 ensures that mail order and online pharmacies adequately communicate with electronic prescribing systems and do not interfere with physician prescribing. Additionally, Policy H-120.956 focuses on internet prescribing and outlines not only efforts to ensure that these platforms are accessible to physicians and advantageous to patients but also to support appropriate pharmaceutical bodies in accreditation.

In addition to mail and internet-based pharmacies, the AMA has extensive policy to ensure that patients have access to the medications prescribed by their physician without interference from payers or PBMs. Policies H-110.991, H-110.990, and H-110.959 are all designed to ensure that patients have timely and affordable access to the medications as prescribed by their physician. Policy H-120.943 outlines AMA efforts to ensure that patients have access not only to affordable medications, but also quantities that are adequate and do not face arbitrary limits. To combat harmful PBM practices, Policies D-120.988, H-120.924, and H-110.963 limit PBM and payer

intrusion in prescription access, increase transparency, and hold these bodies accountable should patient harm occur. Policy H-125.986 outlines the importance of ensuring that payment for prescriptions is adequate to cover the full cost of prescription medications for both pharmacies and physicians/physician practices. Policy D-160.920 outlines efforts to track and work against the vertical integration between payers, PBMs, and pharmacies. This policy outlines efforts to communicate concerns and advocate for change with federal and state legislators and regulators. To further combat poor PBM practices, Policy H-110.957 outlines AMA opposition to spread pricing and discusses efforts to prohibit it on a federal and state level. Policy D-110.987 focuses on efforts to increase transparency in PBM practices, specifically in relation to patient impact and pharmacy payment. To support the aforementioned policies, the AMA also advocates for improved medication access and against PBM harms via the grassroots site TruthinRx. This campaign works to educate and influence patients, physicians, and legislators about harmful payer and PBM practices/policies. Additionally, efforts have been made at the state and federal levels to advocate for legislation to limit PBM and payer harmful practices. The AMA supported these federal PBM reforms as well as the health policy wins included in the Consolidated Appropriations Act of 2026.

Finally, the AMA has policies designed to ensure that pharmacists do not practice beyond the scope of their training. Policy H-35.961 outlines the inappropriateness of pharmacists working to verify the medical rationale or diagnosis behind a treatment/prescription. Policy D-35.987 outlines AMA efforts to monitor and oppose pharmacist scope of practice expansions that constitute the practice of medicine, for which pharmacists are not trained. To further combat these scope expansions, the AMA Advocacy Resource Center has worked to block and mitigate a significant number of bills in states across the country.

DISCUSSION

Pharmacy access is key to ensuring patients have access to the full spectrum of health care. However, across the country millions of Americans are living in areas deemed pharmacy deserts or areas served only by a keystone pharmacy. This can have significant downstream impacts on patient health outcomes and introduce stress on the health care system as a whole. When patients are unable to fill their medications, they are unable to adhere to treatment plans prescribed by their physician. As a result, patients have increased risk of poor health outcomes and are more likely to experience increases in the severity or onset of new health issues. Pharmacies are closing at a rapid rate, an issue that is even more severe in rural areas and communities of color. Individuals living in majority-minority communities are more likely to rely on independent pharmacies, which are closing in these communities. Although there are some promising numbers in terms of how many pharmacies, especially independent pharmacies, are opening these new businesses tend not to open in underserved areas.

Pharmacy access is adversely impacted due to a combination of poor reimbursement rates, PBM interference, and increasingly stringent preferred pharmacy networks. Pharmacies, even those that are a part of a large chain, have seen significant drops in gross revenue over the last several years. Even though pharmacy volume may be increasing, the rates of reimbursement are so low that the gross revenue continues to decrease. While this trend is seen in large pharmacy chains, it is even more significant for smaller and independent pharmacies. These pharmacies lack the market power to be able to negotiate reimbursement rates and are often excluded from preferred pharmacy networks. As a result, prices are higher for patients and pharmacy margins are shrinking. To combat these issues, the Council recommends the adoption of two new policies. First, the Council recommends policy that supports efforts to ensure pharmacy reimbursement across payer types covers the actual cost of obtaining and dispensing each prescription. Second, the Council recommends that policy be adopted to ensure preferred in-person pharmacy network adequacy. In

line with existing network adequacy policy, this policy would work to ensure that a minimum preferred network standard be enforced across payers and bolster independent pharmacy inclusion when possible. In conjunction, these two policies could work to support existing pharmacies in continuing ongoing operations.

In an effort to improve pharmacy access, innovative alternative delivery and practice methods, and legislative and regulatory changes have been implemented or proposed. These dispensing methods allow patients to have access to a pharmacist via telecommunication and receive their medication either by mail or in-person. Some health systems have even begun to implement these practices in kiosk or "vending machine" form for shelf stable medications. These practices build on existing mail order dispensing where patients are sent drugs, typically maintenance medications, via the mail. Although these methods are promising, there is some concern with pharmacy communication, medication management, and prescription accuracy. However, with appropriate guardrails, the Council believes that these dispensing methods could work in conjunction with other strategies to decrease the number of pharmacy deserts. Accordingly, the Council recommends the adoption of new policy that recognizes these dispensing methods, supports their coverage, and outlines appropriate guardrails. These guidelines ensure that pharmacists practice in their defined scope, medications are delivered timely, accurately, and without major cost increases, and that existing community pharmacies are not displaced. Further, the Council recommends the reaffirmation of Policy H-120.989, which outlines appropriate guidelines for mail order pharmacies and recognizes their legitimacy as a component to improving pharmacy access.

In addition to alternative dispensing methods, governmental and non-governmental organizations have implemented changes and made investments to support improvements to pharmacy access. States have taken the opportunity to implement regulatory and legislative changes dictating fairer reimbursement rates, dispensing fees that cover actual costs, and the reining in of PBMs. The federal government has introduced legislation and regulations that target PBMs in an effort to promote their transparency. Some states along with private organizations and associations have also stepped in to provide grants and support to pharmacists operating pharmacies in deserts. To support these, and future innovative efforts, the Council recommends the adoption of new policy that not only encourages innovation, but also the associated regulatory changes necessary to implement them. To limit anticompetitive practice by PBMs or payers, the Council recommends the adoption of new policy that supports fair market competition in order to support the financial health of full-service independent/community pharmacies. Finally, to further address PBM interference, the Council recommends the reaffirmation of Policy D-110.987, which outlines AMA efforts to advocate for active regulation of PBMs, with a particular focus on increasing transparency and regulation.

RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted in lieu of Resolution 113-A-25, and the remainder of the report be filed:

1. Our American Medical Association (AMA) supports efforts to ensure that pharmacy reimbursement by all payers covers the actual cost of obtaining and dispensing the medication, including necessary staffing and operational costs with a sufficient margin to ensure pharmacy viability.
2. Our AMA supports the establishment and enforcement of a minimum preferred pharmacy network adequacy standard requiring all health plans to contract with sufficient numbers of pharmacies, including independent and/or physician-owned pharmacies, such that patient

medications or medical products are accessible without unreasonable travel or delay. (New HOD Policy)

3. Our AMA recognizes telepharmacy and remote dispensing as avenues to improve access to prescription medications and supports their expansion and encourages payer coverage when the following criteria are met:
    a. Services are provided by pharmacists within a clearly defined scope of practice that does not constitute the practice of medicine without appropriate physician supervision.
    b. Medications are delivered to patients accurately and in a timely manner.
    c. Communication between pharmacy systems is maintained to ensure an accurate medication list so that patients are educated on all their medications with key safety information.
    d. Patients are not subjected to increased cost-sharing or major shipping and handling fees to receive their medications.
    e. Existing community pharmacies are not displaced.
    f. Patients and physicians are able to opt out of telepharmacy and remote dispensing
4. Our AMA supports the development of innovative programs designed to improve access to pharmacies and the appropriate regulatory changes to allow for these programs to be implemented while ensuring high-quality, physician-led care in alignment with AMA policy. (New HOD Policy)

5. Our AMA supports practices by payers/insurers or pharmacy benefit managers (PBMs) that promote fair market competition, patient access and choice of pharmacy, and supports the financial viability of full-service independent/community pharmacies. (New HOD Policy)

6. That our AMA reaffirm Policy H-120.989, which recognizes mail order pharmacy services as legitimate method for drug distribution and outlines its appropriate use. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy D-110.987, which outlines AMA advocacy and support for PBM regulation. (Reaffirm HOD Policy)

Fiscal Note: Minimal

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Council on Medical Service Report 3-A-26
Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts
Policy Appendix

Mail Service Pharmacy H-120.989

1. Our American Medical Association (AMA) believes that MSP is an established alternative method of distributing drugs in the United States.
2. Our AMA believes that controlled studies in the 1970s support the fact that MSPs are less vulnerable to drug diversion than retail pharmacies. Although numerous concerns about lack of safety and drug diversion have been expressed in trade publications and newsletters, documented controlled data regarding these concerns are minimal. There is no evidence of lack of safety in the peer-reviewed controlled-study literature. Presently, the practice of obtaining drugs from mail service pharmacies appears to be relatively safe.
3. Our AMA believes that mail service pharmacy for prescription drugs is probably most appropriate for patients who have a well-established diagnosis, who have long-term chronic illnesses, whose disease is relatively stable and in whom the dose and dosage schedule is well regulated, who are isolated because of geographic or personal reasons, who have a drug history profile on record, who have been adequately informed about their medication, and who continue to see their physician regularly. Certainly, MSP is not best utilized for medications that are to be used acutely. Further, there must be assurance that generic substitution occur only by order of the prescribing physician.
4. Our AMA believes that any purported price savings from the use of MSP is difficult to assess, since studies are generally limited to regional and limited patient populations.
5. Our AMA believes that physicians have the responsibility to prescribe reasonable amounts of prescription medications based on the diagnosis and needs of their patients. Physicians must not be influenced by purely economic reasons, but they must take into account the patient's ability to pay and be aware of the guidelines recommended by particular health benefit programs for drugs. (BOT Rep. I, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: BOT Rep. 8, A-11; Reaffirmed: CSAPH Rep. 1, A-21)

Improve Safety of Mail-Ordered Medication H-120.936

Our American Medical Association supports the establishment of national guidelines for mail-order pharmacies to ensure that medications reach patients in a safe and timely manner with full potency, and that when medication is damaged or loses potency during shipment, it should be replaced by the pharmacy at no cost to the patient. (Res. 917, I-14; Reaffirmed: CSAPH Rep. 01, I-24)

National Mail Order Pharmacy Practices H-120.962

1. Our American Medical Association insists that mail-order pharmacy companies respect the prescribing authority of physicians and dispense prescription medications only in the amounts prescribed; and recommends that mail order pharmacy companies charge only a reasonable and small shipping and handling fee per shipment in order not to encourage patients to request amounts of medications greater than those warranted by their physician's best judgment.
2. Our AMA opposes charging patients more than one co-pay for multiple prescriptions of the same or varying doses of a long-term medication within a 90-day period when evidence-based medicine dictates that less than 90-day prescriptions should be written during the initialization and dose stabilization of a newly prescribed long-term medication or during change in dosing of a long-term medication currently being taken. (Sub. Res. 506, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Appended: Res. 121, A-07; Reaffirmed: BOT Rep. 8, A-11; Reaffirmation A-14; Modified: CSAPH Rep. 01, A-24)

Mail Order Pharmacies and Interface with Current Pharmacy Hubs H-120.940

1. Our American Medical Association (AMA) will work with mail order pharmacies to make sure that such pharmacies adopt interfaces with current pharmacy hubs and physician electronic prescribing systems at no cost to physicians.
2. Our AMA will advocate for penalties and/or incentives for mail order pharmacies to encourage the adoption of a functional system to automate the prescribing process through interfaces with physicians electronic prescribing systems. (Res. 708, A-10; Reaffirmed: BOT Rep. 8, A-11; Reaffirmed: CSAPH Rep. 1, A-21)

Internet Prescribing H-120.956

1. Our AMA supports the use of the Internet as a mechanism to prescribe medications with appropriate safeguards to ensure that the standards for high quality medical care are fulfilled.
2. Our AMA will work with state medical societies in urging state medical boards to ensure high quality medical care by investigating and, when appropriate, taking necessary action against physicians who fail to meet the local standards of medical care when issuing prescriptions through Internet web sites that dispense prescription medications.
3. Our AMA will work with the Federation of State Medical Boards and others in endorsing or developing model state legislation to establish limitations on Internet prescribing.
4. Our AMA will continue to work with the National Association of Boards of Pharmacy and support their digital pharmacy accreditation program so that physicians and patients can easily identify legitimate Internet pharmacy practice sites.
5. Our AMA will work with federal and state regulatory bodies to close down Internet web sites of companies that are illegally promoting and distributing (selling) prescription drug products in the United States.
6. Our AMA will keep pace with changes in technology by continually updating standards of practice on the Internet. (BOT Rep. 35, A-99; Reaffirmed: BOT Rep. 3, I-04; Reaffirmed: Sub. Res. 522, A-05; Modified: CSAPH Rep. 1, A-15; Modified: CSAPH Rep. 01, A-25)

Price of Medicine H-110.991

Our AMA: (1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications; (2) will pursue legislation requiring pharmacies, pharmacy benefit managers and health plans to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication; (3) opposes provisions in pharmacies' contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient's co-pay is higher than the drug's cash price; (4) will disseminate model state legislation to promote drug price and cost transparency and to prohibit "claw backs"; (5) supports physician education regarding drug price and cost transparency, manufacturers' pricing practices, and challenges patients may encounter at the pharmacy point-of-sale; and (6) work with relevant organizations to advocate for increased transparency through access to meaningful and relevant information about medication price and out-of-pocket costs for prescription medications sold at both retail and mail order/online pharmacies, including but not limited to Medicare's drug-pricing dashboard. (CMS Rep. 6, A-03; Appended: Res. 107, A-07; Reaffirmed in lieu of: Res. 207, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Reaffirmation: A-19; Appended: Res. 126, A-19)

Cost Sharing Arrangements for Prescription Drugs H-110.990
Our AMA:
1. believes that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients;
2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes;
3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and patient-specific out-of-pocket costs of individual prescription drugs, taking into account insurance status or payer type, prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition;
4. supports public and private prescription drug plans in offering patient-friendly tools and technology that allow patients to directly and securely access their individualized prescription benefit and prescription drug cost information; and
5. believes payers should not establish a higher cost-sharing requirement exclusively for prescription drugs approved for coverage under a medical exceptions process. (CMS Rep. 1, I-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed in lieu of Res. 105, A-13; Reaffirmed in lieu of: Res. 205, A-17; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: CMS Rep. 07, A-18; Appended: CMS Rep. 2, I-21; Reaffirmed: Res. 113, A-23; Appended: CMS Rep. 01, A-23)

Prescription Medication Price Negotiation H-110.959
1. Our AMA supports efforts to ensure that patients have affordable access to medications.
2. Our AMA encourages all payers, both public and private, in efforts to establish a reasonable and affordable cap on patient out-of-pocket prescription drug spending in a manner that does not increase patient premiums.
3. Our AMA opposes drug payment methodologies that result in physician practices being paid at less than the cost of acquisition, inventory, storage, and administration of relevant drugs and other necessary related clinical services. (CMS Rep. 06, A-25)

Adequate Prescription Medication Supply H-120.943
1. Our AMA urges health plans to: (a) define a month's supply as a minimum of 31 days and three month's supply as a minimum of 93 days, so that patients are not shorted on their one-month or three-month supply of prescription drugs; and (b) allow prescription refills to provide the appropriate number of doses for the time period specified by the physician.
2. Our AMA will advocate and support advocacy at the state and federal levels against arbitrary prescription limits that restrict access to medically necessary treatment by limiting the dose, amount or days of the first or subsequent prescription for patients with pain related to a cancer or terminal diagnosis. (Res. 510, A-07; Reaffirmed: CMS Rep. 04, A-16; Appended: Res. 918, I-16)

Inappropriate Actions by Pharmacies and Pharmacy Benefit Managers D-120.988
Our AMA, in cooperation with pharmacy benefit managers, pharmacy companies, and other drug retailing organizations, shall develop model procedures that physicians may use when prescribing off-formulary pharmaceuticals that are medically indicated and that these procedures be in compliance with the Health Insurance and Portability and Accountability Act of 1996. (Res. 528, A-02; Reaffirmation I-04; Reaffirmation A-06; Reaffirmed: CSAPH Rep. 01, A-16)

Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care H-120.924

Our AMA will: (1) urge the National Association of Boards of Pharmacy, Federation of State Medical Boards (FSMB), and National Association of Insurance Commissioners (NAIC) to support having national pharmacy chains, health insurance companies,
and pharmacy benefits managers (PBMs) testify at state-level public hearings by state medical/pharmacy boards and state departments of insurance, on whether the pharmacy chains, health insurance companies, and PBMs' policies to restrict the prescribing/dispensing of opioid analgesics are in conflict with state insurance laws or state laws governing the practice of medicine and pharmacy; and (2) oppose specific dose or duration limits on pharmacologic therapy that are not supported by medical evidence and clinical practice. (BOT Rep. 17, A-18; Reaffirmed: 235, I-18)

Third-Party Pharmacy Benefit Administrators H-110.963

1. Our American Medical Association recommends that third-party pharmacy benefit administrators that contract to manage the specialty pharmacy portion of drug formularies be included in existing pharmacy benefit manager (PBM) regulatory frameworks and statutes, and be subject to the same licensing, registration, and transparency reporting requirements.
2. Our AMA will advocate that third-party pharmacy benefit administrators be included in future PBM oversight efforts at the state and federal levels. (Res. 820, I-22; Reaffirmed: CMS Rep. 06, A-24)

Pharmaceutical Benefits Management Companies H-125.986

Our AMA:
(1) encourages physicians to report to the Food and Drug Administration's (FDA) MedWatch reporting program any instances of adverse consequences (including therapeutic failures and adverse drug reactions) that have resulted from the switching of therapeutic alternates;
(2) encourages the Federal Trade Commission (FTC) and the FDA to continue monitoring the relationships between pharmaceutical manufacturers and PBMs, especially with regard to manufacturers' influences on PBM drug formularies and drug product switching programs, and to take enforcement actions as appropriate;
(3) pursues congressional action to end the inappropriate and unethical use of confidential patient information by pharmacy benefits management companies;
(4) states that certain actions/activities by pharmacy benefit managers and others constitute the practice of medicine without a license and interfere with appropriate medical care to our patients;
(5) encourages physicians to routinely review their patient's treatment regimens for appropriateness to ensure that they are based on sound science and represent safe and cost-effective medical care;
(6) supports efforts to ensure that reimbursement policies established by PBMs are based on medical need; these policies include, but are not limited to, prior authorization, formularies, and tiers for compounded medications; and
(7) encourages the FTC and FDA to monitor PBMs' policies for potential conflicts of interests and anti-trust violations, and to take appropriate enforcement actions should those policies advantage pharmacies in which the PBM holds an economic interest. (BOT Rep. 9, I-97; Appended: Res. 224, I-98; Appended: Res. 529, A-02; Reaffirmed: Res. 533A-03; Reaffirmation I-08; Reaffirmation A-10; Reaffirmed: Alt. Res. 806, I-17; Modified: Res. 242, A-18; Reaffirmed: CMS Rep. 08, A-19; Reaffirmed: CMS Rep. 06, A-24)

Opposing Pharmacy Benefit Manager Spread Pricing H-110.957

1. Our AMA opposes the use of spread pricing by Pharmacy Benefit Managers (PBMs).
2. Our AMA will advocate for federal and state legislation and regulation that prohibits the use of spread pricing by PBMs.
3. Our AMA supports policies requiring PBMs to use transparent, pass-through pricing models that ensure fair and consistent reimbursement to pharmacies, physicians, and patients. (Res. 121, A-25)

AMA Response to Pharmacy Intrusion Into Medical Practice H-35.961

Our American Medical Association deems inappropriate inquiries from pharmacies to verify the medical rationale behind prescriptions, diagnoses, and treatment plans to be an interference with the practice of medicine and unwarranted. (CSAPH Rep. 8, A-23)

Health Insurance Company Purchase by Pharmacy Chains D-160.920

Our AMA will: (1) continue to analyze and identify the ramifications of the proposed CVS/Aetna or other similar merger in health insurance, pharmacy benefit manager (PBM), and retail pharmacy markets and what effects that these ramifications may have on physician practices and on patient care; (2) continue to convene and activate its AMA-state medical association and national medical specialty society coalition to coordinate CVS/Aetna-related advocacy activity; (3) communicate our AMA's concerns via written statements and testimony (if applicable) to the U.S. Department of Justice (DOJ), state attorneys general and departments of insurance; (4) work to secure state level hearings on the merger; and (5) identify and work with national antitrust and other legal and industry experts and allies. (BOT Action in response to referred for decision Res. 234, I-17)

Evaluation of the Expanding Scope of Pharmacists' Practice D-35.987

1. Our American Medical Association will re-evaluate the expanding scope of practice of pharmacists in America and develop additional policy to address the proposed new services provided by pharmacists that may constitute the practice of Medicine.
2. Our AMA will continue to collect and disseminate state specific information in collaboration with state medical societies regarding the current scope of practice for pharmacists in each state; studying if and how each state is addressing these expansions of practice.
3. Our AMA will develop model state legislation to address the expansion of pharmacist scope of practice that is found to be inappropriate or constitutes the practice of medicine, including but not limited to the issue of interpretations or usage of independent practice arrangements without appropriate physician supervision and work with interested states and specialties to advance such legislation.
4. Our AMA opposes federal and state legislation allowing pharmacists to independently prescribe or dispense prescription medication without a valid order by, or under the supervision of, a licensed doctor of medicine, osteopathy, dentistry or podiatry.
5. Our AMA opposes federal and state legislation allowing pharmacists to dispense medication beyond the expiration of the original prescription.
6. Our AMA opposes the inclusion of Doctors of Pharmacy (PharmD) among those health professionals designated as a "Physician" by the Centers for Medicare & Medicaid Services. (Res. 219, A-11; Appended: Res. 218, A-12; Reaffirmed: BOT Rep. 9, A-22)