**We affirm**

**Resolved:** The United States federal government should impose price controls on the pharmaceutical industry.

#### First. The standard is mitigating structural violence because should is implication of a moral framework,

**Morality is based on response to problems in the world, which justifies focus on resolving material conditions of violence. Pappas writes in 2016**[[1]](#endnote-1) that the judge should frame policy discussions through the lens of rejecting racism. Otherwise identity is intentionally excluded, and marginalized debaters internalize self-hatred**. Crenshaw writes in 94[[2]](#endnote-2) that** minority students’ experiences clash because of the dominant view in academe that legal analysis can be taught without directly addressing conflicts of individualexperiencesbeliefs in the objectivity of legal discourse serve to suppress the conflict by discounting the relevance of any particular perspective discourse proceeds with the expectation that students will learn to perform and embrace presumption of perspectivelessness**.** What is neutral is the embodiment of a white middle-class world view,minority students are expected to stand apart from theiridentity. The result is that minority students can seldom ground their analysisexperiences are deemed to be irrelevant**,** the pricecan be intense alienation.Ultimately, you vote for whichever team fights the oppression of minorities because that is the only scenario where your vote has immediate real impact. By voting neg, you actually harm somebody in real life, but by voting affirmative you help solve for internalized self-hatred of minorities. Overall, a judge’s votes are only important when you vote affirmative in today’s round.

**Now with an observation. The form of price controls put in place would be the plan outlined by Trump to restrict Pharmaceutical Benefit Managers.** Pharmaceutical

Benefit Managers, or PBMS, are the middlemen between manufacturers and local pharmacies. **Obrien writes in 2018[[3]](#endnote-3)** that Trump has detailed a plan to limit pharmaceutical

Prices charged by PBMs and reducing the middle man role.

**Our Sole Contention is Stopping Abuse of Minorities**

**Ross explains[[4]](#endnote-4)** that independent pharmacies are helping mitigate the issue of minority neighborhoods suffering from pharmacy deserts. Pharmacy deserts are simply when areas have severe lack of access to pharmacies. This is very important as **Ross furthers** that the presence of independent pharmacies in deserts is very important to the minorities living in the area as they rely heavily on access to the prescriptions provided. **Medscape reports[[5]](#endnote-5)** that PBM’s are overcharging for generic pharmaceutical drugs to make large hidden profits. **Garis of Creighton University Medical Center published a study stating that** PBM’s are costing independent pharmacies as well as the initial clients. **Leaf of Forbes explains[[6]](#endnote-6)** that these middle men are being heavily targeted under Trump’s plan to decrease pharmaceutical drug costs for American citizens. **Leaf quotes** the FDA commissioner who explicitly describes how PBM negotiations are hurting affordability and competition between different medications. **Loria explains[[7]](#endnote-7)** that by restricting pharmaceutical benefit managers, the citizens of the United States would be able to have better access to medication by effectively cutting out the expensive middle man. **Loria furthers** that PBMs pose a huge threat because their resistance to dropping prices. The warranting provided is what’s called manufacture kickback. The reason why PBMs low prices is because they profit off negotiating discounts on the medicine. The more room to discount, the more profits PBMs receive. Fortunately, Trump’s plan to cut out the middle man is key to creating more affordable drugs and decreases the abuse of local pharmacies. **Coppock explains[[8]](#endnote-8)** that there is a much-needed change to the way PBMs interact with independent pharmacies. In fact, **Coppock furthers** that PBMs are shutting down independent pharmacies who do not submit to their strict rebate rates.

**The impacts are two-fold**

**First, is generics**

**Forbes[[9]](#endnote-9) finds in 2015** through a meta-analysis, 200 generic drugs have seen a 100% increase in prices within a year while 17 others have seen a 1 thousand percent increase in the same time frame. This is problematic as **The FDA explains[[10]](#endnote-10)** that the U.S is using generics in the status quo at major rates. **The FDA continues** that 9 out of 10 Americans fill prescriptions with generic brand drugs which help treat diseases without the huge price tags. This is extremely important as expensive drugs are only accessible to the rich and white upper-class. The only solvency is provided by affirming and controlling PBMs who are the reason for generics increasing.

**Second, are independent pharmacies**

**Firozi of the Washington Post explains[[11]](#endnote-11)** that independent pharmacies are closing and the reason they cite is explicitly pharmaceutical benefit managers. It is important as **Firozi explains** that Trump’s implementation of price controls on PBMs are direct solvency for the closures maintaining the care of minority groups in the long-term.

**Thus,**

**We you urge you to affirm**

1. Gregory Fernando **Pappas** is Associate Professor of Philosophy at Texas A& M University. He is the author of numerous articles on the philosophy of William James and John Dewey. He has been the recipient of **a Ford Foundation Postdoctoral Fellowship as well as the William James and the Latin American Thought prizes by the American Philosophical Association**. "The Pragmatists' Approach to Injustice", The Pluralist Volume 11, Number 1, Spring 2016, WM

   Experience and Nature, Dewey names the empirical way of doing philosophy the “denotative method” (LW 1:371).18 What Dewey means by “denotation” is simply the phase of an empirical inquiry where we are concerned with designating, as free from theoretical presuppositions as possible, the concrete problem (subject matter) for which we can provide different and even competing descriptions and theories. Thus **an empirical inquiry about** an **injustice must begin with a** rough and tentative **designation of where the injustices from** within **the broader context of** our **everyday life** and activities **are**. Once we designate the subject matter, we then engage in the inquiry itself, including diagnosis, possibly even constructing theories and developing concepts. Of course, that is not the end of the inquiry. We must then take the results of that inquiry “as a path pointing and leading back to something in primary experience” (LW 1:17). This looping back is essential, and it never ends as long as there are new experiences of injustice that may require a revision of our theories. **Injustices are** events **suffered by concrete people at a particular time and** in a **situation**. We need to **start by pointing out and describing these problematic experiences instead of** starting with **a theoretical account** or diagnosis of them. Dewey is concerned with the consequences of not following the methodological advice to distinguish designation from diagnosis. Definitions, theoretical criteria, and diagnosis can be useful; they have their proper place and function once inquiry is on its way, but if stressed too much at the start of inquiry, they can blind us to aspects of concrete problems that escape our theoretical lenses. We must attempt to pretheoretically designate the subject matter, that is, to “point” in a certain direction, even with a vague or crude description of the problem. But, for philosophers, this task is not easy because, for instance, we are often too prone to interpret the particular problem in a way that verifies our most cherished theories of injustice. One must be careful to designate the subject matter in such a way as not to slant the question in favor of one’s theory or theoretical preconceptions. A philosopher must make an honest effort to designate the injustices based on what is experienced as such because **a concrete social problem** (e.g., injustice) **is independent and neutral with respect to the different** possible **competing diagnoses** or theories **about its causes**. Otherwise, there is no way to test or adjudicate between competing accounts. That designation precedes diagnosis is true of any inquiry that claims to be empirical**. To start with the diagnosis is to not start with the problem. The problem is** pretheoretical or **preinquiry**, not in any mysterious sense but **in that it is first suffered by someone in a particular context.** Otherwise, **the diagnosis about the causes** of the problem **has nothing to be about, and the inquiry cannot even be initiated**. In his Logic, Dewey lays out the pattern of all empirical inquiries (LW 12). All inquiries start with what he calls an “indeterminate situation,” prior even to a “problematic situation.” Here is a sketch of the process: Indeterminate situation → problematic situation → diagnosis: What is the problem? What is the solution? (operations of analysis, ideas, observations, clarification, formulating and testing hypothesis, reasoning, etc.) → final judgment (resolution: determinate situation) To make more clear or vivid the difference of the starting point between Anderson and Dewey, we can use the example (or analogy) of medical practice, one that they both use to make their points.19 The doctor’s starting point is the experience of a particular illness of a particular patient, that is, the concrete and unique embodied patient experiencing a disruption or problematic change in his life. “The patient having something the matter with him is antecedent; but being ill (having the experience of illness) is not the same as being an object of knowledge.”20 The problem becomes an object of knowledge once the doctor engages in a certain interaction with the patient, analysis, and testing that leads to a diagnosis. For Dewey, “diagnosis” occurs when the doctor is already engaged in operations of experimental observation in which he is already narrowing the field of relevant evidence, concerned with the correlation between the nature of the problem and possible solutions. Dewey explains the process: “A physician . . . is called by a patient. His original material of experience is thereby provided. This experienced object sets the problem of inquiry. . . . He calls upon his store of knowledge to suggest ideas that may aid him in reaching a judgment as to the nature of the trouble and its proper treatment.”21 Just as with the doctor, empirical inquirers about injustice must return to the concrete problem for testing, and should never forget that their conceptual abstractions and general knowledge are just means to ameliorate what is particular, context-bound, and unique. In reaching a diagnosis, the doctor, of course, relies on all of his background knowledge about diseases and evidence, but a good doctor never forgets the individuality of the particular problem (patient and illness). The physician in diagnosing a case of disease deals with something individualized. He draws upon a store of general principles of physiology, etc., already at his command. Without this store of conceptual material he is helpless. But he does not attempt to reduce the case to an exact specimen of certain laws of physiology and pathology, or do away with its unique individuality. Rather he uses general statements as aids to direct his observation of the particular case, so as to discover what it is like. They function as intellectual tools or instrumentalities. (LW 4:166) Dewey uses the example of the doctor to emphasize the radical contextualism and particularism of his view. The good doctor never forgets that this patient and “this ill is just the specific ill that it is. It never is an exact duplicate of anything else.”22 Similarly, the empirical philosopher in her inquiry about an injustice brings forth general knowledge or expertise to an inquiry into the causes of an injustice. She relies on sociology and history as well as knowledge of different forms of injustice, but it is all in the service of inquiry about the singularity of each injustice suffered in a situation. The correction or refinement that I am making to Anderson’s characterization of the pragmatists’ approach is not a minor terminological or scholarly point; it has methodological and practical consequences in how we approach an injustice. The distinction between the diagnosis and the problem (the illness, the injustice) is an important functional distinction that must be kept in inquiry because it keeps us alert to the provisional and hypothetical aspect of any diagnosis. To rectify or improve any diagnosis, we must return to the concrete problem; as with the patient, this may require attending as much as possible to the uniqueness of the problem. This is in the same spirit as Anderson’s preference for an empirical inquiry that tries to “capture all of the expressive harms” in situations of injustice. But **this requires that we begin with** and return to **concrete experiences of injustice** and not by starting with a diagnosis of the causes of injustice provided by studies in the social sciences, as in (5) above. For instance, a diagnosis of causes that are due to systematic, structural features of society or the world disregards aspects of the concrete experiences of injustice that are not systematic and structural. **Making problematic situations of injustice our explicit methodological commitment as a starting point rather than a diagnosis of the problem is** an important and useful **imperative for nonideal theories**. It functions as a directive to inquirers toward the problem, to locate it, and designate it before venturing into descriptions, diagnosis, analysis, clarifications, hypotheses, and reasoning about the problem. These operations are instrumental to its amelioration and must ultimately return (be tested) by the problem that sparked the inquiry. The directive can make inquirers more attentive to the complex ways in which such differences as race, culture, class, or gender intersect in a problem of injustice. Sensitivity to complexity and difference in matters of injustice is not easy; it is a very demanding methodological prescription because it means that no matter how confident we may feel about applying solutions designed to ameliorate systematic evil, our cures should try to address as much as possible the unique circumstances of each injustice. The analogy with medical inquiry and practice is useful in making this point, since the hope is that someday we will improve our tools of inquiry to practice a much more personalized medicine than we do today, that is, provide a diagnosis and a solution specific to each patient.

   [↑](#endnote-ref-1)
2. **Crenshaw**, Kimberle Williams**, Acting Professor of Law, University of California, Los Angeles, B.A., Cornell University**, 1981; J.D., **Harvard Law School**, 1984; L.L.M., **University of Wisconsin**, 1985.. "Foreword: Toward a Race-Conscious Pedagogy in Legal Education." S. Cal. Rev. L. & Women's Stud. 4 (1994): 33. WM

   Minority students across the country have waged a series of protests to draw attention to problems of diversity in the nation's law schools.1 Although the students' bottom line demand is often for the recruitment of more minority faculty and students, the anger and frustration apparent in these protests indicate that the disappointment is not simply over the lack of "color" in the hallways.2 The dissatisfaction goes much deeper-to the substantive dynamics of the classroom and their particular impact on minority students.3 In many instances, minority students' values, beliefs, and experiences clash not only with those of their classmates but also with those of their professors.4 Yet because of the dominant view in academe that legal analysis can be taught without directly addressing conflicts of individual values, experiences, and world views, these conflicts seldom, if ever, reach the surface of the classroom discussion. Dominant **beliefs in** the **objectivity o**f legal discourse serve to suppress the conflict by discounting the relevance of any particular perspective in legal analysis and by positing an analytical stance that has no specific cultural, political, or class characteristics. I call this dominant mode "perspectivelessness." This norm of perspectivelessness is problematic in general, and particularly burdensome on minority students. While it seems relatively straightforward that objects, issues, and other phenomena are interpreted from the vantage point of the observer, many law classes are conducted as though it is possible to create**,** weigh, and evaluate rules and arguments in ways that neither reflect nor privilege any particular perspective or world view. Thus, law school **discourse proceeds with the expectation that students will learn to perform** the standard mode of legal reasoning **and embrace** its **presumption of perspectivelessness.** When this expectation is combined with the fact that **what is** understood as objective or **neutral is** often **the embodiment of a white middle-class world view,** minority students are placed in a difficult situation. To assume the air of perspectivelessness that is expected in the classroom, minority students must participate in the discussion as though they were not African-American or Latino, but colorless legal analysts.5 The consequence of adopting this colorless mode is that when the discussion involves racial minorities, minority students are expected to stand apart from their history, their identity, and sometimes their own immediate circumstances and discuss issues without making reference to the reality that the "they" or "them" being discussed is from their perspective "we" or "us." Conversely, on the few occasions when minority students are invited to incorporate their racial identity and experiences into their comments, they often feel as though they have been put on the spot. Moreover, their comments are frequently disregarded by other students who believe that since race figures prominently in such comments, the minority students-unlike themselves-are expressing biased, selfinterested, or subjective opinions. **The result is that minority students can seldom ground their analysis** in their own racial experiences without risking some kind of formal or informal sanction. Minority students escape the twin problems of objectification and subjectification in discussions when minority experiences are deemed to be completely irrelevant, or are obscured by the centering of the discussion elsewhere. The price of this sometimes welcomed invisibility, however, can be intense alienation. [↑](#endnote-ref-2)
3. Jack **O’Brien**, 5-11-**2018**, "'Eliminating the Middlemen': Trump Takes Aim at PBMs in Drug Pricing Speech," **Health Leaders**, <https://www.healthleadersmedia.com/finance/eliminating-middlemen-trump-takes-aim-pbms-drug-pricing-speech>

   **The president outlined his plan to lower prescription drug costs and aid low-income Americans by reshaping Medicare and boosting competition.** President Donald Trump delivered his long-awaited speech Friday on prescription drug prices, promising to focus the administration's attention on four key strategies to make trips to the pharmacy less expensive for consumers**. Trump's plan seeks to eliminate what he described as the "dishonest double dealing" of healthcare middlemen, such as pharmacy benefit managers (PBMs), to receive rebates and discounts, instead aiming to have those savings redirected to consumers and patients.** "We're very much eliminating the middlemen," Trump said. "The middlemen became very rich. They won't be so rich anymore.". The president also directed the Department of Health and Human Services to allow more substitution through Part D for single-source generics, require health plans to share a minimum portion of drug rebates with patients, and limit Part B price increases above the inflation rate. [↑](#endnote-ref-3)
4. Meghan **Ross**, FEBRUARY 16, **2015**, "Independent Pharmacies: Fostering Strong Relationships with Satisfied Customers," **Pharmacy Times**, https://www.pharmacytimes.com/publications/career/2015/pharmacycareers\_february2015/independent-pharmacies-fostering-strong-relationships-with-satisfied-customers

   **Dr. Sokhal[‘s]**, who described Hayat as a company open to changes, highlighted a few other areas where Hayat pharmacists can expand their role. Besides getting involved in Medication Therapy Management services and immunization delivery, pharmacists can work with other health care providers to decrease hospital readmission rates for their patients. “We are establishing collaborations with other health care providers to work as an interprofessional team to serve our patients, where pharmacists offer comprehensive medication reviews for patients who are on multiple medications, were recently discharged from hospital, or have a health literacy concern,” Dr. Sokhal said. Place in Society Independent pharmacies can also serve an important role in society today in areas where access to prescription medicine can be limited. A **new study published in Health Affairs examined “pharmacy deserts” in Chicago, and found there were fewer pharmacies in minority segregated communities than in segregated white communities and integrated communities. Independent pharmacies, however, covered a 20% higher share of the drugstores serving the minority neighborhoods, the researchers found. These results reaffirm the importance of independent pharmacies.**

   [↑](#endnote-ref-4)
5. **Study findings that suggest PBMs are overcharging for generic drugs at the expense of retail pharmacies, consumers, and health plans have ignited a war of words between the Pharmaceutical Care Management Association (PCMA), representing PBMs, and the National Community Pharmacists Association (NCPA), representing independent pharmacies**. The study, "The Spread: Pilot Study of an Undocumented Source of Pharmacy Benefit Manager Revenue," describes how some **PBMs are making impressive, and largely hidden, profits on generic drugs.** Findings **of the study, conducted by Robert I. Garis, MBA, PhD, and Bartholomew E. Clark, PhD, of Creighton University Medical Center, were published in the January/February issue of the Journal of the American Pharmacists Association.** Garis and Clark describe how **some PBMs are increasing their clients' prescription drug expenditures by creating a significant price spread between what they charge employers and what they pay pharmacies.** The average generic spreads for the 2 PBMs studied were more than $10 per prescription for one, and nearly $32 for the other. One PBM billed an employer more than $200 for a single generic ranitidine prescription, for which it paid the dispensing pharmacy $15. In another instance, the PBM billed $80 for generic atenolol and paid the pharmacy $7. [↑](#endnote-ref-5)
6. Clifton **Leaf**, MAY 21, **2018**, "Canada Is Considering Cancer Warning Labels Printed on Individual Cigarettes”, **Fortune**, <http://fortune.com/go/health/drug-prices-pharmacy-benefit-managers/>

   **At issue, says the Trump Administration in its 44-page blueprint for lowering drug prices, “American Patients First,” isn’t quite that the PBMs are getting rich. (In point of fact, Mr. Trump tends to like that quality.) Rather, the “hidden negotiation and wealth transfer between drug manufacturers and PBMs,” which is now leading to “a direct increase on consumer out-of-pocket spending that likely decreases drug adherence and health outcomes.”** Subscribe to Brainstorm Health Daily, our newsletter about the most exciting health innovations. **FDA Commissioner Scott Gottlieb was even blunter in a speech the week before the president—suggesting that these hidden negotiations might even be “kickbacks”: “To take one example, one of the dynamics I’ve talked about before that’s driving higher and higher list prices, is the system of rebates between payers and manufacturers. And so what if we took on this system directly, by having the federal government reexamine the current safe harbor for drug rebates under the Anti-Kickback Statute? Such a step could help restore some semblance of reality to the relationship between list and negotiated prices, and thereby boost affordability and competition.”** I won’t get into the nitty gritty of what exactly PBMs do. You can read my previous Brainstorm Health essay here and—definitely—read Katherine Eban’s 2013 feature in Fortune, “Painful Prescription,” here. But in any case, I agree with the President and with Commissioner Gottlieb, the PBM business at large deserves extra scrutiny right now. Notably, however, this may come from various states before it comes from Uncle Sam. Earlier this month, the Connecticut legislature easily passed its own bill to control prescription drug costs, Public Act No. 18-41, which is awaiting the signature of Governor Dannel Malloy. That bill, among other things, requires PBMs, beginning in 2021, to report to the state’s insurance commissioner any rebates they receive, including drug formulary rebates collected from pharmaceutical companies—and disclose what share goes to consumers. [↑](#endnote-ref-6)
7. **On June 12, the Senate Health, Education, Labor, and Pensions Committee held a hearing to review the Trump administration’s plan to lower drug costs, with Alex Azar, secretary of the U.S. Department of Health and Human Services, testifying that pharmacy benefit managers (PBMs) are to blame for the high prices.** As part of his written testimony, **Azar said that since PBMs are paid based on the number of rebates they negotiate, the possibility exists for them to retaliate against manufacturers who cut prices by dropping them from formularies or placing them on a higher tier.** “We may need to move toward a system without rebates, where PBMs and drug companies just negotiate fixed-price contracts,” he said. “Such a system’s incentives, detached from artificial list prices, would likely serve patients far better, as would a system where PBMs receive no compensation from the very pharma companies they’re supposed to be negotiating against.” This, he said, would prevent PBMs from impacting prices, as a major criticism of the current system is that PBMs keep some of the rebates instead of passing them to consumers in the form of lower out-of-pocket costs. [↑](#endnote-ref-7)
8. **Change is needed to create a better working relationship between pharmacy benefit managers (PBMs) and independent pharmacies**, **according to a panel of experts at the American Pharmacy Purchasing Alliance (APPA) conference in Orlando, FL. The 5 professionals appeared to share a common sentiment that current PBM practices are hurting the business of independent pharmacy**, as well as the patients they serve. Independent pharmacy owner James Wright, PharmD and former president of the Florida Pharmacy Association (FPA) president, discussed some of the issues his business experiences. To start, he said PBMs are often run by large companies that are in competition to independent pharmacies. The system creates an environment in which it is very difficult for an independent pharmacy to survive. “Your competition controls how much you’re reimbursed, they control audits, they control providers, whether or not you can accept insurance,” Wright said. **“The challenges are very significant. They (the PBMs) can completely wipe you out.” In some incidences, where he was reimbursed for less than what he paid for the medication, his business lost money in the transaction. The complaint is common among independent pharmacists.** Wright said his solutions include cutting costs, trying to be more efficient, and selling more medications for cash, rather than utilizing insurance plans. “That’s pretty solid. With cash, there’s less uncertainty,” he said. Panelist Allen David Knee, RPh, said PBMs impact patient decisions with insurance plans that restrict where customers can receive lower rates. “PBMs try to limit their networks,” Knee said.

   [↑](#endnote-ref-8)
9. **Forbes 15**

   Team Trefis. "Why Are Generic Drug Prices Shooting Up?." *www.forbes.com*, 27 Feb. 2015, https://www.forbes.com/sites/greatspeculations/2015/02/27/why-are-generic-drug-prices-shooting-up/. Accessed 22 Oct. 2018.

   However, **generic prices have been moving up** for some time now, which is leading to some serious concerns for the pharmacy retail industry in the form of reimbursement rate pressure (Here’s a detailed analysis of this issue**). The Rise Of Generic Prices According to a report by Elsevier, a drug product and pricing information provider, out of a research sample of 4421 drug groups, 222 drug groups increased in price by 100% or more (between Nov’13 and Nov’14). There are also some extreme cases (17 drug groups) where price increases of more than 1000% were seen. One such product is tetracycline, which is commonly prescribed for bacterial infections. During the same period (between Nov’13 and Nov’14), it’s per tablet price increased from $0.0345 to $2.3632. That is a 67-fold increase in one year**! But, why are generic drug prices increasing at such high rates? YOU MAY ALSO LIKE Factors That Contributed To The Price Rise Industry Consolidation In 2009, generic drug markets were saturated and projections looked dull. To avoid falling into losses, generic drug makers began to consolidate through mergers and acquisitions to achieve the scale needed to maintain profitability. Typically, when a branded drug loses patent protection, multiple generic manufacturers produce the drug and compete on price. But post-industry consolidation, fewer generic manufacturers are applying to the FDA for permission to produce those drugs. With substantially fewer manufacturers producing a particular generic drug (in some cases only 2 or 3 makers), generic prices have crept up with time. However, there are more influential factors than this. [↑](#endnote-ref-9)
10. <https://www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/GenericDrugs/default.htm>

    **In the United States, 9 out of 10 prescriptions filled are for generic drugs. Increasing the availability of generic drugs helps to create competition in the marketplace, which then helps to make treatment more affordable and increases access to healthcare for more patients.** The FDA's Office of Generic Drugs (OGD) within the Center for Drug Evaluation in Research ensures that people have access to safe, affordable generic drugs by following a rigorous review process that includes: New Educational Resources Managing the regulatory process to facilitate drug approvals, Establishing science initiatives to research generic drugs, Publishing data and reports on generic drug development and review, and Offering educational materials and information. Overview & BasicsOverview & Basics Information about the generic drug review process, FDA standards and pricing, and answers to frequently asked questions Industry ResourcesIndustry Resources Electronic submission forms, requirements, guidance, reports, and other resources to help facilitate generic drug applications and approvals Approval & ReportsApprovals & Reports First-time generic drug approvals, generic drug application review metrics, and Generic Drugs Program reports [↑](#endnote-ref-10)
11. Paulina **Firozi**, 08-23-**2018**, "Analysis," **Washington Post**, <https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2018/08/23/the-health-202-here-s-why-rural-independent-pharmacies-are-closing-their-doors/5b7da33e1b326b7234392b05/>

    **Local independent pharmacies,** particularly those in rural communities**, are steadily closing their doors.** And the **closures are leaving some of the most vulnerable populations in the country with few options to obtain medication and other health services. More than 16 percent of the independently owned rural pharmacies in the United States shut down between March 2003 and March 2018, according to a policy brief published last month by the RUPRI Center for Rural Health Policy Analysis at the University of Iowa. The report found a drop of more than 1,200 independently owned retail pharmacies during that time, bringing the total down to 6,393.** Some **pharmacists and experts are in part blaming pharmacy benefit managers, which negotiate drug prices between insurers and drug companies, for opaque practices that leave these smaller pharmacies struggling to cover their costs. The Trump administration and lawmakers have targeted pharmacy benefit managers. When President Trump announced his blueprint to reduce drug costs in May, he decried PBMs as a “dishonest, double-dealing” middleman driving up drug prices.**

    [↑](#endnote-ref-11)