AMERICAN ECONOMIC LIBERTIES PROJECT

The Honorable Buddy Carter
Chair, House Committee on Energy and Commerce Subcommittee on Health
2432 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Neal Dunn, M.D.
Vice Chair, House Committee on Energy and Commerce Subcommittee on Health
466 Cannon House Office Building
Washington, D.C. 20515

The Honorable Diana Degette
Ranking Member, House Committee on Energy and Commerce Subcommittee on Health
2111 Rayburn House Office Building
Washington, D.C. 20515

February 26, 2025

RE: House Committee on Energy and Commerce Subcommittee on Health Hearing Examining PBM Reform Policies

Dear Chairman Carter, Vice Chairman Dunn, and Ranking Member Degette:

We write to urge the House Committee on Energy and Commerce Subcommittee on Health to advance legislation that will structurally separate the largest pharmacy benefit managers (PBMs), therefore eliminating the conflicts of interest that these vertically-integrated Big Medicine conglomerates exploit to drive prices up, quality down, and independent pharmacies out of business.

The Subcommittee, alongside congressional leaders in both chambers and on both sides of the aisle, has demonstrated a desire to rein in PBMs, healthcare middlemen who negotiate prescription drug benefits on behalf of health plans with drug manufacturers and pharmacies. The "Big Three" — CVS Caremark, Cigna Group's Express Scripts, and UnitedHealth Group's OptumRx — account for nearly 80% of U.S. prescription drug claims.[1] Each is also vertically integrated with an insurer that owns pharmacies.

The Big Three leverage their market power to drive up the cost of prescription drugs — by more than 1,200% between 1999 and 2017, in the case of one brand-name insulin — leaving patients unable to afford life-saving medications, with sometimes fatal consequences.[2] They also wield

[1] Adam Fein, "The Top Pharmacy Benefit Managers fo 2023: Market Share and Trends for the Biggest Companies – – and What's Ahead," Drug Channels Institute, April 9, 2024, https://www.drugchannels.net/2024/04/the-top-pharmacy-benefit-managers-of.html#:~:text=Three%20is%20still%20the%20magic,Rx%20business%20of%20UnitedHealth%20Group.

[2] "FTC Sues Prescription Drug Middlemen for Artificially Inflating Insulin Drug Prices," Federal Trade Commission, Sept. 20, 2024, https://www.ftc.gov/news-events/news/press-releases/2024/09/ftc-sues-prescriptiondrug-middlemen-artificially-inflating-insulin-drug-prices; Jonathan Edwards, "Man dies of asthma attack after inhaler cost skyrockets to more than $500," *The Washington Post*, Feb. 10, 2025, https://www.washingtonpost.com/business/2025/02/10/inhaler-cost-death-optum-rx-walgreens/.

this power to demand untenably low reimbursement rates from independent pharmacies in exchange for inclusion in their networks.[3] Many pharmacies accept these rates for fear of losing access to a larger share of the covered patients who make up their customer base. But these rates are squeezing them out of business, stranding their most vulnerable customers — including older Americans, rural residents, and individuals with chronic conditions — in pharmacy deserts without access to care.[4] Indeed, since 2015, nearly 800 ZIP codes that had at least one pharmacy now have none.[5] This desertification is intensifying, with 2,275 pharmacy closures — evenly split between small and mid-sized independents and large chains like CVS, Walgreens, and Rite Aid — in the first eight months of 2024 alone.[6]

The Big Three's vertically-integrated business model is also rife with conflicts of interest. For instance, the Big Three steer patients to their affiliated pharmacies, which they then pay at much higher rates — up to 7,736% more — than unaffiliated pharmacies.[7] Doing so is very lucrative; Big Medicine, including the Big Three's parent companies, dominates the Fortune 20.[8] But Big Medicine's profits come at the expense of patients and health plan sponsors, who pay extreme markups, and independent pharmacies, who lose business and access to a fair market.

Given these harms, the American Economic Liberties Project recently launched a new campaign, Break Up Big Medicine, to urge Congress and other policymakers to structurally separate Big Medicine's business lines. Doing so would eliminate the conflicts of interest that these conglomerates exploit to drive prices up, quality down, and independent pharmacies out of business. We applaud the Subcommittee, whose members have co-sponsored the best structural reform legislation, including:

- The Patients Before Monopolies Act (S.5503, H.R. 10362), introduced by Sens. Elizabeth Warren (D-MA) and Josh Hawley (R-MO) and Reps. Jake Auchincloss (D-MA-04) and Diana Harshbarger (R-TN-01) late last session, would force health insurers and PBMs to divest their pharmacy businesses within three years. It also serves as a template for future legislation, including a Glass-Steagall Act for health care. Like its namesake, the New

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3 "Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies," Federal Trade Commission, July 9, 2024, https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacybenefit-managers-staff-report.pdf.

4 Rachel Wittenauer et al., "Locations and characteristics of pharmacy deserts in the United States: a geospatial study," *Health Affairs Scholar*, March 16, 2024, https://pmc.ncbi.nlm.nih.gov/articles/PMC11034534/; Claire Gillespie, "Pharmacy Deserts Are on the Rise. Here's What That Means for Your Health," *HealthCentral*, Nov. 15, 2024, https://www.healthcentral.com/chronic-health/pharmacy-deserts-are-on-the-riseheres-what-that-means-for-your-health.

5 Reed Abelson and Rebecca Robbins, "The Powerful Companies Driving Local Drugstores Out of Business," *The New York Times*, Oct. 19, 2024, https://www.nytimes.com/2024/10/19/business/drugstores-closing-pbmpharmacy.html.

6 Benjamin Jolley, "2275 pharmacies have closed so far in 2024," Ramblings of a pharmacist, Sept. 16, 2024, https://benjaminjolley.substack.com/p/df63c75f-2215-4dbf-95c9-f94c7e38cfe3?postPreview=paid&updated=2024-09-12T16%3A44%3A06.874Z&audience=everyone&free_preview=false&freemail=true.

7 "Specialty Generic Drugs: A Growing Profit Center for Vertically Integrated Pharmacy Benefit Managers," Federal Trade Commission, January 2025, https://www.ftc.gov/system/files/ftc_gov/pdf/PBM-6b-Second-Interim-Staff-Report.pdf.

8 Molly Gamble, "Fortune 500's top 25 healthcare companies," *Becker's Hospital Review*, June 6, 2024, https://www.beckershospitalreview.com/rankings-and-ratings/fortune-500s-top-25-healthcare-companies-2024.html.

Deal-era law that structurally separated commercial and investment banks in the wake of the Great Depression, a Glass-Steagall Act for health care would break up Big Medicine's business lines by structurally separating insurers from providers, insurers from middlemen, and wholesale drug distributors from specialty medical practices.

- The Pharmacists Fight Back Act (H.R. 9096), also introduced by Representatives Auchincloss and Harshbarger last session and ultimately co-sponsored by 55 bipartisan members, would bolster independent pharmacy revenue by setting baseline pharmacy reimbursement rates in federal healthcare programs. Like the price benchmarks already used in state Medicaid programs, these baseline rates would shield independent pharmacies from the largest PBMs' immense market power, which they use to underpay independent competitors. This bill would also prohibit PBMs acting on behalf of federal healthcare programs from engaging in anticompetitive business practices, such as patient steering and spread pricing, in which a PBM charges a health plan far more for a prescription than it reimburses a pharmacy for dispensing it.
- The Lower Costs, More Transparency Act (H.R. 5378) by Rep. Cathy McMorris Rodgers (R-WA-05) would similarly require all state Medicaid managed care programs and the PBMs with which they contract to reimburse pharmacies according to their acquisition and dispensing costs. In doing so, the bill would establish parity in pharmacy reimbursements across Medicaid managed care and fee-for-service settings. It would also prohibit spread pricing.

We urge the Subcommittee to advance these structural reforms, which address the root cause of the PBM problem.

There is growing public support for a more aggressive approach. Just five days after launching Break Up Big Medicine, more than 55,000 individuals had joined our coalition urging Congress and other policymakers to break up these behemoths via structural legislative reforms.

As Congress continues to debate PBM reform, we strongly urge the Subcommittee to heed the public and advance the Patients Before Monopolies Act, the Pharmacists Fight Back Act, and the Lower Costs, More Transparency Act. We also urge the Subcommittee to introduce and advance legislation repealing the PBM safe harbor. Doing so would achieve the Subcommittee's goals of reining in PBMs, lowering out-of-pocket drug costs, improving healthcare quality, and strengthening market competition. However, if Congress solely pursues more incremental reforms, such as increased transparency requirements, that do not address the structural issue, or none at all, PBMs will continue to run wild, pharmacies will continue to close, and patients will continue to suffer—and, in some cases, even die.

Sincerely,

American Economic Liberties Project