Statement for the Record to the House Committee on Oversight and Accountability

Ending the Big PBMs' Predatory Grip on Patient Access and Affordability

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American healthcare reads like a dystopian novel.

A crisis, born from unchecked power consolidation, threatens the foundation of patient care and access to essential medications. At the heart of this healthcare nightmare stand three colossal predators: CVS Caremark, Express Scripts, and OptumRx.

These Pharmacy Benefit Managers (PBMs), nestled within larger health conglomerates, have amassed unprecedented control over the pharmaceutical supply chain. Their tentacles reach into every aspect of healthcare, from insurance coverage to drug pricing, creating an oligopoly that preys on the sick and vulnerable. As these corporate giants grow ever more powerful, patients find themselves trapped in a system where their long-term health and well-being is discarded and replaced with short-term financial engineering.

CVS Caremark, the PBM arm of CVS Health, looms large over the pharmaceutical landscape. With its parent company also owning Aetna, a major insurer, and a vast network of retail pharmacies, CVS Health has its fingers in every pie of the healthcare ecosystem. This vertical integration allows CVS to control multiple aspects of a patient's healthcare journey, from insurance coverage to drug pricing and distribution.

Not far behind is Express Scripts, now a part of Cigna Corporation. This merger created another healthcare giant, combining a major insurer with one of the largest PBMs in the country. The result? A company with unprecedented power to influence drug prices, coverage decisions, and patient access to medications.

Completing this triad is OptumRx, owned by UnitedHealth Group. As part of the largest health insurance company in the United States, OptumRx wields enormous influence over drug pricing and availability, often prioritizing its financial interests over patient needs.

Together, these three PBMs process nearly 80 percent of all prescription claims in the United States, creating an oligopoly that stifles competition, innovation, and patient access. Their practices have led to skyrocketing drug prices, restricted access to medications, and a healthcare system that seeks absolute control over patient care.

The victims in this story are clear: American patients. Caught in the crossfire of complex rebate schemes, opaque pricing practices, and discriminatory formularies, patients find themselves facing ever-increasing out-of-pocket costs for their medications, defying the fundamental role of health insurance. Many are forced to choose between their health and their financial stability, a choice no one should have to make.

Sarah, a 32-year-old with rheumatoid arthritis, experienced this firsthand. Her PBM suddenly moved her long-standing medication to a higher tier, increasing her out-of-pocket costs from $50 to $500 per month. "I had to choose between paying rent and managing my pain," Sarah recounts. "It's not just about money; it's about quality of life."

Similarly, Michelle, a two-time cancer survivor and rare disease patient, was paying $60 a month for an important prescription medicine. One day her pharmacist informed her that the drug only costs $40, but the PBM required that she pay $60 for the prescription. Puzzled, Michelle asks, “Why would I have to pay more by using my insurance than if I was just paying the cash price?”

One of the most concerning practices is the lack of transparency in formulary decisions. PBMs often make opaque choices about which drugs to include or exclude, without clear criteria or public oversight. This can lead to situations where patients are denied access to medications they desperately need.

John, a 45-year-old diabetic, fell victim to this practice. His PBM removed his insulin brand from the formulary, forcing him to switch to a different type that was less effective for him. "I spent months trying to stabilize my blood sugar levels," John says. "It felt like my health was being compromised for someone else's profit."

PBMs also engage in unethical practices like "lasering" and adverse tiering, which unfairly target specific patient groups or treatments. These tactics can have devastating consequences for patients with chronic or severe conditions. Even in the employer insurance market, we frequently hear that companies are shocked to learn these discriminatory practices are being used against their employees.

Maria, a 55-year-old cancer survivor, experienced this firsthand. When her cancer returned, she found that her PBM had placed all cancer medications on the highest-cost tier. "I felt like I was being punished for having cancer," Maria shares. "The stress of figuring out how to afford my medication was almost as bad as the cancer itself."

But hope is not lost. Patients Rising commends Chairman Comer, Ranking Member Raskin, and the other distinguished members of the House Oversight Committee for placing the predatory

practices of PBMs at the top of the committee's busy agenda. Today's hearing demonstrates a bipartisan commitment to stop the secrecy and shady deal-making and to seek constructive reforms that prioritize the needs of patients. We applaud the committee for recognizing the urgent need to address the anticompetitive practices of PBMs and their parent companies.

The committee's efforts have shed light on the harmful practices of PBMs, including spread pricing, where PBMs charge payers more than they reimburse pharmacies and pocket the difference. They've also exposed how PBMs manipulate formularies to favor high-cost drugs that generate larger rebates, often at the expense of patient health and affordability.
Patients Rising joins the chorus of voices that are calling for the enforcement of antitrust laws to break up these healthcare conglomerates. By separating PBMs from insurers and pharmacy chains, lawmakers can restore competition to the market and begin to realign incentives towards what is in the long-term interests of patient health and wellbeing.

The DRUG Act (Delinking Revenue from Unfair Gouging) has emerged as a potential game-changer. This legislation aims to decouple PBM revenue from drug list prices, removing the perverse incentive for PBMs to favor higher-priced medications. Patients Rising thanks the committee for their support of this bill earlier this year, and we urge House leadership to bring the DRUG Act to the floor.

Other potential solutions include increasing transparency by requiring public disclosure of formulary criteria, prohibiting unethical practices like lasering and adverse tiering, and promoting open formularies that include all FDA-approved generics and biosimilars at lower cost tiers. Moreover, there's a pressing need to reduce PBM influence by limiting rebating practices and increasing oversight of their activities. Streamlining access restrictions, such as implementing reasonable standards for prior authorization and step therapy, could also significantly improve patient care.

But today is about having the top executives and the big three predatory benefit managers answer the tough questions and to justify their discriminatory practices. Patients Rising represents more than 100,000 chronic disease patients and caregivers across America and our network of patients have a few questions they would like answered.

- Given that the three major PBMs process nearly 80% of all prescription claims in the U.S., how do you respond to concerns about oligopolistic practices and lack of competition?
- How do you justify the practice of moving long-standing medications to higher tiers, significantly increasing out-of-pocket costs for patients like Sarah with rheumatoid arthritis?
- Can you explain the criteria and decision-making process behind formulary exclusions, such as removing specific insulin brands that patients like John depend on?
- What is your response to accusations that PBMs engage in "lasering" and adverse tiering, which disproportionately affect patients with chronic or severe conditions?

- How do you justify the practice of spread pricing, and what percentage of your company's revenue comes from this practice?

Patients have caught on to the PBM game. In my conversations with patients across the country, it is clear that the promise that health insurance equates to healthcare is not being met.

Across America, there's a growing recognition that the entire healthcare system needs to be redesigned with a focus on long-term patient health and well-being.

The battle against the healthcare oligopoly is far from over, but with dedicated lawmakers, informed patients, and a growing coalition of healthcare advocates, there's reason for hope.

The future of American healthcare hangs in the balance, and it's up to all of us to ensure that patients are at the center of our healthcare system. The health and financial stability of millions of Americans depend on it.

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