

To: House of Representatives Committee on Energy and Commerce, Subcommittee on Health
From: Professor Rachel E. Sachs, Washington University in St. Louis School of Law
Date: May 4, 2026
Re: Response to Questions for the Record

As a witness for the House of Representatives Committee on Energy and Commerce Subcommittee on Health Hearing *Lowering Health Care Costs for All Americans: An Examination of the Prescription Drug Supply Chain*, I thank you very much for the opportunity to provide responses to additional questions for the record.

The Honorable Debbie Dingell (D-MI)

1. How does vertical integration obscure pricing, enable price manipulation, and ultimately harm patients?

I am appreciative of the Committee’s focus on this important issue, and as the Committee knows, this issue extends beyond the specific subjects of our hearing. There are important interactions between this Committee’s hearing in January focused on health insurance companies and the February hearing focused on prescription drugs, as the largest health insurers are vertically integrated with a wide range of actors in the supply chain, including pharmacy benefit managers (PBMs), specialty pharmacy, retail pharmacy, private-label drug manufacturers, and others.¹

Governmental reports and scholarly publications have articulated different ways in which vertical integration (both in the prescription drug context and involving physician services) may have the consequences articulated in the question, obscuring prices, enabling price manipulation, and ultimately harming patients. Consider the Federal Trade Commission’s (FTC) July 2024 Interim Staff Report on PBMs, which argues that their vertical integration with other supply chain entities enables them to steer specialty prescriptions to PBM-affiliated pharmacies and to pay higher reimbursements to PBM-affiliated pharmacies than to unaffiliated pharmacies, among other practices.² The United States Governmental Accountability Office’s September 2025 report on physician consolidation reviewed studies suggesting that “physician consolidation with hospital systems can, but does not always, lead to increased spending and prices, and no change or a decrease in the quality of care provided.”³ Many studies attributed this increase in spending and prices to substituting “physician office visits with visits in more expensive hospital-outpatient facilities.”⁴ However, the report concluded that “the effects of physician consolidation with health insurers, other corporate entities, or private equity firms on spending, prices, and quality were less clear or unknown.” One reason for this lack of clarity may be the interaction between horizontal consolidation and vertical integration. One recent study, for example, found that Optum’s acquisition of physician practices led to price increases, and that the price increase “was concentrated in markets where the acquired [ambulatory surgical centers] already had a high market share and where Optum had a substantial co-location of its owned physician practices.”⁵

Vertically integrated entities may use these types of strategies, including steering patients to affiliated entities and paying affiliated entities rates greater than non-affiliated entities. They may couple them with market dominance across multiple levels of the supply chain, which increases their bargaining leverage. Combined, these strategies make it much more difficult for competitors to enter – a difficult enough task “if a company has market power in one level of the health care ecosystem,” but an even harder one “if a company can acquire companies across the

healthcare ecosystem.”⁶ To the extent that these types of practices increase costs and spending and do not increase access or quality, harms to patients and the system as a whole are likely to result.

2. What additional reforms do you think are needed to rein in PBMs?

The recent reforms enacted as part of the FY 2026 appropriations package⁷ are an important first step towards promoting transparency for plan sponsors and also for addressing some of the industry’s long-criticized practices. At the same time, I am appreciative of the Congresswoman’s recognition that continued reforms may be needed, in part because PBMs have already adjusted their business models in preparation for the passage of the reform package. As a result, additional efforts that enable Congress and executive branch regulators to identify and quickly disrupt anticompetitive practices will be important to pursue. Correspondingly, in this answer I identify specific business practices of potential concern for regulators, but it is important to be clear that I do not think reforms should be limited to or focused solely on those practices.

Additional reforms should focus both on horizontal consolidation across the industry, with the three leading PBMs (CVS Caremark, Express Scripts (ESI), and Optum Rx) processing nearly 80% of prescriptions,⁸ and on vertical integration across the supply chain, with the three major PBMs being vertically integrated with insurers Aetna, Cigna, and UnitedHealthcare (respectively).⁹ Congress has already begun to take notice of one recent business practice relating to PBMs’ vertical integration, their use of in-house group purchasing organizations.¹⁰

Another business practice relating to vertical integration that Congress may wish to learn more about is the PBMs’ increasing use of private-label biosimilars. I have provided additional detail on this practice in my written testimony and in a recently published co-authored article.¹¹ In brief, all three major PBMs are now vertically integrated with private-label drug entities whose biosimilar products are preferred on the PBMs’ formularies. In theory, patients benefit from these lower-priced biosimilars. However, this practice may stifle biosimilar competition both in the short term by inhibiting patients’ access to biosimilars that are or could be priced lower than the private-label products, and in the longer term by discouraging the development of biosimilars by manufacturers that are not already affiliated with one of the big three PBMs.

There is no single way to address issues like these, and this Committee should develop a package of reforms. Reforms should keep in mind three common themes. First, for decades, our system has relied more on competition than on regulation to drive down drug prices. Attention should be paid to policy reforms that can make competition more effective. Second, where the market is already highly concentrated both horizontally and vertically, solutions beyond those that encourage competition may be needed. Some of these solutions may relate to oversight and transparency. For example, the Committee may exercise its oversight functions to bring more transparency to supply chain intermediary business models and develop relevant data. In the private-label biosimilar area, this Committee might draw from the FTC’s 1990s investigations of drug manufacturers’ proposed acquisitions of PBMs.¹² In at least two cases (Eli Lilly/PCS Health System and Merck/Medco), FTC reached a settlement aiming to minimize the financial conflicts of interest and enabling the FTC to continue monitoring competition over time. Third and relatedly, companies’ ability to alter their internal business practices to avoid proposed or enacted legislation and regulation may be significant. As such, it may not be ideal to tie proposals too closely to particular market structures. It will be important to consider approaches that address reimbursement prices directly, which are agnostic to the structure of the market, or the structure of supply chain entities themselves.

The Honorable Lizzie P. Fletcher (D-TX)

1. In your oral testimony, you mentioned that the Medicare Drug Negotiation Program will benefit a “much broader range of Americans” than TrumpRx and that the latter will only cover a “small number” of products. Can you expand on the differences between the two and how the Medicare Drug Negotiation Program will provide more cost savings to consumers generally?

Thank you for the opportunity to provide additional detail on this important question. In short, the Medicare Drug Price Negotiation Program and the associated reforms included within the Inflation Reduction Act of 2022 provide benefits to all Medicare beneficiaries, including the 56 million enrolled in Medicare Part D,¹³ even though the Negotiation Program applies to only a finite number of drugs each year. Although available data on TrumpRx is very limited, the information that has been made public so far suggests that it is not having a broad impact and, for some consumers, it may increase their costs.

More specifically, consider the first cycle of the Negotiation Program, where the negotiated prices went into effect on January 1 of this year. The 10 selected drugs had been dispensed to about 8.8 million people with Part D coverage, and the Centers for Medicare & Medicaid Services (CMS) estimated that “the negotiated prices would have saved an estimated \$6 billion in net covered prescription drug costs, which would have represented 22% lower net spending in aggregate.”¹⁴ For the second cycle of the program, where the negotiated prices are scheduled to go into effect on January 1, 2027, the 15 selected drugs had been dispensed to about 5.3 million people with Part D coverage, and CMS estimated that “the negotiated prices would have saved an estimated \$12 billion in net covered prescription drug costs, which would have amounted to approximately 44% lower net spending in aggregate.”¹⁵ Importantly, these benefits are experienced not only by the millions of Part D beneficiaries being prescribed these drugs but also indirectly by other Part D beneficiaries. This is because the Inflation Reduction Act combines the Negotiation Program with a more generous Part D benefit for all beneficiaries, who now have their overall out-of-pocket costs capped for all covered drugs, even if they are prescribed drugs that have not been selected for the Negotiation Program.

By contrast, TrumpRx’s benefits appear to be much more narrow, at least to date. When it launched, TrumpRx listed 43 branded drugs, and 18 of those (41.8%) “have cheaper generics available via GoodRx or Mark Cuban’s Cost Plus Drugs.”¹⁶ For some of these drugs, “consumers could save hundreds of dollars by going with the exact same generic medicine, instead of TrumpRx’s price.”¹⁷ That is, although President Trump has called TrumpRx the “largest reduction in prescription drug prices in history,”¹⁸ for many patients it could mean paying hundreds of dollars more than an available generic. More recently, Chris Klomp, currently the Director of Medicare and Deputy Administrator of CMS, offered a more circumscribed view of TrumpRx, stating that “the goal was not actually some massive reach,” and “170 million Americans are commercially insured, 68 million Americans are on Medicare, the balance are on Medicaid and CHIP largely. TrumpRx is not for most of them, it’s cash pay.”¹⁹ Although Klomp’s statements do not match the President’s rhetoric, they do more accurately reflect the primary case for TrumpRx, highlighting the platform’s use for GLP-1s and fertility drugs, which are less commonly covered by insurance. Even here, a pharmaceutical expert recently analyzed all prescriptions for Gonal-F, one of the fertility drugs available through TrumpRx, and concluded that “the script numbers don’t seem to

suggest that TrumpRx has created an affordability unlock for a huge number of patients.”²⁰ If the Trump Administration has information to the contrary, it would be of interest to a wide range of experts.

¹ Adam Fein, *Mapping the Vertical Integration of Insurers, PBMs, Specialty Pharmacies, and Providers: DCI's 2025 Update and Competitive Outlook*, DRUGCHANNELS (April 9, 2025), <https://www.drugchannels.net/2025/04/mapping-vertical-integration-of.html>.

² FED. TRADE COMM’N, PHARMACY BENEFIT MANAGERS: THE POWERFUL MIDDLEMEN INFLATING DRUG COSTS AND SQUEEZING MAIN STREET PHARMACIES (2024).

³ GOV’T ACCOUNTABILITY OFFICE, HEALTH CARE CONSOLIDATION: PUBLISHED ESTIMATES OF THE EXTENT AND EFFECTS OF PHYSICIAN CONSOLIDATION 17 (Sept. 2025).

⁴ *Id.* at 18.

⁵ Derek T. Lake et al., *Strategic Selection And Pricing Power: Optum's Acquisitions Of Ambulatory Surgery Centers And Physician Practices*, 45 HEALTH AFFAIRS 218, 224 (2026).

⁶ Dep’t of Justice, *Assistant Attorney General Jonathan Kanter Delivers Remarks on the Platformization of Health care* (Nov. 12, 2024), <https://www.justice.gov/archives/opa/speech/assistant-attorney-general-jonathan-kanter-delivers-remarks-platformization-health-care>.

⁷ Consolidated Appropriations Act, 2026, H.R. 7148 (2026), <https://www.congress.gov/bill/119th-congress/house-bill/7148>.

⁸ Adam J. Fein, *The Top Pharmacy Benefit Managers of 2024: Market Share and Key Industry Developments*, DRUG CHANNELS (Mar. 31, 2025), <https://www.drugchannels.net/2025/03/the-top-pharmacy-benefit-managers-of.html>.

⁹ Erin Trish, Karen Van Nuys & Robert Popovian, *PBMs Are Inflating the Cost of Generic Drugs. They Must Be Reined In*, UNIV. OF S. CAL. LEONARD D. SCHAEFFER INST. FOR PUB. POL’Y & GOV’T SERV. (July 5, 2022) <https://schaeffer.usc.edu/research/pbms-are-inflating-the-cost-of-generic-drugs-they-must-be-reined-in/>.

¹⁰ Laura Wadsten & Nathaniel Horwitz, “Bullshit” – *The New Way Health Giants Hide Billions*, HUNTERBROOK (Jan. 6, 2026), <https://hntrbrk.com/pbmppo/>.

¹¹ Michael A. Carrier & Rachel E. Sachs, *Competitive Concerns from Pharmacy Benefit Managers Selling Their Own Drugs*, 24 YALE J. HEALTH POL’Y L. & ETHICS 71 (2026).

¹² For more detailed discussion of these proposed acquisitions, investigations, and settlements, see Carrier & Sachs, *supra* note 11.

¹³ Juliette Cubanski, Nancy Ochieng, & Tricia Neuman, *Analyzing Changes in Medicare Part D Enrollment for 2026*, KFF (March 3, 2026), <https://www.kff.org/medicare/analyzing-changes-in-medicare-part-d-enrollment-for-2026/>.

¹⁴ Centers for Medicare & Medicaid Servs., *Medicare Drug Price Negotiation Program: Negotiated Prices for Initial Price Applicability Year 2026* (Aug. 2024), <https://www.cms.gov/files/document/fact-sheet-negotiated-prices-initial-price-applicability-year-2026.pdf>.

¹⁵ Centers for Medicare & Medicaid Servs., *Medicare Drug Price Negotiation Program: Negotiated Prices for Initial Price Applicability Year 2027* (Nov. 2025), <https://www.cms.gov/files/document/fact-sheet-negotiated-prices-ipay-2027.pdf>.

¹⁶ John Wilkerson et al., *TrumpRx claims to offer the lowest prices. But many drugs have cheaper generics*, STAT (Feb. 6, 2026), <https://www.statnews.com/2026/02/06/trump-rx-discount-drug-website-undercut-by-cheaper-generics/>.

¹⁷ *Id.*

¹⁸ Stephanie Sy & Jackson Hudgins, *How effective will TrumpRX be at lowering prescription drug prices for Americans?*, PBS NEWSHOUR (Feb. 6, 2026), <https://www.pbs.org/newshour/show/how-effective-will-trump-rx-be-at-lowering-prescription-drug-prices-for-americans>.

¹⁹ Tara Bannow, *Trump's Medicare director seeks to rein in expectations for TrumpRx*, STAT (March 19, 2026), <https://www.statnews.com/2026/03/19/chris-klomp-hhs-medicare-discusses-mfn-drug-pricing-trump-rx/>.

²⁰ Brian Reid, LinkedIn (May 2026), <https://www.linkedin.com/posts/brianbreid-this-week-sen-elizabeth-warren-sent-rfk-share-7456048030207660032-w9H4/>.