

STATEMENT



In Support of Rhode Island House Bill 7189 (Kislak) March 24, 2026

Position: The Pharmaceutical Research and Manufacturers of America (PhRMA) appreciates the General Assembly’s focus on the full range of market actors that influence what patients pay for medicines, including the role pharmacy benefit manager (PBM) practices play in shaping patient access and affordability.

House Bill 7189 (HB 7189) takes meaningful steps to promote greater transparency and consistency in PBM reimbursement practices by addressing differences in reimbursement between affiliated and non-affiliated pharmacies and by prohibiting contract terms or methodologies that have the effect of disadvantaging non-affiliated pharmacies for the same drug or service.

Situated between the biopharmaceutical companies that research and develop innovative medicines and the patients likely to benefit from those treatments, PBMs play a central role in controlling prescription medicine access and affordability for more than 289 million publicly and privately insured Americans.ⁱ Through horizontal and vertical integration, PBMs’ role in the prescription drug supply chain has grown, as has their influence over which medicines patients have access to and whether they are affordable for patients.

After nearly two decades of horizontal consolidation, the PBM industry has become increasingly dominated by a small number of large companies: CVS Caremark, Express Scripts, and OptumRx.ⁱⁱ These same companies are vertically integrated with the three largest health insurance companies, Aetna, Cigna, and UnitedHealthcare. They each also own a specialty and mail order pharmacy, and some have and are acquiring provider groups at a rapid pace. The combined market share of the three largest PBMs has grown significantly, from 48 percent in 2010 to 80 percent in 2024.^{iii, iv} Today, just six companies control 96 percent of the PBM market.^v

The FTC has found that this level of concentration may enable PBMs to enter into complex and opaque contractual relationships that may disadvantage smaller, unaffiliated pharmacies.^{vi} Large PBMs – who create pharmacy networks for their clients – can disadvantage independent pharmacies, creating an unsustainable market for these businesses and compelling them to accept unfavorable and unsustainable contracts in order to remain in-network. These large companies deploy multiple practices, such as unfavorable reimbursement terms where pharmacies are reimbursed below their acquisition cost^{vii} and high fees, to capture more market share from independent pharmacies. Pharmacies that reject low reimbursement rates or other PBM contract terms face exclusion from networks that cover a large share of patients. As a result, independent pharmacies are increasingly closing, particularly in rural and low-income areas,^{viii} leaving patients in those communities with fewer options to access their medicines.^{ix} Pharmacy closures are associated with an immediate and sustained reduction in medication adherence, leading to poorer health outcomes for patients in impacted communities.^x

Vertical integration also creates opportunities for insurers and PBMs to shift revenue within affiliated entities in ways that are difficult to detect and not always subject to meaningful oversight. For instance, insurers may pay their vertically integrated pharmacies and providers above-market rates. A recent Health Affairs study found that UnitedHealthcare reimburses its affiliated Optum providers at rates 17 percent higher than the relative price of its

competitors, a gap that widens to 61 percent in markets where UnitedHealthcare holds at least a 15 percent market share.^{xi} Similarly, investigations by the FTC and the Wall Street Journal show that commercial insurers and PBMs pay their vertically integrated pharmacies significantly more than unaffiliated pharmacies for generic medicines used to treat cancer, HIV, multiple sclerosis, and other conditions – sometimes thousands of dollars more per prescription.^{xii}

PhRMA supports continued examination of PBM practices and broader supply chain dynamics that can impact patients, employers, and state programs, and welcomes the General Assembly’s attention to these issues in HB 7189. We look forward to opportunities to work with policymakers on solutions that promote transparency, strengthen competition, and improve affordability for Rhode Island patients.

The Pharmaceutical Research and Manufacturers of America (PhRMA) represents the country’s leading innovative biopharmaceutical research companies, which are laser focused on developing innovative medicines that transform lives and create a healthier world. Together, we are fighting for solutions to ensure patients can access and afford medicines that prevent, treat and cure disease. Over the last decade, PhRMA member companies have invested more than \$850 billion in the search for new treatments and cures, and they support nearly five million jobs in the United States.

ⁱ Pharmaceutical Care Management Association (PCMA). About PCMA. Accessed: March 23, 2025. <https://www.pcmnet.org/about/>.

ⁱⁱ Herman B. FTC may probe pharmacy benefit managers. Axios, February 2022. <https://www.axios.com/ftc-study-pharmacy-benefit-managers-drug-prices-3078116f-382a-4b05-ac62-da5bc1d1b892.html>.

ⁱⁱⁱ “Top 50 PBM Companies and Market Share by Annual Prescription Volume (Second Quarter 2010).” *Drug Benefit News*. April 16, 2010.

^{iv} Fein AJ. “The Top Pharmacy Benefit Managers of 2024: Market Share and Key Industry Developments.” *Drug Channels*. March 31, 2025. <https://www.drugchannels.net/2025/03/the-top-pharmacy-benefit-managers-of.html>.

^v *Ibid.*

^{vi} FTC. Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies. July 2024. Available: <https://www.ftc.gov/reports/pharmacy-benefit-managers-report>.

^{vii} Khemlani A. Amid increased federal scrutiny, PBMs pivot strategy to further squeeze independent pharmacies. *YahooHealth*, March 2024. <https://finance.yahoo.com/news/amid-increased-federal-scrutiny-pbms-pivot-strategy-to-further-squeeze-independent-pharmacies-150017649.html?guccounter=1>.

^{viii} Guadamuz JS, Alexander GC, Zenk SN, Qato DM, Wilder JR, Mouslim MC. Fewer Pharmacies in Black and Hispanic/Latino Neighborhoods Compared with White or Diverse Neighborhoods, 2007–15. *Health Affairs*, 802-11, 2021. doi/full/10.1377/hlthaff.2020.01699.

^{ix} Hawryluk M. The last drugstore: Rural America is losing its pharmacies. *The Washington Post*, November 2021. <https://www.washingtonpost.com/business/2021/11/10/drugstore-shortage-rural-america/>.

^x Levin JS, Komanduri S, Whaley C. Association between hospital-physician vertical integration and medication adherence rates. *Health Serv Res*. 2023; 58(2): 356-364. doi:10.1111/1475-6773.14090.

^{xi} Arnold D.R., Fulton, B.D. (November 2025). UnitedHealthcare Pays Optum Providers More Than Non-Optum Providers: Article examines UnitedHealthcare payments to Optum providers compared with other non-Optum providers. *Health Affairs*. Available: <https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.00155>.

^{xii} FTC. (January 2025). Specialty Generic Drugs: A Growing Profit Center for Vertically Integrated Pharmacy Benefit Managers. Available: <https://www.ftc.gov/reports/specialty-generic-drugs-growing-profit-center-vertically-integrated-pharmacy-benefit-managers>; Walker J. (September 2023). Generic Drugs Should Be Cheap, but Insurers Are Charging Thousands of Dollars for Them. *Wall Street Journal*. Available: https://www.wsj.com/health/healthcare/generic-drugs-should-be-cheap-but-insurers-are-charging-thousands-of-dollars-for-them-ef13d055?gaa_at=eafs&gaa_n=AWETSqeG6SHnrV7skkp9nkyrisEv2ji8hcxNdz9x46atthC1sb3DE-eE-1WuVVEAF2E%3D&gaa_ts=69c1994d&gaa_sig=V7PFyUfH2NA4HC6N_etiweYnApEDMDUa_ybkKOfhctAvy1lWvY798-QoAb-OX8HCQ4dBKPPTEhNArXgXX9CFsmg%3D%3D.