



Statement on Senate Bills 2462, 2466, 3059, and 3060

March 26, 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.

Senate Bills 2462 (Ujifusa), 2466 (Ujifusa), 3059 (Britto), and 3060 (Appollonio) take meaningful steps to strengthen oversight of pharmacy benefit manager (PBM) practices and to improve transparency and accountability in the prescription drug supply chain. In particular, these bills would advance PBM reforms in Rhode Island, including by limiting spread pricing in Medicaid contracting, expanding PBM transparency requirements, and establishing new statutory duties governing PBM conduct, such as duties of care and good faith and fair dealing.

Today, a small number of large, vertically integrated corporations wield substantial influence over health care decisions.

For decades, competitive market dynamics have worked successfully to balance innovation, patient access to medicines, and cost containment. But that balance is increasingly threatened by the misaligned financial incentives and conflicts of interest that characterize the PBM market today. PhRMA is increasingly concerned that the substantial rebates and discounts paid by pharmaceutical manufacturers, approximately \$356 billion in 2024,ⁱ do not make their way to offsetting patient costs at the pharmacy counter.

PBMs act as intermediaries on behalf of payers to control coverage and reimbursement arrangements for prescription medicines. 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.ⁱⁱ 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. Moreover, the amount and proportion of value extracted out of the health care system by these vertically integrated intermediaries has risen dramatically.

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.ⁱⁱⁱ 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.^{iv, v} Today, just six companies control 96 percent of the PBM market.^{vi}

As a result of this consolidation and vertical integration, PBMs now exercise significant power over Americans’ access to prescription drugs and the prices they pay.

Today, the leading PBMs are each part of massive healthcare conglomerates that are often comprised of health insurers, pharmacies, and the PBM negotiator between health insurers and pharmacies – all rolled into one. The result is that the dominant PBMs can often exercise significant control over which drugs are available, at what prices, and which pharmacies patients can use to access their prescribed medications.

PBMs often bill their health plan clients more than they pay to the pharmacy for medicines and keep the difference, enriching themselves instead of their clients or the patients they claim to serve.^{vii} This business practice, known as spread pricing, adds opacity to a supply chain that needs transparency to best serve the needs of patients. PBMs have attempted to rebrand the practice, calling it “risk mitigation pricing,”^{viii} and contending that it provides predictability for plan sponsors and lowers drug costs, but a 2020 analysis by the Congressional Budget Office found that prohibiting the use of spread pricing contracts just in Medicaid alone would save approximately \$929 million over 10 years.^{ix}

Large PBMs – who create pharmacy networks for their clients – can also 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^x 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. Currently, 94 percent of stand-alone Medicare Part D plans, 51 percent of Medicare Advantage (MA) PDPs, and 61 percent of large commercial plans have a preferred pharmacy network.^{xi} As a result, independent pharmacies are increasingly closing, particularly in rural and low-income areas,^{xii} leaving patients in those communities with fewer options to access their medicines.^{xiii} Pharmacy closures are associated with an immediate and sustained reduction in medication adherence, leading to poorer health outcomes for patients in impacted communities.^{xiv}

Given the current level of consolidation, health insurers, and drug manufacturers also often have little choice but to interact with the large, dominant PBMs when distributing certain drugs.^{xv} PBMs hold themselves out as the only part of the supply chain devoted to lowering drug costs, supposedly negotiating “fair deals” for their health insurer and employer clients and for the patients enrolled in those plans, agnostic to how to achieve the lowest net cost. However, PBMs have a vested interest in benefit administration because the rebates and/or fees received are usually tied to the price of a medicine.

While PhRMA supports oversight of PBM practices, SB 3060’s rebate contract reporting requirements should be narrowed to protect confidential commercial information while still advancing transparency.

SB 3060 takes important steps to strengthen oversight of PBMs, including by requiring PBMs to obtain a certificate of authority from the Department of Business Regulation (“Department”) and by establishing annual transparency reporting requirements. PhRMA supports efforts to improve understanding of PBM practices and how savings flow through our health care system and appreciates the intent of proposed R.I. Gen. Laws § 27-84-6 in SB 3060. At the same time, PhRMA recommends certain amendments to the bill’s reporting provisions to ensure transparency measures improve understanding of rebate use and patient out-of-pocket impacts while protecting confidential, proprietary, and trade secret information.

PhRMA has long raised concerns about misaligned incentives driven by current market dynamics and their impact on patients, particularly where negotiated savings do not reduce patients’ out-of-pocket costs at the pharmacy counter. However, the reporting framework in proposed § 27-84-6 is granular in its treatment of PBM-manufacturer rebate contracts. As drafted, proposed § 27-84-6 would require disclosure of drug and NDC-level

reporting, utilization volumes, and detailed summaries of formulary and market share based contract terms. Reporting at this level of specificity risks undermining competitive market dynamics.

To address these concerns while preserving transparency objectives, PhRMA respectfully urges the Committee to modify SB 3060 to prioritize aggregate reporting rather than drug-specific, NDC-level disclosure. An aggregate approach would enable regulators to assess PBM incentives, retention practices, and cost impacts without exposing sensitive commercial information.

For example, Rhode Island could require PBMs to report:

- the aggregate dollar amount of rebates received by the PBM from all pharmaceutical manufacturers;
- the aggregate dollar amount of administrative fees received by the PBM;
- the aggregate dollar amount of administrative service fees paid to the PBM by insurers or health plans;
- the aggregate dollar amount of manufacturer rebates retained by the PBM rather than passed through to insurers;
- the aggregate dollar amount of manufacturer administrative or service fees retained by the PBM; and
- the aggregate retained rebate percentage across the PBM's book of business.

PhRMA is also concerned that proprietary manufacturer information could become subject to public disclosure once submitted to the Department. We recommend clarifying that the Department may not disclose any trade secret, proprietary, or confidential information contained in PBM filings, consistent with existing public records law. Current language in the bill appears to allow broad disclosure where the Department determines disclosure would otherwise be in the public interest, which may be inconsistent with existing public records protections. We recommend that any public disclosure be limited to aggregate, de-identified information.

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 SBs 2462, 2466, 3059, and 3060. 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 Fein, A. "The 2025 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers," Drug Channels Institute. March 2025.

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

ⁱⁱⁱ 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>.

^{iv} "Top 50 PBM Companies and Market Share by Annual Prescription Volume (Second Quarter 2010)." *Drug Benefit News*. April 16, 2010.

^v 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>.

^{vi} *Ibid*.

^{vii} Robert Langreth, David Ingold and Jackie Gu, "[The Secret Drug Pricing System Middlemen Use to Rake in Millions](#)," Bloomberg, September 11, 2018.

^{viii} PCMA, "How Risk Mitigation (Spread) Pricing Helps Drive Lower Drug Costs," accessed at National Conference of State Legislators, <https://www.ncsl.org/documents/health/PCMA%20Spread%20Pricing%20Infographic%2035782.pdf>.

^{ix} Congressional Budget Office, Analysis of Prescription Drug Pricing Reduction Act of 2019. March 13, 2020. <https://www.cbo.gov/system/files/2020-03/PDPRA-SFC.pdf>.

^x 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>.

-
- ^{xi} Fein A. The 2022 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers. Drug Channels Institute. March 2022.
- ^{xii} 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.
- ^{xiii} 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/>.
- ^{xiv} 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.
- ^{xv} Federal Trade Commission. Pharmacy Benefit Mangers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies. July 2024. Available at: <https://www.ftc.gov/reports/pharmacy-benefit-managers-report>.