

Federal Trade Commission
Washington, D.C.

March 13, 2026

Re: Public Comment in Support of the Proposed Decision and Order in *In the Matter of Caremark Rx, LLC et al.*, Docket No. 9437 (Decision and Order as to Express Scripts, Inc., Evernorth Health, Inc., Medco Health Services, Inc., and Ascent Health Services LLC)

Submitted via Regulations.gov

Dear Chairman Ferguson and Commissioner Meador:

The PBM Accountability Project respectfully submits this comment in strong support of the Federal Trade Commission’s proposed Decision and Order (“Order”) against Express Scripts, Inc., Evernorth Health, Inc., Medco Health Services, Inc. and Ascent Health Services LLC (collectively, “ESI”).

The PBM Accountability Project brings together leaders and stakeholders across healthcare, labor, business, pharmacy, consumer and patient advocacy to promote transparency, fairness and accountability in our prescription drug supply chain to help ensure that Americans aren’t overpaying for prescription medicines we need.

Patients, independent community pharmacies, employers and health plan sponsors have long suffered from the anticompetitive and opaque practices of the nation’s largest pharmacy benefit managers (PBMs). We support solutions that create transparent competition among PBMs and address the ways PBM practices profit at the expense of Americans. For these reasons, **we commend the Commission for taking this landmark enforcement action. We urge the Commission to finalize the Order without weakening its core patient-protective and pro-competitive provisions.**

I. Background and the PBM Accountability Crisis

The three largest PBMs, CVS Caremark, Express Scripts/Evernorth and OptumRx, collectively manage pharmacy benefits for more than 200 million Americans. These vertically integrated middlemen sit between the innovators making medicines and the patients who need them. In that position, PBMs wield enormous market power to extract rebates from manufacturers, steer patients toward high-rebate drugs without sharing cost-

savings, exclude independent pharmacies from networks and obscure their compensation from the plan sponsors they purportedly serve.

The FTC's own July 2024 Interim Staff Report documented how the largest PBMs have leveraged their dominant position to inflate drug costs, disadvantage lower-cost alternatives and harm patients. Often PBMs anchor patient-out-of-pocket costs for deductibles and coinsurance to list prices rather than the actual negotiated net cost of their medications. The abuses at issue in this matter are not anomalies; they are features of a broken system that your proposed Order begins to address.

The order addresses core PBM anticompetitive abuses and deserves finalization. Each provision addresses a documented harmful practice:

A. Non-Discrimination of Lower-Cost Drug Versions (Section I)

The Order's prohibition on formulary discrimination against lower-list-price versions of drugs ("Low-WAC versions") directly addresses one of the most harmful incentive distortions in the PBM industry. ESI and other large PBMs have historically placed lower-cost versions of drugs on less favorable formulary tiers or imposed additional access restrictions, such as prior authorization and step therapy, compared to higher-list-price versions of the same drug. The reason? Because higher-list-prices generate larger rebates that the PBM retains.

This practice harms patients twice over: patients pay higher out-of-pocket costs when cheaper alternatives are placed on unfavorable tiers and lower drug prices become commercially unviable because PBMs depress demand for them. The Order's requirement that Low-WAC versions be placed on Standard Formularies on equal or better terms than their high-list-price counterparts provided the manufacturer can supply the product at an equal or lower net unit cost is a precisely calibrated and overdue reform.

B. Capping Patient Out-of-Pocket Costs at Net Unit Cost (Section II)

Perhaps no single provision will provide more immediate relief to patients than the requirement that member out-of-pocket costs be capped at the actual cost after rebates rather than the artificially inflated list price. Today, millions of Americans in high-deductible health plans calculate their cost sharing against inflated list prices, even when their PBM has negotiated rebates that dramatically reduce the actual cost of the drug. It means that a PBM may require a patient to pay \$400 out of pocket for a drug though the PBM actually paid \$40. The Order squarely prohibits this.

The PBM Accountability Project strongly supports this provision and urges the Commission to ensure robust enforcement to prevent evasion through complex plan designs or

contractual carve-outs that effectively replicate list-price-based cost sharing under a different label.

C. Point-of-Sale Rebates and Prohibition on Spread Pricing (Section V)

The requirement that ESI make point-of-sale rebate pass-through available without charging an additional fee to do so and the prohibition on spread pricing are critically important structural reforms. Spread pricing has drained billions of dollars from state Medicaid programs, employer health plans and union funds while providing zero value to patients or payers. Its elimination from ESI's standard offering is a model for the industry.

D. Transparency and Compensation Disclosure (Sections VI and VII)

The Order's requirements that ESI delink its Drug Manufacturer compensation from list prices and provide meaningful transparency to plan sponsors address a fundamental information gap at the heart of the PBM accountability issues. Plan sponsors today often lack the data necessary to independently evaluate whether their PBM is acting in their interest. These transparency requirements will empower employers, union health funds and other payers to hold their PBMs accountable, and we urge the Commission to ensure these reporting obligations are specific, timely and provided in an easily usable format.

E. Fair Treatment of Independent Community Pharmacies (Section VIII)

Independent community pharmacies serve as essential healthcare providers in rural and underserved communities, yet the largest PBMs have used their market power to reimburse these pharmacies below their cost of acquisition, exclude them from preferred networks and deny them fair compensation for clinical services they perform. Pharmacy deserts and limited patient access are tragic results of these practices. Section VIII of the proposed Order works to correct this.

The PBM Accountability Project strongly supports these provisions. Independent pharmacies are essential community health infrastructure. Their financial viability is a patient access issue, and we urge the Commission to define "acquisition cost" broadly enough to prevent PBMs from using data manipulation to understate that cost and undermine the intent of this provision.

While we support the Order as written, we offer the following recommendations to ensure its provisions are effective in practice:

- **Extend the Order's model to other PBMs.** ESI is one of three vertically integrated mega-PBMs and the conduct addressed in the proposed Order is not unique to ESI. The Commission should use the proposed Order as a template for industry-wide enforcement, investigation and rulemaking to ensure that patients and plan

sponsors across the country benefit from these reforms and not just those whose plans use ESI. Disarming one PBM may serve to increase market share and potentially embolden others.

- **Accelerate implementation timelines where possible.** Several critical provisions – including the point-of-sale rebate requirement, spread pricing ban and community pharmacy protections – have proposed implementation deadlines of January 1, 2028. Given the ongoing harm patients and pharmacies face, the Commission should require ESI to report interim progress milestones and should not grant extensions absent a compelling showing of genuine operational necessity.
- **Coordinate with Congress and state regulators.** The Commission should share the factual record in this proceeding with Congressional committees working on PBM reform legislation and with state insurance commissioners and Medicaid agencies that independently regulate PBM conduct. Federal-state coordination will maximize the impact of this enforcement action.
- **Consider meaningful financial penalty.** The Commission should consider assessing substantial financial penalties if ESI does not comply with the requirements outlined in the settlement.

The proposed Order represents one of the most significant federal enforcement actions against PBM anticompetitive behaviors. It directly addresses patient harm, pharmacy access and the lack of transparency that has allowed PBMs to flourish as unaccountable intermediaries limiting medication access and driving prices higher.

The PBM Accountability Project urges the Commission to finalize the Order without dilution, appoint a rigorous and qualified monitor and use this action as the foundation for broader industry-wide reform. American patients, independent pharmacists and the plan sponsors who pay for their care deserve nothing less.

We appreciate the Commission's diligent work on this matter and stand ready to provide any further information that would be useful to the Commission.

Respectfully submitted,



Mark Blum
Managing Director, PBM Accountability Project