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Vertical Integration and Healthcare: How Pharmacy Benefits Managers Tend to Benefit Themselves.

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I. Introduction

The American healthcare marketplace has become increasingly concentrated over recent years. The concentration has been seen not only with hospitals and care providers, but with insurance companies, pharmacies, and pharmacy benefit managers ("PBMs"). This has largely come via mergers and acquisitions, with the largest corporations purchasing their up-and-coming competition and doing what they can do to minimize or eliminate the competition that cannot be bought outright. As companies, such as CVS Health, become vertically integrated, they have been able to streamline their costs associated with the prescription drug process and push remaining costs along to the everyday consumer. Vertical integration is the process in which noncompeting companies, whose products are necessary components or compliments of one another, integrate.[1]

Vertical integration is common with hospitals and outpatient care providers merging, but vertical integration between insurers, PBMs, and pharmacies poses a more daunting problem to consumers. When considering the vertical integration of certain industries, one must consider how the integration fits within United States Antitrust legislation. The concept of antitrust, commonly understood as the law against monopolization, exists to prohibit monopolization by illegal means and to stop unreasonable restraints on trade. Antitrust law aims to allow fair competition and to keep markets and industries from being controlled by a single firm (a monopoly) or by a small group of firms (an oligopoly).

Antitrust laws exist at both the federal and state levels and is enforced by the Federal Trade Commission, the Department of Justice, respective state agencies, and private parties. Antitrust law transcends industry and has existed in the United States for over a century, but its

[1] *Vertical Merger Enforcement Challenges at the FTC*, Fed. Trade Comm'n, (July 17, 1995), https://www.ftc.gov/news-events/news/speeches/vertical-merger-enforcement-challenges-ftc/.

application to healthcare has not been as robust as it could, and arguably should, have been, especially with recent market consolidation.

PBMs became major players in the healthcare industry in the 1980s. They were created as intermediaries to negotiate between drug manufacturers, prescription drug plans, and pharmacies.[2] These negotiations are largely opaque, leading to practices such as rebates and spread pricing, which allow PBMs to not only take a significant portion of each transaction for themselves, but to keep the final percentage private. When an insurance company, a PBM, and a pharmacy are all housed within one organization, the conflict of interest is clear.

PBM rebates, in which they negotiate a percentage of revenue to be kept when a drug is prescribed and ultimately distributed to the end consumer, had previously benefited from protection from the federal Anti-Kickback Statute ("AKS").[3] The AKS is a federal statute that prohibits the knowing and willful remuneration to induce referrals or any other health services paid for by a federal healthcare program.[4] The AKS has a number of "safe harbors" which protect entities from AKS enforcement when they follow requirements for certain transactions.[5] PBM rebates were previously covered by an AKS safe harbor, and were excluded from enforcement.[6] PBMs can no longer claim certain rebates with federally funded healthcare services, i.e., Medicare and Medicaid, are protected under safe harbors, and must follow more stringent regulations.

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[2] Janet Brierton, *Pharmacy Benefit Managers*, Conn. Gen. Assembly (Dec. 24, 2003), https://www.cga.ct.gov/2003/olrdata/ins/rpt/2003-R-0903.htm/.
[3] Removal of Safe Harbor Protections Involving Prescription Pharmaceuticals, 85 Fed. Reg. 76666, (Nov. 30, 2020) (to be codified at 42 C.F.R. 1001).
[4] *Fraud and Abuse Laws*, Dep't of Health and Hum. Serv., Off. of Inspector Gen., https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws, *See Generally* 42 U.S.C.A. §1320a-7b
[5] For a complete list of AKS Safe Harbors, which are largely outside the scope of this discussion, *See* 42 C.F.R. §1001.952.
[6] The safe harbor was 42 C.F.R. § 1001.952(h) and has since been repealed.

The removal of the AKS safe harbor is a step in the right direction, but there is still significant work to be done in regulating healthcare, and more specifically the PBMs. State and federal governmental entities can, and have begun to, regulate these industries to ensure there is more transparency in these organizations, but the task is not without its difficulties. Legislatures must navigate lobbying, disinformation, and the stereotypical "revolving door" of government, which blurs the lines between looking out for the public and looking out for themselves.[7]

One of the biggest concerns in the healthcare space right now should be PBMs: their intermediary role between insurance companies and pharmacies, and the total lack of transparency into almost all of their practices. PBMs, following the trend of other healthcare sectors, have become increasingly concentrated over the years. For instance: Caremark, the PBM owned and operated by CVS Health, handled 33% of managed claims in 2022.[8] PBMs, as intermediaries, provide a service that can be useful to all outside parties. However, when they become vertically integrated, the PBM is an intermediary for two parties that are both within its corporate umbrella. Different levels of a single organization negotiating with one another will almost always lead to one conclusion: the unavoidable costs will be pushed to outside consumers and the profits will be divided internally.

The analysis below will suggest certain courses of action that regulators and industry officials can take to eliminate these practices and put the focus of healthcare back on the patients rather than the dollar signs.

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[7] *Guide to Revolving Door and Post-Public Employment*, State of R.I. Ethics Comm'n, https://ethics.ri.gov/ethics-education/guide-revolving-door-and-post-public-employment/.
[8] Page Twenter, *Top PBMs by 2022 market share*, Becker's Hosp. Rev., (May 23, 2023), https://www.beckershospitalreview.com/pharmacy/top-pbms-by-2022-market-share.html/.

Part II will give a brief history of relevant U.S. antitrust legislation and how those statutes could, and should, be used to slow the integration and potentially unwind healthcare companies that have integrated too far. Part III will explain what a PBM is, what PBMs were created to do, and what PBMs have actually done. The analysis will also have an explanation of anticompetitive practices that PBMs undertake and how their existence in a vertically integrated healthcare company is rife with conflict of interest. Part IV will give a history of CVS Health, arguably the most successful vertically integrated healthcare company.[9] It will show how CVS has a history of using the anticompetitive practices outlined in Part III to its benefit, and how its growth has only led to a lesser standard of care for the average consumer. Part V will briefly conclude the argument.

II. Antitrust legislation and regulation in the United States

For a multitude of reasons, the United States in the late 1800s was vastly different than it is today. Specifically, business was not as competitive as it is today. Many industries were dominated by large "trusts" which consisted of the respective titans of industry.[10] The original "trusts" that led to the original pieces of U.S. antitrust legislation were the railroads, oil companies and banks, among others.[11] For the purposes of antitrust legislation, a trust can be understood as a business or group of businesses that "form a monopoly to dictate pricing in a particular market."[12]

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[9] CVS Health is the parent company for the three most relevant corporate entities for this article: CVS Pharmacy, Inc., Caremark Rx L.L.C., and Aetna Inc., amongst hundreds of other subsidiaries. When the company as a whole is referenced, it will be referred to as "CVS", whereas more specific instances will use the names of the specific corporate entities.
[10] Ellen Terrell, *Sherman Anti-Trust Act Signed into Law*, Libr. Of Cong.(April 2023), https://guides.loc.gov/this-month-in-business-history/july/sherman-antitrust-act-enacted
[11] Id.
[12] Alexandra Twin, *Antitrust Laws: What They Are, How They Work, Major Examples*, Investopedia (Jan. 31, 2023), https://www.investopedia.com/terms/a/antitrust.asp/.

To combat these trusts, the United States has enacted a variety of legislation, but three federal statutes in particular comprise its core: the Sherman Antitrust Act of 1890, the Federal Trade Commission Act of 1914, and the Clayton Antitrust Act of 1914.[13] These laws establish agencies, delegate prosecutorial jurisdiction, and outline business practices considered to be unlawful.[14] The U.S. antitrust laws are regulated and enforced by two agencies in particular.[15] The Department of Justice Antitrust Division enforces the Sherman Act, the Federal Trade Commission enforces the Federal Trade Commission Act, and both agencies share jurisdiction to enforce the Clayton Act.[16]

Both the Department of Justice Antitrust Division ("DOJ") and the Federal Trade Commission ("FTC") have the ability to review proposed mergers before they are finalized.[17] This statutory authority is provided by the Hart-Scott-Rodino Antitrust Improvements Act of 1976.[18] Where one of the two aforementioned agencies will review the merger, with the opportunity to consult with the other agency, and decide whether to approve the merger or not.[19] Mergers are regularly concluded by consent agreements being signed by the applicable agency and the merging entities, which would outline the protocols that must be put in place to avoid potential anticompetitive conduct.[20] If the merged entity engages in subsequent anticompetitive

[13] *The Antitrust Laws*, Fed. Trade Comm'n, https://www.ftc.gov/advice-guidance/competition-guidance/guide-antitrust-laws/antitrust-laws/.
[14] Id.
[15] *The Enforcers*, Fed. Trade Comm'n, https://www.ftc.gov/advice-guidance/competition-guidance/guide-antitrust-laws/enforcers/.
[16] Id.
[17] *Premerger Notification and the Merger Review Process*, Fed. Trade Comm'n, https://www.ftc.gov/advice-guidance/competition-guidance/guide-antitrust-laws/mergers/premerger-notification-merger-review-process/.; For the purposes of this article the acronym "DOJ" will refer specifically to the Department of Justice Antitrust Division, whereas colloquially the acronym "DOJ" refers to the Department of Justice overall.
[18] Fed. Trade Comm'n, *supra* note 17.; The Hart-Scott-Rodino Act ("HSR Act") requires mergers that reach a certain dollar value threshold to notify antitrust regulators before finalizing the merger for approval. The aim of the HSR Act was to give the DOJ and FTC the ability to review a transaction before the entities integrate to ensure there it not an unreasonable restraint on trade or anticompetitive conduct. Supra note 12.
[19] Fed. Trade Comm'n, *supra* note 17.
[20] Id.

conduct and violates the specifics of the consent agreement, that would constitute a breach of contract.[21] The applicable antitrust enforcement agency would be able to seek remedies under §2 of the Sherman Act, which include fines and structural damages of up to dissolving the merged entity.[22]

A. The Sherman Act and the Origins of United States Antitrust Law

United States antitrust law took shape when a bill was introduced by, and named after, Ohio Senator John Sherman in 1890.[23] The Sherman Antitrust Act of 1890 ("Sherman Act") was introduced with the hope of regulating industries that were dominated by a small number of firms, if not a singular firm, controlling every aspect of the market and quashing competition.[24] Section 1 of the Sherman Act outlaws all "contract[s], combination[s] in the form of trust or other-wise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations…"[25] This has not been taken literally by the Court, as all contracts will technically restrain trade in certain ways. Section 1's verbiage has been viewed to see that all contracts or combinations that unreasonably restrain trade will be found presumptively illegal.[26]

The Sherman Act is the antitrust act that arguably has the most teeth. It creates both civil and criminal penalties. [27] As mentioned above, one way that antitrust regulators can attempt to remedy mergers that have become anticompetitive is through Section 2 of the Sherman Act.[28]

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[21] *Competition And Monopoly: Single-Firm Conduct Under Section 2 Of The Sherman Act: Chapter 9*, U.S. Dep't of Just. Antitrust Div. (Feb. 8, 2023), https://www.justice.gov/atr/competition-and-monopoly-single-firm-conduct-under-section-2-sherman-act-chapter-9
[22] Id.
[23] Terrell, *supra* Note 10.
[24] Id.
[25] Sherman Antitrust Act, 15 U.S.C.A. §1 (2004).
[26] *See* Bd. of Trade of the City of Chicago v. U.S. 246 U.S. 231, 238 (1918).
[27] Fed. Trade Comm'n, *supra* note 13.
[28] U.S. Dep't of Just. Antitrust Div., *supra* note 21.
Supra 19

Section 2 prohibits monopolization and the conspiracy to monopolize.[29] Section 2 of the Sherman Act allows, in extreme circumstances, for structural remedies.[30] Structural remedies allow for the possibility of dissolving the entity, divestiture, or spinning off a piece of the corporate entity into its own corporate being.[31] This is rare and is considered to be the "most drastic" but it is possible.[32]

B. Additional Antitrust Legislation

U.S. antitrust legislation does not stop with the Sherman Act. Congress enacted two additional important pieces of legislation in 1914, passing both the Clayton Antitrust Act of 1914 ("Clayton Act") and the Federal Trade Commission Act of 1914 ("FTC Act").[33] The Clayton Act was passed to strengthen the Sherman Act, prohibiting mergers and acquisitions that would "substantially lessen competition…"[34] The passing of the FTC Act created the Federal Trade Commission and statutorily prohibited "unfair methods of competition" and "unfair or deceptive acts or practices."[35] The FTC does not have regulatory powers to enforce the Sherman Act, but the Supreme Court has held that an act that violates the Sherman Act also violates the FTC Act, giving the FTC jurisdiction to bring suit.[36] Both the Clayton Act and the FTC Act were enacted to strengthen U.S. antitrust law after the Sherman Act[37]. These acts reach other conduct that is anticompetitive or could have anticompetitive affects but were not found to be covered by the Sherman Act.[38] The Clayton Act is especially important when it comes to state antitrust

[29] 15 U.S.C. § 2.
[30] U.S. Dep't of Just. Antitrust Div., *supra* note 21.
[31] Id.
[32] United States v. Microsoft Corp., 253 F.3d 34, 106 (D.C. Cir. 2001) (en banc) (per curiam).
[33] Fed. Trade Comm'n, *supra* note 13.
[34] Id.
[35] Id.
[36] Id.
[37] Id.
[38] Id.

enforcement. As seen in Section 4(c) of the Clayton Act, any of the state attorneys general may bring a civil action in the name of their respective state as parens patriae on behalf of residents in the state.[39] Parens patriae is a doctrine of law that gives a governmental entity to "prosecute a lawsuit on behalf of a citizen…"[40]

C. Vertical Integration and its Application to Healthcare.

A vertically integrated company or market is one that has gone through consolidation by vertical mergers or acquisitions. Vertical mergers, by definition, involve entities that can be viewed as having a "buyer-seller relationship."[41] By consolidating with an upstream or downstream entity, costs can be streamlined, efficiencies can be gained, and productivity can increase.[42] More specifically, the National Library of Medicine has defined a vertically integrated healthcare system as "an arrangement whereby a health care organization offers, either directly or through others, a broad range of patient care and support services.[43]

A good example of vertical integration in the healthcare space can be seen through the lens of CVS. CVS owns three levels of the healthcare supply chain: (1) insurance company Aetna; (2) PBM Caremark; and (3) CVS Pharmacy.[44] Caremark would work as an intermediary between Aetna and CVS Pharmacy to set prescription drugs covered by Aetna and amounts reimbursed to CVS Pharmacy when those prescription drugs are dispensed to consumers.

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[39] *See* 15 U.S.C. § 15(c).
[40] Black's Law Dictionary 1221 (9th ed. 2009).
[41] *Competitive Effects*, Fed. Trade Comm'n, https://www.ftc.gov/advice-guidance/competition-guidance/guide-antitrust-laws/mergers/competitive-effects/.
[42] Id.
[43] D A Conrad & W L Dowling, *Vertical integration in health services: theory and managerial implications*, 15(4) Health Care Manage Rev. 9-22 (1990).

[44] *Subsidiaries of CVS Health Corporation*, SEC Edgar, https://www.sec.gov/Archives/edgar/data/64803/000006480319000013/subsidiariesofcvshealthcor.htm/.

The FTC has historically focused more on horizontal mergers, with sets of "Horizontal Merger Guidelines" being promulgated from the 1980s until 2010 most recently.[45] A "horizontal merger" is a merger between competitors, such as two manufacturers of the same product.[46] These are viewed to lessen competition as there is one (or more) less firm in a specific market.[47] The FTC issued their "Vertical Merger Guidelines" in 2020, signaling a more aggressive approach to mergers that had historically not been seen as anticompetitive.[48] In a vertical merger, the entities are at different levels of the supply chain, so they were seen to not be technically competing with one another. This is an outdated way of viewing these transactions, and the Vertical Merger Guidelines is an example of antitrust regulators realizing that transactions that are not facially anticompetitive can still have significant anticompetitive effects.

Vertical integration in a healthcare company should lead to lower premiums and prescription drug costs as the integrated company can now streamline their costs.[49] Not only are costs streamlined, but it should eliminate double marginalization.[50] Double marginalization can best be explained by a non-vertically integrated company, in which a producer of a product marks up their product for profit and the retail distributor of that product also marks the price up so they can profit.[51] If Aetna, Caremark, and CVS Pharmacy were separate entities, it is likely that Caremark would mark up a service it provides to Aetna, and CVS Pharmacy would mark up

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[45] *FTC and DOJ Seek Comment on Draft Merger Guidelines*, Fed. Trade Comm'n (July 19, 2023), https://www.ftc.gov/news-events/news/press-releases/2023/07/ftc-doj-seek-comment-draft-merger-guidelines
[46] *Horizontal Merger Guidelines*, Fed. Trade Comm'n (Aug. 19, 2010) https://www.ftc.gov/system/files/documents/public_statements/804291/100819hmg.pdf
[47] Id. at 1.
[48] *The 2020 Vertical Merger Guidelines: A Suggested Revision*, Fed. Trade Comm'n (Mar. 26, 2020) https://www.ftc.gov/system/files/attachments/798-draft-vertical-merger-guidelines/salop_suggested_vertical_merger_guidelines.pdf
[49] Charles Gray et al., *Disadvantaging Rivals: Vertical Integration In The Pharmaceutical Market*, Nat'l Bureau of Econ. Rsch. (August 2023), https://www.nber.org/system/files/working_papers/w31536/w31536.pdf
[50] Id. at 1.
[51] John Kwoka and Margaret Slade, *Second Thoughts on Double Marginalization*, Soc. Sci. Res. Ctr. (Sept. 11 2019) https://economics.ubc.ca/wp-content/uploads/sites/38/2022/10/2020Antitrust.pdf/.

the prescription drug it provides to the consumer so they can profit. That added layer of price increasing is the double marginalization, which should be eliminated through vertical integration.[52]

A perfect illustration of vertical integration in healthcare is the corporate structure of CVS. CVS Health is a parent company with hundreds of subsidiaries, many of whom have further subsidiaries.[53] Under CVS Health Corporation is CVS Pharmacy, Inc. ("CVS Pharmacy")[54]. CVS Pharmacy itself has both Aetna Inc. ("Aetna"), a nationwide insurance carrier, and Caremark Rx, L.L.C. ("Caremark"), a PBM, as subsidiaries. This is of significant importance as these three entities as separate businesses would negotiate with one another to ensure low costs for themselves while attempting to obtain savings for their customers.[55] When these negotiations happen between unrelated companies, they tend to have their own interests in mind, which should lead to better pricing for their end users. When these negotiations happen between different levels of a vertically integrated company, the corporate entity is essentially negotiating with itself. Aetna, CVS Pharmacy, and Caremark may all be individual corporate entities, but they are all wholly owned and operated under the umbrella of CVS Health. It is absolutely reasonable to assume that all of their transactions are made with the bottom line of CVS Health in mind.

[52] Id.
[53] SEC Edgar, *supra* note 44.
[54] Id.
[55] In this sense, customers can be viewed as policyholders for insurance companies and patients who are receiving prescription drugs from pharmacies, as well as those entities who contract with PBM; *See* Dylan Scott, *The mysterious middlemen being blamed for America's sky-high drug prices*, Vox (May 10, 2023, 7:00 AM) https://www.vox.com/2023/5/10/23709448/what-are-pbms-pharmacy-benefit-managers-bernie-sanders/.

III. What is a PBM and What is Their Place in Healthcare?

Healthcare in the U.S. can be defined simply as "a complex system comprised of providers, payers…and patients who receive care."[56] Despite its potentially simple definition, a wide variety of individuals and corporate entities make up each sector of healthcare. The way that insurers, PBMs, and pharmacies interact with one another is of particular importance. PBMs and their power to negotiate between insurers, drug manufacturers, and pharmacies play a very important role in the American healthcare system, which is elevated even further when a company becomes vertically integrated.[57] PBMs are viewed as an important part of the healthcare system, but whether they still provide the value they did when they began negotiating drug prices and availability in the 1980s is up for debate. The below analysis will discuss what PBMs were created to do, how they have deviated from that original mission, how vertical integration has increased that deviation, and specific practices that PBMs use to stifle competition.

All of the above analyses – from anticompetitive practices, to deviating from a mission, to vertical integration – can be almost perfectly explained by looking at CVS. CVS has consolidated its businesses and has regularly engaged in the anticompetitive practices that will be discussed.

[56] *The Business of Health Care in the United States*, Harv. Online (June 27, 2022), https://www.harvardonline.harvard.edu/blog/business-health-care-united-states/.
[57] Shawn Bishop, *Pharmacy Benefit Managers and Their Role in Drug Spending*, The Commonwealth Fund (Apr. 22, 2019) https://www.commonwealthfund.org/publications/explainer/2019/apr/pharmacy-benefit-managers-and-their-role-drug-spending/.

A. What is a PBM and What Do They Do?

Pharmacy Benefit Managers are "third party companies that function as intermediaries between insurance providers and pharmaceutical manufacturers."[58] They came into existence in the 1960s when insurance companies began offering prescription drugs in their healthcare plans.[59] Their original purpose was to help insurers limit the amount of money spent on prescription drugs for their policyholders, with insurers advertising it as a way to keep costs low for the policyholders.[60] PBMs attempt to limit money spent by insurance companies by creating formularies, which are "list[s] of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits.[61] In plain terms, a formulary can be viewed as a drug list.[62] The drugs on the formulary of an individual's health plan are the drugs that the insurance will cover.[63] A formulary gives a PBM enormous bargaining power, as they negotiate pricing with drug manufacturers who want to be included on the formulary.[64] If a drug manufacturer wants one of their prescription drugs on a PBM's formulary, the PBM will be able to wield that bargaining power to ensure the price is favorable to them.

Formularies are typically tiered, and those tiers outline how the cost is shared between the insurer and the policyholder.[65] The lower tiers typically require less out-of-pocket expenses for the policyholder and are therefore a more popular choice amongst policyholders.[66] As the

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[58] *Pharmacy Benefit Managers*, Nat'l Ass'n of Ins. Carriers, (June 1, 2023), https://content.naic.org/cipr-topics/pharmacy-benefit-managers/.
[59] Id.
[60] Id.
[61] *Formulary*, Healthcare.gov, https://www.healthcare.gov/glossary/formulary/
[62] Id.
[63] *How to Read a Drug List*, Blue Cross Blue Shield of Mich., https://www.bcbsm.com/individuals/help/pharmacy/read-drug-list/
[64] Bishop, *supra* note 57.
[65] Sam Hughes & Nicole Rapfogel, *Following the Money: Untangling U.S. Prescription Drug Financing*, Ctr. for American Progress (Oct. 12, 2023) https://www.americanprogress.org/article/following-the-money-untangling-u-s-prescription-drug-financing/.
[66] Id.

lower tiers are typically more popular amongst policyholders, they are more attractive to drug manufacturers, as the formularies are used for more policyholders giving the manufacturers greater access to policyholders.[67] Many consumers choose their healthcare plans based on what is covered, and if they find that regularly prescribed drugs are covered on a certain plan and will lead to minimal, if any, out-of-pocket costs, they will be inclined to choose that healthcare plan.

After setting their formularies, PBMs have two main functions: (1) working with drug manufacturers to set pricing for the prescription drugs, along with rebates paid to the PBMs when those drugs are filled, and (2) working as an intermediary to get pharmacies paid by insurers for prescriptions that are given out to patients.[68] These two functions go hand-in-hand. When a prescription is filled by a pharmacy (assuming the person receiving the medicine uses their insurance coverage) the insurance company pays the balance that is not covered by copays or out of pocket costs.[69] The insurance company pays the pharmacy through the PBM, a process known as reimbursement.[70] Additionally when the drug is filled, the manufacturer pays a rebate to the PBM, typically a percentage of the list price of the medication on the formulary, for its inclusion on the formulary.[71] It is similar to a mail-in rebate of any typical consumer product, where the money is not given back until after the product is sold, the PBM doesn't receive a rebate until a drug on its formulary is prescribed and given out.

Drug manufacturers typically pay higher rebates per prescription filled to for inclusion on lower tiered formularies.[72] As more people are enrolled in plans that use these formularies,

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[67] Id.
[68] Bishop, *supra* note 57.
[69] Id.
[70] Id.
[71] Id.
[72] Hughes & Rapfogel, *supra* note 65.

manufacturers that pay a higher rebate to ensure their inclusion on the formulary can ensure they are still breaking even by having a larger pool of people to have their drugs prescribed to. As stated by the Pharmacists Society of the State of New York, a New York pharmacist trade organization, "PBMs profit at nearly every stage of the supply chain…"[73]

B. The Integration History of PBMs.

PBMs have been involved in vertical integration for decades. Looking back to the early 1990s, PBMs were consolidating with drug manufacturers. Merck & Co., Eli Lilly, and SmithKline Beechum (now known as GlaxoSmithKline), all owned PBMs.[74] By 2000, all but Merck & Co. had sold their PBMs.[75] Merck & Co. spun off their PBM in 2003, clearing itself of any conflict-of-interest claims.[76] These conflicts were related to the PBMs including the prescription drugs of the drug manufacturers, who they were consolidated with, and favoring them on their formularies over readily available alternatives.[77] These unbundling transactions were due to fears that PBMs who owned, or were owned by, drug manufacturers would heavily favor that manufacturer's drugs.[78] Those fears were valid, as the merged entities' business practices were under FTC investigation for conflicts of interest.[79] The companies unwound operations to avoid further regulatory scrutiny or antitrust litigation. They took the initiative and removed the PBMs from their corporate structure.

PBMs and their integration with insurance companies and pharmacies have not gone through unbundling in the same way that PBMs and drug manufacturers did. Most large PBMs

[73] *PBM Basics*, Pharmacists Soc'y of the State of N.Y., https://www.pssny.org/page/PBMBasics/.
[74] Barbara Martinez, *Pharmacy-Benefit Managers At Times Toil for Drug Firms*, Wall St. J., Aug. 14, 2002
[75] Id.
[76] Id.
[77] Id.
[78] Id.
[79] Denise Myshko, *Beyond the Big Three and How We Got Here*, Managed Healthcare Exec., Dec. 2022 at 18.

operate mail-order pharmacies and specialty pharmacies, which they use to get certain drugs direct to consumers.[80] Without being vertically integrated, this is not necessarily a concern. PBMs were created to negotiate between insurers, pharmacies, and drug manufacturers. As PBMs own or are owned by insurers and pharmacies, it's clear who their negotiating will favor. For example, Caremark, a PBM owned by CVS, will be unlikely to negotiate in favor of a drug manufacturer when negotiating on behalf of Aetna, an insurer owned also owned by CVS.

The consolidation in the PBM market is clear. For 2022, the top six PBMs handled 96% of the American healthcare market.[81] The top three alone – Express Scripts, CVS Caremark, and OptumRx – handled 79% of the American healthcare market.[82] The three largest PBMs are so dominant in their industry that they are colloquially known as the "big three."[83] Those three largest PBMs are consolidated with insurance companies, with Caremark also operating retail pharmacies under their corporate umbrella.[84]

The three largest PBMs, who themselves manage almost 80% of the market, are all owned by specific parent companies. Chronologically, UnitedHealth purchased PacifiCare in 2005, which operated a PBM.[85] That PBM has grown and eventually came to be OptumRx in 2011, the PBM currently owned and operated by UnitedHealth.[86] Insurance company The Cigna

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[80] Matt Fielder et al., *A brief look at current debates about pharmacy benefit managers*, The Brookings Institute (Sept. 7, 2023), https://www.brookings.edu/articles/a-brief-look-at-current-debates-about-pharmacy-benefit-managers/.
[81] Twenter, *supra* note 8.
[82] Id.
[83] Myshko, *supra* note 79 at 17.
[84] Id. at 18.
[85] Jeff Byers, *Optum a step ahead in vertical integration frenzy*, Healthcare Dive (Apr. 12, 2018) https://www.healthcaredive.com/news/optum-unitedhealth-vertical-integration-walmart/520410/.
[86] Id.

Group ("Cigna") completed its acquisition of Express Scripts in December of 2018.[87] Express Scripts was the last of the "big three" PBMs to be a standalone entity, as OptumRx was contained within UnitedHealth and Caremark was already integrated with CVS Pharmacy. The final "big three" PBM to merge with an insurance company was Caremark, with CVS Health's acquisition of Aetna closing in September of 2019.[88] CVS was already vertically integrated, having pharmacies and a PBM together under one roof before the Aetna acquisition.

C. Anticompetitive Practices by PBMs and Proposed Solutions.

When it comes to anticompetitive practices by PBMs, the two primary practices that require addressing are (1) excessive rebates and (2) spread pricing. Rebates themselves are not per se problematic, but when the PBM is charging exorbitant rebates to the point that drug manufacturers increase their list prices, it becomes something that needs to be addressed by regulators. Spread pricing is the practice of "charging payers…more than they pay the pharmacy for a medication and [keeping] the 'spread' or difference as profit."[89] This process is possible due to the transparent nature of the PBM processes. PBMs set the prices that insurers will pay, and PBMs pay pharmacies what they decide a fair price for the prescription to be. There is no insight into this process, and PBMs have the market power to decide how much of the money the insurers pay actually goes to the pharmacies.

Regulators are attempting to step in and change the PBM landscape. The recent prohibition on gag clauses is one of the more influential pieces of legislation that has curtailed

[87] *Express Scripts, Establishing a Blueprint to Transform the Health Care System*, The Cigna Group (Dec. 20, 2018), https://newsroom.thecignagroup.com/Cigna-Completes-Combination-with-Express-Scripts-Establishing-a-Blueprint-to-Transform-the-Health-Care-System/.

[88] *CVS Health Completes Acquisition of Aetna*, CVS Health (Nov. 28, 2018), https://www.cvshealth.com/news/company-news/cvs-health-completes-acquisition-of-aetna-marking-start-of.html/.

[89] *Spread Pricing 101*, Nat'l Cmty. Pharmacists Ass'n, https://ncpa.org/spread-pricing-101/.

the power of PBMs.[90] Additionally, a recent Supreme Court case has paved the way for further state legislation regulating PBMs.[91] In the *Rutledge* case, Arkansas legislators implemented Act 900 which required PBMs to reimburse pharmacies equal to, or greater, the amount that the pharmacy would pay to purchase the drug from a wholesaler.[92] The Pharmaceutical Care Management Association, a PBM trade organization, argued that the act was invalid as it was pre-empted by the Employee Retirement Income Security Act of 1974 ("ERISA").[93] This argument is based on the text of the statute, which states that ERISA "shall supersede any and all State laws…[that]…relate to any employee benefit plan…"[94] The Supreme Court held that Act 900 regulated rates of prescription drug coverage and did not force PBMs to follow any specific scheme.[95] As Act 900 was found to not have an impermissible connection with ERISA, it was not pre-empted and could be enforced in the state of Arkansas.[96] This type of rate regulation is something that can, and should, be implemented in other states to ensure the PBMs are reimbursing pharmacies a reasonable rate for prescription drugs.

i. Rebates

Rebates paid by drug manufacturers to PBMs are complicated negotiations that are regularly referred to as trade secrets and kept out of the public eye.[97] As PBMs create

[90] Gag clauses were contractual provisions that prohibition pharmacists from disclosing to patients that their prescription would be less expensive if they paid out-of-pocket rather than using their insurance company. Gag clauses also prohibited pharmacists from recommending generic alternatives to the prescription drug being filled. Michael Gabay, *Rx Legal: Pharmacist Gag Clauses*, Hosp. Pharmacy v.53(6) 376-77, (2018); The prohibition can be found in the Gag Clause Prohibition Compliance Attestation of the Consolidated Appropriations Act of 2021. Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, 134 Stat. 2890-94.
[91] *See Generally* Rutledge v. Pharm. Care Mgmt. Ass'n, 141 S. Ct. 474 (2020) (holding that state laws regulating reimbursement costs are not pre-empted by ERISA). ERISA is a very involved federal statute, most of which is outside the parameters of this article.
[92] *See Rutledge*, 141 S. Ct. at 478-79.
[93] Id. at 479.
[94] *See* 29 U.S.C. §1144(a).
[95] *See Rutledge*, 141 S. Ct. at 480-81.
[96] Id. at 481-82.
[97] PBM Basics, *supra* note 73.

formularies, they work closely with drug manufacturers to have a list of prescription drugs that will be covered by a specific drug plan.[98] Drug manufacturers, who benefit from being on these formularies due to an increase in availability of their prescription drugs, typically offer rebates that are paid to the PBMs.[99]

Whether or not these savings are actually passed through to the consumer is highly disputed, with no concrete figures regularly being presented.[100] As rebates increase, and are likely kept by the PBMs, drug manufacturers have been raising list prices on their prescription drugs to offset rebates being paid.[101] This is a circular event, as PBMs are incentivized to keep drugs with high list prices on their formularies due to them typically receiving percentages of that list price as a rebate.[102] As those rebates increase, list prices increase, which leads to higher rebates and so on.

This ultimately benefits the PBMs. Drug manufacturers are willing to raise their list prices to be kept on the formularies as they know they will earn revenue from their drugs being prescribed and being by paid insurers. Further, drug manufacturers are willing to pay increased rebates for the same reasoning. Paying a larger rebate is simply a cost of doing business to be included on the formulary. Having a prescription drug on a formulary increases market share and availability of the prescription drug, allowing greater sales even if the drug manufacturer is profiting less per pill due to the rebates paid to the PBMs.

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[98] Id.
[99] Id.
[100] Id.
[101] Bishop, *supra* note 57.
[102] Id.

PBMs' incentive to increase rebates not only leads to higher pricing but can also lead to patients involved with the PBMs receiving lesser standards of care.[103] As prices continue to rise, it may price certain patients out of their prescriptions, forcing them to ration their medication or seek out alternative treatment that fits their financial capacities. PBMs, in seeking out high list price prescription drugs for their formularies, often avoid less expensive alternatives to those brand name prescriptions as their share would be smaller due to the lower list price.[104] This also affects the insurance markets, as prescription drug plans that don't have household name prescriptions on their formularies may not be as appealing to certain consumers and may be avoided altogether.

PBM rebates previously benefited from certain protections from enforcement of the federal Anti-Kickback Statute ("AKS") via statutory interpretation of one of the AKS's safe harbors.[105] The Anti-Kickback Statute is a federal law prohibiting the knowing and willful payment of any remuneration to induce referrals or any other health services paid for by a federal health care program.[106] The AKS only applies to health programs administered by the federal government, i.e., Medicare or Medicaid, which work regularly with PBMs.[107] The AKS contains "safe harbors" which protect transactions that would otherwise constitute illegal remuneration.[108] To be protected by a safe harbor, a transaction must satisfy all required elements of the respective safe harbor.[109]

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[103] Id.
[104] Id.
[105] Removal of Safe Harbor Protections, *supra* note 3.
[106] Fraud and Abuse Laws, *supra* note 4.
[107] Id.
[108] Fraud and Abuse Laws, *supra* note 4.
[109] Id. *See* 42 C.F.R. §1001.952 for complete list of safe harbors and their requirements.

The very concept of PBM rebates could be viewed as a kickback. PBMs are receiving rebates from drug manufacturers largely for the fact that the PBM is including the manufacturer's prescriptions on the PBM's formulary. That transaction, by definition, is knowing remuneration for health services. When PBMs transact on behalf of federal health care plans, federal funds pay for the prescription drugs sent out by drug manufacturers. The contents of these transactions are likely to fulfill the "remuneration" requirements of the AKS.

Recent regulatory action was the passing of a final rule by the Department of Health and Human Services, Office of Inspector General ("DHHS OIG").[110] The rule, which became effective January 29, 2021, strips PBMs of their rebate safe harbor.[111] The rule itself describes how rebates can create a "perverse incentive" which leads to drug manufacturers being rewarded for increasing their list prices as it leads to higher rebates for the PBMs and will lead to higher out-of-pocket costs for the end user, the beneficiary.[112] DHHS OIG has recognized, and acted, on the fact that there is a circular type of transaction happening between PBMs and drug manufacturers, and that the only piece of the supply chain not receiving a benefit is the person prescribed the drug. This promulgation only applies to AKS regulations, and it therefore does not apply to private healthcare plans and the ways those transactions are completed.

Transparency into the drug rebate process is one of the simplest ways to slow the steady rise of prescription drug prices. If PBMs were no longer able to claim their rebate process was a trade secret it would allow consumers, regulators, competitors, and drug manufacturers to see

[110] Fraud and Abuse Laws, *supra* note 4.
[111] Id.
[112] Id.

what percentage of the rebates are being passed along to the consumer.[113] Considering the problems this opacity causes, regulation is being enacted and enforcement is continuing.

In New Jersey alone, this past legislative session included two bills that regulate the healthcare industry with specific focus on PBMs. S-1615 outlines regulation that requires analysis of healthcare data by the New Jersey Division of Consumer Affairs ("Division").[114] The Division will annually notify PBMs of specific drugs, or drug groups, for which reporting is necessary.[115] Within those reporting standards are rebates and discounts between PBMs and drug manufacturers. A-536/2841 requires PBMs to register with the New Jersey Department of Banking and Insurance, a state regulatory agency who must approve the PBM's application for licensing in the state.[116] The bill contains language requiring PBMs to remit payment of rebates to the "covered person" – i.e., the patient – who is purchasing the prescription.[117] These pieces of legislation are exactly what states need to enact to combat the bloated influence that PBMs have over the healthcare industry.

ii. Spread Pricing

The "spread" that PBMs charge is another way that PBMs make money. PBMs argue that spread pricing is needed, as PBMs lose money on certain drugs, so the spread on other drugs allows them to remain profitable.[118] Whether or not that statement is true is up for debate. Spread

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[113] Trade secrets are difficult to dispute, companies have great leeway when it comes to claiming their proprietary information as a trade secret and can fall back on the Economic Espionage Act of 1996 to defend these claims. *See* 18 U.S.C. §§ 1831-1839.
[114] *2023 N.J. ALS 106, 2023 N.J. Laws 106, 2023 N.J. Ch. 106, 2022 N.J. S.N. 1615*
[115] Id.
[116] *2023 N.J. ALS 107 | 2023 N.J. Laws 107 | 2023 N.J. Ch. 107 | 2022 N.J. A.N. 536*
[117] Id.
[118] Stephen Barlas, *Employers and Drugstores Press for PBM Transparency*, PubMed Central (Mar. 2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4357353/.

pricing, similar to the rebate formulae, is considered to be a trade secret by the PBMs, and therefore there is little to no information on what spreads are being charged.[119]

Spread pricing is more damaging when it is done to companies that are not vertically integrated. Imagine a PBM that is completely unaffiliated from all other healthcare companies and has no level of vertical integration. The PBM receives $100 from a health plan for a drug, which it then reimburses the pharmacy $50. The $50 variance between the two numbers is the spread, kept by the PBM as pure profit. If this were to happen in a vertically integrated company, such as CVS, Aetna would pay Caremark $100, and Caremark would reimburse CVS $50. Caremark would be left with a $50 profit. Despite it seeming like the pharmacy – CVS – is losing money, all three entities are under the umbrella of "CVS Health." The costs simply get shifted around, and one entity's loss is netted out by another entity recording a gain. In both scenarios, the patient is likely paying a higher out-of-pocket amount for the drugs.[120]

There has been similar guidance on a federal level. The Center for Medicare and Medicaid Services ("CMS") is a federal agency housed within the Department of Health and Human Services ("DHHS"), which provides federally funded health services via Medicare and Medicaid.[121] In 2019, CMS issued guidance to address the growing problem of spread pricing in Medicare and Medicaid.[122] The guidance set forth requirements for federal health plans' "Medical Loss Ratio" ("MLR"), which represents the percent of premium revenue that goes

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[119] Id.
[120] As of September 13, 2023, twelve states have legislation that limits or bans spread pricing. These laws either ban spread pricing outright or require the PBMs to disclose their spread pricing practices. *State Pharmacy Benefit Manager Legislation*, Nat'l Acad. For State Health Pol'y (Sept. 13, 2023), https://nashp.org/state-pharmacy-benefit-manager-legislation/. States should also follow CMS guidance on the medical loss ratios to keep as much money going to PBMs to pay for actual medical claims.
[121] *About CMS Topics*, Ctr. for Medicare and Medicaid Serv.,https://www.cms.gov/About-CMS/.
[122] Chris Traylor, *Medical Loss Ratio (MLR) Requirements Related to Third-Party Vouchers*, Ctr. for Medicare and Medicaid Serv. (May 15, 2019), https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib051519.pdf/.

toward actual claims rather than administrative costs or profits.[123] Amounts kept by PBMs as spreads do not go towards actual claims as they are not medical expenses, they are profit to the PBM. If PBMs were to take significant spreads, they would likely not meet the MLR threshold on their Medicare or Medicaid claims. These types of thresholds and enforcement capabilities should be instituted for private insurers as well and should be instituted nationwide.

IV. CVS, the Poster Child for the Dangers of PBM Vertical Integration.

A. CVS's History, Growing from Single Store to International Enterprise.

CVS began as a single store pharmacy in 1963 and has sustained consistent growth, largely through acquisitions of other healthcare companies.[124] Much of CVS's early consolidation was horizontal, but in 2007 CVS acquired Caremark, one of the largest PBMs in the country.[125] Subsequently, CVS acquired Aetna in 2018, which was lauded as the largest healthcare merger in history.[126] These acquisitions ensured CVS's control of almost all levels of the healthcare supply chain.

Despite Congressional and industry warnings, the FTC approved the CVS-Caremark merger, only to launch an investigation into anticompetitive practices just two years later in 2009.[127] The FTC closed the investigation in 2012, assessing CVS a $5 million fine related to their misrepresentation of Medicare Part D prescription drug costs.[128] The FTC was able to close their investigation as the conduct by CVS was fraudulent but was not an apparent antitrust issue.

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[123] Id.
[124] *Our History*, CVS Health, https://www.cvshealth.com/about/our-strategy/company-history.html/.
[125] Id.
[126] Id.
[127] Chelsey Ledue, *FTC investigating CVS-Caremark merger*, Healthcare Finance (Nov. 10, 2009), https://www.healthcarefinancenews.com/news/ftc-investigating-cvs-caremark-merger/.
[128] *CVS Caremark Corporation, FTC File No. 091 0106*, Fed. Trade Comm'n, (Jan. 3 2012), https://www.ftc.gov/sites/default/files/documents/closing_letters/cvs-caremark-corporation/120112cvsclosingletter.pdf/.

The CVS-Aetna merger, unlike the CVS-Caremark acquisition, did not undergo an FTC investigation. Despite the FTC's blessing, the CVS-Aetna merger prompted a 2018 lawsuit by the DOJ.[129] The suit settled the following year, in which Aetna was ordered to divest a part of its business that competed with CVS Pharmacy's prescription drug plan directly.[130]

B. Anticompetitive Practices and How CVS Has Sustained its Growth.

CVS did not grow to become the 11th largest company in the world by revenue overnight; this was accomplished by consistent growth and the acquisitions of other companies.[131] Unfortunately, it was also accomplished by anticompetitive business practices and unfair dealings. CVS ultimately won both antitrust challenges – Caremark in 2007 and Aetna in 2018 – but those transactions have allowed CVS to unfairly diminish their competition while growing exponentially.

CVS, in its 2007 acquisition of Caremark Rx, was required to have an effective firewall so that the two entities could not collude with one another.[132] This was an important detail of the agreement with the FTC in it allowing the acquisition to take place.[133] CVS has been accused of breaching this in a whistleblower complaint, which alleges that CVS orchestrated a fraud scheme to increase drug prices and obstruct senior citizen Medicare members from receiving cheaper generic alternatives, keeping only name brand prescriptions on the formularies in exchange for

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[129] *Judge Decides CVS-Aetna Final Judgment is in the Public Interest and Grants United States' Motion*, U.S. Dep't of Just. Antitrust Div., (Sept. 4 2019), https://www.justice.gov/opa/pr/judge-decides-cvs-aetna-final-judgment-public-interest-and-grants-united-states-motion/.
[130] Id.
[131] *Fortune Global 500*, Fortune Media, https://fortune.com/ranking/global500/2023/search/.
[132] Marty Schladen, *Former CVS exec accuses it of ripping off seniors, taxpayers*, Ohio Capital Journal (June 28, 2022 3:50 AM), https://ohiocapitaljournal.com/2022/06/28/former-cvs-exec-accuses-it-of-ripping-off-seniors-taxpayers/.
[133] Id.

larger rebates.[134] The excluded prescription drugs are noted as “frequently authorized generics,” which likely would have been available to Medicare members but for the scheme.[135]

If PBM rebates and spread pricing between their own pharmacies and third-party pharmacies were made public, or at least available to regulators, these types of schemes would be much easier to catch and to stop. CVS data in Ohio made its way to a newspaper, where the newspaper found that Caremark was paying CVS Pharmacies 46% more than it was paying Walmart and Sam’s Club for generic drugs, and 25% more than Kroger.[136] Having public data of how much pharmacies are being reimbursed would be able to significantly alleviate these problems.

CVS has not only been found to breach firewalls, but they also regularly engage in spread pricing on a large scale.[137] In another reception of CVS data, an Ohio newspaper found that CVS Caremark was charging the Ohio taxpayers 12% more for prescriptions than it was paying to the pharmacies.[138] This was of particular importance, as CVS Caremark handles most of Ohio’s Medicaid prescription drug transactions, which led to an independent analysis by the state Department of Medicaid.[139] In 2017 alone, this practice cost Ohio residents upwards of $200 million in tax dollars.[140] This information was only passed along to state regulators after the data became public.[141]

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[134] Id.
[135] Id.
[136] Id.
[137] Marty Schladen, *Federal authorities move to close mammoth drug-pricing loophole*, Ohio Capital Journal (May 31, 2023 4:55 AM), https://ohiocapitaljournal.com/2023/05/31/federal-authorities-move-to-close-mammoth-drug-pricing-loophole/.
[138] Id.
[139] Id.
[140] Id.
[141] Id.

This is a perfect example of why transparency should be required. Businesses may profit, and we live in a highly capitalistic society that praises said profits. However, when those profits come at the expense of senior citizens and the indigent by subjecting them to unnecessarily expensive care, regulators should step in and limit the amount of profits that can be charged to these vulnerable groups.

Lastly, (for the purposes of the article, not for lack of CVS's other anticompetitive practices) CVS is currently litigating a class-action suit in California that alleges that CVS Caremark required the class members to fill their prescriptions at CVS.[142] This class was of specific importance, as it was a class of patients suffering from HIV/AIDS, of which their prescriptions are typically filled by specialty pharmacies.[143] Per the National Association of Specialty Pharmacy, a specialty pharmacy is a "state-licensed pharmacy that solely or largely provides only medications for people with serious health conditions requiring complex therapies."[144] These types of pharmacies often provide training and other types of assistance for the patients attending them, as the pharmacists are more well-versed in serious health conditions than the average pharmacist.[145] This type of honed knowledge improves the quality of care that patients receive, not only with the actual medication but with advice and other monitoring that would be unlikely to come from the average pharmacy. Caremark, in steering the HIV/AIDS patients to CVS Pharmacies for their specialty prescriptions, diminished the quality of care they received and did not give the patients any discretion.

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[142] David Lim, *HIV patients claim in court CVS steered beneficiaries to its pharmacies*, Healthcare Dive (Feb. 22, 2018), https://www.healthcaredive.com/news/hiv-patients-claim-in-court-cvs-steered-beneficiaries-to-its-pharmacies/517631/.
[143] Id.
[144] Michelle Byrne, *The Ins and Outs of Specialty Pharmacy*, Pharmacy Times (Dec. 6, 2018) https://www.pharmacytimes.com/view/the-ins-and-outs-of-specialty-pharmacy/.
[145] Id.

C. How Antitrust Enforcement Should Be Applied to CVS's Conduct

The most efficient way to enforce existing antitrust legislation is with a combination of state and federal enforcement. Whether the states are enforcing antitrust regulations through parens patriae, or the DOJ or FTC are investigation and enforcing regulation, both levels should be active. As the mergers have already been approved, the next step for an antitrust regulator would be to prove the merged entity has engaged in anticompetitive conduct. Once the respective agency can prove anticompetitive conduct, the agency should bring a suit alleging a violation of Section 2 of the Sherman Act.

Section 2 prohibits monopolization, and monopolization can typically be achieved by anticompetitive conduct.[146] If anticompetitive conduct can be proved, the respective agency would seek either conduct or structural remedies, depending on how drastic the anticompetitive conduct is proven to be.[147] Conduct remedies seek to terminate the anticompetitive conduct and install requirements to prevent that anticompetitive conduct from happening again and to try and revive the stifled competition.[148] Structural remedies seek to entirely re-establish competition in the respective market, requiring things such as divestiture or dissolution of the merged entity if their anticompetitive conduct cannot be cured.[149]

The level of CVS's anticompetitive conduct is certainly up for debate. As instances such as the data leaks in Ohio come to light, it shines light on the practices so that regulators and the general public can finally get information as to what has been going on. Conduct remedies are appropriate for the singular instances of anticompetitive conduct, but where there is one, there

[146] *See Generally* 15 U.S.C. § 2.
[147] U.S. Dep't of Just. Antitrust Div., *supra* note 21.
[148] Id.
[149] Id.

are typically many. As investigations continue, it is entirely fathomable that structural remedies may be viable.

V. Conclusion

The aforementioned policy suggestions should be viewed as potential supplements to state and federal legislation that can allow the respective regulators to begin to reign in the power that PBMs, and their affiliated healthcare entities, have accumulated over the years. Federal and state regulation on certain anticompetitive practices used by PBMs have begun to trickle in, which should be viewed positively. Despite these efforts, there is still room to improve and practices to prohibit. Antitrust regulators in particular must continue their investigations into the anticompetitive practices in the healthcare industry. Only then can they begin the process of breaking up these companies, companies that arguably should have never had the opportunity to integrate to this degree. Hopefully then genuine competition can return to these markets, and patients can once again receive high quality care at an affordable cost.