# What If PBMs Couldn't Own Pharmacies?

The unlikely story behind Arkansas Act 624 and why other states are paying attention.

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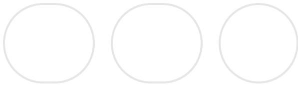

When I first became involved in conversations that would eventually lead to Arkansas Act 624, I don't think anyone believed we were participating in something that would draw national attention. Most of us were focused on what seemed like a fairly practical problem. Independent pharmacies across Arkansas were struggling, reimbursement concerns were mounting, and there was a growing sense that Pharmacy Benefit Managers had accumulated an extraordinary amount of influence over how prescription drugs moved through the healthcare system.

What struck me most, however, wasn't the business side of the discussion. It was watching how that complexity translated into real consequences for patients. Specialty medications had become increasingly difficult to navigate. Physicians, pharmacists, and their staff were

spending enormous amounts of time overcoming administrative barriers simply to ensure patients received the right medication, at the right dose, at the right time, while coordinating with the rest of their treatment plan. Somewhere along the way, the system had become remarkably good at creating obstacles for the very people it was supposed to serve.

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One of my favorite memories from that period happened during a meeting in Little Rock in 2024. Several members of the Highlands leadership team joined representatives from the Arkansas Pharmacists Association to discuss potential solutions. Like most healthcare policy meetings, the conversation started with people describing the problem and brainstorming ways to address it. We spent hours discussing ideas that ranged from moderately difficult to completely unrealistic, but eventually the discussion found its way back to a much simpler observation.

The complexity itself wasn't improving patient care. It wasn't helping physicians make better clinical decisions. It wasn't making medications safer. It was simply making access harder.

Once we got back to that basic truth, someone in the room asked a remarkably simple question.

"What if we just made it illegal for PBMs to own a pharmacy?"

The reaction was much less dramatic than people might imagine. Nobody jumped out of their chair. Nobody declared we had found the answer. People looked around the room, shrugged, and essentially said, "I don't know... let's give it a shot."

Looking back, what strikes me is not how revolutionary the idea seemed at the time. Quite the opposite. It felt almost too obvious. We had spent so much time trying to solve an incredibly complicated problem that nobody had stopped to ask whether one of the most basic conflicts in the system should exist in the first place.

As the effort progressed, it became clear that the pharmacy issue was really just one manifestation of a much larger question about incentives, market power, and vertical integration in healthcare. The discussion was no longer simply about pharmacies. It was about whether organizations responsible for determining where patients could fill prescriptions should also be allowed to own the pharmacies benefiting from those decisions.

One of the things healthcare does remarkably well is create complexity. We tend to take relatively straightforward problems and surround them with enough contracts, intermediaries, reimbursement methodologies, and acronyms that eventually nobody can explain exactly how the system works anymore. If you've ever sat through a healthcare finance presentation and found yourself wondering whether anyone in the room actually understands the slide being presented, you know what I mean.

The deeper we dug into the issue, the more I found myself coming back to a lesson I've seen repeated throughout healthcare.

Healthcare may be complicated, but incentives are usually pretty straightforward.

If you reward a particular ownership model, the market eventually moves toward that ownership model. If you reward administrative complexity, complexity tends to grow. If you reward patient access, organizations become remarkably creative at improving access. Incentives have an uncanny ability to shape behavior, even when they weren't intended to.

Many patients have never heard the term "PBM," yet PBMs influence nearly every aspect of how prescription drugs move through the healthcare system. They influence formularies, reimbursement, pharmacy networks, specialty pharmacy access, and increasingly, the economics of organizations operating throughout the prescription drug supply chain. Most patients don't know much about PBMs, but they often experience the consequences of PBM decisions every time they encounter a formulary restriction, receive a prior authorization denial, or discover that their insurer, PBM, and pharmacy all happen to share the same corporate parent.

As more conversations unfolded, I also noticed something else. Many of the debates centered on defending institutions, business models, or existing practices while the patient slowly faded

into the background. We spent a tremendous amount of time discussing who should control what, who should be reimbursed, and who should bear responsibility. Far less time was spent asking whether the current system was actually making it easier for patients to receive timely, coordinated care.

Whenever the discussion drifted too far into politics or economics, I found myself coming back to the same question.

Is this making life better or worse for the patient?

If the answer wasn't obvious, we were probably discussing the wrong thing.

One unexpected outcome of those early conversations was the realization that legislation alone wouldn't solve the problem. Patients rarely think about PBMs, vertical integration, or reimbursement policy until they are personally affected by them, and by then they're understandably focused on something much more important than healthcare policy. That realization helped lay the foundation for Patients First Arkansas, an effort to educate the public about the healthcare policies quietly shaping access to care long before anyone receives a diagnosis. The goal was never simply to advocate for one bill. It was to help people better understand the incentives driving the healthcare system around them.

What I find most interesting today isn't simply Act 624 itself. It's the number of states beginning to ask similar questions. The specifics vary, but the underlying theme is remarkably consistent. Policymakers are becoming increasingly uncomfortable with the concentration of influence that exists within certain parts of healthcare, particularly when those incentives become difficult for patients, employers, and even providers to understand.

Looking back, I don't think Arkansas started this movement. The frustrations already existed, and the questions were already being asked. If anything, Arkansas became one of the first places where a group of people decided to stop accepting complexity as an inevitable part of healthcare.

When we walked out of that conference room in Little Rock, none of us expected the conversation to spread beyond our state. We were simply trying to remove barriers that had

slowly become accepted as “the way healthcare works.”

Sometimes meaningful reform doesn’t begin with a sweeping policy proposal. Sometimes it begins with a room full of people asking whether the patient is actually better off because of the system we’ve built.