AMERICAN ECONOMIC LIBERTIES PROJECT

BREAK UP BIG MEDICINE:

A Health Care Agenda to Restore Power to Patients and Practitioners and Save Families $6,000 a Year

August 2026

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ACKNOWLEDGEMENTS

Thanks to those who contributed to this paper, including:

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FOREWORD

By Will Flanary, MD

I am an independent ophthalmologist and practice owner in Portland, Oregon, who swore an oath to take the best possible care of my patients. I am also a two-time testicular cancer survivor, experiences that deepened both my empathy for patients and my love for comedy as a coping mechanism.

But the business of medicine has changed dramatically since I started my career. The U.S. health care system, once made up of mostly independent practices like mine, is now dominated by Big Medicine behemoths — including private insurance conglomerates, Big Pharma manufacturers, pharmaceutical middlemen, mega hospitals, and private equity-backed practices — whose only fiduciary duty is to executives and investors. This makes it increasingly difficult to keep my practice afloat and uphold my oath, resulting in moral injury.

So, I now have a second career as an advocate. I moonlight as a medical comedian under the stage name "Dr. Glaucomflecken" on social media, where I entertain and educate an audience of more than 6 million followers about the harms of Big Medicine.

What my patients need most is bold policy reforms to break up Big Medicine and build a better health care system, one where they can access affordable, high-quality care and independent physicians like me can thrive. I am proud to endorse the following agenda, which directly targets the Big Medicine problem. I hope policymakers will enact these proposals to end the corporatization of health care and restore power to patients and practitioners. Doctors have done all we can to uphold our oaths. Now it's time for elected officials to do the same.

I. INTRODUCTION

The U.S. health care system is at a reckoning point. Following decades of unchecked consolidation and vertical integration, Big Medicine — insurance conglomerates, Big Pharma manufacturers, pharmaceutical middlemen, mega hospitals, and private equity-backed practices — controls nearly every aspect of this system. As a result, health care costs have skyrocketed, even as both patient outcomes and physician supply relative to demand decline.[1]

Between 2005 and 2025, the annual cost of employer-sponsored family coverage nearly tripled, from $12,214 to $35,119, and it continues to rise.[2] Employer health care costs are projected to increase 10% — to more than $17,000 per employee — this year alone, and employers report shifting these costs to workers in the form of higher deductibles, lower wages, and more frequent layoffs.[3]

The passage of President Donald Trump's and congressional Republicans' One Big Beautiful Bill Act has only exacerbated cost and coverage issues, pushing an already strained system to the brink. The typical family enrolled in an Affordable Care Act (ACA) health plan is expected to pay $3,735 more in annual premiums as a result of the legislation.[4] It is also estimated that nearly 5 million Americans will lose coverage entirely this year for the same reason, fueling uncompensated care costs at hospitals and further driving up premiums for those who remain insured.[5]

All this spending might be worth it if the U.S. health care system delivered better patient outcomes. Instead, both insured and uninsured patients alike delay or forgo care because of cost, with predictably tragic — and too often fatal — results.[6] Americans' life expectancy, maternal health, and other quality metrics fall far short of those of peer nations.[7]

Health care practitioners are also leaving clinical practice in droves, unable to continue dealing with private insurers that dictate unsustainably low payment rates, impose increasing administrative burdens, and interfere with clinical decision-making.[8] As a result, the United States faces a shortage of more than 96,000 physicians — mostly in primary care — and the average time to schedule a doctor's appointment is now more than four weeks.[9] Independent providers, especially, are forced to shutter, stranding patients in care deserts or leaving them with only corporatized options that charge higher prices for lower-quality care.[10]

There's increasingly bipartisan consensus, among both Americans and their representatives in Washington, that this spiraling crisis cannot be fixed without addressing the power of Big Medicine over our health care system.[11] This agenda lays out bold, structural policy

solutions to break up Big Medicine and rebuild a more effective U.S. health care system, one that delivers better care at lower costs.

Our proposed reforms would wrest control over our health care system from Big Medicine, whose fiduciary duty is to investors, and restore it to patients and the practitioners who have sworn an oath to care for them. Research shows that at least 15% of U.S. health care spending goes toward Big Medicine administrative waste, a far larger share than in peer nations, where overhead accounts for just 1% to 4% of overall spending.[12] These reforms could save Americans up to $795 billion annually — or more than $6,000 per household — by reducing such administrative waste.[13] And that's before accounting for hundreds of billions of dollars of savings from increased competition, quality of care, and clinician capacity.

II. THE DIAGNOSIS: BIG MEDICINE PUSHES PATIENTS AND PRACTITIONERS TO THE BRINK

Over the past 50 years, Big Medicine has come to dominate the U.S. health care system. Six corporate behemoths now rank among the Fortune 15, making nearly $34 billion in annual profit.[14] For context, in 2000, there were no Big Medicine companies on the Fortune 15 and only one in 2010.[15]

Company	Fortune Rank	2025 Revenue	2025 Profit
UnitedHealth Group	3	$447B	$19B
CVS Health	6	$402B	$2B
McKesson	8	$359B	$3B
Cencora	10	$321B	$2B
Cigna	14	$275B	$6B
Cardinal Health	15	$226B	$2B

These companies have largely grown through aggressive merger and acquisition strategies, enabled by neoliberal federal policy choices that allowed them to consolidate entities along the health care supply chain, exploit financial conflicts of interest, and escape regulatory oversight.[16] For instance, since its founding in 1974 as a management services provider for insurers, UnitedHealth Group has grown to comprise nearly 2,700 subsidiaries.[17] Today, UnitedHealth Group is the nation's largest private insurer, physician employer, and health care claims processor; third-largest pharmacy benefit manager (PBM) and health savings account (HSA) provider; and fourth-largest pharmacy operator.[18]

Likewise, the three largest wholesale drug distributors — McKesson, Cencora, and Cardinal Health — control 98% of the market, giving them leverage to gouge prescription drug manufacturers, providers, and consumers.[19] Since 2024, the "Big Three" wholesalers have also proposed or completed acquisitions of their specialty provider customers worth approximately $16 billion, spanning more than 1,000 locations across 35 states and creating new opportunities for extractive rent-seeking and abuse.[20]

As a result of all this consolidation and vertical integration, it has become difficult for any American patient, clinician, employer, worker, or taxpayer to escape Big Medicine or the huge toll it levies.

On the payer side, most U.S. residents (55%) are covered by private health plans either sponsored by their employer or purchased via the ACA marketplace or directly from an insurer or broker.[21] Nearly every U.S. metro-level private insurance market is highly concentrated, and, in nearly half, just one insurer controls at least 50% of the commercial market.[22] This market power enables them to charge patients inflated premiums, even as they financially squeeze independent providers through low reimbursement rates and anti-competitive practices.

More than a third (37%) of residents are covered by public plans, including Medicaid, Medicare, and TRICARE or the Department of Veterans Affairs.[23] However, even many of those enrolled in ostensibly public plans now often receive coverage through a private insurer. For example, more than half of Medicare beneficiaries are enrolled in a for-profit Medicare Advantage plan.[24] The same is true in Medicaid, where an even greater share of beneficiaries are enrolled in state managed care programs administered by private insurers.[25]

The remaining 8% of U.S. residents are uninsured.[26] The ACA has shrunk this rate by half since 2010, with more than 21 million residents gaining coverage.[27] But the combination of rising health care costs and the expiration of ACA enhanced premium subsidies is quickly eroding these gains, as Americans are increasingly likely to find private ACA health plans unaffordable and drop them.[28]

On the clinician side, more than four in five doctors are now employed by Big Medicine, which includes mega hospitals, insurance conglomerates, wholesale drug distributors, and private-equity firms.[29] This represents a sea change since the early 1980s, when the same share of physicians owned their own practices, and has exacerbated concerns that corporate interests are taking precedence over patient care and clinical autonomy.[30]

In tandem with the rapid disappearance of physician practice owners, the number of independent pharmacies shrunk by more than half between 1980 and 2000, a trend that has since intensified.[31] The largest pharmacy operators are now Big Medicine insurance conglomerates, including CVS Health, Cigna Group, and UnitedHealth Group, as well as large retail chains, such as Walmart.[32] The share of dentists who own their own practice is also in decline, dropping from 85% in 2005 to 73% in 2023, and there were at least 161 private-equity deals in the dental sector in 2024, more than in any other area of health care.[33] These same trends are playing out across the industry, including among therapists and audiology clinics.[34]

On the patient side, Big Medicine has exacted incalculable costs, both direct and indirect. In addition to increasingly unaffordable coverage, decreasing wages, worsening outcomes, expanding care deserts, and lengthening wait times, patients face pervasive administrative barriers to accessing care and mounting medical debt when they do so. There are also constant shortages of essential drugs and other medical supplies, as Big Medicine consolidation pushes manufacturers overseas or out of business entirely, embrittling the health care supply chain.[35] Finally, because most patients are also taxpayers, they pay twice: first for their own families' care, and then again through ever-increasing federal health care spending. (See "The High Cost of Big Medicine" sidebar, page 9.)

All told, Big Medicine not only dominates the U.S. health care system but also has pushed its two major constituencies — patients and practitioners — to the brink.

The High Cost of Big Medicine

- The United States spends **more than $15,000 per person on health care each year** — roughly one-fifth of our entire economy, and more than twice what peer nations spend, in return for worse patient outcomes on a variety of metrics.[36]

- The annual **cost of employer-sponsored family coverage nearly tripled** — from $12,214 to $35,119 — between 2005 and 2025.[37] And the cost keeps rising: Employer contributions are projected to increase another 10% this year alone, topping $17,000 per employee.[38]

- Six Big Medicine companies **now rank among the Fortune 15** — more than Big Tech or any other sector.[39] In 2025, they pocketed nearly $34 billion in profit.[40] For context, there were no health care companies on the Fortune 15 in 2000 and only one in 2010.[41]

- More than **two in five U.S. adults have medical debt**, a leading cause of bankruptcy.[42] Nearly one in four U.S. adults have donated to a crowdfunding campaign to help cover someone else's health care costs.[43]

- Private insurers initially rejected claims for 70% of new brand-name drug prescriptions in 2025, up from 57% in 2021.[44] Within a year of the initial claim, the denial rate fell to 24%, but only after many patients and practitioners had spent months on appeals and other administrative processes.[45] Overall, insurers' drug "utilization management" techniques — which include prior authorization, deductibles, and co-pays — **cost patients $36 billion annually.**[46]

- Big Medicine now employs **more than four in five U.S. doctors.**[47] A generation ago, the same share owned their own practice.[48]

- Medical practices complete, on average, **40 prior authorizations per physician per week**, time that would be better spent on patient care given intensifying shortages of health care professionals.[49]

- U.S. prescription drug prices are nearly **three times higher than in other countries**, the direct result of Big Pharma patent abuse and pharmaceutical middlemen markups.[50] In addition, the market power of middlemen and their anti-competitive practices cause frequent shortages of life-saving generic drugs, even when demand is steady and predictable.[51]

- The three largest PBMs control 80% of U.S. prescriptions and are vertically integrated with the nation's biggest insurers and pharmacies.[52] This business model allows them to **jack up drug costs by as much as 7,736%** while squeezing independent pharmacies out of business.[53]

- In nearly half of U.S. metro areas, just one or two hospitals or health systems provide all inpatient care.[54] These dominant systems use their leverage to demand prices from commercial insurers that are **more than twice what Medicare pays**, on average, driving up costs for patients and employers alike.[55]

- Private-equity buyouts lead to an **11% increase in prices** negotiated by private equity-owned hospitals and insurers post-buyout.[56] Likewise, negotiated prices for primary care physician office visits are **11% higher for hospital-affiliated practices and 8% higher for private-equity practices** than at independently owned practices.[57]

- American taxpayers foot much of the bill for Big Medicine's inflated costs. Federal spending on health care programs — including subsidies to help families pay for the ever-rising cost of private insurance — **neared $2 trillion** in 2024, the latest year for which data is available.[58]

III. THE HISTORY: NEOLIBERAL FEDERAL POLICIES ENABLED THE RISE OF BIG MEDICINE

Our current health care crisis is the result of several decades of federal policymaking by both political parties based on the flawed premise that empowering private insurers to ration access to health care, rather than addressing the underlying root causes of high prices, would effectively contain costs.

Beginning in the 1970s, lawmakers and regulators adopted a new philosophy of deference to private market forces, based on a belief that this would result in efficiency gains and, ultimately, lower costs. Instead, in health care as in other sectors, this neoliberal approach by policymakers resulted in extreme market consolidation and vertical integration between payers and providers, enabling the rise of Big Medicine at the expense of patients practitioners, employers, workers, and taxpayers.[59]

A core tenet of this approach was the purported "moral hazard" of coverage. In 1968, economist Mark Pauly published an influential paper that argued insured patients would overuse health care relative to uninsured patients because they are not responsible for the full cost.[60] His hypothesis — based on economic theory, not empirical research — implicated physicians, who, as some later argued, would likewise overprescribe care, assuming insurers bore most of the expense.[61]

It also gave rise to the "managed care" revolution, shifting health care financing from a fee-for-service model, in which insurers reimbursed providers a set rate for each service, to a new model, in which insurers took a more active role in cost containment.[62] They disincentivized patients and practitioners from overusing benefits by narrowing provider networks, increasing patient cost-sharing requirements, and imposing "utilization management" techniques like prior authorization.[63] Rather than cut costs, however, this approach coincided with a sustained increase in health care expenditures and access challenges.[64] Meanwhile, Big Medicine has reaped ever-increasing profits, suggesting that the managed care revolution has facilitated corporate rent-seeking rather than the promised efficiency gains.

Several laws enacted by Congress facilitated this revolution, starting with the **Health Maintenance Organization Act of 1973**, which pressured states to create exceptions to longstanding corporate practice of medicine laws — intended to protect clinical decision-making from corporate financial interests — for certain managed care organizations, i.e., private insurers.[65] Along with other government actions, the resulting loopholes enabled Big Medicine to acquire and control physician practices and then raise their prices, among other harms.

The **Medicare and Medicaid Patient and Program Protection Act of 1987** weakened protections against corporate conflicts of interest and self-dealing. Post-sale rebates paid by drug manufacturers to middlemen had been illegal since the passage of the 1972 Anti-Kickback Statute.[66] That statute was premised on concerns that rebates result in corruption and higher costs, such as insurers and their affiliated PBMs refusing to cover certain drugs unless manufacturers paid steep rebates, and manufacturers then raising their list prices to account for rebates.[67] This law weakened those protections by decriminalizing many such rebates. Since then, Big Medicine conglomerates that own PBMs as well as the dominant group purchasing organizations (GPOs) have weaponized rebates to make drugs and other medical supplies more expensive and harder to access for consumers and providers alike.[68]

The **Medicare Modernization Act of 2003** accelerated the privatization of the federal health care program under the managed care model by establishing Medicare Advantage and Medicare Part D as alternatives to traditional, fee-for-service Medicare.[69] Under these programs, the federal government pays private insurers to provide medical and prescription drug coverage, respectively, to older adults and people with disabilities. The same law also established tax-free HSAs to incentivize enrollment in private high-deductible health plans. It led to a windfall for private insurers, which gained not only additional market power but also new revenue streams, including federal subsidies that could be driven higher via regulatory gaming, such as upcoding and spread pricing.[70] As a result, Medicare Advantage costs taxpayers 14% more per patient — a projected $76 billion this year alone — than traditional, fee-for-service Medicare, despite similar patient populations and coverage criteria across the two programs.[71] Research also shows that Medicare Advantage beneficiaries have worse health outcomes than their counterparts in traditional Medicare.[72]

The **Affordable Care Act of 2010** achieved several lasting reforms, including significantly expanded coverage under Medicaid and new ACA health plans, and eliminating coverage denials based on pre-existing conditions.[73] But, alongside these gains, the law planted the seeds of a new consolidation era by continuing to promote managed care — since rebranded

as "value-based care" — and by creating structural incentives that promoted vertical integration between insurers and providers, which continue to have consequences today.[74]

One of the law's provisions illustrates how this unfolded. The medical loss ratio (MLR) requirement that large insurers spend at least 85% of premiums on medical care in an effort to cap overhead costs was a reasonable idea in theory.[75] However, in practice, due to a regulatory loophole, insurers are incentivized to engage in transfer pricing among their corporate affiliates — i.e., overpaying their provider subsidiaries and then booking the cost as spending on medical care to circumvent the cap while shifting costs to consumers in the form of higher premiums.[76] Indeed, research shows that UnitedHealth Group's insurance arm pays affiliated providers up to 61% more than unaffiliated competitors.[77] The same is true on the pharmacy side: A 2025 Federal Trade Commission (FTC) report found the "Big Three" PBMs, including UnitedHealth Group's OptumRx, overpaid their affiliated pharmacies up to 7,736% more than unaffiliated competitors.[78] The MLR and other provisions created new opportunities for Big Medicine conglomerates to divert public subsidies away from patient care toward their own bottom lines — an outcome the ACA's architects did not intend but which its structure made inevitable.[79]

Against this backdrop, private insurers consolidated to gain leverage in price negotiations with providers and win managed care contracts with employer health plan sponsors, state Medicaid programs, and, later, the federal Medicare Advantage program.[80] Providers also began to consolidate for the same reason.[81] Meanwhile, during the same period, Democratic and Republican administrations alike failed to adequately enforce antitrust laws, accelerating this arms race and undercutting small and independent providers who lacked negotiating leverage.[82] Eventually, the two camps — payers and providers — began to consolidate vertically, a process that has accelerated over the last decade.

The managed care revolution continues to shape today's health care policy landscape, and, until recently, neither party has offered comprehensive solutions to respond to the underlying structural issues in health care markets. President Trump and congressional Republicans continue to push his "Great Healthcare Plan," which largely repackages decades-old ideas that have failed to lower costs.[83] These ideas include federal subsidies for high-deductible — or "junk" — health plans, price transparency requirements, and his most-favored-nation prescription-drug pricing policy.[84] Coupled with the One Big Beautiful Bill Act, these policy changes will only further drive health care costs up, access and quality down, and independent providers out of business.

In response, Democrats fought unsuccessfully to extend enhanced federal subsidies for ACA health plans, which would have used taxpayer dollars to offset low-income households' private ACA health plan premiums.[85] While additional subsidies could have helped many

Americans afford coverage and had merit on those terms, they do not address the underlying drivers of health care costs. Without structural reforms, subsidies ultimately flow to Big Medicine insurance conglomerates, which continue to profit by raising prices, unchecked by either regulation or competition. Therefore, subsidies built on the existing foundations are not a solution; instead, they shift costs rather than lower them, an increasingly unsustainable arrangement in which taxpayers are on the hook for ever-rising premiums.

IV. THE TREATMENT PLAN: BREAK UP BIG MEDICINE AND BEYOND

Policymakers must abandon this neoliberal approach and embrace structural policy solutions that address the root causes of Big Medicine's harms. This policy agenda provides such bold solutions that will restructure health care markets to lower costs, improve quality, and restore power over our system to patients and practitioners. It has four components: (1) break up Big Medicine, (2) bring down health care prices, (3) build capacity, and (4) bolster enforcement of existing laws.[86]

Break Up Big Medicine

- **Eliminate conflicts of interest** that inflate prices by enacting a "Glass-Steagall" for health care to structurally separate private insurers and other middlemen — including PBMs and wholesale drug distributors — from providers so that a single conglomerate cannot be on both or multiple sides of a transaction.[87]

  Research shows that insurance conglomerates overpay their affiliated providers to game federal regulations meant to cap profits, and conservatively estimates that the divestiture of vertically integrated pharmacies would reduce drug costs by more than 7%.[88]

  Specifically, Congress should pass:

  - The bipartisan **Break Up Big Medicine Act** (S.3822), introduced by Sens. Elizabeth Warren (D-MA) and Josh Hawley (R-MO) in February 2026, which would prohibit insurers, PBMs, and wholesalers from owning or controlling providers.
  - The **Patients Over Profits Act** (S.2836, H.R.5433), introduced by Sen. Jeff Merkley (D-OR) and Rep. Val Hoyle (D-OR-04) in September 2025, which would force insurers to divest certain Medicare providers, achieving a component of the Break Up Big Medicine Act.
  - The bipartisan **Patients Before Monopolies Act** (S.5503, H.R.10362), reintroduced in May 2026 by Sens. Warren and Hawley and Reps. Diana Harshbarger (R-TN-01) and Jake Auchincloss (D-MA-04), which would force health insurers and PBMs to divest their pharmacy businesses, likewise achieving a component of the Break Up Big Medicine Act.

A poll conducted by YouGov on June 10-12, 2026, for the American Economic Liberties Project, found that a supermajority (71%) of U.S. voters — including most Democrats (75%) and Republicans (70%) — support federal break-up legislation.

A second poll, conducted by OnMessage for the Insurance Watchdog Coalition, found even stronger support, with 90% of voters agreeing that health insurance companies have too much control and should be broken up.[89]

Pending structural legislative reform, Congress should close the MLR loophole — which incentivizes vertical integration between payers and providers — by raising the percentage of premium dollars that insurers must spend on medical care and directing the Centers for Medicare and Medicaid Services to use its existing authority under the ACA to prohibit transfer pricing.[90]

For more information, see "Medicare Advantage and Vertical Integration in Health Care," an April 2024 white paper, and "UnitedHealth Group Is a Bank: How Policymakers Can Protect Independent Physician Practices from Becoming Loan Shark Bait," a December 2025 policy brief.

- **End the corporate practice of medicine** by repealing the 1973 Health Maintenance Organization Act, which pressured states to create managed care loopholes, and enacting a federal ban modeled on Oregon's 2025 law to close these loopholes.[91] Doing so would proactively ban private-equity firms and wholesale drug distributors from owning or controlling health care providers.

  Congress should also pass:

  - The **Take Back Our Hospitals Act** (S.4085, H.R.7920), introduced by Sen. Chris Murphy (D-CT) and Rep. Mary Gay Scanlon (D-PA-5) in March 2026, which would effectively prohibit private-equity ownership of hospitals and skilled nursing facilities by prohibiting them from receiving Medicare reimbursements.

    The YouGov poll found a majority (66%) of U.S. voters — including most Democrats (73%) and Republicans (60%) — support a federal ban on private-equity firms and other corporate entities from owning or controlling physician practices and hospitals.[92]

- The **Corporate Crimes Against Health Care Act** (S.3829, H.R.7537), reintroduced by Sens. Warren, Richard Blumenthal (D-CT), Peter Welch (D-VT), and Merkley and Rep. Maggie Goodlander (D-NH-2) in February 2026, which would create new criminal and civil penalties for private-equity executives whose firm takes control over a health care organization and contributes to a triggering event, such as looting, that results in the injury or death of a patient.

The YouGov poll found that a supermajority (76%) of U.S. voters — including most Democrats (81%) and Republicans (74%) — support such penalties.[93]

Bring Down Prices

- **Standardize and cap health care prices** across public and private payers using traditional Medicare reimbursement rates for inpatient and outpatient services and negotiated drug prices as benchmarks. This approach would streamline payment processes by eliminating Big Medicine administrative bloat; undo incentives to consolidate by ensuring mega hospitals and Big Pharma manufacturers cannot use their market power to charge above-market rates; ensure independent providers can compete on a level playing field by guaranteeing fair payment; and obviate the need for indirect funding mechanisms, like the federal 340B Drug Pricing Program.[94]

  As a stopgap measure, Congress could pursue site-neutral payment in federal health care programs, which would equalize prices for the same service regardless of where it is provided, as well as pass the **Hospital Competition Act** (H.R.8098), introduced by then-Rep. Jim Banks (R-IN-3) in August 2020, which would lower certain health care prices and deter provider consolidation by requiring hospitals in highly concentrated markets — i.e., almost all of them — to accept Medicare rates from private insurers.

  The YouGov poll found that a supermajority (85%) of U.S. voters — including most Democrats (88%) and Republicans (83%) — support federal health care price caps.

- **Invest in public options** that eliminate Big Medicine administrative waste to lower costs for drugs and insurance.

  Several state Medicaid managed care programs have carved out pharmacy benefits, either administering pharmacy benefits directly under their Medicaid fee-for-service program or replacing private insurers' affiliated PBMs with independent PBMs.[95] In 2017, West Virginia became the first state to do the former, saving $54 million in its first year.[96] In 2019, Ohio chose the latter option, saving $333 million over a two-year period, much of

which the state reinvested in increasing the dispensing fees paid to pharmacies.[97] Congress should likewise create a public, fee-for-service alternative to private Medicare Part D prescription drug plans to eliminate the role of private insurers and their affiliated PBMs.[98]

California's CalRx program — under which the state contracted with nonprofit drug manufacturer Civica Rx to expand access to an affordable insulin biosimilar — provides a template for a public drug manufacturing option.[99] Specifically, Congress should enact the **Medicines for the People Act** (H.R.7854), introduced by Rep. Rashida Tlaib (D-MI-12) in March 2026, which would break Big Pharma's monopoly by creating a public option for pharmaceutical research and development.[100]

There is also broad public support for a public insurance option. Congress should consider expanding traditional, fee-for-service Medicare to increase access to affordable, high-quality care — without Big Medicine administrative waste.

A recent poll conducted by Impact Research for the Roosevelt Institute found 89% of U.S. voters — including 96% of Democrats and 83% of Republicans — support establishing a public option for health insurance.[101]

- **End utilization management practices**, which private insurers use to deter, delay, and deny necessary care while saddling patients with medical debt and both patients and practitioners with administrative costs.[102]
    - **Ban prior authorization** by prohibiting the use of the corporate care veto by private insurers and their corporate affiliates with a financial conflict of interest. Such a ban would eliminate prior authorization except in narrow, clearly defined circumstances — where the Department of Health and Human Services has documented a pattern of fraud or overuse — and only when adjudicated by an independent third party, subject to firm time limits and free from AI-based denials. It would also improve patient outcomes, restore physician autonomy over medical decision-making, and free up clinician capacity — equivalent to nearly 100,000 full-time physicians and advanced practice clinicians, more than our current physician shortage — to deliver care.[103]

      The YouGov poll found a supermajority (71%) of U.S. voters — including most Democrats (76%) and Republicans (69%) — would support legislation prohibiting private insurers from using prior authorization.[104]

For more information, see "Ban Prior Authorization: Ending Big Medicine's Strategy to Boost Profits by Denying Medically Necessary Care", a forthcoming policy brief.

- **End patient cost-sharing obligations** — including deductibles and co-pays — across private and public payers. Research shows that cost-sharing is associated with lower utilization; worse patient outcomes, including increased mortality; and greater financial burden.[105] Recent federal legislation, including the Inflation Reduction Act of 2022, and bills, including the **Medicare Cost Cap Act of 2026** (S.4886), target out-of-pocket spending for those enrolled in Medicare.[106] But cost-sharing requirements affect all patients, not just older adults and people with disabilities. Ending these requirements across the board would simplify payment processes and broaden access to medically necessary care.[107] The administrative savings from this proposal and others in this agenda would help offset any increase in spending on care.

  The YouGov poll found a supermajority (74%) of U.S. voters — including most Democrats (77%) and Republicans (72%) — would support federal legislation that caps how much patient cost-sharing insurers can require.[108]

Build Capacity

- **Invest in providers**, especially safety-net hospitals in rural and low-income metro areas, independent medical and dental practices, community pharmacies, and primary care physicians.

  - **Create a revolving loan fund for independent practices** that lack leverage in payment and coverage negotiations with Big Medicine insurance conglomerates, resulting in unfair terms and — in many cases — either acquisition or closures. Their patients then struggle to access care for lack of options.

    In addition to adopting the previous proposals to ensure independent providers can compete on a level playing field, Congress should reinforce existing capacity by creating such a fund for new independent practices and those at risk of closure or acquisition.[109] Doing so would ensure such practices have a reliable source of capital during the current crisis and as structural reforms are enacted. For instance, such a fund could help independent pharmacies purchase pharmacies divested by PBMs in states that have prohibited their common ownership.[110]

- **Ban noncompete agreements** to ensure workers' mobility, including negotiating better pay, taking a better job, or going independent. This is especially important for health care workers employed by Big Medicine, who lack leverage in wage and benefit negotiations, often resulting in restrictive noncompete clauses that lock them in place. An estimated 37% to 45% of physicians were subject to such agreements in 2023.[111] Research has found that such clauses lead to greater concentration and higher prices for consumers.[112] The FTC specifically found that noncompetes increase health care costs and that banning them would reduce health care costs by up to $194 billion over the next decade in reduced spending on physician services.[113]

- **Invest in a pipeline of new physicians** to address the workforce shortage by increasing and reallocating medical residency slots across specialties and geographic areas; expanding medical school debt forgiveness and repayment assistance programs; and expanding publicly owned health care providers at which new physicians can train and work.[114]

- **Expand public ownership** to increase access to affordable care by funding new and existing programs, such as expanding federally qualified health centers, the National Health Service Corps, and local publicly owned hospital systems, among others.

The YouGov poll found that a supermajority (70%) of U.S. voters — including most Democrats (77%) and Republicans (64%) — support federal investment in new and existing independent providers to address current workforce shortages.[115]

For more information, see "Out of Practice: How Capital Costs and Corporate Power Are Destroying Independent Medicine," a May 2026 policy brief.

- **Invest in the U.S. prescription drug manufacturing base** to ensure affordability and access. In addition to Big Medicine's anti-competitive practices, policy-driven offshoring and the domestic consolidation of pharmaceutical middlemen have driven generic drug manufacturers overseas, resulting in a foreign dependency crisis that threatens national security and constant shortages of essential medicines that threaten public health.

  In addition to passing the aforementioned Medicines for the People Act, Congress and other federal policymakers should also adopt an anti-monopoly solution set that combines competition, industrial, and trade policies to rebuild a competitive private-

sector U.S. pharmaceutical manufacturing base that can withstand supply chain shocks, such as the Iran War and the prolonged closure of the Strait of Hormuz.[116]

The YouGov poll found that a supermajority (85%) of U.S. voters — including most Democrats (83%) and Republicans (89%) — support federal legislation to reshore generic drug manufacturing.[117] The supermajority increases to 91% if such legislation would create new jobs.[118]

For more information, see "Making Medicine in America Again: Why Breaking Monopolies Is Key to Building a Resilient U.S. Pharmaceutical Manufacturing Base," a February 2026 report.

Bolster Enforcement of Existing Laws

- **Close loopholes that allow anti-competitive business practices**, which Big Medicine uses to drive up prescription drug costs. Specifically, Congress should repeal the 1987 safe harbor for PBMs and other pharmaceutical middlemen and prohibit price discrimination, spread pricing, self-preferencing, network discrimination, and sole-source or exclusive contracting terms across all payers.

  Congress should also prohibit Big Pharma patent abuse — including patent thickets and product hopping — which forecloses generic competition and keeps prescription drug prices high.

  The YouGov poll found that a supermajority (79%) of U.S. voters — including most Democrats (85%) and Republicans (75%) — support legislation prohibiting Big Pharma patent abuse.[119]

  For more information, see "The Costs of Pharma Cheating," a May 2023 report by the American Economic Liberties Project and the Initiative for Medicines, Access, & Knowledge.

- **Increase funding for federal antitrust enforcers** so that the FTC and Department of Justice (DOJ) Antitrust Division have the resources they need to vigorously enforce existing federal laws and, where applicable, implement new structural legislative reforms. During the Biden administration, these regulatory agencies used their authorities to block or force the abandonment of several proposed health care mergers; challenged hundreds of junk patent listings; sued private equity-backed U.S. Anesthesia Partners and the "Big Three" PBMs for engaging in illegal schemes to gouge consumers; finalized a rule to ban noncompete agreements (that was later struck down); and launched an ongoing fraud investigation into UnitedHealth Group's Medicare Advantage billing practices.[120] The previous proposals will not be successful in restructuring health

care markets to promote competition and lower costs without regulators who are well resourced and free from industry conflicts to enforce them.[121]

V. CONCLUSION

From billionaires to breast cancer surgeons, everyone agrees: The U.S. health care system is in a spiraling crisis.[122] This is the result of deliberate policy choices that ushered in the managed care revolution and ceded control of the system to Big Medicine at the expense of patients, practitioners, employers, workers, and taxpayers. The good news is that deliberate policy choices can also end this crisis. The four-part agenda outlined here — breaking up Big Medicine, bringing down prices, building capacity, and bolstering enforcement of existing laws — would save Americans hundreds of billions of dollars annually, improve care quality, and invest in independent providers and essential drugmakers. It is grounded in robust empirical research and the lived experiences of patients and practitioners, many of whom are organizing themselves against Big Medicine.[123] It is also supported by most voters in both parties. Indeed, bipartisan state and federal policymakers have introduced legislation that would accomplish its goals.

Congress should use this momentum to dismantle the neoliberal policies that enabled the rise of Big Medicine by privatizing coverage and rationing access to care in a misguided attempt to contain costs. Congress must also restore power over our health care system to patients and the clinicians who have sworn an oath to care for them.[124] Big Medicine has failed everyone except corporate executives and shareholders. It's time to build the health care system American families have always deserved.

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