April 27, 2026

The Honorable Bill Lee
Governor, State of Tennessee
State Capitol
Nashville, TN 37243

Dear Governor Lee:

Americans for Lower Drug Prices (ALDP) is a nonpartisan, nonprofit patient advocacy organization dedicated to addressing the root causes of unaffordable prescription drugs for patients and taxpayers in Tennessee and across the country. We are independent, and our Board-passed policy strictly prohibits us from working with the pharmaceutical, pharmacy benefits manager (PBM) or pharmacy interests of any kind, so that our policies are in the best interests of patients – particularly rural patients, who have the fewest alternatives and resources when it comes to navigating an increasingly challenging health care environment.

We write to urge you to veto Senate Bill 2040/House Bill 1959, the "FAIR Rx Act." We do so not to defend PBMs, not to protect any corporation's market position, and not to minimize the real problems this legislation was intended to address. We do so because the evidence – including testimony from your own administration's officials – strongly indicates that this bill will harm the very patients it claims to protect, cost Tennessee taxpayers $91.6M per year, and produce outcomes that are the opposite of what its supporters have promised.

We further ask that you call upon 1) the General Assembly to adopt public policies that will better support the pharmacies and services that Tennesseans – particularly rural, elderly and disabled patients – rely on, and 2) state government agencies to vigorously enforce current law.

I. Divestiture Does Equal Closures

Supporters of SB 2040 have offered a reassuring answer to concerns about pharmacy access: "Divestiture doesn't equal closure." A pharmacy required to change owners, the argument goes, simply changes owners. The license transfers, the shelves stay stocked, and patients barely notice the difference. This claim misses what actually happens when a distressed seller is required by law to divest on a fixed timeline.

The American pharmacy sector is under profound structural stress that predates this legislation by years. CVS, Walgreens (now owned by private equity), and Rite Aid (now out of business) have collectively announced or completed thousands of closures since 2022. The Medicare Payment Advisory Commission (MedPAC), an independent congressional advisory body, reported just this month that pharmacy closures more than doubled between 2021 and 2025, rising from 1,764 to 3,929 annually. By last year, chain pharmacies accounted for 62% of all closures – up from just 25% in 2021. This is a story about an entire sector in distress, for reasons rooted in unfair and inadequate reimbursement, rising operating costs, and a shifting competitive landscape. Our work across rural Tennessee has given us first-hand experience with independent pharmacy closures, and we are deeply concerned by their plight, as well. Covering rural Tennessee requires all types of pharmacies – it is a both/and endeavor, not an either/or one.

Against this backdrop, SB 2040 asks companies already closing locations to find buyers on a statutorily mandated deadline. CVS has no obvious incentive to facilitate rapid transactions that benefit a competitor. Walgreens, which operates 114 of its own stores in Tennessee, has strong competitive incentives to let the clock run out. In a distressed market with sellers under a mandate and no obvious buyers, forced sales do not produce new owners. Communities aren't likely to get new pharmacy owners; they're likely to get closed pharmacies.

II. Your Own Officials Testified to $91.6M in Annual Costs

On Feb. 25, three senior officials from your administration testified before a Tennessee Senate committee about the fiscal consequences of this bill – testimony that was precise and sober.

State Finance Commissioner Jim Bryson testified that his agency's analysis projects a cost increase of $29.1M annually to the state's three health benefits plans – covering state employees, local government employees, and public school teachers and staff – driven by reduced pharmacy network access and rising dispensing costs.

TennCare Director Stephen Smith, supported by Chief Pharmacy Officer T. Renee Williams-Clark, PharmD, testified that outpatient specialty pharmacy costs are projected to rise by $38M annually – costs that would have been approximately 16% lower under the status quo. Physician-administered specialty drugs are projected to increase by an additional $6.5M, costs that would have been approximately 25% lower under the status quo. And pharmacy dispensing fees are expected to climb by $18M as the market shifts from high-volume toward lower-volume pharmacies that charge more per prescription.

Together, their testimony totals $91.6M in new annual costs. This is not an estimate from opponents, but rather, the judgment of Tennessee's own officials that the legislation will cost the state, state employees, and taxpayers more money while reducing access.

III. The Patients Most at Risk Are the Least Visible: Specialty Pharmacy Patients

The retail pharmacy disruption created by SB 2040 is serious. The mail-order disruption – affecting the millions of prescriptions filled annually for enrollees in employer-based health plans, Medicare Part D, TRICARE, and Medicaid managed care – is broader. But the specialty pharmacy consequences are, in our view, the gravest and the most overlooked in this legislative debate.

Specialty pharmacy is not a larger version of a retail pharmacy. Oncology biologics, multiple sclerosis treatments, hemophilia factor products, antiretrovirals, and dozens of other complex therapies require cold-chain logistics, disease-specific clinical expertise, and direct contractual relationships with drug manufacturers through limited distribution agreements. These agreements designate which pharmacies are authorized to dispense a specific drug. They often do not transfer automatically in a sale, and renegotiating them takes months. When a specialty pharmacy closes, the cancer patient whose targeted therapy was dispensed through that pharmacy cannot simply walk to the nearest retail pharmacy. There may be no authorized alternative in their region.

IV. Chemotherapy Deserts and the Rural Hospital Crisis

As you already know, Tennessee is contending with a rural hospital crisis that makes these concerns more acute. Research from Chartis, a health care analytics firm, identified rural hospitals nationwide that have eliminated oncology and chemotherapy services, creating what researchers

have begun to call "chemotherapy deserts." In Tennessee, Chartis reports that nearly half of the state's rural hospitals dropped chemotherapy services between 2014 and 2022, ranking the state 4th nationally for these losses. For the growing class of oral chemotherapy agents and targeted therapies, specialty pharmacy is often the only access point available to rural patients whose local hospital no longer offers infusion services. When both the rural hospital's oncology service and the specialty pharmacy dispensing oral chemotherapy are unavailable, the patient's options disappear entirely. Moreover, when specialty pharmacy volume shifts to hospital-based dispensing, patients frequently face higher out-of-pocket costs for the same medication, and drugs currently self-administered at home may shift to far more expensive physician-administered versions. Your own officials' testimony about rising specialty pharmacy and physician-administered drug costs reflects exactly this dynamic. MedPAC's April 2026 data makes the geographic stakes concrete: 33% of rural Medicare Part D beneficiaries already live in ZIP codes with no pharmacy at all. These are Tennesseans with no margin for further disruption. SB 2040 provides no transition plan for anyone who loses access to their current pharmacy care provider.

V. The Carve-Outs Are Not What They Seem

The bill added federal carve-outs – exempting Department of Veterans Affairs, Department of Defense, Indian Health Service, and OPM-contracted pharmacies – specifically to blunt the patient access arguments raised against it. We note these carve-outs for what they are: an acknowledgment that the access concerns are real. At best, however, the carve-out is of a facility, like a VA facility, that the state had no jurisdiction over in the first place. Each carve-out therefore fails in practice, even if it succeeds on paper, and together they illustrate rather than resolve the bill's fundamental problem.

A pharmacy does not close selectively by patient type. Every patient who relied on a location that closes – veteran or civilian, insured or uninsured, TennCare enrollee or Medicare beneficiary – loses access simultaneously. The carve-out language protects these populations on paper while leaving them exposed in practice.

Veterans are putatively carved out, but seniors are not – and that omission is difficult to justify. Fifty-four percent of seniors report taking four or more prescription drugs per month, so they depend on pharmacy access more than virtually any other population, and are among the least equipped to navigate care disruptions. They are precisely the patients this bill should protect most, and precisely the patients its carve-out structure overlooks entirely.

The extended 2028 compliance deadline is similarly instructive. When supporters extended the original 11-month timeline by roughly two years, they implicitly acknowledged that the original deadline posed serious patient care risks. But in a distressed market, a longer runway almost certainly gives a struggling company more time to close locations rather than sell them.

VI. Arkansas Is the Cautionary Tale

Arkansas enacted a substantially similar pharmacy divestiture law, Act 624 of 2023, which is currently enjoined in federal court. In July 2025, the court found that the Act appeared to overtly discriminate against out-of-state companies and that the state failed to show it had no other means to advance its stated interests – a likely violation of the Dormant Commerce Clause. The court also found the Act was likely preempted by federal law governing military health benefits under TRICARE. An ERISA preemption claim has also been made in the Arkansas case – notable

because, this month, the Sixth Circuit ruled in *McKee* that ERISA preempted a Tennessee PBM reform law. Tennessee will face the same legal challenges as Arkansas, and the cost of defending this legislation will fall on Tennessee taxpayers. Tennessee should not replicate that outcome.

VII. The Right Answer to Unfair Reimbursement Is Reimbursement Reform

The pharmacy access crisis in Tennessee is real. MedPAC's April 2026 report documents it in terms that should alarm any policymaker: closures accelerating, rural access deteriorating, mail order failing to fill the gap. The cause is not who owns the pharmacy. It is how the pharmacy is paid. A pharmacy whose income does not cover its operating costs will close regardless of whether it is owned by a PBM-affiliated chain, an independent pharmacist, or a new buyer assembled under the terms of SB 2040. Reimbursement reform – establishing dispensing fee floors that cover actual costs, prohibiting below-cost reimbursement, closing the rebate aggregator loophole, requiring point-of-sale rebate pass-through, banning patient steering practices – addresses the financial stress driving closures. Ownership restructuring does not.

Tennessee has already enacted meaningful PBM reforms, including licensure, reimbursement, and appeals protections. It should continue that work, alongside strong enforcement of current law.

In conclusion, Governor Lee, we respectfully urge you to veto SB 2040/HB 1959. Your own administration's officials testified to steep new annual costs for reduced access. Arkansas – the one state that has tried this approach – has watched it enjoined in court while pharmacies continue to close. The patients most vulnerable to this bill's disruption are the least equipped to absorb what your own fiscal officers testified is coming, and the carve-outs do not protect them. A pharmacy that closes closes for everyone.

We are prepared to work with your office and with members of the General Assembly on a strong reform package that will genuinely lower drug prices and strengthen pharmacy access for Tennesseans. We believe that work is both urgent and achievable, and we appreciate your careful consideration of the concerns we have raised.

Respectfully submitted,

Michael Glassner and Jason Young
Co-founders, Americans for Lower Drug Prices
www.lowerrxprices.org