Glass-Steagall for Healthcare: What t Break Up Big Medicine Act Actually Means for Founders and Investors

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Abstract

Introduced February 10, 2026 by Sens. Elizabeth Warren (D-MA) and Josh Hawl MO), the Break Up Big Medicine Act is the most significant structural health pc

proposal since the ACA. It is explicitly modeled on the Glass-Steagall Act, which separated commercial and investment banking after the 1929 crash.

Key provisions:

- Prohibits common ownership of a medical provider or MSO and an insurer or P

- Prohibits wholesale drug distributors (think McKesson, Cencora, Cardinal Hea from owning medical provider organizations

- One-year compliance window for violations

- Automatic disgorgement of profits and forced asset sales for non-compliance

- FTC, DOJ, HHS, state AGs, and private citizens all have standing to sue

- FTC and DOJ can review and block future actions that would recreate banned structures

Companies immediately affected: UnitedHealth Group (owns Optum, 2,000+ prc orgs, 10% of US physician workforce), CVS Health (Aetna, Caremark, Oak Street Cigna/Evernorth (Express Scripts), Elevance Health (Carelon), McKesson, Cencor Cardinal Health.

Scale of concentrated market power:

- Three PBMs process 79-80% of all US prescription drug claims for ~270M Americans

- Three drug wholesalers control 98% of US drug distribution

- Nearly 80% of US physicians now work for a corporate parent

- ~4,000 independent pharmacies have closed since 2019

- Healthcare spending approaching 20% of GDP, over $14,500/person/year

- FTC found Big Three PBMs paid affiliated pharmacies up to 7,736% more thar unaffiliated competitors

- UnitedHealth pays affiliated providers 17% more on average, up to 61% more ir markets where it holds at least 25% share

Bipartisan momentum: Warren-Hawley previously teamed up on PBM legislatio 2024. The bill has House co-sponsors across both parties including a physician (Murphy, R-NC) and a pharmacist (Harshbarger, R-TN). New PBM regulations w included in the recent appropriations package signed by President Trump. As of January 2026, over 77,000 Americans have signed onto the Break Up Big Medici initiative.

Investment thesis in brief: Even if this bill does not pass in its current form, it is already reshaping the competitive landscape for health tech. The arc of regulatic bending toward structural separation, and the assets being shed or stranded crea multi-billion dollar whitespace for founders and capital.

The Setup: What Is This Bill and Why Does It Matter Right Now

There is something almost funny about Elizabeth Warren and Josh Hawley team on anything. These two senators occupy basically opposite corners of the Americ political universe. Warren has spent her career going after Wall Street; Hawley b his brand by going after Big Tech. The fact that they found each other on health should tell investors something important: the political risk calculus on vertical integration in health has flipped. When the populist right and the progressive le converge, the corporate center gets squeezed. That is not a partisan observation, just how legislative momentum works.

The Break Up Big Medicine Act dropped on February 10, 2026, and the concept rests on is dead simple. One company should not be on both the payer side and t provider side of the same healthcare transaction. The bill draws an explicit paral Glass-Steagall, the 1932 Depression-era law that forced commercial banks to sep

from investment banking. The analogy is more apt than it sounds. In both cases, had giant institutions that were essentially judging their own homework, self-de through affiliated entities, gaming regulations designed to protect the public, ar doing it all at scale under a veneer of market efficiency. The banking sector did that voluntarily, and healthcare will not either.

The sheer scale of what these companies have assembled is worth sitting with fo second. UnitedHealth Group is simultaneously the country's largest insurer, its largest private physician employer, its largest claims clearinghouse (via Change Healthcare), and the third-largest PBM through Optum Rx. It has contractual or employment ties to roughly 10% of the entire US physician workforce. CVS own Aetna, Caremark, and now runs Oak Street Health, a primary care chain. Cigna's Evernorth division houses Express Scripts, Accredo specialty pharmacy, and behavioral health services. Together, Caremark, OptumRx, and Express Scripts process somewhere around 79-80% of all US prescription drug claims for approximately 270 million Americans. On the distribution side, McKesson, Cen and Cardinal Health collectively control 98% of drug distribution in this country McKesson has quietly become the largest owner of community oncology clinics i US while also being the distributor shipping drugs to those same clinics.

These are not coincidences or organic outcomes of competitive markets. They ar product of roughly two decades of acquisitions that regulators mostly waved thr and the resulting conflict of interest is structural, not incidental. When you own insurer, the PBM, the pharmacy, and the doctor's office, you are not a healthcare company, you are a toll booth at every single intersection of the patient journey.

How We Got Here: A Very Brief, Very Grim History of Vertical Integration

The story of how this happened is not mysterious. After the ACA passed in 2010 medical loss ratio provisions created an interesting problem for insurers: they w now required to spend at least 80 to 85 cents of every premium dollar on medica The obvious fix was to redefine what counts as medical care. If you own the prov

the PBM, and the pharmacy, you can run a lot of "medical" spending through yo own affiliates and count it toward the MLR while still effectively capturing that money as profit within the parent company. This is not speculation; it was the ex finding of healthcare economists and eventually the FTC.

Cigna bought Express Scripts in 2018 for $67 billion. CVS bought Aetna that sa year for $69 billion. UnitedHealth had been building Optum as a services and da business since the 2000s and steadily accumulated provider organizations throu the early 2010s. By 2023, CVS added Signify Health and Oak Street Health. Each these acquisitions was defended at the time with some version of the "aligned incentives" argument: that owning payer and provider under one roof would pro care coordination and cost savings that the fragmented system could not. Emplo health plan sponsors and the FTC spent the next few years running the numbers the numbers did not support the thesis. The 2025 FTC report found that the Big Three PBMs paid their affiliated pharmacies up to 7,736% above the estimated d acquisition cost for specialty generics from 2017 to 2022, generating more than $ billion in excess revenue. UnitedHealth was found to pay its own affiliated provi 17% more than independent competitors on average, scaling up to 61% more in markets where it controls at least 25% of the market. These are not the economi efficiency; they are the economics of a closed loop.

Meanwhile, the independent market got hollowed out. Close to 4,000 independe pharmacies have shut down since 2019. Nearly 80% of US physicians now work f corporate parent of some kind. More than a third of Americans now live in healt deserts, which researchers and the bill's sponsors attribute at least in part to independent practice closures driven by the economic squeeze from vertically integrated competitors operating on unfair terms. Healthcare spending is appro 20% of GDP, or roughly $14,500 per person per year, which is well above any comparable developed economy and produces mediocre outcomes to match.

The backlash did not start with Warren and Hawley. Arkansas passed a first-in-t nation law in 2025 prohibiting PBMs from owning pharmacies. Oregon went aft corporate practice of medicine. Democrats introduced the Patients Over Profits September 2025 targeting insurer ownership of Medicare providers. New PBM

regulations were folded into the most recent federal appropriations package, sig by President Trump. Trump also issued executive orders directing a reevaluatio the role of middlemen in prescription drug pricing. The Warren-Hawley bill lan into a legislative environment that has been warming up for this fight for at leas years.

What the Bill Actually Does (In Plain English)

The mechanics of the Break Up Big Medicine Act are actually pretty clean, whic explain why it has attracted bipartisan support in both chambers. The core prohibitions are structural and categorical: a parent company cannot own both a medical provider organization or a management services organization (MSO) and PBM or an insurer. Separately, parent companies of prescription drug or medica device wholesalers cannot own medical provider organizations. That second pro is specifically aimed at the McKesson/Cencora/Cardinal Health situation where wholesale distributors have been quietly acquiring oncology clinics and other hi drug-utilization specialty practices.

Companies found to be in violation get one year to come into compliance after t is enacted. If they do not hit that deadline, the penalties are automatic: disgorge of profits and forced sales of assets. The bill also creates a remarkably broad enforcement umbrella. The FTC, HHS, DOJ, state attorneys general, and private citizens can all bring lawsuits. The FTC and the DOJ Antitrust Division get exp authority to review and block future transactions that would recreate the banne ownership structures. This is the provision that makes the bill more durable tha one-time structural fix. Even if the covered companies successfully restructure, bill builds a prospective regulatory firewall that prevents them from simply re-acquiring their way back to the same position.

This last piece matters a lot for investors trying to model what happens after pas The point is not just that UnitedHealth has to sell Optum's provider business or CVS has to divest Oak Street. The point is that the exit from these assets does n

back to the same buyer pool. The major insurers and PBMs are effectively prohi
from serving as consolidators in the newly liberated provider market. That restr
on the most well-capitalized natural acquirers changes the competitive dynamic
permanent ways, and opens the door for independent operators, private equity, a
venture-backed platforms to enter markets that were previously foreclosed.

The Divestiture Math: Assets Looking f Owners

Let us think through the asset dispositions this bill would require, because this
where the investor thesis gets concrete. UnitedHealth's Optum Health segment a
employs or has contractual ties with roughly 10% of the US physician workforce
across more than 2,000 provider organizations. The Optum Health segment repo
revenue of approximately $105 billion in 2024. That business cannot stay inside
company that also runs UnitedHealthcare, the insurer. CVS would face a similar
choice: keep the Aetna insurance business, or keep Oak Street Health, Signify H
and the broader care delivery portfolio. Oak Street alone operates over 200 prim
care clinics. McKesson would have to divest its US Oncology network, which has
become one of the largest community oncology platforms in the country, or exit
distribution.

Now, none of these assets disappear. They become available for acquisition by bu
who are not restricted by the bill: independent physician groups, private equity-
backed consolidators, nonprofit health systems, tech-enabled care delivery platfo
and yes, venture-backed startups. The assets come with existing patient panels,
established payor contracts, functioning clinical workflows, and in many cases re
estate. They are not distressed assets; they are mature operating businesses that
bill forces onto the market. That is a fundamentally different situation from typi
distressed M&A. The sellers will not be motivated by desperation, but the time
constraint of a one-year compliance window does change negotiating leverage in
that favor acquirers.

The wholesale distribution side is similarly interesting. If McKesson, Cencora, a Cardinal Health have to exit their provider ownership positions, the specialty practices they currently own, particularly in oncology, rheumatology, and other l drug-cost specialties, go into play. These are highly cash-generative businesses v sticky payor relationships. In a world where the distributor can no longer own tl the question becomes who builds the next aggregation platform. That is a ventu scale question.

Opportunity Map Part 1: The Independent Provider Stack

The most direct opportunity created by this bill is in the independent physician practice market. Right now, roughly 80% of US physicians work for a corporate parent, and a significant fraction of those corporate parents are the exact entitie bill targets. When Optum Health and the Oak Street networks are forced to restructure their ownership, some physicians will be acquired by hospitals or he systems. Others will seek to re-enter independent practice, a route that has beco economically unviable for most specialties over the last decade precisely because the competitive disadvantage created by vertically integrated insurers negotiatin against their own employed physicians. If the structural conflicts go away, independent practice starts penciling again, but only if the infrastructure exists support it.

That infrastructure is the opportunity. Independent physicians need revenue cyc management, coding and billing, payor contracting support, credentialing, care coordination technology, malpractice management, and increasingly, AI-powere prior authorization tools. None of that is new. What is new is the addressable ma For the last decade, the best sales target for an independent practice managemer platform was a shrinking pool of holdouts. If this bill passes and a material fract the Optum and Oak Street physician base seeks independent or semi-independe operating structures, the addressable market for that infrastructure stack expan dramatically and quickly.

The plays here are not necessarily greenfield builds. The smarter angle is probab roll-up or platform plays that can absorb newly independent practices at scale. T of it as an aggregation opportunity in a market that just got forcibly defragment Companies that already have the tech stack, the payor relationships, and the operational playbook for independent practice management are positioned to m fast in a one-year compliance window. The bottleneck will be capital and operati bandwidth, not deal flow.

There is a subspecialty angle here worth calling out explicitly. High-drug-utiliza specialties like oncology, rheumatology, and infusion medicine have been the pri targets of distributor-owned consolidation precisely because the drug economics so attractive. When McKesson has to divest its US Oncology network, those prac need a new home that can replicate the operational support, group purchasing leverage, and clinical data infrastructure that US Oncology provided. Whoever b that independent alternative is competing for a market that currently generates hundreds of millions in annual revenue from drug margin alone, without the con of-interest structure that made the distributor-owned model untenable.

Opportunity Map Part 2: PBM Alternatives and Drug Distribution

The PBM side of this is where the investment thesis gets more speculative but al potentially larger. CVS Caremark, OptumRx, and Express Scripts processing 79- of US prescription drug claims through three entities that each have obvious con of interest is not a market structure, it is a regulatory failure that has compound two decades. The bill does not tell insurers they cannot have a PBM affiliate; it t them they cannot have a PBM affiliate and a provider network simultaneously. In practice, that constraint still forces significant restructuring at the parent comp level, and it reopens the question of what an unconflicted PBM actually looks lik

The honest answer is that independent PBMs have been losing market share for because they cannot match the pricing leverage that integrated incumbents can when they are negotiating against their own network. If the structural conflict g

away, the pricing dynamics shift. Independent or employer-directly-contracted P start competing on a more level field, and the last few years have already produc some interesting experiments in this space. Transparent PBM models, pass-thro pricing structures, and employer-direct contracting platforms have been gaining traction precisely because sophisticated employer buyers figured out they were getting played by the integrated model. That trend accelerates in a post-bill wor

On the distribution side, the structural separation of wholesalers from providers smaller near-term opportunity but a significant long-term one in specialty pharm and specialty drug administration. When the big three wholesalers can no longe the specialty practices that are their highest-margin customers, the integrated b and-bill model that has made oncology and rheumatology so profitable for them disrupted. Independent specialty pharmacy platforms and group purchasing organizations that can aggregate purchasing power for newly independent speci practices without the distributor ownership conflict are going to have a lot more negotiating leverage than they do today.

Arkansas in 2025 showed a preview of this. The first-in-the-nation state law prohibiting PBMs from owning pharmacies has already produced estimates of 7. drug price reductions, and some researchers think that number is conservative g the FTC's finding that affiliated pharmacies were getting paid up to 7,736% abov drug acquisition costs for specialty generics. If you believe those markups comp when the structural conflict is removed, the savings flow somewhere, and at leas of them flow to whoever is operating an unconflicted dispensing or distribution platform.

Opportunity Map Part 3: MSO Infrastructure

The management services organization angle is the one that gets the least attent early coverage of this bill, but it may be the most interesting for early-stage inve The bill explicitly covers MSOs, not just direct ownership relationships, which m the covered companies cannot simply restructure their provider relationships as

management contracts and call it compliance. An insurer or PBM cannot own ar that controls a physician practice any more than it can directly employ the physi

This matters because MSOs have become the dominant vehicle for private equity backed physician practice aggregation over the last decade. PE-backed MSOs op in virtually every specialty: dermatology, ophthalmology, orthopedics, urgent car behavioral health, you name it. The bill does not restrict PE-backed MSOs; it res insurer and PBM-backed ones. That distinction is where the opportunity lives. I currently integrated insurer and PBM-controlled MSO structures have to unwin replacement model is an independent MSO structure that can provide the same administrative and operational services without the payor conflict. That is a fun thesis right now, today, regardless of whether the bill passes, because the regula trajectory is clearly moving in this direction even if this particular bill stalls.

The more interesting play is what happens to the tech layer inside those MSOs. large integrated systems have built proprietary clinical data platforms, care management tools, and predictive analytics capabilities inside their provider networks. When those networks get divested, the technology either gets carved o separately, licensed back, or the acquiring entity has to rebuild it. That creates demand for clinical data infrastructure, interoperability tooling, and care management platforms that can serve an independent MSO without the integrat payor conflict. Health tech startups building in that stack are not just selling to market of interest; they are selling to a market that the bill helps create.

What the Bears Get Right

There is a credible bear case on this, and any serious investor needs to sit with it before getting too excited. The first and most obvious objection is passage proba This is a structural reform bill targeting some of the most profitable and politica connected companies in the American economy. CVS, UnitedHealth, and Cigna collectively spend tens of millions on lobbying annually. The last time Congress on PBMs in a serious way, the legislation was defanged before it got to a floor vo The Patients Before Monopolies Act, which Warren and Hawley introduced in

December 2024, was narrower and did not get to a vote either. Warren and Hawl have made good political theater before without converting it to law.

The bipartisan framing does matter this cycle, though, and here is why: the 2026 midterms are shaping up to be fought heavily on economic cost-of-living issues, healthcare costs are near the top of that agenda for both parties. PBMs in partic have become a nearly universally reviled entity across the political spectrum, wh genuinely rare in American politics. The CVS Health CEO was confronted direc Rep. Alexandria Ocasio-Cortez at a House hearing in January 2026 and his defen the integrated model was not exactly a winning performance. New PBM regulati were included in the recent appropriations bill that Trump signed. Trump's own executive orders have called for reevaluating the role of middlemen. The politica tailwinds are real, even if the lobbying headwinds are also real.

The second objection is transition risk. The one-year compliance window is aggressive, and forced divestitures of businesses this large and this operationally complex are genuinely disruptive. When Cigna acquired Express Scripts in 2018 took several years to meaningfully integrate the businesses. Reversing that kind integration in twelve months while maintaining continuity of care for millions o patients is not straightforward. There is a legitimate policy argument that an ove compressed transition timeline creates patient harm. Opponents will make this argument, and regulators implementing the bill will have to navigate it carefully

The third thing bears will point to is the CVS counterargument, which is that ev you accept the critique of the integrated model, the savings from payor-provider integration were real in some cases and the disruption of unwinding them is not CVS CEO David Joyner argued in February 2026 that Aetna's network negotiatic produced over $235 billion in savings for members and clients, and Caremark negotiations delivered $45 billion in annual savings. These are self-reported nun from a conflicted source, but the underlying point that integration can produce genuine efficiencies is not entirely wrong. The policy question is whether those efficiencies are worth the conflicts they introduce, and the FTC data on markup suggests pretty strongly they are not, but smart founders and investors should n walk into this thesis assuming the incumbents offer zero real value.

How to Think About Timing and Passag Probability

Honest answer: nobody knows if this bill passes in its current form. But that is actually not the right question for investors. The right question is whether the regulatory direction of travel is toward or away from structural separation of insurer/PBM and provider assets, and that question is much easier to answer. Th direction of travel has been clearly toward separation for at least two years, acro multiple administrations and legislative sessions. The trajectory includes the FT aggressive 2024 and 2025 reports on PBM conduct, the Arkansas state law, Oreg corporate practice restrictions, the Patients Over Profits Act, new PBM regulati the recent appropriations bill, and Trump's executive orders. The Warren-Hawle is the most comprehensive expression of that trajectory, but it is not the first and not be the last.

For early-stage founders, the takeaway is that building a company that benefits f structural separation is not a binary bet on this bill. It is a bet on a regulatory ar is already in motion. The specific timing and form of the eventual rules matter f timing and market sizing, but they do not change the directional case. Founders building independent MSO infrastructure, unconflicted PBM alternatives, independent pharmacy platforms, or tech stacks for newly independent physicia practices are building for a market that gets bigger every time any version of thi legislation moves forward, at the state or federal level.

For investors doing deals in the next 12 to 24 months, the more specific tactical question is which assets come loose first and at what prices. The compliance wir if the bill passes, creates a predictable timeline. The covered companies will star quiet divestiture conversations almost immediately after enactment rather than waiting for the forced-sale deadline. That means the most attractive assets, specifically the ones that are operationally mature, geographically concentrated, have clear independent operating viability, will transact in the first six months. T rump assets, the ones that are deeply integrated with parent company technolog payor contracts, will be messier and cheaper. Investors with operational capabili

run a divested physician network or specialty pharmacy independently are bette positioned to look at the rump assets. Investors who need clean, turnkey deals w want to be at the front of the queue for the prime assets.

There is also a signal-watching strategy worth considering. The covered compan already making moves. CVS Health has been restructuring its business segments the last two years and shed the Centene PBM contract in late 2023, a move that significantly in the short term but reduced its integrated exposure. Whether tha forward-looking regulatory preparation or just business strategy is not entirely but the pattern is worth watching. Companies that start announcing strategic re of their provider or PBM businesses before any bill passes are essentially pre-announcing their compliance posture, and that advance signal is useful for inves who want time to line up financing before the formal divestiture process begins.

Closing Take

The Break Up Big Medicine Act is not guaranteed to become law in its current f That is boring conventional wisdom and it is probably right. But the investor an founder question was never whether Warren and Hawley's exact bill passes word word. The question is whether the era of insurer-PBM-provider vertical integrat a dominant organizational model in American healthcare is over, and the eviden that it is ending is everywhere. The FTC thinks it is ending. Several state legisla think it is ending. Both populist wings of the two major parties think it is endin CVS CEO, arguing on an earnings call that his integrated model creates value, is making the case more defensively than his predecessors were even three years ag

When the Glass-Steagall analogy gets invoked, it is worth remembering how tha actually played out. The original Glass-Steagall passed in 1933. Banks argued fo decades it was unnecessary and harmful, and eventually got it repealed in 1999. Fifteen years later, the 2008 financial crisis produced Dodd-Frank, which reimp many of the same restrictions the industry had successfully removed. The health version of that cycle is probably already in its middle stages. The era of rampant vertical integration is not going to survive politically, economically, or regulator

The only question for founders and investors is whether they are positioned to b from the unwinding or still holding exposure to the structures being unwound.

The market that emerges on the other side of structural separation is not small. Healthcare is 20% of GDP and climbing. Seven of the Fortune 20 companies are effectively healthcare conglomerates. When those structures start to come apart, assets they shed and the whitespace they create represent some of the most inter investment opportunities in the sector in a generation. The bill just dropped yesterday. The queue for the good assets is already forming.

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