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The Role of Pharmacy Benefit Managers in Prescription Drug Markets Part I: Self-Interest or Health Care?

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Chairman Comer, Ranking Member Raskin, members of the Committee, thank you for the opportunity to testify today at this hearing focused on *The Role of Pharmacy Benefit Managers in Prescription Drug Markets.* It is an honor to be with you this afternoon. My name is Frederick Isasi, and I am the executive director of Families USA, a leading national, non-partisan voice for health care consumers. For more than 40 years, Families USA has been working to achieve our vision of a nation where the best health and health care are equally accessible and affordable to all. We greatly appreciate the past work of this Committee to explore the root causes of high and irrational drug prices and urge you to continue to tackle the complex network of abusive practices that underpin the American pharmaceutical market.

The high and rising cost of prescription drugs in the United States is both a profound health problem and significant economic burden on our nation's families. Nearly 20 million Americans cannot afford their prescription drug medication because of the unchecked power of big drug companies and their ability to price gouge our nation's families.[1] In July 2022, the U.S. Department of Health and Human Services reported that over the previous year, drug makers raised prices on more than 1,200 drugs beyond the rate of inflation (8.5 percent for that period), resulting in price increases averaging more than 30% with some prices increasing by $20,000 or 500%.[2] There is no economic rationale for price increases that are higher than inflation long after a drug has been introduced and priced, particularly when there are no changes in clinical value or innovation. Yet, this trend is not new - from 2008 to 2021 prescription drug launch prices increased 20% ***per year,*** far exceeding increases in inflation and forcing millions of Americans to choose between life-saving drugs or putting food on the table to feed their families.[3,4]

These high prices are particularly concerning given that people in America pay so much more for drugs than those in other, comparable countries; a recent RAND report found that overall drug prices in the United States are more than 250% higher than prices in 32 other countries. For brand-name drugs, that figure rises to 344%.[5]

Not only are prices high but they are exploitative. Ten years ago, Naloxone, a life-saving drug used to treat opioid overdoses, cost just one dollar.[6] Amid the opioid crisis, the price rose to $150 (for two doses), and the auto-injectable version to a stunning $4,500.[7] Last Congress, the Senate Finance Committee conducted a report on the skyrocketing cost of Insulin - a century-old drug - and found that these price increases were completely unjustified, providing no new clinical benefit to the patient.[8] In addition, the Committee unveiled that the drug manufacturers aggressively increased prices "in lock step" with each other, invested only a small fraction of those price increases back into research and development, and ultimately used the price increases to increase their profit margins.[9]

It is clear the rising costs of prescription drugs is a national crisis, with devastating impacts on the millions of families and individuals that rely on prescription medication. Behind this crisis are big drug corporations that have built an entire business model off of price gouging the American people, maximizing profits by unscrupulously raising the prices of both existing and new prescription drugs on the backs of our nation's families.

The Impact of High Drug Prices on Families

While high drug prices are a source of seemingly constant policy debate in Washington, D.C., millions upon millions of people are suffering at the hands of a broken system that has allowed drug manufacturers to set monopolistic prices that threaten the health and financial security of America's families, including their ability to secure basic needs. Nearly three in ten adults – approximately 80 million people – in our country have not taken required medicine as prescribed in the past year due to its costs.[10] The financial burden of unaffordable drug prices is substantial: for the 176 million Americans who get their health coverage from the private market, drug prices account for almost a quarter - 22% - of monthly premiums.[11]

To illustrate the impact of unaffordable drug prices on our nation's families, I'd like to share the story of just one of the millions of consumers struggling under the burden of high drug costs – a woman named Maureen, who is 80 years old and living in a small house in the North Georgia Mountains:

> Maureen depends on Medicare for her health insurance and social security for income – living check to check - and describes herself as extremely healthy apart from blood clots in her left leg and lungs.
>
> She was prescribed an anticoagulant treatment and told she would need to take the medication for the rest of her life. She pays $400 every three months, as prescribed. But at that price, Maureen simply cannot make ends meet and live out her retirement dream of focusing on animal rescue. So, she decided to "give up food." She eats one meal a day and drinks tons of water because it fills her up, and she has also given up the dentist and non-essential driving to save on gas and repair costs. "Funding Big Pharma was not in my Social Security budget plan, yet here I am. Drug prices are life-changing, and not in a good way."

These are the impossible trade-offs people are making because of our broken drug pricing system. An 80-year-old woman gave up food to pay for her prescription. It is unconscionable that for decades, policymakers allowed big corporate drug companies to force Maureen and the millions of Americans like her to choose between food or lifesaving medicine.

Big Drug Corporations Are Responsible for High Drug Costs

Prescription drugs are not getting more expensive because manufacturers are creating innovative, more effective drugs. Instead, drug companies routinely and abusively increase the price for existing prescription drugs far in excess of inflation.[12] For example, in a 2015 study, the HHS Office of Inspector General found that drug company price increases exceeded inflation for 78 percent of the drugs studied.[13] Of the 12 most expensive drugs for Medicare, almost all have experienced at least 20 separate price increases since launching, some of which have increased in price at astronomical rates of 825% or 1219%.[14] Enbrel, a rheumatoid arthritis therapy,

launched in 1998 for $10,400 per year.[15] By 2021 it cost $72,000 annually – making its price a 486% increase and bringing the company a net revenue of over $5 billion.[16]

Importantly, although big drug companies claim they price gouge America's families to fund research and development or to create more innovative drugs, the reality is that those price increases are predominantly about profit maximization. In 2021, this very Committee investigated increases in drug costs and found that the largest drug corporations deploy intentional strategies to raise prices in order to meet revenue targets and incentivize executives to hike prices to increase their own profits – at the expense of families and individuals who require that medication and at great expense to Medicare.[17] Similarly, the Senate Finance Committee's 2021 report analyzed financial data from large drug companies and found they spend significantly more on stock buybacks and dividends than on drug Research & Development.[18]

Furthermore, every time we allow pharmaceutical corporations to price gouge abusively, we are *disincentivizing* new life saving interventions. Drug makers focus on hiring lawyers to extend patents instead of investing in research in the next life-saving cure. For example, the makers of the top 12 best-selling drugs in the United States have filed, on average, 125 patents per drug, resulting in an average 38 years of blocked competition, far in excess of the exclusivity envisioned under Federal law.[19, 20]A Stanford business professor, Dr. Robert Pearlman, concluded in an article in *Forbes* this year: "In the 21st century, most drug companies have replaced moonshots with chip shots: strategies aimed at minimizing risk. Rather than chasing the elusive game-changing drug, today's biopharma giants focus on monetizing easy wins." [21]

The U.S. also pays egregiously high costs for new medications, which too often do not provide any additional clinical benefit than those already on the market. According to Johns Hopkins Bloomberg School of Public Health, Medicare spent over a billion dollars in 2019 on new drugs that have yet to show any clinical benefit.[22] In 2021, Biogen set the price of its unproven and potentially harmful Alzheimer's drug, Abucanumab, at $56,000 — although experts overwhelmingly determined it provided no proven clinical benefit.[23]

The Role Pharmaceutical Benefit Managers Play in High Drug Costs

While big drug companies bear the lion share of responsibility for our high drug costs, Pharmacy Benefit Managers (PBMs) also have played an important role in driving unaffordable drug prices.[24] As third party administrators designed to serve as intermediaries between health insurance providers and drug manufacturers, the key function of a PBM is to negotiate drug price concessions from pharmacies and drug manufacturers to lower prescription drug costs for health plans and employers.[25] To be clear, some drug costs are lower than they otherwise would be because of PBMs – and pharmaceutical corporations have taken particular aim at PBMs because of their role in negotiating a better price.

However, there is far too much opaqueness in the functioning of PBMs and certain business practices that are good for PBMs are bad for consumers. PBMs receive rebates and discounts

from drug companies in exchange for formulary placement, or a place of the list of drugs a PBM has agreed to cover.[26] Importantly, although PBMs negotiate rebates, their revenue is based on a percentage of the drug's list price.[27] The result is that PBMs have a strong financial incentive to prioritize higher cost drugs. In many plan designs, PBMs pocket a percent of the rebate they get for consumers, making it advantageous for them to negotiate a higher rebate for a higher priced drug than a lower overall list price.[28,29] Pharmaceutical companies, then, raise both the list price and the rebate year after year making the overall cost of the drug higher.[30] A 2020 study showed that for every $1 increase in drug rebates there is a $1.17 correlating increase in the drug list price.[31] As result, PBMs are able to substantially increase their profits from rebates in addition to their normal revenue cycle, which relies on administrative fees, and in some cases they are not actually lowering the costs of drugs for consumers.[32,33]

This problem is intensified by an increasingly concentrated prescription drug market fueled by both mergers and vertical integration of PBMs, insurers, and pharmacies. Now the top three PBMs control 80% of the market: CVS, including Caremark and Aetna, Express Scripts owned by Cigna, and Optum owned by UnitedHealth Group.[34] Just as consolidation causes price increases in hospitals and large health care corporations, this trend can lead to increased costs for patients who are trying to access and afford their medications.[35,36,37] As PBMs buy up more and more of the market, they have increased negotiating power with drug manufacturers, which results in pricing structures that serve PBM financial interests at the expense of the financial security of our nation's families. For example, a Delaware state auditor report found the PBM Express Scripts overcharged the state employee prescription drug plan by $24.5 million.[38] Or, take the Ohio Department of Health which found that CVS Caremark and Optum Rx pocketed the nearly 9% difference between what they billed managed care plans and what they paid pharmacies.[39] Consolidation in the PBM market also allows PBMs to prioritize the pharmacies they own, which reduces patient choice and access to some drugs by "steering" patients to specific pharmacies.[40] As of 2017, PBM-owned pharmacies represented 46% of the industry's revenue growth.[41] This is a major threat to the ability of independent pharmacies to operate and threatens access to pharmaceuticals for millions of families living in rural and underserved communities.

This consolidation of PBM markets is further exacerbated by a significant lack of transparency in their contracts with payers and the rates that they negotiate with drug manufacturers.[42] *Not even the employers who hire PBMs know the actual drug prices the employers are paying, what rebates the PBMs are receiving, or the true negotiated price*. It's this lack of transparency that allows for abusive practices like spread pricing, where PBMs charge a different amount of reimbursement than they pay to pharmacies for generic drugs, to fly under the radar.[43]

Congress Has Taken Important Steps to Address High Drug Costs

I applaud Congress and members of the Oversight Committee for taking key steps in the 117th Congress to address these issues. The drug pricing investigation and related report, undertaken by this Committee in 2021, was central to unveiling the many abuses and closed-door practices drug companies use to boost their own profits and increase drug costs for the rest of us.[44]

Without that important investigation, we might not have the specific evidence – which I have cited back to several times in this testimony – to show the extent of the abuses these companies commit. This report was also illustrative to show the range of deceptive and abusive practices these companies engage in, from patent abuse to inflationary practices.

And that work was key to passage of the *Inflation Reduction Act (IRA),* the most significant legislation ever passed by Congress to address abusive price gouging by pharmaceutical corporations. Most notably, the Inflation Reduction Act allows the federal government, for the first time in history, to negotiate prices with pharmaceutical corporations for a small subset of high-cost drugs.[45] This will not only provide savings directly for individuals but will also provide billions in savings to Medicare itself – ensuring the long term solvency of the Medicare trust fund. Additional reforms that were enacted with the savings created through negotiating a reasonable price for drugs also will provide critical health services for our nation's older adults and family members with disabilities that rely on Medicare for their health care – these reforms include: finally capping the total out of pocket costs in the Medicare drug benefit, creating inflationary rebates to limit the growth in drug prices year over year, and offering vaccines free of cost sharing.[46]

It will take time for the full benefits of this new law to take effect, and we know pharmaceutical industry interests will aggressively try to undermine implementation every step of the way. Decades of industry behavior and actions just this year, show us that drug companies are working every angle legislatively and legally to weaken implementation of the new law. I urge Congress to resist their thinly disguised attempts to protect their own profit margins at the expense of American families, and to instead come together to pass further reforms to address the root causes of high drug prices.

Now Is the Opportunity for Additional Reform

Congress has the opportunity to continue the momentum from last year's reforms to address high drug costs. We support the Committee's work to investigate the role of PBMs and urge you to continue to take action on abusive and anti-competitive business practices – holding onto a large percentage of rebates, not negotiating for the lowest possible price, instituting spread pricing, and using contracting practices like gag-clauses – simply because they have been operating with little regulatory oversight or insight.[47] There are three commonsense, comprehensive policy solutions that would help to fix abusive practices and broken incentive systems:

1. **Increase transparency into PBM negotiation and contracting:** PBMs should be required to report comprehensive and accurate data - including but not limited to revenue, price, and utilization data - resulting from their negotiations with drug manufacturers and contracts with insurers, as well as participate in fully transparent contracting practices. Requiring that plans and employers (the clients of PBMs) receive key information including negotiated prices, gross PBM profits, cost-effectiveness of the PBM's drug lists, and spending patterns, would help to reduce drug benefit costs by increasing

competition between PBMs, and would empower the clients of PBMs to negotiate better contract terms.[48,49] Greater transparency into the business practices that PBMs use in their contacts is a critical first step to ensuring PBMs financial incentives are not driving up drug costs for America's families. Non-compliance with transparency requirements should result in significant monetary penalties.

2. **Increase oversight and regulation of vertical and horizontal PBM consolidation:** The Federal Trade Commission (FTC) and other regulatory bodies should have increased authority to study, oversee, and approve PBM integration in an effort to crack down on anti-trust violations, control consolidation that does not benefit the consumer, and ensure that the prescription drug market has fair competition.

3. **Ensure 100% pass-through of rebates and cost-sharing based on the actual price paid:** 100% of rebates collected by PBMs from drug manufacturers should be passed through to the consumer. Similarly, consumers should never be required to pay cost-sharing based off a list price that is much higher than the post-rebate, negotiated rate paid. Instead, consumers should pay cost-sharing off of the final, negotiated price paid. Both reforms would help to realign the negotiating incentives for PBMs; protect consumers against vertically consolidated PBM, plan, and pharmacy systems that might hinder the rebate benefit from truly reaching the consumer; and begin to effectively reduce the financial burden of prescription drugs on consumers.

In addition to the above solutions to address PBM abuses, there are additional reforms Congress can pursue that would take on the systemic abuses from big drug companies that have led to high prices. *These are, by far, the most important reforms that must occur if we are going to end pharmaceutical corporations' greed at the expense of American families' economic stability and health*.

4. **Extend the *Inflation Reduction Act's* Medicare inflation rebate to the commercial market:** The IRA requires that drug manufacturers pay a rebate when they increase prices faster than the rate of inflation for some drugs covered under Medicare Part B and almost all covered drugs under Medicare Part D. For drug manufacturers that do not pay the rebate, there is a significant monetary penalty. CBO estimates that there will be a net $63.2 billion reduction in the federal deficit over 10 years resulting from this provision alone.[50] Inflation rebates should be extended to include drugs covered in the commercial market to better protect individuals in employer-sponsored plans and other private plans from drug manufacturers' high prices and exorbitant yearly increases.

5. **Expand the number of drugs subject to negotiation and allow commercial health insurance to voluntarily adopted the negotiated rate**: The IRA limits the number of drugs that may be subject to government negotiation each year, starting with ten drugs in 2026. These prices are not automatically available to consumers with private health insurance, which drives up the costs of prescription drugs for hundreds of millions of families. The Secretary of Health and Human Services should be authorized and required

to expand this list of drugs subject to negotiation (e.g., to at least 50 drugs) and to extend all negotiated prices to private sector health insurance, on a voluntary basis.

6. **End patent abuses:** For decades, drug makers have systematically abused patent and market exclusivity rules to block competition. One common abuse is to make minor tweaks to existing drugs that typically confer no additional clinical benefit but allow for extended patent protections. Marketers of the 12 best-selling drugs in the U.S. filed, on average, 125 patent applications per drug for the sole purpose of extending their monopolies and blocking competition for up to four decades.[51] Practices like pay for delay and patent thickets should be eliminated.

Thank you again for holding this hearing today. Congress and the Administration have begun to take critical steps to ensure prescription drugs are truly affordable and accessible to all those who rely on them. Members of Congress have introduced legislation to increase transparency in PBM contracting and the FTC has begun analysis and oversight efforts to PBM anti-competitive and contracting habits.[52] Congress should seize this momentum to immediately implement commonsense policies that rein in abusive drug prices and make health care more affordable for everyone. The journey to fully transform our health care system so that it truly works for American families is long, but Congress holds the power to take the next critical steps. Families USA stands ready to support you in this essential and urgently needed work.

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[1] Witters, D., *In U.S., an Estimated 18 Million Can't Pay for Needed Drugs,* Gallup, Sept. 2021, https://news.gallup.com/poll/354833/estimated-million-pay-needed-drugs.aspx

[2] Bosworth, A., Sheingold, S., et al, *Price Increases for Prescription Drugs, 2016-2022,* Office of the Assistant Secretary for Planning and Evaluation, Sept. 2022, https://aspe.hhs.gov/reports/prescription-drug-price-increases

[3] Bosworth, A., Sheingold, S., et al*, Price Increases for Prescription Drugs, 2016-2022*, Office of the Assistant Secretary for Planning and Evaluation, Sept. 2022, https://aspe.hhs.gov/reports/prescription-drug-price-increases

[4] Alltucker, K., *Why Drugmakers Have Raised Prices on Nearly 1,000 Drugs So Far This Year,* USA Today, Jan. 2023, https://www.usatoday.com/story/news/health/2023/01/30/drug-price-increases-2023/11084913002/

[5] Andrew W. Mulcahy et al., *International Prescription Drug Price Comparison: Current Empirical Estimates and Comparisons with Previous Studies,* Rand Corporation, 2021, https://www.rand.org/pubs/research_reports/RR2956.html

[6] Hufford, M., and Burke, D., *The Costs of Heroin and Naloxone: A Tragic Snapshot of the Opioid Crisis*, STAT News, Nov. 2018, https://www.statnews.com/2018/11/08/costs-heroin-naloxone-tragic-snapshot-opioid-crisis/

[7] Hufford, M., and Burke, D., *The Costs of Heroin and Naloxone: A Tragic Snapshot of the Opioid Crisis*, STAT News, Nov. 2018, https://www.statnews.com/2018/11/08/costs-heroin-naloxone-tragic-snapshot-opioid-crisis/

[8] United States Senate Finance Committee Staff Report, *Insulin: Examining the Factors Driving the Rising Cost of a Century Old Drug*, Jan. 2021, https://www.finance.senate.gov/imo/media/doc/Grassley-Wyden%20Insulin%20Report%20(FINAL%201).pdf

[9] United States Senate Finance Committee Staff Report, *Insulin: Examining the Factors Driving the Rising Cost of a Century Old Drug*, Jan. 2021, https://www.finance.senate.gov/imo/media/doc/Grassley-Wyden%20Insulin%20Report%20(FINAL%201).pdf

[10] Kirzinger, A., Lopes, L., Wu, B., and Brodie, M., *KFF Health Tracking Poll—February 2019: Prescription Drugs,* The Henry J. Kaiser Family Foundation. March 2019, https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-february-2019-prescription-drugs/.

[11] *Where Does Your Health Care Dollar Go?,* AHIP, Sept. 2020, www.ahip.org/health-care-dollar/.

[12] Boswoth, A., Sheingold, S., et al, *Price Increases for Prescription Drugs, 2016-2022,* ASPE, Sept. 2022, https://aspe.hhs.gov/reports/prescription-drug-price-increases
[13] Murrin, S., *Calculation of Potential Inflation-Indexed Rebates For Medicare Part B Drugs,* HHS- OIG, Aug. 2017, https://oig.hhs.gov/oei/reports/oei-12-17-00180.pdf
[14] Meyers Collette, R., *Congress: Pharma's Price Gouging is Purposeful,* Arnold Ventures, Dec. 2021, https://www.arnoldventures.org/stories/congress-pharmas-price-gouging-is-purposeful
[15] The Pink Sheet, *Immunex/Wyeth Enbrel Launch Price Is $10,400 Per Year,* Pharma Intelligence, Nov. 1998, https://pink.pharmaintelligence.informa.com/PS033120/ImmunexWyeth-Enbrel-Launch-Price-Is-10400-Per-Year
[16] Pagliarulo, N., *Novartis Challenge to Amgen's Enbrel Patents Ends at Supreme Court's Door,* Biopharma Dive, May 2021, https://www.biopharmadive.com/news/novartis-challenge-to-amgens-enbrel-patents-ends-at-supreme-courts-door/600329/
[17] Majority Staff Report, *Drug Pricing Investigation,* House of Representatives Committee on Oversight and Reform, Dec. 2021, https://oversightdemocrats.house.gov/sites/democrats.oversight.house.gov/files/DRUG%20PRICING%20REPORT%20WITH%20APPENDIX%20v3.pdf
[18] Fishman, E., Wilkniss, S., *Our Broken Drug Pricing and Patent System Diverts Resources Away From Innovation and Into Mergers, Patent Gaming and Price Gouging,* Families USA, Aug. 2021, https://familiesusa.org/resources/our-broken-drug-pricing-and-patent-system-diverts-resources-away-from-innovation-and-into-mergers-patent-gaming-and-price-gouging/
[19] Kelmar, P. "Hacking through thickets of drug patents to get to affordable medicine" U.S. PRIG Education Fund. March 31, 2021. Available at: https://pirg.org/edfund/articles/hacking-through-thickets-of-drug-patents-to-get-to-affordable-medicine/#:~:text=One%20study%20analyzed%20patent%20practices,intended%20under%20U.S.%20patent%20law.
[20] I-MAK, *Overpatented, Overpriced Special Edition: Humira*, October 2020. http://www.i-mak.org/wp-content/uploads/2018/08/I-MAK-Overpatented-Overpriced-Report. pdf.
[21]Pearlman, R. "Pharma Companies: A Conglomerate Of Monopolies" Forbes. January 31, 2023. Available at: https://www.forbes.com/sites/robertpearl/2023/01/31/pharma-companies-a-conglomerate-of-monopolies/?sh=387ee8f81ce1
[22] *Medicare Program Spent $1.8 Billion in 2019 on Drugs Without Confirmed Clinical Benefits,* Johns Hopkins Bloomberg School of Public Health, May 2022, https://publichealth.jhu.edu/2022/medicare-program-spent-1-8-billion-in-2019-on-drugs-without-confirmed-clinical-benefits
[23] Cooney, E., *Pharmalittle: ICER Medical Experts Find No Benefit For Aduhelm; FDA Panel Votes Down Fibrogen's Anemia Drug,* STAT, July 2021, https://www.statnews.com/pharmalot/2021/07/16/pharmalittle-icer-aduhelm-alzheimers-fda-fibrogen-anemia-drug/
[24] *Pharmacy Benefit Managers and Their Role in Drug Spending,* The Commonwealth Fund, April 2019, https://www.commonwealthfund.org/publications/explainer/2019/apr/pharmacy-benefit-managers-and-their-role-drug-spending
[25] *Pharmacy Benefit Managers,* The Center for Insurance and Policy Research, NAIC, April 2022, https://content.naic.org/cipr-topics/pharmacy-benefit-managers
[26] Bhatnagar, S., *High Drug Prices: Are PBMs the Right Target?,* Bipartisan Policy Center, Feb. 2023, https://bipartisanpolicy.org/blog/are-pbms-the-right-target/#:~:text=The%20role%20of%20PBMs&text=For%20certain%20prescriptions%2C%20some%20PBMs,and%20copays%20for%20plan%20enrollees.
[27] *Pharmacy Benefit Managers and Their Role in Drug Spending*, The Commonwealth Fund, April 2019, https://www.commonwealthfund.org/publications/explainer/2019/apr/pharmacy-benefit-managers-and-their-role-drug-spending
[28] Yeung, K., Dusetzina, S., Basu, A., *Association of Branded Prescription Drug Rebate Size and Patient Out-of-Pocket Costs in a Nationally Representative Sample, 2007-2018,* JAMA Network Open, June 2021, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2780950
[29]*Statement of Commissioner Rohit Chopra: Regarding the Commission's Report on Pharmacy Benefit Manager Rebate Walls,* Federal Trade Commission, May 2021,

https://www.ftc.gov/system/files/documents/public_statements/1590528/statement_of_commissioner_rohit_chopra_regarding_the_commissions_report_on_pharmacy_benefit_manager.pdf
[30]Sood, N., Ribero, R., et al, *The Association Between Drug Rebates and List Prices,* USC Schaeffer, Feb. 2020, https://healthpolicy.usc.edu/research/the-association-between-drug-rebates-and-list-prices/
[31] Sood, N., Ribero, R., et al, *The Association Between Drug Rebates and List Prices*, USC Schaeffer, Feb. 2020, https://healthpolicy.usc.edu/research/the-association-between-drug-rebates-and-list-prices/
[32] *Pharmacy Benefit Managers*, The Center for Insurance and Policy Research, NAIC, April 2022, https://content.naic.org/cipr-topics/pharmacy-benefit-managers
[33] Yeung, K., Dusetzina, S., Basu, A., *Association of Branded Prescription Drug Rebate Size and Patient Out-of-Pocket Costs in a Nationally Representative Sample, 2007-2018*, JAMA Network Open, June 2021, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2780950
[34] *The Top Pharmacy Benefit Managers of 2021: The Big Get Even Bigger,* Drug Channels, April 2022, https://www.drugchannels.net/2022/04/the-top-pharmacy-benefit-managers-of.html
[35] Cooper, Z., Craig, S., et al, *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured,* The Quarterly Journal of Economics, Sept. 2018, https://academic.oup.com/qje/article-abstract/134/1/51/5090426?redirectedFrom=fulltext&login=false
[36] Gaynor, M., *Diagnosing the Problem: Exploring the Effects of Consolidation and Anticompetitive Conduct in Health Care Markets,* Statement Before the Committee on the Judiciary Subcommittee on Antitrust, Commercial, and Administrative Law, Mar. 2019, https://www.congress.gov/116/meeting/house/109024/witnesses/HHRG-116-JU05-Bio-GaynorM-20190307.pdf
[37] House Committee on Oversight and Reform Minority Staff, *A View from Congress: Role of Pharmacy Benefit Managers in Pharmaceutical Markets,* Committee on Oversight and Reform, Dec. 2021, https://oversight.house.gov/wp-content/uploads/2021/12/PBM-Report-12102021.pdf
[38] Bhatnagar, S., *High Drug Prices: Are PBMs the Right Target?,* Bipartisan Policy Center, Feb. 2023, https://bipartisanpolicy.org/blog/are-pbms-the-right-target/
[39] Bhatnagar, S., *High Drug Prices: Are PBMs the Right Target?,* Bipartisan Policy Center, Feb. 2023, https://bipartisanpolicy.org/blog/are-pbms-the-right-target/
[40] Freed, Z., *the Pharmacy Benefit Mafia: The Secret Health Care Monopolies Jacking Up Drug Prices and Absuing Patients and Pharmacists,* American Economic Liberties Project, http://www.economicliberties.us/wp-content/uploads/2022/06/2022-6-22-PBM-Quick-Take.pdf
[41] Carrier, M., *A Six-Step Solution to the PBM Problem,* Health Affairs, Aug. 2018, https://www.healthaffairs.org/content/forefront/six-step-solution-pbm-problem (Report Source: Fein, A., *The 2017 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers,* Drug Channels Institute, Feb. 2017, https://drugchannelsinstitute.com/files/2017-PharmacyPBM-DCI-Overview.pdf)
[42] Bai, G., Socal, M., et al, *Policy Options to Help Self-Insured Employers Improve PBM Contracting Efficiency,* Health Affairs, May 2019, https://www.healthaffairs.org/do/10.1377/forefront.20190529.43197/full/
[43] *Pharmacy Benefit Managers and Their Role in Drug Spending,* The Commonwealth Fund, Apr. 2019, https://www.commonwealthfund.org/publications/explainer/2019/apr/pharmacy-benefit-managers-and-their-role-drug-spending
[44] Majority Staff Report, *Drug Pricing Investigation,* House of Representatives Committee on Oversight and Reform, Dec. 2021, https://oversightdemocrats.house.gov/sites/democrats.oversight.house.gov/files/DRUG%20PRICING%20REPORT%20WITH%20APPENDIX%20v3.pdf
[45] *Medicare Drug Price Negotiation Program,* Centers for Medicare and Medicaid Services, Jan. 2023, https://www.cms.gov/files/document/medicare-drug-price-negotiation-program-next-steps-implementation-2026.pdf
[46] *Inflation Reduction Act and Medicare*, Centers for Medicare and Medicaid Services, https://www.cms.gov/inflation-reduction-act-and-medicare
[47] Clark, B., Puthiyath, M., *Are Pharmacy Benefit Managers the Next Target for Prescription Drug Reform,* The Commonwealth Fund, April 2022, https://www.commonwealthfund.org/blog/2022/are-pharmacy-benefit-managers-next-target-prescription-drug-reform

[48] Miller, M., *Response to FTC RFI: Business Practices of Pharmacy Benefit Managers and Their Impact on Independent Pharmacies and Consumers,* Arnold Ventures, May 2022, https://craftmediabucket.s3.amazonaws.com/uploads/AV-FTC-PBM-Comment-Letter.pdf

[49] Bai, G., Socal, M., et al, *Policy Options to Help Self-Insured Employers Improve PBM Contracting Efficiency, Health Affairs*, May 2019, https://www.healthaffairs.org/do/10.1377/forefront.20190529.43197/full/

[50] *How CBO Estimated the Budgetary Impact of Key Prescription Drug Provisions in the 2022 Reconciliation Act,* Congressional Budget Office, Feb. 2023, https://www.cbo.gov/system/files/2023-02/58850-IRA-Drug-Provs.pdf

[51] I-MAK, *Overpatented, Overpriced Special Edition: Humira*, October 2020. http://www.i-mak.org/wp-content/uploads/2018/08/I-MAK-Overpatented-Overpriced-Report. pdf.

[52] Cohen, J., *Federal Trade Commission and Congress Want to Rein in PBMs,* Forbes, Jun. 2022, https://www.forbes.com/sites/joshuacohen/2022/06/03/federal-trade-commission-and-congress-want-to-rein-in-pbms/?sh=7310590d4de9