NARFE
THE ASSOCIATION FOR FEDERAL EMPLOYEES AND RETIREES

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July 21, 2026

Committee on Oversight and Government Reform
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Comer, Ranking Member Garcia and members of the Committee:

On behalf of the National Active and Retired Federal Employees Association (NARFE) and the federal employees, retirees, and their families we represent, I write to express our views on H.R. 6610, the Pharmacists Fight Back [in Federal Employee Health Benefit (FEHB) Plans Act], as the Committee prepares to mark up the bill. We appreciate the bipartisan leadership behind this effort to confront pharmacy benefit manager (PBM) practices that have raised prescription drug costs, undermined patient choice, and threatened the community pharmacies that federal employees and retirees depend on. We support much of the bill and offer our perspective and hesitation on one provision (setting a price floor) where further analysis and potential adjustment would strengthen it.

We strongly support the bill's anti-steering and anti-restriction provisions (new 8904(c)(1)(B)). The pharmacy benefit market is extraordinarily concentrated and vertically integrated. Three companies—CVS Caremark, Express Scripts, and Optum Rx—processed roughly 80 percent of all equivalent prescription claims in 2025, and each of the three owns its own retail, mail-order, or specialty pharmacies. This combination of market dominance and pharmacy ownership gives PBMs both the incentive and the ability to direct patients toward the pharmacies they control.

The Committee's own investigation documented that they do exactly that. The Committee's July 2024 report, the product of a 32-month investigation, found that the three PBMs steer patients to pharmacies the PBM owns and favor more expensive brand-name drugs that yield larger rebates, identifying 300 examples of the three PBMs preferring medications costing at least $500 more per claim than a safe, excluded alternative. In the Committee's August 2024 letter to CVS Caremark, the Chairman cited evidence that Caremark reimburses competing pharmacies below the acquisition cost of the drug—and below what it pays its own pharmacies—and that some patients are being forced to fill prescriptions at Caremark-affiliated pharmacies rather than the location they choose. The Federal Trade Commission (FTC) reached parallel conclusions, finding that a disproportionate share of the most profitable specialty generic prescriptions—those marked up more than $1,000 per prescription—were dispensed by the Big 3 PBMs' affiliated pharmacies, a pattern suggesting the PBMs steer highly profitable prescriptions to their own pharmacies and away from unaffiliated ones.

The bill responds directly to these tactics. Section 8904(c)(1)(B)(i) prohibits a PBM from directing or requiring an enrollee to use a specific pharmacy, including an affiliate;

(B)(ii) bars promoting one pharmacy over another in-network pharmacy; (B)(iii) prohibits network designs and practices—including accreditation or credentialing standards, day-supply limitations, and delivery-method limitations—that exclude or restrict an in-network pharmacy, squarely addressing the practice of narrowing a network until only a mail-order affiliate remains; and (B)(iv) prohibits inducing a manufacturer to restrict distribution to a small number of pharmacies or to non-affiliates, reaching the limited-distribution specialty tactic the FTC identified.

For a federal annuitant managing a chronic condition, a trusted local pharmacist is a matter of health and safety, not convenience. We commend these provisions and urge their retention. We equally welcome the enrollee protection at 8904(c)(1)(B)(v), which bars PBMs from passing the dispensing fee back to enrollees, and the prohibition at 8904(c)(1)(C) on retroactive and post-adjudication clawbacks that erode pharmacy reimbursement.

We support ensuring community pharmacies are reimbursed at a sufficient rate and are not undercut by PBMs with competing pharmacy interests. The below-cost reimbursement of independent pharmacies documented by the Committee—while PBMs advantage their own affiliates—is unsustainable and has contributed to a wave of pharmacy closures. The reimbursement standard in 8904(c)(1)(A)(i)–(ii), which sets ingredient-cost reimbursement at the National Average Drug Acquisition Cost (or the wholesale acquisition cost where NADAC is unavailable) plus a capped margin equal to the lesser of 4 percent of ingredient cost or $50, and pairs it with a professional dispensing fee equal to the pharmacy's state Medicaid dispensing fee, is a serious and well-intentioned response to that problem.

We would, however, encourage the Committee to examine alternatives to a fixed price floor. A rigid statutory formula—acquisition cost plus a capped margin plus a dispensing fee—guarantees a fair payment, but it can also function as a de facto set price that dampens competition on cost, and its effects may vary considerably across regions and drug categories. We would welcome exploration of mechanisms that guarantee fair pharmacy reimbursement while preserving flexibility and market discipline. Our concern is not with the goal of protecting community pharmacies, which our members value, but with ensuring that reforms do not unintentionally increase costs for FEHB enrollees

Relatedly, we urge that the Congressional Budget Office (CBO) be asked to assess the bill's impact on enrollees' out-of-pocket costs—both premiums and coinsurance. The point-of-sale rebate provision in 8904(c)(1)(A)(iii)(I) is a welcome design: it requires that an enrollee's coinsurance or copayment be calculated on the drug's net cost after rebates, rather than on list price, with the balance of the rebate remitted to the carrier under (iii)(II). But the combined effect of the reimbursement standard, capped margin, and dispensing fee on what enrollees ultimately pay is not self-evident. Because the reimbursement formula could inadvertently become the basis on which a patient's cost-sharing is calculated, a clear CBO assessment of premium and coinsurance effects could give Congress and

beneficiaries confidence that these reforms lower, rather than raise, the costs federal workers and retirees bear.

We support the other important provisions of the bill, including the point-of-sale rebate pass-through in 8904(c)(1)(A)(iii), the inspection-cooperation requirement in 8904(c)(1)(D), and the civil enforcement framework in the new section 8902b—civil monetary penalties, carrier remediation plans, debarment of repeat violators, and hearing and judicial-review rights—that gives these protections real teeth.

We appreciate your attention to these issues and stand ready to work with the Committee to advance legislation that protects patient choice, sustains community pharmacies, and lowers costs for the federal workforce.

If you have any questions or concerns, please contact NARFE Staff Vice President for Policy and Programs John Hatton at 571-483-1267 or jhatton@narfe.org.

Sincerely,

William Shackelford
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