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Testimony of Anthony Wright
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Before the House Energy and Commerce Health Subcommittee

" An Examination of How Reining in PBMs Will Drive Competition and Lower Costs for Patients."

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Chair Guthrie, Health Subcommittee Chair Carter, Ranking Member Pallone, and Health Subcommittee Ranking Member DeGette, thank you for holding this hearing and the opportunity to discuss the need for oversight of pharmacy benefit managers as part of the work to improve access and affordability to prescription drugs and health care in general. Americans need answers for the ongoing affordability crisis that many families face when trying to obtain lifesaving and sustaining medications and care.

It is an honor to be with you this morning. My name is Anthony Wright, and I am the executive director of Families USA, the long-time 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 and health care prices and urge you to continue to tackle the complex network of harmful incentives and abusive practices that underpin the American health care system.

Voters in the November 2024 elections demanded action on affordability, as Americans across the country sounded a clarion call of concern about the cost of everyday necessities like food, housing and health care. In 2023, nearly half of families with commercial health coverage were spending up to 25% of their monthly budget on health care costs.[1] These high costs have left 100 million families grappling with medical debt they may never pay off.[2]

Prescription drugs costs are – as they have been for decades – a major piece of the growing health care affordability crisis. This translates to 30% of adults reporting they are not taking their medications as prescribed due to cost: rationing medications, skipping doses, or not filling their prescriptions at all.[3] An estimated 125,000 deaths a year happen because people don't take their drugs as prescribed, in part due to costs.[4] Whether you take ten medications or none, inflated prescription drug prices impact everyone, as they contribute to rising insurance premiums (20% of which are attributable to high drug prices), higher deductibles, and stagnant wages.[5]

Rising prescription drug and health care costs in general stem from a fundamental misalignment between the business interests of the health care sector — including drug corporations, hospital systems, PBMs, and insurers — and the health and financial security of our nation's families. The unchecked growth of big health care corporations and a lack of oversight over their business practices have led to monopolistic health care practices and prices, reduced access to care, worse health outcomes and lower wages for workers: all of which pose a direct threat to the health and financial security of every American. The health care industry charges excessive health care prices and takes advantage of loopholes that drive inefficient health care spending that has little to do with the quality of care they provide. Prescription drugs are not getting more expensive because manufacturers are creating innovative, more effective drugs; but because drug companies routinely and abusively increase the price for existing prescription drugs far faster than inflation.[6]

While they try to shift blame and scrutiny, big drug companies still bear the lion's share of responsibility for our high drug costs by setting high drug prices in the first place, and we urge

policymakers to build on recent progress to address that problem through protecting and expanding Medicare drug negotiation and advancing bipartisan efforts to stop patent gaming, among other key reforms.

In the absence of federal drug price regulation or price negotiation authority, public and private payers turned to pharmacy benefit managers to negotiate for better prices. 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.[7] PBMs have been one of the only tools that employers and insurers have had to negotiate for rebates and discounts that ultimately ensure families can access prescription drugs at a price they might be able to afford.

But this solution has become part of the problem. PBMs also have a role in driving unaffordable drug prices.[8] They create people have access to, what they will pay for those drugs, and even which pharmacies people can use.[9] any of these middlemen's operations are opaque, leaving patients and plans wondering if they are negotiating for the best cost, quality, and overall value of prescription drugs, or simply trying to get the biggest rebate even if that means others pay more as a result. Put simply, many of the practices that are good for PBMs have the potential to be bad for families' access to affordable prescription drugs, which this Subcommittee is right to investigate.

As Congress takes a closer look at the drivers of unaffordable prescription drugs and other rising health care costs, we urge this Committee and your colleagues to pursue an agenda that provides families relief and reduces wasteful spending without undermining access to health coverage or care. Policies that strip away access to public and private health insurance from our nation's families will only serve to further threaten their financial stability. Instead, we implore policymakers to work together to advance well-vetted, commonsense, bipartisan health care affordability reforms that create a more efficient and transparent health care system while lowering costs for the American people and the federal government, as you did in your laudable work on the *Lower Costs, More Transparency Act* in the 118th Congress.

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 experiencing real-world repercussions every day 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 earn a living wage and secure basic needs.

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 people struggling under the burden of high drug costs: Maureen, 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 described 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 paid $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 ate one meal a day and drank large volumes of water to fill her up, and she gave up going to 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."

Americans are making impossible trade-offs because of our broken drug pricing system. Thanks to the recently enacted Medicare Drug Price Negotiation Program and creation of $2,000 out-of-pocket cap in Medicare, people like Maureen are starting to see some relief as Medicare is finally able to negotiate for fairer prices on some of the most widely used and costly medications, including anticoagulants like Eliquis (apixaban) and Xarelto (rivaroxaban).

But much more needs to be done. Just as high and rising drug prices drive up health care costs for people at the pharmacy counter, they also drive up health care premiums and deductibles, and in turn result in reduced wages for our nation's workers. [10,11,12] For example, if a person with employer-sponsored insurance is charged a very high price for a prescription drug, not only will the individual receiving the drug have higher cost sharing, that high price will be factored in when establishing future premium costs for *all* employees insured in the employer's insurance pool. Additionally, as monthly premiums increase, wages rise more slowly because increased health care costs cause employers to spend more of their annual budgets on employee health care and less on employees' take home pay.[13] In fact, 90% of large employers now say that high and rising health care prices are a major threat to offering benefits to their employees.[14] This is just one way in which we all end up paying the price for the anticompetitive practices of drug manufacturers and PBMs whether or not we take a prescription drug.

For the 60% of U.S. adults currently taking at least one prescription drug, and particularly for the 25% taking four or more, this means paying for prescription drugs multiple times: through monthly premium payments, out-of-pocket costs and co-payments to reach their deductibles, and expenses paid at the pharmacy counter.[15]

The Role Pharmaceutical Benefit Managers Play in High Drug Costs

While big drug companies are responsible for limiting competition and arbitrarily increasing prices year after year, PBMs play a role in increasing costs and limiting access. The first issue is a startling lack of transparency and oversight of the PBM market, which enables anticompetitive behaviors and further exacerbates the fundamental misalignment between the business interests of PBM companies and their corporate owners and the needs of our nation's families.

Part of this business model is that PBMs receive rebates and discounts from drug companies in exchange for formulary placement, or a place on the list of drugs a PBM has agreed to cover.[16]

Importantly, although PBMs negotiate rebates, their revenue is based on a percentage of the drug's list price.[17] 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.[18,19] Pharmaceutical companies then raise both the list price and the rebate year after year, making the overall cost of the drug higher.[20] A 2020 study showed that for every $1 increase in drug rebates there is a $1.17 correlating increase in the drug list price.[21] As result, PBMs are able to substantially increase their profits from rebates on top of their normal revenue, which relies on administrative fees. In some cases, they are not actually lowering the costs of drugs for consumers at all.[22,23]

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.[24] 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.[25,26,27] 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.[28] Or, take the Ohio Department of Medicaid 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.[29]

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.[30] As of 2017, PBM-owned pharmacies represented 46% of the industry's revenue growth.[31] This threatens the ability of independent pharmacies to operate, and jeopardizes access to pharmaceuticals for millions of families living in rural and underserved communities. People are up to twice as likely to visit their community pharmacist as their primary care physician – making this relationship extremely important, particularly for those with chronic or multiple health conditions.[32] Access to community pharmacies is key to improving health outcomes while reducing costs.

The negative impacts of PBM market consolidation are compounded by a significant lack of transparency in their contracts with payers and the rates that they negotiate with drug manufacturers.[33] *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 higher amount to insurers and employers than they pay to pharmacies for generic drugs and pocket the difference – all while flying under the radar.[34]

Now Is the Opportunity for Additional Reform

In the last Congress, bipartisan leaders in both the House and Senate – including those on this Committee – did significant work to build momentum on health care affordability and transparency, including around efforts to rein in abusive PBM practices. We support the Committee's work to address the role of PBMs, and we urge you to continue to take action on the industry's abusive and anti-competitive business practices in the 119th Congress.

There are several commonsense, broadly bipartisan, comprehensive policy solutions that would help to fix abusive practices and broken incentive systems and save consumers and taxpayers money:

- **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 to participate in fully transparent contracting practices. Requiring that the purchasers — whether the plans, employers, union trusts, or other 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.[35,36] Some of these reforms were included in the *Lower Cost More Transparency Act* that passed the House of Representatives in 2023 and are estimated to save **$2.3 billion** over ten years**.** Greater transparency into the business practices that PBMs use in their contracts is a critical 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.
- **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 order 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.
- **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 payer, and policies should also seek to ensure patients share in the savings. 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 based on the final, negotiated price paid. The Committee could go even further to explore ways to eliminate the perverse incentives in the PBM business model that prioritize higher priced drugs by considering proposals to reform the PBM business model such as "delinking" PBM compensation from drug prices altogether or addressing the practice of spread pricing. These 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 reaching the consumer; and begin to effectively reduce the financial burden of prescription drugs on consumers.

The goal and incentives of pharmacy benefits managers must be to negotiate on behalf of patients and payers for the best value, including the lowest price for the most effective medications, rather than a way to use their place in the chain to rake off the most money possible from these lucrative transactions. We urge Congress to push more transparency, more limits on specific abuses and oversight over ownership structures, and more assurances that savings actually accrue to payers and patients.

In addition to acting on the above solutions to address specific PBM abuses, Congress should consider additional reforms to take on systemic abuses across the drug supply chain that have led to high prices. *These are, by far, the most impactful cost-saving reforms that could end the devastating effects of drug companies' greed at the expense of American families' economic stability and health:*

- **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.[37] Practices like "pay for delay" and patent thickets should be eliminated. *Reining in these patent abuses, coupled with other drug price reforms, is estimated to save $4.6 billion over 10 years*.[38]
- **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 a net $63.2 billion reduction in the federal deficit over 10 years resulting from this provision alone*.[39] 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.
- **Expand the number of drugs subject to negotiation and allow commercial health insurance to voluntarily adopt 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.

Beyond PBM and prescription drug reforms, this Subcommittee and your colleagues in Congress have an important opportunity and responsibility to take concrete action and advance pro-consumer reforms to the health care system that improve transparency, promote healthy

competition and curb industry abuses, while protecting the coverage safety net and providing needed relief to working families and patients across the country. These solutions are a part of a proactive and bipartisan affordability agenda that includes:

- Strengthening hospital and health plan price transparency by requiring all hospitals and health plans to disclose their negotiated rates in dollars and cents;
- Ending dishonest hospital billing to ensure that big hospital corporations are not overcharging in outpatient settings;
- Enacting a comprehensive 'same service, same price' policy to stop big hospital corporations from charging more for the same care in outpatient settings;
- Prohibiting anti-competitive contracting terms between providers and insurers; and
- Requiring greater transparency around the role of private equity and corporate ownership in health care to ensure all Americans have access to the health care they need at a price they can afford.[40]

Protecting Coverage is Key to Reducing High Drug Costs

As Congress works to find solutions to our nation's affordability crisis, a foundational goal must be to maintain the important gains the country has made in coverage and access. While millions of families, regardless of insurance type, struggle every day to afford their medication, we know that those without insurance are often paying the highest costs. Without insurance, a person often pays the "usual and customary" price (the full retail price of the drug) which does not have any insurer or PBM negotiation or discount, and tends to be higher than the cost for those with insurance.[41] Uninsured families are far more likely to not take their medications as prescribed due to cost. Research shows 33% of uninsured adults were likely to forgo medications as prescribed, more than double those with Medicaid coverage at 12% and four times as much as those with private insurance at 8%.[42,43]

Our health system works better when more people are included, and in the specific context of this discussion, when more people have coverage for their prescription drugs, they are more likely to take those drugs, and have better health and economic impacts as a result.
We've seen record gains in coverage over the last 15 years, with over 300 million Americans now with insurance,[44] and the uninsured rate falling from 16.1% in 2010 to 7.6% in early 2024.[45] These gains in coverage have ensured greater access to affordable prescription drugs, preventive care, and treatment for chronic health conditions — and Congress must work to protect them. Any policies that threaten access to Medicaid, Medicare, or private coverage through the Affordable Care Act Marketplaces would directly lead to increased costs for families to a magnitude that far exceeds the negative impacts that result from PBM abuses.

Thank you again for holding this hearing today. Consumers across the country are feeling the negative impacts of our nation's affordability crisis firsthand and are eager for Congress to pass an actual affordability agenda that provides relief and reaffirms that their representatives are doing all they can to deliver on their promises to lower costs and improve health care. 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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