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AN EXAMINATION OF HOW REINING IN PBMS WILL DRIVE COMPETITION AND LOWER COSTS FOR PATIENTS

WEDNESDAY, FEBRUARY 26, 2025

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:01 a.m., in Room 2123, Rayburn House Office Building, Hon. Earl L. Carter [chairman of the subcommittee] presiding.

Present: Representatives Carter of Georgia, Dunn, Griffith, Bilirakis, Crenshaw, Joyce, Balderson, Harshbarger, Miller-Meeks, Obernolte, James, Bentz, Langworthy, Kean, Rulli, Guthrie (ex officio), DeGette, Ruiz, Dingell, Kelly, Barragan, Schrier, Trahan, Veasey, Fletcher, Ocasio-Cortez, Auchincloss, Carter of Louisiana, Landsman, and Pallone (ex officio).

Staff Present: Ansley Boylan, Director of Operations; Clara Cargile, Professional Staff Member, Energy; Jessica Donlon, General Counsel; Brian Fahey, Professional Staff Member, Health; Sydney Greene, Director, Finance and Logistics; Jay Gulshen, Chief Counsel, Health; Emily Hale, Staff Assistant; Megan Jackson, Staff Director; Sophie

Khanahmadi, Deputy Staff Director; Chris Krepich, Senior Communication Advisor; Joel Miller, Chief Counsel; Gavin Proffitt, Professional Staff Member, Oversight & Investigations; Seth Ricketts, Special Assistant; Jackson Rudden, Staff Assistant; Emma Schultheis, Clerk, Health; Kaley Stidham, Press Assistant; James Stursberg, Professional Staff Member, Health; Matt VanHyfte, Communications Director; Nick Wooldridge, Professional Staff Member, Health; Lydia Abma, Minority Policy Analyst; Sam Avila, Minority Health Fellow; Jacquelyn Bolen, Minority Counsel, Health; Keegan Cardman, Minority Staff Assistant; Tiffany Guarascio, Minority Staff Director; Saha Khaterzai, Minority Professional Staff Member; Elizabeth Kittrie, Minority Fellow, Health; Una Lee Minority Chief Counsel, Health; and Gayle Mauser, Minority Health Adviser.

Mr. Carter of Georgia. The subcommittee will come to order. The chair recognizes himself for 5 minutes for an opening statement.

Let me begin by welcoming everyone to today's hearing on how reining in pharmacy benefit managers, or PBMs, will drive competition and lower costs for patients.

Before I dive into the policy, I want to take a moment to address the true reason why we are having this hearing today, and that is patients, -- patients like Matthew.

Matthew is a 16-year-old Georgia resident who suffers from a rare genetic disorder. CVS Caremark denied Matthew's access to a life-saving drug that he had been at home for 2 years. As a result of that, Matthew was forced back into the hospital.

Let me be clear. PBMs' greed -- greed -- sent a 16-year-old back to the hospital in critical condition.

While tragic this story is far from unique. So how did we get here? PBMs are the pharmaceutical supply chain's hidden middlemen that are driving up costs of prescription medications, delaying access to necessary treatments, adding hoops for patients to jump through, and robbing hope from patients.

They have only created perverse incentives throughout the drug supply chain. Their extensive market control has only grown due to consolidation and vertical integration, leading to less competition and decreased patient choice.

After nearly two decades of consolidation, the PBM ministry is now dominated by three companies that control over 80 percent of the market -- three companies that control over 80 percent of the market.

They own or are owned by insurers and have vertically and horizontally consolidated their businesses to own doctors, pharmacies, group-purchasing organizations, and more. One of them even owns a bank.

We have heard directly from our constituents that the harmful and

anti-competitive tactics of some PBMs have only gotten worse and that congressional action is desperately needed.

We have heard a constant stream of reports that some PBMs are reimbursing independent pharmacies less than the pharmacies they own. For example, a Mississippi audit revealed that Optum pays its own stores up to 22 times -- 22 times -- what it pays independent pharmacies for the same drug.

How are you supposed to stay in business when your competitor makes 2,200 percent more than you do for the exact same service?

The answer is, you don't. Unfortunately, you don't.

In 2023, there were over 300 independent pharmacy net closures, almost one per day. Unfortunately, that trend continued in 2024.

Pharmacists are some of the most accessible and highly trusted healthcare professionals. Yet PBMs are putting pharmacies out of business and removing patients' access to care.

We now have pharmacy deserts in rural and underserved communities. That is affecting the accessibility, affordable, and quality of healthcare for all Americans.

As I say all the time, whether you are a Republican, Democrat, or independent, we all want the same thing. We want accessible, affordable, quality healthcare.

Recently the Federal Trade Commission released its second interim report which found that PBMs charged significant markups for cancer, HIV, and other critical specialty generic drugs, by thousands of percent, and many others by hundreds of percent.

Another egregious example of PBMs' abusive taxpayer-funded programs is the United States Postal Service health plan. In an audit released in March of 2024, the Inspector General of the U.S. Office of Personnel Management found that Express Scripts overcharged the health plan and the Federal Government nearly $45 million -- $45

million.

Thankfully President Trump is committed to holding PBMs accountable. I commend him and I look forward to working with this administration to drive solutions that lower costs for patients at the pharmacy counter.

The House Energy and Commerce Committee has made common sense PBM reform policies a bipartisan process. Last Congress, this committee advanced bipartisan legislation that saved significant taxpayer dollars in Medicaid managed-care programs and for the first time in Medicare Part D, enforces reasonable and relevant contract terms to support pharmacies' ability to serve patients in addition to delinking PBM compensation from list price.

Further, this committee championed reporting requirements which would increase transparency by shining the light on the opaque drug pricing system that is driving up drug spending for patients and employers in addition to harming pharmacies.

Americans deserve and expect protection from inflated prescription drug costs, force pharmacy closures, and barriers to healthcare access.

I look forward to working with my colleagues on both sides of the aisle to enact these meaningful PBM reforms for patients like Matthew who are suffering at the expense of PBMs' abusive tactics.

I want to now recognize the gentlelady from Colorado, Representative DeGette, for 5 minutes for an opening statement.

[The prepared statement of Mr. Carter of Georgia follows:]

******** COMMITTEE INSERT ********

Ms. DeGette. Thank you so much, Mr. Chairman, and here is something that we can agree on. Republicans and Democrats agree we must reign in PBM abuses. We know how PBMs play games to pad their bottom lines at the expense of consumers.

We know how they take money out of State and Federal taxpayers' pockets when they charge a Medicaid plan more than a drug they pay for in a pharmacy. This isn't news.

I see a number of pharmacists here in the audience, and I want to welcome all of you to our committee hearing. Thank you for being here. You put a face on this for us.

So you might be wondering, if we all agree, why haven't we gotten PBM reform signed into law yet. Last Congress, Democrats and Republicans held more than a dozen hearings in committees in the House and Senate, including three in this committee, to discuss PBMs.

So to me, this feels like deja vu all over again. The need to reform the prescription drug system is clear, including cleaning up how PBMs operate and stopping abuses of their market system at the cost of consumers.

So that is why this committee passed PBM reforms last Congress, and that is why we took the work this committee did and folded it into December's government funding bill. We were on the brink of passing historic reforms.

And then, at the behest of Elon Musk, Republicans balked. So let me be really clear. Donald Trump and Elon Musk ordering congressional Republicans to renege on a bipartisan, bicameral agreement is the reason PBM reforms are not law today.

This agreement included PBM reforms, but it also included bipartisan wins, like reauthorizing and adding new funding to the special diabetes programs, encouraging innovation in pediatric, rare-disease drugs, and reauthorizing CDC support for maternal mortality review committees.

Mr. Chairman, I have here in my hand a 17-page list of the policies that the Democrats and the Republicans in the House and Senate agreed upon last year, that have not yet been signed into law because Elon Musk and Donald Trump forced everybody -- or forced the Republicans to remove them from the continuing resolution last year, and I would ask unanimous consent to place this in the record.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Carter of Georgia. Without objection.

Ms. DeGette. Thank you. So here we are again, we are just talking in a topical hearing yet again about reforms that we all agree upon, rather than just passing those reforms and moving on to other pressing business.

Instead of this reiteration of previous work, this subcommittee could be examining what effect indiscriminate mass layoffs at HHS will have, including slowing down drug and device approvals and hindering our ability to assure the safety of nursing home residents.

We could be talking about the threat of avian flu which grows every day, and what this administration is doing to prevent it from becoming a pandemic but also getting eggs back on our shelves.

We could be talking about the impact gutting Medicaid for working families to pay for tax cuts the wealthy would have, and we could be looking ahead to oversight of the PBM reforms that should have been law last December.

Thousands of my constituents have contacted my office worried about these issues in the last few weeks, and I am sure everybody in this room has been hearing the same.

But the majority knows all these questions that are important to our constituents are embarrassing to the administration, and so we are not talking about them, which is very frustrating to me.

So, Mr. Chairman, I want to ask you, if you don't mind, what is the plan of the majority to get that bipartisan plan, including PBM reform, and also all of these other important healthcare extenders that we agreed on last year to the floor?

Mr. Carter of Georgia. At this point, we are uncertain whether we are going to -- excuse me -- at this point, we are uncertain as to exactly what we are going to do, but I can assure you that it will be cleared up soon.

Ms. DeGette. One of my concerns is some of the parts of your PBM bill, some of the important parts will not be in budget reconciliation, and so I think -- and you and I have discussed, Mr. Chairman, the idea of bringing up a bill that would be the PBM reform and all of these Medicaid extenders and putting it on suspension. And so I hope you are considering that, Mr. Chairman.

Mr. Carter of Georgia. Oh, absolutely. Absolutely.

Ms. DeGette. And as I told you, and I am going to say this publicly for the record, it if you did that, I am going to guarantee you every Democrat would vote for that on suspension.

Mr. Carter. Thank you.

Ms. DeGette. So I am going to urge you to bring it up before March 15th, because that is when these provisions all expire.

Mr. Carter of Georgia. Understood. Thank you.

Ms. DeGette. I yield back.

[The prepared statement of Ms. DeGette follows:]

******** COMMITTEE INSERT ********

Mr. Carter of Georgia. The gentlelady yields. I now recognize the chairman of the full committee, Chairman Guthrie, for 5 minutes for an opening statement.

The Chair. Thank you and I appreciate the ranking member's comments on that. You know, to be able to move these outside of reconciliation means we are going to have to work together. We are going to have to do in a bipartisan way, and hopefully we are going to find that pathway to do it in a bipartisan way.

I just want to thank the chairman and the ranking member for this hearing today. Our first Health Subcommittee hearing was to discuss the illicit drug threats ravaging our communities, in particular, the continued threat of fentanyl.

I am happy to report that after that hearing concluded, we are able to pass the Halt Fentanyl Act in strong bipartisan support on the House floor. And today we are continuing our fight to lower healthcare costs for everyday Americans and especially our seniors.

Last Congress, the Committee on Energy and Commerce worked to advance legislative solutions to make our health system more transparent -- that is what the gentlelady was just referring to -- to empower patients.

The cause of this work included holding pharmacy benefit managers accountable by making their business practice transparent and passing legislation to cut unnecessary spending on prescription medications in Medicare and Medicaid.

As chairman of the full committee, I have heard from many of our members of this committee loud and clear, and I can tell you it is a priority of mine to ensure these commonsense and bipartisan policies become law.

Today over 80 percent of prescription drug benefits are managed by just a few vertically integrated PBMs. As a result, patients have less choice when they fill their prescription and often times have less access to affordable prescription medications.

Data shows pharmacies that are not affiliated with the largest PBMs are frequently reimbursed less than their affiliated competitors. I remain concerned by PBMs using their market power to hurt our independent pharmacies and restrict patients' access to pharmacies.

I want to remind members of the subcommittee that over 26,000 local retail and community pharmacies have closed in the past 15 years.

The Government Accountability Office recently studied how the current system of rebate negotiation is working for Medicare beneficiaries. They characterized the problem by stating that rebates do not lower beneficiary payments and that higher cost drugs generally result in higher beneficiary payments.

In GAO's analysis of the top 100 most highly rebated drugs in Medicare, for 79 out of these, out of a hundred, drugs, seniors ultimately paid substantially more than their Part D plans paid for the drugs.

Today I hope we are able to come together again and focus on our bipartisan solutions to rein in spending at the pharmacy counter for America's families.

I appreciate the Health Subcommittee for holding this hearing, and I will yield the remainder of my time to vice chair, and my friend from Florida, Mr. Dunn -- Dr. Dunn.

[The prepared statement of The Chair follows:]

******** COMMITTEE INSERT ********

Mr. Dunn. Thank you very much, Mr. Chairman, and let me just say thank you to our witnesses for being here today. It is apparent to me that PBM reform is ripe to address. Last Congress, this subcommittee did excellent work to advance policies that would shed light on the inner workings of PBMs and provide transparency into their practices.

Prohibiting spread pricing in Medicaid and delinking PBM compensation from the list price of drugs are simply commonsense reforms that I am confident enjoy bipartisan support as you have heard today.

I am excited to continue that work and thank Chairman Carter for his commitment to ensuring that the PBM reform remains a priority for this subcommittee.

With that, I yield back.

The Chair. I yield back.

Mr. Carter of Georgia. The gentleman yields. I now recognize the ranking member of the full committee, my friend from New Jersey, Mr. Pallone, for 5 minutes for an opening statement.

Mr. Pallone. Thank you, Chairman Carter.

Today committee Republicans are holding a hearing on pharmacy benefit managers, PBMs, at the same time they are trying to take healthcare away from millions of Americans.

The bottom line is that if people don't have healthcare, they are not going to get drugs at all and PBM reform won't even matter to them.

Republicans continue to push a budget resolution that would direct this committee to cut at least $880 billion from programs within this committee's jurisdiction, and we all know the vast majority of these cuts will come out of the Medicaid program.

Republicans are also hiding the true price tag of their Medicaid cuts. Since their

budget resolution is over 9 years rather than 10 now, the size of the Medicaid cuts will actually be closer to a trillion dollars over 10 years. And that is hundreds of billions of dollars more than an entire year of Federal Medicaid funding.

And we have the Freedom Caucus demanding that the House find an additional $500 billion in spending cuts which will almost certainly come from Medicaid if they prevail.

Now, once again, Republicans are showing they are willing to rip healthcare coverage out of the hands of everyday Americans to provide tax cuts to Elon Musk and his billionaire friends.

The people who will suffer are children, seniors, and people with disabilities, pregnant women, and families trying to get by. The shocking part is that many of these people live in Republican districts.

For instance, Representative Obernolte has one of the highest percentages of Medicaid beneficiaries in the country, with 47 percent of the people living in his district relying on Medicaid.

Over 31 percent of the good people living in Chair Guthrie's district rely on Medicaid as a vital lifeline, with 42 percent of kids in his district relying on Medicaid and CHIP.

Now, Republicans will claim that they want to cut the Medicaid program because they want to address fraud, waste, and abuse and that no one's going to get hurt. But that is absurd. You simply cannot take that amount of money out of the Medicaid program and not hurt the people who rely on it.

Medicare is, in fact, a lean program, despite picking up the tab for cost of care that no other payer covers. Per-person spending is a fraction of the cost of private insurance or even Medicare.

The reality is that gutting State Medicaid budgets will lead to fewer people with coverage, fewer benefits for the people who manage to keep their coverage, worse access to care, higher healthcare costs for everyone, and more medical debt, and hospitals and community health centers will be forced to close.

And Republicans are turning their backs on the American people to hand out giant tax breaks to their billionaire friends.

Now, turning to the topic of PBMs, I believe we should be working together to bring greater transparency to PBM practices so we can lower the cost of prescription drugs for consumers.

Increasing transparency of PBM practices can help employers, consumers, and the American people better understand how drug prices are ultimately determined at the pharmacy counter.

Last December, we had a bipartisan, bicameral agreement on a number of policies to reform PBMs and to address the lack of transparency within the market.

But as you know, Speaker Johnson reneged on the agreement after Elon Musk voiced his opposition to it. The agreement he walked away from would have helped lower prescription drugs for consumers, rein in abusive practices that lead to higher drug costs, and help employers better understand drug price information in order to effectively reduce healthcare costs.

The package also included a number of other critical components such as funding for community health centers, teaching health centers, and 2 years of telehealth in Medicare.

But again at Elon Musk's direction, House Republicans pulled the bipartisan agreement, leaving these important bipartisan solutions on the cutting room floor.

And now we are 2 weeks away from the continuing resolution expiring. And like

Chairman Carter, who I respect, says he is going to have a plan soon, to bring up the package with the PBMs again.

But I have to be honest, I am only going to believe it when I see it, right? It is more likely, in my opinion, that you have some plan, and Elon Musk just waves the magic Musk wand once again, and that is the end of PBM reform.

I might sound cynical, but I saw it happen, and I see it every day with Musk, and that is what I think is going to happen.

But we are ready to work with you on PBM reform and try to pass this entire package again, but I will believe it when I see it.

And with that, Mr. Chairman, I yield back the balance of my time.

[The prepared statement of Mr. Pallone follows:]

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Mr. Carter of Georgia. The gentleman yields. This concludes member opening statements. The chair would like to remind members that pursuant to committee rules, all members' opening statements will be made part of the record.

I want to thank all of our witnesses for being here today and taking the time to testify before the subcommittee. Our witnesses today are, first of all, my good friend, Mr. Hugh Chancy, a pharmacist and owner of Chancy Drugs; Mr. Shawn -- excuse me -- Mr. Shawn Germminger -- Germminger? Is that okay.

Mr. Gremminger. Gremminger.

Mr. Carter of Georgia. Gremminger. Okay. Gremminger, everybody -- Mr. Shawn Gremminger, a president and CEO of the National Alliance of Healthcare Purchaser Coalitions; Mr. Anthony Wright, executive director of Families USA; and Dr. Matthew Fiedler, senior fellow in economic studies at the Brookings Institute on the center around health policy. I thank all of you for being here today.

Per committee custom, each witness will have the opportunity for a 5-minute opening statement followed by a round of questions from members. The light on the timer in front of you will turn from green to yellow when you have 1 minute left.

I now recognize Mr. Chancy for 5 minutes to give an opening statement.

STATEMENTS OF HUGH CHANCY, RPH, PHARMACIST AND OWNER, CHANCY DRUGS; SHAWN GREMMINGER, MPH, PRESIDENT AND CEO, NATIONAL ALLIANCE OF HEALTHCARE PURCHASER COALITIONS; ANTHONY WRIGHT, EXECUTIVE DIRECTOR, FAMILIES USA; DR. MATTHEW FIEDLER, PHD, JOSEPH A. PECHMAN SENIOR FELLOW, CENTER ON HEALTH POLICY, BROOKINGS INSTITUTION; SHAWN GREMMINGER, MPH, PRESIDENT AND CEO, NATIONAL ALLIANCE OF HEALTHCARE PURCHASER COALITIONS; ANTHONY WRIGHT, EXECUTIVE DIRECTOR, FAMILIES USA; AND DR. MATTHEW FIEDLER, PHD, JOSEPH A. PECHMAN SENIOR FELLOW, CENTER ON HEALTH POLICY, BROOKINGS

INSTITUTION

STATEMENT OF HUGH CHANCY, RPH

Mr. Chancy. Chairman Guthrie, Ranking Member Pallone, Subcommittee Chairman Carter, Vice Chairman Dunn, Ranking Member DeGette, and members of the committee, my name is Hugh Chancy. I am a pharmacist and co-owner of Chancy Drugs and a former president of the National Community Pharmacist Association.

I greatly appreciate the opportunity to share with you my experience as a pharmacist and a small business pharmacy owner about how PBMs have negatively impacted my ability to care for my community.

My family has been in the pharmacy services in south Georgia since 1966, when my father, Hubert Chancy, opened our original Chancy Drugs location.

Chancy Drugs specializes in compounding, in specialty packaging, and enhanced clinical services, and we employ over a hundred people.

I am proud of the work that Chancy Drugs has done over the decades, offering essential healthcare to patients, but this important work is being jeopardized by the PBMs that determine which patients have access to our pharmacy, the prices that they pay, and with reimbursement pharmacies receive, and the medications that are on formulary.

The top three PBMs control over 80 percent of the market. Due to vertical integration, they steer patients to their own affiliate pharmacies. Many patients who are required to use PBM-owned mail order pharmacy, receive their medications late or sometimes not at all.

Recent reports from the Federal Trade Commission found PBMs steer patients to use specialty drugs at their affiliated pharmacies, allowing the PBMs to generate more

than $7.3 billion in revenue.

PBMs are also engaging in anticompetitive tactics, like cost inflation, spread pricing, low pharmacy reimbursements, coercive contracts for nonaffiliated pharmacies, leading to higher costs for government, limited patient choices, and increasing pharmacy deserts.

PBMs claim that they save money for the State-funded health plans, like Medicaid-managed care, yet numerous reports show something very different -- excessive amounts of taxpayer dollars funneled to PBMs.

Eliminating spread pricing and moving to a transparent, cost-based reimbursement saved West Virginia and North Dakota $54.4 million and $17 million respectively in their Medicaid program.

Kentucky identified $123 million of spread pricing annually, precipitating a wholesale change to their Medicaid pharmacy model.

Meanwhile, Ohio's Attorney General -- or Auditor General found over $224 million of spread pricing. Likewise, Illinois, Virginia, and Maryland have also found egregious sums of spread pricing in their States. Do you see a theme?

That is why Congress must pass Medicaid-managed care pharmacy payment reform and ban spread pricing by requiring a hundred percent pass-through to the pharmacy of the ingredient cost and the professional dispensing fee, which the CBO has scored a savings of $2 billion.

On top of this, our contracts with PBMs are take-it-or-leave-it, especially in Medicare Part D. Pharmacists are not able to negotiate better terms in our contracts, in direct opposition to what the PBMs have sworn in Congress.

Some of the most basic, yet most life-sustaining medications are often under-reimbursed, and we are rarely paid for the actual cost to dispense.

Georgia's professional dispensing fee for Medicaid pays $10.63, but it is not unusual for me to get paid only a nickel and oftentimes receive no dispensing fee at all for Part D patients.

In addition to the Medicaid-managed care reform, I support the legislative provision requiring reasonable and relevant contracts between PBMs and pharmacies and Medicare Part D, quelling PBM exploitation.

Both policies were included in the negotiated healthcare package at the end of last year. Altogether, the PBM reform policies included in that package saved nearly $5 billion and are a huge step forward in protecting pharmacists and patients from PBM greed.

It is critical these bipartisan, bicameral policies get passed and as quickly as possible. Because of the PBMs, we have lost nearly 2,700 retail pharmacies in the last 4 years. If the PBM industry continues to go unchecked, thousands more, like Chancy Drugs, could go out of business, further reducing access and increasing costs.

In conclusion, I want to end with a personal story that gets to the heart of independent pharmacy.

My community was devastated by Hurricane Helene, and our town was without power for days. In this time, my pharmacy in Valdosta served as a disaster relief hub to collect and deliver vital supplies like water, baby wipes, formula, and toiletries.

Now you tell me, can a PBM do that?

I implore you to take immediate action and pass commonsense legislation to rein in harmful PBM practices to pharmacies and patients alike.

We are not asking for favorable treatment. We are asking for a level playing field. I encourage lawmakers on both sides to continue to work in a bipartisan manner to pass these reforms that save $5 billion.

If not, we will see more deserts -- pharmacy deserts and less access to care.

I applaud this committee for its bipartisan efforts to shine light on the PBMs, and I am happy to answer any questions. Thank you.

[The prepared statement of Mr. Chancy follows:]

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Mr. Carter of Georgia. Thank you, Mr. Chancy. The chair now recognizes Mr. Gremminger for 5 minutes.

STATEMENT OF SHAWN GREMMINGER, MPH

Mr. Gremminger. Thank you, Chairman Carter, Ranking Member DeGette, and members of the subcommittee. It is an honor to speak to you today on behalf of the National Alliance of Healthcare Purchaser Coalitions. We are the voice for more than 40 regional and local purchaser coalitions which together represent employers, private companies, public entities, labor union trust funds, and others, covering more than 45 million covered Americans.

I am here to provide the perspective of self-funded employers and purchasers on the immediate and pressing need for PBM reform. In particular, I am here to voice our strong support for Sections 901 and 902, of Title 9 of H.R. 10445, the original version of the continuing resolution released in December.

Those two provisions provide for real transparency to employers and purchasers and mandate full pass-through of all rebates and discounts negotiated by PBMs from the initial purchase of the drug by their wholly owned GPO, all the way down to the sale to the final purchaser.

Over 100 million people receive their healthcare through self-funded employer health plans governed under ERISA. Self-funded employers directly contract with PBMs to manage their pharmacy benefit.

Given that self-funded employers directly pay for the costs of their pharmacy and medical benefits and hold the risk of variation in plan spending, employers essentially hand PBMs their credit card and say, Go out and spend our money wisely.

Since ERISA's creation in 1974, self-insured employers and purchasers have been held to a fiduciary standard, to oversee plan assets set aside by their employer on behalf of covered individuals.

The Consolidated Appropriations Act of 2020 raises the bar for self-funded health plans, requiring them to pay fair prices for goods and services.

Unfortunately, over the past several decades, the PBM market has become highly dysfunctional to the detriment of employers, purchasers, and working families.

I want to focus on two key market distortions -- wasteful formulary placement and deeply rooted opacity.

While clearly against the best interests of employers, purchasers, and patients, PBMs will often place drugs with limited clinical value and higher net costs at preferred tiers on an employer's formulary.

Wasteful formulary placement occurs when a PBM is able to extract higher discounts or fees not passed on to employers for manufacturers seeking to expand market to the overpriced or low-value drug.

Section 901 of the bill in front of you requires PBMs to disclose and provide a rationale for formulary placement and disclose when formularies are changed.

Perhaps the most pernicious flaw in the PBM market is the level of opacity between PBMs and their plan sponsor clients. In general, plan sponsors are unable to determine the initial price of a drug paid by the GPO, the extent to which negotiated rebates are passed on to them, and whether there is a differential in pricing between wholly owned pharmacies and those by other entities.

Section 901 provides vital information to employers to answer those key questions. Let me say this very clearly.

Most self-funded employers to this day do not know how much money they are

spending on any specific drug. Given that, how can employers act as prudent fiduciaries under ERISA.

I want to give you a specific example of one of the challenges employers face. Earlier this week I spoke to the benefits leader of a large, self-funded plan with more than 200,000 covered lives.

They are currently conducting an RFP on a new PBM. This benefit leader asked the applicant PBMs if they would be willing to provide claims-level rebate information.

All of the big PBMs refused to do so.

The legislation before you would mandate it.

Before I end, I want to address some of the claims you will hear from the big PBMs. The PBM industry will tell you that employers are happy with their vendors and don't want reforms.

If that is the case, I will ask you why 89 percent of the employers in the National Alliance Survey of 188 large and mid-market employers said they support PBM reform.

If employers are happy with their PBMs, then why are the Nation's leading employer representatives -- ourselves, the ERISA Industry Committee, the American Benefits Council, the HR Policy Association, and many others on record supporting this legislation?

The PBM industry will tell you that employers are able to engage in real negotiations with employers to design their contracts the way they want them.

If so, then why is one of the largest, most sophisticated, most aggressive purchasers in our network unable to get answers to a simple question -- how much am I paying for each drug?

The PBMs will tell you they already pass on all or nearly all rebates and discounts. If so, then why are they so dogged in opposing a bill mandating they do what they already

claim to do?

There is a reason that big PBMs are willing to make false claims to you. They cannot stand the thought of a functional market in which empowered employers and purchasers can demand better prices.

The legislation before you represents the most significant reform to the PBM industry in history. It is fundamentally rooted in establishing a more transparent, freer, fairer market. The big PBMs will do everything in their power to stop that from happening.

Thank you again for holding this hearing, and I look forward to your questions.

[The prepared statement of Mr. Gremminger follows:]

******** COMMITTEE INSERT ********

Mr. Carter of Georgia. Thank you, Mr. Gremminger. The chair now recognizes Mr. Wright for 5 minutes for an opening statement.

STATEMENT OF ANTHONY WRIGHT

Mr. Wright. Thank you. Chairman Guthrie and Carter, Ranking Members Pallone and DeGette, on behalf of Families USA, the long-time healthcare consumer advocate, thank you for the opportunity to discuss the need for transparency and oversight of pharmacy benefit managers as part of broader efforts to advance affordability and access for families seeking life-saving medications and care.

In last year's election, Americans made it clear their concerns about costs, and while they have talked about the price of eggs for months, they have been screaming about the price of prescription drugs and healthcare for decades.

Nearly 3 in 10 adults report rationing, skipping doses, or not filling their prescriptions at all because they can't afford it. An estimated 125,000 people die each year as a result of not taking their medications as prescribed, in part, due to cost.

Inflated prescription drug prices affect everyone, as they contribute to rising insurance premiums, higher deductibles, and stagnant wages for workers. Drug companies seek to shift the scrutiny and blame, but ultimately they are the ones who take advantage of our system to set high initial prices and then routinely increase them far faster than inflation.

To counter these ever increasing costs, Congress should continue its bipartisan efforts to stop the gaming of patents and also to protect and expand Medicare's ability to negotiate drug prices.

In the absence of broader government regulation or negotiation of drug prices,

payers like insurers, employers, and union trusts turn to pharmacy benefit managers as an important tool to help them bargain for the best value.

Yet the PBMs' solution has sometimes become part of the problem, building a business model where their own revenue depends on high drug prices.

Many of these middlemen's operations are opaque. As was stated, not even employers who hire PBMs know the actual drug prices they are paying or what rebates the PBMs are receiving.

This leaves patients and plans wondering if the PBMs are negotiating for the best cost, quality, and value of the prescription drugs or just simply to try to rake the most money off the top.

These issues get bigger as mergers lead to more consolidation of PBMs, insurers, and pharmacies. As was stated by the chair, now the top three PBMs control 80 percent of the market, making it less competitive, allowing prices to rise, undercutting independent pharmacies, reducing patient choice, and access for families in many rural and underserved communities.

This impacts people like my mom who until her passing recently was a diabetic and breast cancer survivor who took ten different drugs, not unlike many seniors with a burgeoning bill.

She benefitted from a small pharmacy around the corner from her home in the Bronx, glad not to have to trek to the chain store in the next neighborhood over.

I was grateful for that community pharmacist who sometimes checked in on her and hand-delivered her medications.

That such options are unfairly undercut by PBMs seeking to steer patients to not necessarily the most affordable or convenient choice which might make sense, but to the big chain that they own.

Families USA recommends that this committee take action to address PBM abuses and reduce prices in four ways: One, reduce -- I mean, sorry -- require greater transparency of PBM negotiations, their operations, and their ownership structure; two, increase oversight and regulation of PBM consolidation at the FTC and other agencies; three, explore ways to eliminate perverse incentives for PBMs to prioritize higher priced drugs; and four, seek to ensure all savings paid to PBMs are passed through to payers and consumers.

We strongly support PBM reform as part of the broader affordability agenda on drug prices and healthcare costs.

However, we must also convey the context that any benefits of PBM reform would be exponentially overwhelmed by negative impacts of massive Medicaid cuts that this Congress is currently considering, from the loss of coverage to health impacts to increasing costs.

The uninsured don't have a PBM or a plan or anyone to negotiate drug discounts. As a result, the uninsured pay more for prescription drugs than any anyone else in the entire world and are twice as likely to forego meds as those with Medicaid coverage.

And that neighborhood pharmacist in the Bronx, who might be undercut by PBM practices, may likely go under if Medicaid faces major cuts as contemplated. And that would be true in rural areas as well.

Rather than taking a chainsaw to healthcare programs, the PBM policies discussed today recommend a careful, commonsense, and consumer-oriented approach and would yield some initial savings and provide transparency to inform further reform.

Like the laudable Lower Costs, More Transparency Act in the last Congress that this committee worked on, PBM reform is a way that policymakers can work together to advance well-vetted bipartisan reforms to the healthcare system that improve

transparency, fix misaligned financial incentives, and lower the costs for the American people and the Federal Government.

Americans are asking policymakers to make care more affordable, not less. PBM reform can and should be passed as part of a broader affordability agenda to provide real relief on healthcare costs that Americans are demanding.

Thank you for your time for holding this hearing.

[The prepared statement of Mr. Wright follows:]

******** COMMITTEE INSERT ********

Mr. Carter of Georgia. Thank you, Mr. Wright. The chair now recognizes Dr. Fiedler for 5 minutes for an opening statement.

STATEMENT OF MATTHEW FIEDLER, PHD

Dr. Fiedler. Chairman Carter, Ranking Member DeGette, and members of the subcommittee, my name is Matthew Fiedler, and I am a health economist and a senior fellow at the Brookings Institution.

I am grateful to be here to discuss how the market for PBM services is working, as well as the potential, and limits, of recent reform proposals.

A core problem with the PBM market is that competition is weak. By some estimates, the three largest PBMs control almost four-fifths of the market.

Various frictions in this market also dampen competition. The complexity of the contracts between PBMs and their clients, who may be insurers or self-insured employers, can make comparison shopping hard.

This may be particularly true for self-insured employers whose core expertise typically lies outside of healthcare.

Switching PBMs is also challenging since it requires a plan's enrollees to adapt new formulary rules and pharmacy networks. As a result, PBMs wield market power that they can use to demand prices in excess of their costs of delivering services and, in turn, earn excessive profits.

One way that policymakers have considered addressing this problem is by requiring PBMs to give their clients additional information about how the plans they manage are operating.

Greater transparency would likely reduce the price of PBM services by making it

easier for payers to comparison shop, enforce existing contracts, or press their PBMs for better terms.

It is important to recognize, however, that the savings would likely be relatively modest. The Congressional Budget Office has estimated that transparency provisions, like the ones this is committee considered last year, would reduce PBM revenue by around $900 million per year, with that effect fading over time.

As a comparison point, PBMs' pretax profits totalled about $18 billion in 2022.

Another strategy that policymakers have considered is changing how payers compensate PBMs, such as by borrowing PBMs from retaining manufacturer rebates, delinking PBM compensation from drug prices, or prohibiting PBMs from using spread pricing.

Importantly these types of restrictions are unlikely to directly reduce the price of PBM services. Barring PBMs from collecting certain forms of compensation, such as manufacturer rebates, would likely just lead PBMs to collect more compensation in other forms such as administrative fees.

Changing the structure of PBM/payer contracts could affect payers by changing how PBMs manage the underlying drug benefit. Although these effects could be both positive and negative.

Consider, as an example, barring PBMs from retaining rebates. This change would eliminate PBMs' incentives to prefer drugs with large rebates over the drugs with the lowest net prices when they construct formularies, which would reduce drug spending.

But it could also reduce PBMs' incentives to negotiate aggressively for larger rebates, which could increase spending.

Delinking and spread pricing proposals can present similar tradeoffs.

Before I move on, I want make two caveats. First, even where reforming how PBMs are compensated doesn't benefit payers, it might still benefit whoever ultimately pays the plan's premium via interactions with medical loss ratio requirements.

But this would depend on the circumstances and on how payers adjust to the new rules.

Second, reforming PBM/payer relationships is unlikely to have much effect at all in settings where the PBM and the payer are part of the same company. Notably, that is now the typical scenario outside the self-insured employer market.

In closing, I want to make one broader point. If the goal is to make prescription drug coverage cost less or work better, PBM reform is one piece of the puzzle, but it may not be the most important one.

PBM profits amount to only several percent of overall drug spending. So even eliminating those profits would only moderately reduce the overall cost of drug coverage.

If policymakers want to achieve larger cost reductions, that would require reducing the prices received by other actors in the supply chain, especially drug manufacturers.

Policymakers may also be concerned that high cost sharing and onerous utilization management protocols make it hard for patients to get the drugs they need. But where this occurs, that is often not because PBMs are failing payers, but instead because payers' incentives are poorly aligned with patients' interests.

This may be because payers have incentives to avoid high-cost enrollees or because it can be hard for consumers to access a health plan's quality when they pick a plan or choose an employer or for other reasons.

But addressing these types of problems requires reforms to how insurance markets operate, such as improvements to risk adjustment systems or direct regulation of

plan benefits, not reforms to PBM/payer relationships.

Thank you again for the opportunity to testify. I look forward to your questions.

[The prepared statement of Dr. Fiedler follows:]

******** COMMITTEE INSERT ********

Mr. Carter of Georgia. Thank you, Dr. Fiedler. I thank all of you for your testimony today. We will now begin questioning, and I recognize myself for 5 minutes.

Let me begin by asking unanimous consent to submit letters from organizations representing patients, providers, pharmacists, small businesses, and advocates in support of PBM reform.

No objection?

Without objection.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Carter of Georgia. The big three PBMs, vertical integration with health insurance conglomerates enables them to exploit conflicts of interest to drive prices up, quality down, and independent pharmacies out of business.

For instance, the top three PBMs steer patients and the most lucrative prescriptions to their affiliated pharmacies and away from independent competitors.

The FTC's latest interim staff report on PBMs found that the big three reimbursed their affiliated pharmacies by up to 7,736 percent more for specialty generic drugs compared with independent competitors. Unbelievable.

Take the drug pirfenidone, for example. It can be purchased without insurance for $200. However, seniors on Medicare filled pirfenidone 85,000 times in 2022 at an average cost of $8,000 per prescription.

You can buy it for $200. They were charging $8,000 per prescription. 85,000 times they did that. If you do the math on that, you see that is a big number.

Mr. Chancy, I want to start with you. Afterall, I am like you. I stood behind that pharmacy counter for many years, and I was the one who had to tell the patient how much the medication was.

I was the one who watched a senior citizen try to make a decision between buying groceries and buying drugs. I was the one who watched the mother in tears as she tried to figure out how she was going to pay for her child's medication, and you do that as well.

I want to hear from the person that is standing behind the pharmacy counter like yourself. Can you highlight other areas of inefficiencies in our healthcare system where PBMs have impacted independent pharmacies and therefore harmed patient care?

Mr. Chancy. Yes, there is several things that come to mind. One of the things that they are doing now is, they are requiring brand when there is a generic available, and they are making Part D recipients pay the brand copay.

You know, another area, we have -- they are controlling access to the pharmacy. We have one patient. She is 92 years old and her husband is 95, and they are blind. She is legally blind, and we do specialty packaging so that she knows what time to take her dose and her meds. And she wants to be as independent as possible because she is afraid that her husband is going to die and she is going to be left alone.

Well, TRICARE actually took that away from us. They narrowed the network, removed us from it, and now they are making him drive like 20 minutes to a pharmacy when he is 95.

So we were giving them a great deal of healthcare, and they took that opportunity away from us and put it to one of the big box chains.

But the unfortunate thing is, this is a patient that needed care.

I think there is also a waste that we see in mail order. As you have already mentioned, we had one patient that we were filling specialty drugs. They demanded it go to mail order. We later found out that mail order was charging $300 over what they were paying us.

I had a colleague that reached out to me with some information yesterday, and this is still bothering me. He accidentally -- his pharmacy got turned on to a mail order reimbursement rate the 1st of January this year.

So we compared the first 6 weeks of this year with the first 6 weeks of last year, and on average, he was getting 17 times more profit on the mail order pharmacy reimbursement.

You know, that is something you hope that is not right, but it is, because it is proven by the FTC and also by the 3-Axis study in Washington State.

Mr. Carter of Georgia. Well, thank you for that, and thank you for that information. These are real people. These are real examples that you deal with every

day, and we thank you for that.

You know, I want to tell you about my Drug Transparency in Medicaid Act that is part of the original continuing resolution -- that you had mentioned, Representative DeGette -- in December, that includes a ban to prevent PBMs from retaining revenue from spread pricing.

So are you familiar with spread pricing, Mr. Chancy? Can you talk about that for just a second?

Mr. Chancy. Yes, I am. I think that it is really interesting -- and I still don't understand it -- why they actually pay themselves -- pay the chains more than they pay us, and then they pay themselves more than they pay the chains.

But recently, I think it was in January, we had a lady, her insurance rolled over into a new plan, but she didn't tell us. So we filled it on her old plan, and she was charged $135. Her insurance paid $135 on her plan.

Well, a few weeks later, she gets a bill from the PBM saying that she owes $400. So our pharmacist said, well, we only got paid $135. So she got a three-way call with the pharmacist and the PBM, and they said, Well, you owe $400.

And she said -- the pharmacist said, Well, you only paid us $135. Well, this is what the plan got charged.

So that is spread pricing. $135 is what it cost to get the prescription. $400 is what the plan paid.

Mr. Carter of Georgia. Thank you, Mr. Chancy, for that testimony.

At this time, I recognize the ranking member, Representative DeGette, for 5 minutes of questioning.

Ms. DeGette. Thank you so much, Mr. Chairman, and I want to thank all of our witnesses for coming today.

Mr. Chancy, I hear very similar stories from my community pharmacists in Colorado, and I will just say, the reason why they are forcing people to go to the chains is because in many cases they own the chains. So they can get more money.

I want to talk with you for a minute, Mr. Wright, about some of the things that you mentioned, because last Congress, we really worked and now our first hearing in this subcommittee, it is on PBM reform because we are trying to make reforms that will make a difference in people's lives.

But these reforms are only going to work for people who have healthcare coverage. And so I made up a little chart, and the chart I made up shows that Republicans who are on this subcommittee have 3,359,524 people in their districts who are on Medicaid right now.

And so I want to ask you, Mr. Wright, do you know how many people nationally are covered under the ACA's Medicaid expansion option?

Mr. Wright. Roughly around 21 million.

Ms. DeGette. 21 million. Now, what would happen if those folks didn't have Medicaid, if the expansion was eliminated? What would happen to those folks' ability to afford insurance?

Mr. Wright. I mean, by definition, the folks that we are talking about make less than $22,000 as an individual, $44,000 as a family of four, and so private coverage would largely be dramatically unaffordable for them.

They would become uninsured, and as a result, live sicker, die younger, be one emergency away from financial ruin, both health and economic --

Ms. DeGette. So these people make less than $22,000 a year, you're saying, right?

Mr. Wright. As an individual. More if --

Ms. DeGette. And so if they didn't have either private insurance because they couldn't afford it, or Medicaid, what would that do to their prescription drug cost if they had to just buy it without insurance?

Mr. Wright. They would be paying the rack rate, the list price, which often is the most expensive price in the world.

Ms. DeGette. Do you have an example?

Mr. Wright. And hundreds or thousands -- I mean, if you are an MS patient, those drugs cost tens of thousands of dollars. If you are like my mom who had a list of ten drugs, that adds up real quick and --

Ms. DeGette. Like to what? I mean, give me an example.

Mr. Wright. Hundreds -- I mean, it depends on the person, but hundreds or thousands of dollars, and as I said, the people who are uninsured take their drugs, like, adhere to their drugs less than half of what people on Medicaid do.

Ms. DeGette. Yeah. You know I am the co-chair of the Diabetes Caucus with Congressman Bilirakis, and it is the same thing with insulin. If people have insurance or Medicaid, then their insulin is covered. But if they have to pay private costs, it could be $3- or $400 a bottle. And they die if they don't take it.

Now, yesterday my colleagues on the other side said it is not fair for the Federal Government to pick up a greater part of the tab for the expansion population than for other Medicaid-eligible individuals.

But so what would happen if the government ended that commitment to the current Federal assistance for the Medicaid expansion?

Mr. Wright. If the Federal Government reduced how much its share of any population, and there is lots of populations that are at different match rates depending on State, depending on aid category, but that is just basically a cut to the State, and then

the State basically has to make a Sophie's Choice about whether they raise taxes or cut services.

Ms. DeGette. But what if you have a State like Colorado that constitutionally precludes us from raising taxes?

Mr. Wright. Exactly. And so then you are in the choice -- and I was a State health and consumer advocate for three decades, and there is no other choice. You either -- in healthcare, you either cut people, you cut benefits, or you cut provider rates and have that impact.

Ms. DeGette. Okay. I want to talk about one last thing because we keep hearing that the way we are going to save $880 billion is, we are going to cut waste, fraud, and abuse. So I want you to talk about how much fraud there is in Medicaid.

Mr. Wright. I mean, it is a very lean program, probably your best bang for buck within the healthcare system. In terms of beneficiary fraud, it has been estimated at less than one-tenth of 1 percent.

Ms. DeGette. Does that equal $880 billion?

Mr. Wright. No.

Ms. DeGette. What is roughly that?

Mr. Wright. I mean, it would be -- it would be fraction -- it would be fractional, and, again, that is not -- there is other ways to get at fraud, but $880 billion requires massive cuts to coverage, to benefits, and to direct payments to providers.

Ms. DeGette. Thank you. I yield back.

Mr. Dunn. [Presiding.] The gentlelady yields back, and Chairman Guthrie of the full committee is recognized.

The Chair. Yeah, it is a beneficiary waste and fraud, doesn't mean provider waste and fraud, and we give a lot of examples of that. And someone doesn't

understand that you don't have to cut those kind of benefits. That is not an accurate statement.

So I will start with Mr. Gremminger. Much of the conversation on PBMs has been focused on the rebate model, and I question whether this model creates perverse pricing incentives.

Do you believe this model has the unintended consequence of artificially inflating the cost of prescription medications?

Mr. Gremminger. Unquestionably. The rebate model, which is sort of deeply embedded in the way that we pay for drugs in the United States, is -- provides all the incentives toward higher list prices and higher overall prices and very little incentive to actually creating a lower list price and lower rebates.

Ultimately I think -- I mean, this is going to be very challenging, but ultimately I think we need to actually move completely away from a rebate model in which we are paying a set price -- not a government set price, but a market-based price on a drug that is based on its clinical value, over what else is in the market, as opposed to, you know, something that incentivizes very high list and then large rebates to try to get on to formularies.

The Chair. Okay. Thank you. And how can PBM transparency legislation this committee marked up, how can the PBM transparency legislation this committee marked up and passed the House of Representatives last Congress help patients?

Mr. Gremminger. Yeah, it is going to allow employers for the first time to actually understand exactly how much they are paying for each drug, right? So right now, we have no idea.

At this point, you know, one of the big concerns in the PBM industry is we only have three big ones that represent 75, 80 percent of the market. They often have pretty

similar offerings.

But the biggest problem is, we can't even tell -- if you can't tell how much you are paying for each drug, you can't tell which PBM is better for you, you can't tell what other model is better for you.

The kind of transparency that we are going to be able to see is going to give us a better indication of where we are getting real value and where we are not.

It is going to give us a better idea of whether there are alternative PBM models or alternative contracts that employers can drive toward.

It is going to actually create something closer to a fair market which we believe will actually reduce ultimately the price of drugs.

Mr. Fiedler made the suggestion that this particular bill would have a sort of marginal impact on the overall price of drugs. I actually think the CBO and economists are underestimating what the impact could be, because they are going to start creating real competition in a market that really lacks any now, which we think actually will end up reducing the overall price of drugs because PBMs will actually start competing on getting bigger deals rather than competing on getting bigger rebates.

The Chair. Thank you.

Mr. Chancy, the Government Accountability Office recently found that 79 of the most highly rebated drugs in Medicare, seniors are required to pay more out of pocket by more than $15 billion than their plan sponsors for these drugs.

How do you believe that legislation to delink PBM compensation from list price and Medicare Part D can help to alleviate the pressure seniors are facing resulting from the current rebate model?

Mr. Chancy. Well, I think through transparency we are able to follow the numbers and realize where the waste is. I think that is going to help us to bring those

prices back down.

The Chair. But the delinking, do you think that delinking PBM compensation from the list price, how is that going to specifically help?

Mr. Chancy. I am not sure.

The Chair. Okay. In some cases, Mr. Chancy, a generic medication is placed on a specialty drug tier. Does this mean that the generic medicine is more clinically effective than a branded competitor?

Mr. Chancy. No.

The Chair. And if not, what are the implications of this generic medication being placed on a specialty tier from the perspective of patient cost-sharing?

Mr. Chancy. That is a good question. It is not always clear why it is done.

The Chair. Do you think there is a difference?

Mr. Chancy. No.

The Chair. So thank you on that. And on that, and so we talk about, we had some questions on Medicaid, so waste, fraud, and abuse. It is not always fraud. Sometimes our system allows systems to move -- this is not quite specifically to you, but people seem to think that it is just less than one-tenth of a percent that people maybe if you say fraud, then you have providers that we know that have fraud, and so it is not fraud, but is it waste or abuse if a State -- and I was in State government before, and we tried to figure this out -- figured out ways to match the Federal match by taxing providers, getting the Federal match and giving it back to them.

You know, one percent of that is $55 billion. So we are not talking about small money, and we are talking about drawing down the Federal Government. So when everybody thinks it is just a -- we are not talking about small numbers, and there is opportunities to take care of waste, fraud, and abuse in Medicaid. And I think we all

should want to take care of waste, fraud, and abuse in Medicaid.

So I will yield back. Thank you.

Mr. Carter of Georgia. [Presiding.] The gentleman yields. The chair now recognizes the ranking member of the full committee, Representative Pallone, for 5 minutes of questioning.

Mr. Pallone. Thank you, Chairman Carter. I am obviously deeply concerned about the Medicaid cuts that Republicans are considering. And yesterday at our oversight plan markup, you know, I repeatedly heard Republicans on the committee refer to so-called waste, fraud, and abuse in Medicaid. Chairman Guthrie just mentioned it, actually.

But as they provide this misinformation, which I think is what it is, Republicans are seemingly trying to convince even themselves that they can somehow cut a trillion dollars from Medicaid and the American people won't suffer.

That is just not the case.

And I want to stress to everybody and maybe to the public, you know, you can't just say, oh, we are going to cut waste, fraud, and abuse, and that is going to save us $880 trillion, right? You have to actually get into what you are going to do.

You have to say, I am going to cut back on 90 percent from Medicaid expansion, I am going to reduce the FMAP, I am going to do X, Y, and Z.

You just can't say, oh, we will cut waste, fraud, and abuse. When they actually do the bill, they are going to have to say what they are cutting.

So in the many proposals on the House Budget Committee's list of options -- this is for Dr. Fiedler, if you will -- on the many proposals on the House Budget Committee's list of options to cut Medicaid funding, do any of these Medicaid proposals, you know, like the chairman's per capita or the other things I mentioned with FMAP, do any of those

things, if you just do those things, actually cut down on actual waste, fraud, or abuse?

Dr. Fiedler. In my view, these types of proposals are not targeting fraud and abuse. There are broad changes in who is eligible for Medicaid or how costs are shared between the Federal Government and the States, not proposals aimed at targeting particular problematic expenditures.

You know, what is wasteful is ultimately a value judgement, but the policies being targeted -- Federal support for Medicaid expansion, policy changes that make it easier for low-income seniors to get help paying their Medicare premiums, or support for Medicaid generally -- are in my view, fairly high-value use of public dollars.

Mr. Pallone. So, Dr. Fiedler, if they do cut the matching rate to States for Medicaid expansion or just the FMAP, you know, for States even for regular Medicaid, what is the effect of that? How is that going to impact State budgets, for example?

Dr. Fiedler. So if you take the specific example of expansion, if the enhanced match for expansion were to go away, the current expansion States would need to come up with $40 to $50 billion a year to fill in that budget hole.

And so the question is, what are they going to do? You know, in principle, States could raise taxes, they could cut other spending. You know, education is typically the largest line item in State budgets. The transportation, public safety, those things could be on the table.

But in practice, my expectation is many States would conclude they can't make the math work, and instead they would conclude they have to drop expansion. And, you know, the expansion population is 14 million people. So it is hard to imagine that we are not talking, at the end of this, about many million people becoming uninsured.

RPTR MCGHEE

EDTR HUMKE

[11:01 a.m.]

Mr. Pallone. Thank you. Let me go to Mr. Wright. Can you describe who is covered by the Affordable Care Acts Medicaid expansion. For example, how does Medicaid expansion support parents and families? How does losing health coverage affect the health and economic security of these families? And I guess -- well, let me ask you that, and then the next question.

Mr. Wright. The AC expansion allowed for basically every American under 133 percent of the poverty level. Again, that $22,000 a year, $44,000 for a family of four to be able to access basic coverage, primary preventative care. It includes parents. It includes -- it was a patchwork before. This now includes parents. Includes adults without kids at home. And it is essential for having access to care. Otherwise, those folks simply did not have the means to find coverage in other ways, and we are relying on basically getting care in the most inefficient expensive ways in the emergency room or through other means if they did it all.

Mr. Pallone. I don't want to keep -- I want everyone to understand. The reason I am not focusing on PBM reform is not because I don't agree with it. I am totally in favor of the bipartisan issue that we obviously put together on a bipartisan basis, but if you don't have health insurance, you don't have healthcare, you are not going to have prescription drugs and, you know, you are going to talk about PBM reform and they are going to say, Congressman, what are you talking about? I don't even have health insurance.

So last question. How will Medicaid cuts affect the bottom line of small

businesses whether employees are without healthcare and looking to them?

Mr. Wright. Well, first of all, there's a lot of small businesses who have Medicaid coverage. A lot of small businesses, you know, they may do the next big thing, but until then, they actually have very limited income, and so Medicaid actually provides a baseline, a foundation for our entrepreneurial folks.

If you are a diabetic, you can't take the leap to try to do something without coverage to get that life-saving care. And again, a lot of small businesses have their own -- their workers tend to be uninsured, tend to be lower income, and it is desperately needed. If those workers can't come to work if they are sick, can't be productive members of their workforce if they are uninsured.

Mr. Pallone. Thank you. Thank you, Chairman Carter.

Mr. Carter of Georgia. Gentleman yields. The chair now recognizes the vice chair of the full -- of the subcommittee, Representative Dunn, for five minutes of questioning.

Mr. Dunn. Thank you again, Mr. Chair, and thank each of our witnesses for being here today. I want to focus on the Medicare Part D linking. To do this I am going to highlight a common medication. Gleevec. Gleevec is a drug that is used to treat a number of different cancers, including forms of leukemia in children and adults. The generic for Gleevec became available in 2016, and according to data public available through data.cms.gov, in 2022, CMS spent over $90 million on the branded version of Gleevec in the part D program. That is six years after the generic was available.

In 2022, CMS purchased over 455,000 doses of branded Gleevec and spent $249.58 per dose. Per dose. However, a one month supply, 30 pills of generic, can be purchased online for $34.50. That is $1.15 per dose compared to $250 per dose that CMS was paying. This means CMS could have saved $113 million in one year alone on

Gleevec. Add that together with the Pirfenidone that Chairman Carter mentioned, you have got an $800 million plus savings two times in one year.

I understand that over last several years PBMs have moved away from compensation based on rebate retention to compensation based on administrative fees. This merely renames the same sin. It's not different, despite the shift of fees that PBMs charged are often still tied to medicine list prices and are certainly motivated by fee income. Ranking the link between PBM compensation and the price of medicines will help fix misaligned PBM incentives to drive up the cost for patients, employers, and CMS. But we must also make sure these sins don't simply migrate into other areas of the supply chain.

Fixing PBMs misaligned incentives to prefer higher priced medicines, higher priced medicines, could increase the coverage -- fixing this could increase the coverage of lower costs of alternatives, including generics and biosimilars and generate savings for employers, plants, fosters, and CMS.

I also want to mention concerns that I have of PBMs are using the system to steer patients to their affiliated specialty pharmacies. The first FTC interim staff report also looked at Gleevec as a case study on PBM abuses and the report found that 2022 for the PBM affiliated pharmacies, commercial reimbursement rates for generic Gleevec were 40 times higher than the national drug acquisition costs average, and Medicare part D reimbursement rates were 36 times higher.

When the same drug was purchased from an unaffiliated pharmacy, commercial payments were 80 to 90 percent less and part D payments were 30 percent less.

There is massive, massive savings in this for CMS patients, the government, everybody. This is gravely concerning. Misaligned incentives are contributing heavily to the vertical integration of this committee and other committees that Congress have

highlighted.

Mr. Chancy, do you believe that delinking PBM fees from list prices necessary to prevent PBMs from favoring medicines with higher prices and do you believe this can help curb consolidation to PBM industry? Mr. Chancy?

Mr. Chancy. Would you repeat the question.

Mr. Dunn. Microphone.

Mr. Chancy. Would you please repeat your question.

Mr. Dunn. Yes. Do you believe that delinking PBM fees from list prices is necessary and, in fact, effective?

Mr. Chancy. I don't know all the details about delinking. I do know that it will --

Mr. Dunn. They are competing with you, Mr. Chancy. You really need to know your enemy.

Mr. Chancy. I do understand that. I do know that the PBMs are getting a discount off of that.

Mr. Dunn. They sure as heck are. Let me add a second question again, Mr. Chancy. Research suggests that generic medicines in part D were placed on non-preferred generic drug tiers almost 60 percent of the time in 2022. What role do you believe rebates played in this trend and how can delinking compensation from list price ensure seniors have access to cheaper clinically effective generic biosimilars?

Mr. Chancy. Anytime that we see something that we don't understand, we know that there is rebates on the back side of that.

Mr. Dunn. Yeah, you're right. Mr. Gremminger, how do you believe our PDM delinking policy in Medicare part D will help employers in the commercial market?

Mr. Gremminger. So as you know, Mr. Dunn, the delinking policy did not directly

apply to the commercial market. I think that was done intentionally to sort of maintain the ability for some flexibility in the commercial market. I do think that, you know, often we will see Medicare policy will flow down to a risk of plans in commercial markets, so -- but I am hopeful we will see a trend against linking fees to the price of drugs in the commercial market, and certainly it is something that, particularly with better transparency that is built into your bill, we would be able to demand and try to change the way that we are paying our PBMs now.

Mr. Dunn. Thank you very much. I think this is an exciting area to explore. There is a lot of savings to be had here, Mr. Chairman. Don't give up. Thank you. I yield back.

Mr. Carter of Georgia. Gentleman yields. The chair now recognizes the gentleman from California, Dr. Ruiz, for five minutes of questioning on this hearing on how the rein in PBMs will drive competition and lower costs for patients.

Mr. Ruiz. Thank you, Mr. Chairman. As an emergency physician, I came to Congress to improve the affordability and accessibility of healthcare for my patients and the communities that I serve. A large part of that includes lowering the cost of prescription drugs. In the ER, I would treat patients and sometimes send them home with prescriptions. However, if a patient can't afford their medication, they are not going to follow through and buy them.

I oftentimes got called by the pharmacist saying that this patient could not afford this medication and if I can prescribe them perhaps less expensive or maybe even less effective medication. Not taking the medicine they are prescribed can lead to worse health outcomes and increase their chances of ending right back in the emergency room.

Increasing transparency for pharmacy benefit managers is a good idea. It is a bipartisan approach that has the potential to address rising prescription drug costs. Mr.

Gremminger, how does a lack of transparency raise drug prices for patients?

Mr. Gremminger. It enables PBMs to play many games. Often we find that they are sort of one step ahead of us. Every time, you know, you have heard five years ago, eight years ago, rebates and discounts were sort of the biggest way that they made money. Increasingly, they moved away from rebates and discounts and they've added on fees that are difficult to understand.

One of the things that your bill would is at least try to be more transparent about what those fees are and what sort of value add there is, give the employers an opportunity to decide is this something that I am ready to pay for or is this something that I don't really need.

Mr. Ruiz. Okay. Most prescription drug plans have a formulary where the plan is list its covered drugs in a range of tiers from low cost generics to more expensive specialty drugs. PBMs can design these formularies and determine which medications patients have -- can have and at what cost. So Mr. Gremminger, how would increasing transparency help consumers better understand what is on the formulary and result in savings?

Mr. Gremminger. It is a terrific question. So as you had suggested, most PBMs have a formulary, sometimes a relative complicated formulary. We will also see PBMs change the status of a drug on a formulary multiple times per year, sometimes even multiple times per week, depending on what the size of the rebate is. So if they get a rebate differential, they will move something from tier three down to tier one and back again.

Your bill, the bill in front of us, would require PBMs to disclose what is on their formulary, at what tier, and then actually provide a justification for why it is sitting there giving employers better information to decide is this appropriate or is it not. Some of

the larger employers out there have instituted what are called waste free formularies where they really sought to try to do this now.

Mr. Ruiz. Thank you. You know, transparency is always a good idea. It allows sunshine on the working of programs and of government. It prevents corruption. That is why this committee needs to acknowledge the more pressing matter at hand that my Republican colleagues would rather skirt around. The fact of the matter is while this hearing is about transparency for PBMs as a way to lower costs for patients, Republicans are not transparent in their plot to strip many Americans, their own constituents included, of their Medicaid health coverage to pay for billions in tax giveaways to billionaires. Medicaid provides health coverage for 80 million Americans. That is 32 percent. Because my constituents are hard-working, underresourceed families, about 42.1 percent of my constituents rely on Medicaid for their health coverage.

Important health services for beneficiaries are at stake and I have heard from some community health centers and hospitals in my district that have expressed concerns about what would happen to their ability to serve patients should these proposed Medicaid cuts go into effect. Community health centers provide essential health services in underserved community. This is not a blue or red issue. Medicaid cuts would not just hurt residents in blue states. They will hurt people in Republican districts too.

This is about people. It is about Americans. It is an American issue. I urge my colleagues to be more transparent themselves and let's work together in a bipartisan manner to protect Medicaid. None of the other measures we take to lower prices and increase affordability of care matter if our constituents are losing access to care.

With Medicaid, the cost of medicines is less. Without it, people will pay much, much, much more out of pocket or go without their medicine. Indeed, it will make

America sicker and America poorer again. Thank you, and I yield back.

Mr. Carter of Georgia. The gentleman yields. The chair now recognizes, excuse me, the gentleman from Virginia, Representative Griffith, for five minutes of questioning.

Mr. Griffith. Mr. Chairman, I heard earlier this morning Ranking Member Pallone say that based on the budget bill, Energy and Commerce was going to cut a trillion dollars out of Medicaid. While the budget bill does set a goal of $880 billion for the Energy and Commerce Committee to find in savings, it does not say that it has to come out of Medicaid. And to paraphrase former Chairman John Dingell of this very committee, our committee's jurisdiction includes everything on planet earth that you can see in a photo taken from outer space.

We have thousands and thousands of options in which to look for savings in the federal budget. And in fairness, all these statements about a trillion dollars, and I have seen it online this morning being replicated, it is a talking point on the Democrat side to scare the American people, and it is nothing more than disinformation.

Now to the matter at hand. Mr. Gremminger, I agree with you on CBO being wrong. I agree with you that we need more transparency. I agree with you that we need to move away from the rebate model. But hold that thought. I will be back in a minute.

Mr. Wright, I got this simple little bill called the Fairness for Patient Medications Act, which in the last Congress was H.R. 3285. Now what it says is that if a patient goes to pay for medication, they won't pay more in their co-pay than the insurance company or the PBM has negotiated for that price with all the rebates. They won't pay any more than what the insurance company is paying for that medication so that it doesn't become a profit center for the insurance company or the PBM. It looks like to me that is good policy. Are you aware of the issue?

Mr. Wright. I am aware of the issue.

Mr. Griffith. And can you explain any rational reason why a consumer oftentimes that is not making a whole lot of money, or even as you said in your opening statement maybe uninsured, is going to pay more for the medicine than their insurance company? I guess not uninsured, but why an insured who is paying for their insurance or their employer is paying for their insurance, would pay more for the medicine than the insurance company or the PBM is paying? Can you explain that to me?

Mr. Wright. You shouldn't ask me. You should ask the insurers. I would -- the argument that I have heard is that to the extent that the insurer, in some cases the PBM, is negotiating a formulary, a broader range of drugs are included, and then the question of where do various drugs appear in certain formularies as part of the negotiating power of the ensuring PBM.

We think negotiating power is a good thing, but if it ends up actually increasing out-of-pocket and co-pays for patients, that is not good, and so we would be happy to look at the bill.

Mr. Griffith. I appreciate that. You know, in 2018, we had bills in Congress. We also had bills that passed earlier than the Congressional bill. In the Virginia legislature, Senator Todd Pillion, who I happen to represent, introduced the bill to say that pharmacists could tell you if you showed up -- and I had a constituent who had this problem prior to 2018. They showed up one time and their insurance, there was some kind of a glitch, and the pharmacist said well, you can pay me this amount over the counter. And she goes, well, that is more than -- that is less than what my co-pay is. And he goes yes, ma'am, I can't tell you that, but since your insurance is currently lapsed for a day or two, I can inform you that you can pay this, so she never used her insurance again for that medication. She just paid cash to the pharmacist. That doesn't make

any sense to me. Todd Pillion put the bill in and said pharmacists could actually talk -- there used to be a gag order -- and the pharmacist could talk about it.

Now, Mr. Gremminger, when Todd passed that bill, Senator Todd Pillion of Virginia passed that bill, WRIC ABC news of Richmond labeled their article on it as Lawmakers Take Aim at Scam Driving up Prices -- Driving up Drug Prices. Last year your organization opposed my bill. We agree on a lot of things. I am trying to figure out why your organization would be in favor of a scam driving up drug prices. Please tell the American people.

Mr. Gremminger. Mr. Griffith, to be honest, I do not recall that we opposed your bill. I would be delighted to come back and talk to you more about it, because I think on face it makes a lot of sense.

Mr. Griffith. I appreciate that, because last year you all opposed it, and I just for the life of me can't figure out why a patient should pay more, an insured patient pay more than what their insurance company is paying for, what they have negotiated to pay for. And part of it comes back to the rebate issue, which I agree with you we probably need to move away from.

Mr. Chairman, I appreciate this hearing and I appreciate you and I yield my time back.

Mr. Carter of Georgia. The gentleman yields. Chair now recognizes the gentlelady from Michigan, Representative Dingell, for five minutes of questioning on PBM reform.

Mrs. Dingell. Thank you, Mr. Chairman, and as you know, this is one of my deep passions and I freely strongly about it as you do, although I would just say to my colleague if Mr. Dingell were here, he would tell -- he taught me a lot. And the first question I am going to ask is when you look at the world and you look at everything that you are talking

about, where is the $800 billion going to come from? And the only thing we talk about is Medicaid.

And when we want Medicaid, we here are worried about what those kinds of cuts are going to do to Medicaid. So we are really glad if you are not going to cut Medicaid and you are not going to hurt people, but what are you going to cut? And I know you are not going to answer that question, but I thought I would ask that question.

And I will even build on what he said and say negotiating power for PBMs gives the PBMs their cut and screws the parent every single time. And that is one of the problems. And there still is a gag order, and the only way a lot of us learn about this is we go talk to pharmacists that aren't taking care of us but somebody says will give us the answers and they will tell you they -- I go and buy my pills a whole lot cheaper just even at cost than covering them by co-pay, and there is something wrong with that system. So as you can tell, I think they have been allowed to operate unchecked for too long.

I want to work with my colleagues to solve this issue. We had an opportunity to provide critical checks on PBMs last year in the continuing resolution, and as my colleague, the ranking member said it -- said, bipartisan solutions were included in the text, such as bans on spread pricing, clarity and enforcing part D contract terms and establishing surveys to be able to hold PBMs accountable to deliver fair prices. But at the last minute, Elon Musk and the Republican party opted to back out on the deal.

I hope that the hearings today are a sign that we are really going to do it and we are not going to let anybody threaten us but we are really going to get it done this time, Mr. Chair. You know I want to work with you on this.

Back home I am hearing from far too many Michiganders, especially seniors, who can't conveniently access their prescriptions they need due to the exploit of PBM practices complicating access to the local pharmacies they depend on. They are an

invaluable resource in underserved communities, and not even in underserved communities. I get lot more answers from my local pharmacist, and she -- I get educated a lot, and we have got to ensure that they remain open and competitive.

So I have No PBMs Act Legislation, and this bill would implement common sense reforms to the PBM industry that will put a stop to some of the tactics that distort prices, harm pharmacies, and drive profits at the expense of patients. It will strengthen PBM accountability and ensure Americans can get the medications that they need closer to home and at pharmacies they trust.

Mr. Chancy, through your experience as a pharmacist, how would ensuring that PBMs must align with Medicare plans for prescription drugs allow better access for seniors who are trying to fill the prescriptions?

Mr. Chancy. So your question was how does -- would you say that last line again.

Mrs. Dingell. How would ensuring that PBMs have to align themselves with Medicare plans for prescription drugs? How would it help seniors have better access who are trying to fill their prescriptions?

Mr. Chancy. Well, I think the -- a good mentor of mine shared with me where there is mystery, there is margin, and there is way too much mystery with the PBMs. And I think that transparency is going to help to clear up a lot of those issues. There is too many games and there are too many hoops.

Some of the life-saving medications they have to go through all kind of prior approvals and a lot of things, and it is just really to prolong a patient not getting their medication, and unfortunately, the patients pay for that. I think that the relevant and reasonable contract terms between the PBMs and the pharmacies will clear up a lot of the issues that we are dealing with today.

Mrs. Dingell. Thank you.

Mr. Fiedler, PBMs have restricted access to patients choice of pharmacy and medicines that are right for them. Back in my district, I hear from far too many Michiganders, especially seniors who face complications accessing the local pharmacies they depend on because of exploitive PBM practices. I am going to show you an example.

Last night I forgot my inhaler because I only have one because my local pharmacy can't fill it because I can only get the new medicine the doctor prescribed at one of the big ones.

So Mr. Fiedler, you mentioned in your testimony that a small number of firms control a large share of the PBM market, which allows them to demand higher prices to earn excessive profits and I suspect control the supply. What reforms can be made to reform the competitiveness of the PBM market?

Dr. Fiedler. So it is a challenging problem. I think one promising strategy is greater transparency. I think the bigger problem is that is probably somewhat limited solution, and so if you really want this market to be more competitive, you need more PBMs, and the question is how do you get there. Breaking up existing PBMs is probably a challenging undertaking, but I do think there is some room for antitrust regulators to be looking at new entrant PBMs and making sure that those PBMs aren't being acquired by incumbent PBMs in hopes of building a more competitive market over time.

Mrs. Dingell. I am out of time, but I didn't think the creation of more PBMs would be an answer to anything. And with that, I will yield back.

Mr. Carter of Georgia. The gentlelady yields. The chair now recognizes the gentleman from Florida, whose team last night was beat by the Georgia Bulldogs. Representative Bilirakis for five minutes of questioning. Staff wrote that on there. I am just reading what staff wrote.

Ms. DeGette. You can move to take his words down if you want.

Mr. Bilirakis. Let's compare records, Mr. Chair. This is important stuff too.

Mr. Chancy, the Florida legislature recently passed legislation requiring any willing pharmacy language in addition to PBM transparency requirements. This language requires that PBM to include any pharmacy in their network as long as certain conditions are met giving seniors more care options and affordable options. Again, more care choices and affordable options. Excuse me.

One of the policies originally included in the December CR, and of course it was removed at the end, was language to enforce any willing pharmacy in Medicare part D. Can you share how this language will help your patients and seniors and Medicare.

Mr. Chancy. Yes, sir. I think that is a great question. I had a patient just a few weeks ago, she came in on a Friday afternoon around 3:30, 4:00, had her children with her, and she was heading out of town. She said, you know, can I go ahead and get the prescription filled. She dropped it off at the drive-thru and she said I need to go to the bank and come back. Within ten minutes after we filled the medication, she had not come back yet. We got a call from the PBM and they told us that we needed to reverse that claim, back it out, and transfer that claim to Walgreens in the next city.

And our pharmacy, well, said she came to us, she chose us to fill this and you have approved it. And they said well, if you don't do this, you are going to be in violation of your contract. So my pharmacist backed it out and transferred the prescription to Walgreens, and so the onus of having to explain something that we didn't understand was put on us when she came back.

She was in a hurry to get out of town. But that is the type things that are terrible for the patients. They are terrible for us. And it takes away from the care and convenience of the patient. And it also limits access.

Mr. Bilirakis. Thank you.

Mr. Gremminger, can you further detail why building off Florida's PBM accountability law with the PBM transparency policy we have marked off is important for employers at the federal level.

Mr. Gremminger. Certainly. So a couple of thoughts. We have a fundamentally broken market when it comes to the PBMs and the interaction with the drug companies. At some level, the two sides who like to hate each other, are really playing very much the same game. Drug companies are winning. PBMs are winning. Drug companies have justifications to have higher list prices.

PBMs have justifications to have larger rebates and larger fees that are tied to the price of the drugs. The transparency that is provided under your bill would finally allow employers to actually understand how much money the PBMs are making on each drug, how much money the employers are paying on each drug, how much money the chain or retail or mail order pharmacies are making on the drug, whether or not those fees are actually higher for chain or retail and mail order pharmacies owned by the PBMs as opposed to going to one of Mr. Chancey's units.

It would provide the kind of information that employers could actually use to price shop, identify lower cost options, better drugs, and ultimately reduce some of the gaming that we see in the commercial market.

But one of the things that is appealing about your bill is that it does not tell employers specifically how they have to structure their market, right? It says that the PBMs have to pass on all rebates. It still allows for spread pricing.

It still allows for value-based purchasing. It still allows for a lot of different design that PBMs and employers could actually use in sort of a fair and free and transparent market to actually look for better options for drugs.

Mr. Bilirakis. Thank you. Mr. Chancy -- I still have some time here.

Mr. Chancy, I've been a long time supporter of policies to improve the quality of life for diabetic patients and I co-chair, as Ms. DeGette said, the diabetic conference -- caucus. I have become aware of a pharmaceutical manufacturer launching two different versions of an insulin biosimilar, one branded and one unbranded at two different price points in order to land on a PBM formulary.

In many cases, the higher price branded reference product was exclusively covered by plan sponsors completely limiting access to a cheaper therapeutically equivalent biosimilar or requiring patients to go through unnecessary step therapy in order to access a cheaper biosimilar version of the drug.

Can you explain what this means for seniors who rely on insulin in terms of what they are paying at the pharmacy counter. What can we do to address this particular issue? Again, for Mr. Chancy.

Mr. Chancy. Another good question. I think that when -- it doesn't make any sense when there is a cheaper generic version and the preferred drug on the formulary is a brand name drug and they are having to pay a higher brand co-pay for that drug. So, you know, we know that that is rebate driven. So that is unfair to the patients and it takes the cheaper version away from them.

Mr. Bilirakis. Very good. Thank you.

Mr. Chairman, you know, in your particular bill, you have this particular language that is going to be very helpful to the consumer, and it came from the University of Florida School of Pharmacy I am assuming, so it is Florida law.

Mr. Carter of Georgia. The gentleman yields.

Mr. Bilirakis. Very good. Thank you.

Mr. Carter of Georgia. The chair now recognizes the gentlelady from Illinois,

Representative Kelly, for five minutes of questioning on PBM reform.

Ms. Kelly. Thank you, Chair Carter and Ranking Member DeGette, for holding today's hearing and thanks to all the witnesses for your participation. I want to start by pointing out what you have heard already, but it is very important that last Congress, this committee already worked on solutions for the American people regarding PBM reform, including commercial market, PBM transparency, part D delinking, and transparency and a ban on spread pricing and Medicaid.

And yet in December 2024, after a Tweet by Elon Musk, the deal worked out by the four corners of the chambers was taken down. So here we are again all because some of my colleagues don't want to stand up for the well-being of all Americans. Nevertheless, I look forward to working with this committee ahead of the March deadline to see those already negotiated reforms to the finish line.

When we pass the American rescue plan, a provision of my legislation, the Care for Moms Act was included to extend Medicaid post-partum, post-partum coverage from 60 days to one full year. This extension has been a crucial lifeline for mothers and their infants, and I am proud to say that this is no longer a temporary measure.

The expansion of Medicaid postpartum coverage is a critical part of our efforts to address the maternal health crisis in this country as the Medicaid program covers about four in ten births in the United States. Dr. Fiedler, what role does Medicaid play in ensuring pregnant women and children have access to healthcare?

Dr. Fiedler. So Medicaid covers about four in ten births in this country, which is, you know, larger than any other single pair, and so it plays a critical role in ensuring they can both access the healthcare they need but also ensuring financial security, right?

One of the core roles of health insurance is making sure that when you do have big health expenses that is not a big, you know, hit that keeps your family from meeting

other needs, which we know, you know, families expecting kids have a lot of other needs on their budgets.

Ms. Kelly. Thank you. Currently 49 States and Washington, D.C. have already made this extension permanent. Even Republican leaning states like Alabama, Tennessee, Kansas, Oklahoma, and Nebraska have enacted postpartum Medicaid extension legislation. With cuts to Medicaid funding, states will have to come up with significantly new resources of funding or more likely find ways to cut Medicaid. This means cuts to coverage, cuts to benefits, and cuts and payments to hospitals and community health centers.

Dr. Fiedler, with even lower Medicaid payments and more uninsured people, do you expect that more maternity care units will close, particularly in rural and underserved communities? And what impact will that have on maternal and child health?

Dr. Fiedler. So one of the things we have exceptionally good evidence on is that when Medicaid coverage is broader, the uncompensated care burdens born by health care providers and particularly hospitals fall. Now, you know, there are probably some health systems that can, you know, absorb more uncomplicated care, but there are some that can't.

And, you know, ultimately probably some that are forced to close or cut back service lines, so my expectation would be that if we were to see big drops in Medicaid coverage, we would see, you know, some closures of the services that people get.

Ms. Kelly. Thank you for your response. Discussing PBMs means nothing for people who lose their health insurance coverage, because Republicans and the Trump administration want to slash Medicaid.

In the State of Illinois that I am proud to represent, there are 2.4 million residents covered under Medicaid, and that includes 35.4 percent of all children, 40 percent of

moms giving birth, and then newborn babies, 40 percent of working-age adults with disabilities, and 69 percent of people living in nursing homes.

Mr. Wright, what impact has Medicaid expansion had on continuity of coverage and health outcomes, particularly for low-income parents? Thank you.

Mr. Wright. It is -- I mean, your line of questioning on maternity care is absolutely right. There is no more important program for keeping both babies and mothers alive and well than Medicaid. It is 40, in some states 50 percent of the population. And to continuity of care, it is a safety net for all of us.

If we are -- if we find that we are in a situation where we lose a job or get divorced, it is the ability for people to continue to get the care that they need, even if they are in the middle of postpartum treatment, even if they have a chronic condition like diabetes or something that needs ongoing care. It is the ability for people to continue to have the courage and have a usual source of care and not just end up in the emergency room in the most expensive least efficient place to get care.

So it is incredibly important for continuity of care for all folks, but especially for children and parents.

Ms. Kelly. Thank you so much, and there is thousands of people that won't have care because they have just been laid off or fired. I yield the rest of my time to Ranking Member Diane DeGette.

Ms. DeGette. Thank you so much. Mr. Chairman, I would ask unanimous consent to put an article into the record from today's New York Times, which is entitled What Can House Republicans Cut Instead of Medicaid? Not much. It refers to the $880 billion and has been asked to find, and it points out that if you cut everything else in the Energy and Commerce Committee besides Medicaid, you would still be $600 billion short.

But if you used creative budgeting, not to worry, you could save maybe $187 billion. So the only thing we can cut is Medicaid. I would ask unanimous consent to put it in the record.

Mr. Dunn. [Presiding.] So we will study that.

Ms. DeGette. Thank you.

Mr. Dunn. I won't accept that in just yet. Ms. Kelly yields back, and recognize the gentleman from Pennsylvania, Dr. Joyce.

Mr. Joyce. Thank you, Mr. Chairman and Ranking Member DeGette, for holding this important hearing, and to our panel for testifying.

This is a great opportunity to examine the bipartisan cost saving reforms that passed through this committee and the House of Representatives in the last Congress. While these reforms ultimately were not signed into law, we were successful in building the necessary momentum for these positive changes to occur.

We can see the impact of our efforts through actions that some pharmacy benefit managers have taken to institute additional reporting to their patients and to their plan sponsors.

Now in the 119th Congress we have an obligation to return to our work of lowering prescription drug costs and improving access to affordable medications for our constituents, particularly for Medicare and Medicaid beneficiaries.

PBMs were created to negotiate drug prices down on behalf of plan sponsors. Despite this, we have continued to see an increase in what plans and patients are paying for prescription medications. We need to create an environment that increases competition, one of the most consistent drivers of lower costs.

Because of the complexity -- complex nature and opaque component of these operations, it is difficult for plan sponsors to effectively engage in truly competitive

processes for choosing their pharmacy benefit manager.

Mr. Gremminger, can you speak on how the transparency requirements that passed through this committee last Congress can help drive competition through an increased ability for employers to compare options and negotiate effectively.

Mr. Gremminger. Certainly. So as you identified, Congressman, the bill under your consideration provides really end-to-end transparency in a way that we have never seen before in the PBM market. It allows plan sponsors to understand what the initial price of the bill -- of the drug was from the original sale by the group purchasing organization, all of the discounts and fees that might have been assessed on that drug, and then finally get to sort of what the net cost was to the plan sponsor. Right now almost none of that information is available to us.

As I mentioned in my opening statement, plan sponsors are fiduciaries over their plan assets. We actually can be sued. In fact, two large organizations have so far been sued allegedly because they weren't overseeing their PBM contracts effectively. We were paying too much for drugs.

Right now we don't have the ability in many cases to really understand what we are paying for any particular drug, whether we are overpaying because there is a weird formulary placement where you are having a higher priced drug at the bottom of a formulary, a lower priced drug at the higher end of a formulary, et cetera.

This bill would correct all of that and provide us with transparency we need. We would still be fiduciarily liable, but there is no way you are going to see a prudent fiduciary choose to say yeah, I am going to have a $5,000 drug at the base of a formulary and go through prior authorization to get to a $500 drug. That won't happen, because plan sponsors will have the transparency need, and frankly, the fiduciary requirement that they are placing the drugs appropriately and negotiating for the best prices.

Mr. Joyce. The United States is home to world leading medical innovation. In fact, many on this committee have heard me say that innovation is truly the cornerstone of American medicine. There is a need to find creative solutions for coverage and payment of these innovative medications to make them accessible at an affordable price.

Mr. Gremminger, how does value-based purchasing play a role in getting these advanced medications into the hands of the patients who desperately need them?

Mr. Gremminger. Yeah. So value-based purchasing can mean a lot of things, of course, but one of the things that is exciting about it is it is the notion that instead of paying for a drug based on sort of whatever the list price is, whatever rebates you might have been able to negotiate, it is based on sort of unique clinical value above what else is available in the market right now. I think that is definitely the direction we need to head and we are starting to see more innovation.

We are able to see there are absolutely some very high priced drugs that are also transformative. They are life saving. They have the ability to prolong peoples lives and give them back their lives. There are a lot of low value drugs out there that are equally expensive and don't have that same kind of change.

Under a value-based purchasing arrangement, the employer, purchaser, plan sponsor is paying based on unique value above replacement effectively, which is, I think, the direction that we need to go. It would allow for pharmaceutical companies to make quite a bit of money on drugs that are truly innovative and not make much money on drugs that aren't innovative at all.

Mr. Joyce. Again, Mr. Chairman, thank you for holding this hearing today, and I thank the witnesses for taking time out of their schedules to be with us, and I yield.

Mr. Dunn. Thank you to the gentleman from Pennsylvania yields. The gentlelady, Dr. Schrier from Washington, is recognized for five minutes for her questions.

Ms. Schrier. Thank you, Mr. Chairman, and thank you Ranking Member DeGette. Thank you to all of our witnesses today for speaking about this important topic, the role of pharmacy benefit managers or PBMs in raising drug prices for patients, putting local pharmacies out of business, and covering up the financial shenanigans and profit taking behind all of it.

I think or I know we all agree that increased transparency and reform regarding pharmacy benefit managers is needed. In fact, I know this because this committee worked in a bipartisan fashion last Congress to prioritize this issue and pass a number of PBM reforms that were ultimately included in a great end of year bipartisan bicameral package.

In fact, the savings from these bipartisan reforms were set to pay for bipartisan priorities like extending telehealth flexibilities and community health center funding. Unfortunately, my Republican colleagues let unelected billionaire Elon Musk kill this bill via X.

The committee is now again considering PBM reform, but at the same time, they are about to make drastic and unconscionable cuts to Medicaid in order to pay for tax cuts that benefit the very man who tanked this deal in the first place. Let's be clear.

Republicans voted just last night to take an axe to Medicaid. We have heard evidence of this from many of my colleagues. And Medicaid is a program that pays for healthcare for nearly half of the pregnancies and children in this country, for people with disabilities, for rural hospitals and nursing homes, and they are cutting this to pay for tax cuts for billionaires and corporations.

I want to pivot for a moment to something important in my district, rural hospitals. Medicaid is a critical source of insurance coverage for rural America with nearly a quarter of people under 65 on Medicaid and 22 percent of people dually enrolled

in Medicaid and Medicare.

My district is about 10,000 square miles. It is mostly in central Washington. And without rural hospitals, my constituents would have to travel hours either to Seattle or Spokane for regular care. They serve a patient population that is sicker and older and less likely to have private insurance coverage and they operate on the slimmest of margins and are a critical access point for the healthcare system.

They, in fact, will be the first to tell you that Medicaid is the leanest payer out there. They can barely make it through. So the fraud and the abuse and the bloat that my Republican colleagues are trying to go after just does not exist in this program.

I will warn this committee that should these Medicaid cuts go into effect, the first thing to go, especially in our rural communities, will be obstetrics and delivery. And we have already had one hospital system almost have to lose OB/GYN and to not be able to care for pregnant women and deliver babies, and so this poses an additional risk to women and babies.

Dr. Fiedler, you just talked about the impacts of Medicaid cuts to women and children in particular. Can you expand on the impact that almost a trillion dollars in cuts to Medicaid would have on rural hospitals and their ability to deliver care.

Dr. Fiedler. So as I alluded to earlier, you know, we have very good evidence that Medicaid expansion and Medicaid coverage generally reduces the prevent of uncompensated care on hospitals, and which types of hospitals is that going to create the biggest challenges for? It is the ones that are financially precarious to begin with.

And so, you know, in many cases -- it is not always the case, but in many cases rural hospitals are in financially precarious situations, and so that would be one of the places that you would look to see, you know, where our major disruption is likely to occur.

Ms. Schrier. And it is dangerous and expensive to deliver babies in an emergency room. Just touching my last 25 seconds on PBMs, we know that the incentives are perverse in terms of profit making, and I was wondering, Mr. Gremminger, if you could just comment about the importance of transparency in these negotiations between PBMs and drug manufacturers and how that could help us understand, and then lower drug prices for American consumers.

Mr. Gremminger. So today, as I said in the opening statement, employers really don't know what they are paying for each individual drug, which is obviously hugely challenging. I would add very quickly we don't really know the nature of the negotiations between the drug makers and the PBMs themselves, right? All we can sort of suss out is what appears to be in those contracts, and what we see is a situation in which both the drug makers and the PBMs seem to be winning and working families and American employers seem to be losing.

Ms. Schrier. Thank you, and I yield back.

Mr. Dunn. The gentlelady from Washington yields back. I recognize the gentleman from Ohio, Representative Balderson, for five minutes to ask his questions.

Mr. Balderson. Thank you, Chairman Dunn, and thank you all for being here today. During the 118th Congress, there was thoughtful legislation put forward by my colleagues, which we have talked a lot about this morning, pushing for increased transparency and accountability for pharmacy benefit managers. Today I am hoping we can further illustrate why this sort of legislation is so desperately needed.

PBMs were designed to help manage prescription drug benefits, negotiate better prices with manufacturers, and help control costs for insurers and patients. However, as time has gone on, the role has morphed into something that has seemingly lost sight of these goals. In 2018, the Ohio Department of Medicaid conducted an audit finding

PBMs were making significant profits through spread pricing. This audit, which covered 2017 to 2018, showed that PBMs overcharged the State of Ohio $224 million.

Ohio is not alone in this abuse. Following the findings of the of the audit, my state became the first to act, and as of now, 16 states have banned spread pricing.

I look forward to hearing from all of the witnesses today and I appreciate your time in discussing this very important matter.

My first question is for the pharmacist, Mr. Chancy. As a result of PBMs indecent practices, independent pharmacies around the country are closing. I know that in my district we are not strangers to this issue.

I hear from my friends, family, and constituents alike that their trusted pharmacies have closed after decades of serving their communities. Pharmacy deserts have continued to grow and patients no longer have access to patient/pharmacist relationships that has helped them manage complex medication regimes and diseases.

It is estimated that between 2018 and 2021 alone, the number of pharmacies have declined in 41 states. So this is not just an Ohio problem. This is not a rural problem. This is a countrywide issue that needs addressed. And transparency is unlikely to be the sole solution. As I discussed earlier, the Medicaid spread pricing ban prevents PBMs from engaging in spread pricing and requires them to pass along the full reimbursement amount to pharmacies addressing transparency and reducing the financial burden on the Medicaid system.

Mr. Chancy, can you talk to me about how the spread ban can help address the pharmacy's issues that you have experienced.

Mr. Chancy. Yes. Certainly. I would like to start off by saying that 20 percent, this legislation really addresses over half of the independent community pharmacy businesses. 20 percent of the business on average is Medicaid and 35 percent is part D.

I think that this transparency and stopping the spread pricing is going to -- it is going to lower the cost of the drugs and it is going to level the playing field. Right now it is not very level.

And just since June of '23 we have lost 450 of my colleagues, and at that rate we just can't continue. It seems like a crisis to me. We have got to put -- enact this legislation, and I would like to say yesterday, but even if we voted it in today, it is going to take two to three years before that is going to really have the impact that it needs, so I think it needs to be done sooner than later.

Mr. Balderson. Thank you. My next question is for Mr. Gremminger. Thank you for being here. What a PBM does with rebates is a critical part of transparency.

Of course, we want to see -- excuse me, see competitive market, but the other part of this that I really want to drive home is we want to see 100 percent of rebates passed on to clients. This is a critical part of this equation.

Quite frankly, how is it right now we aren't seeing these large PBMs aimed to lower the cost of goods for their own profit margins and lower the cost of goods sold for their clients by passing these savings on.

How can Congress ensure competition while also ensuring that the clients, the employers, and patients feel the effects of savings?

Mr. Gremminger. Thank you for the question, Congressman. I think one of the things that's really appealing about this legislation is that it includes all rebates and discounts from the very beginning of the chain all the way to the very end.

I want to -- I spoke about this just a little bit in my written and oral testimony. The role of group purchasing organizations or sometimes called rebate aggregators, these are theoretically separate companies, separate corporate entities often based overseas that are wholly owned by the PBM.

Their entire reason for being is to aggregate rebates and be the initial purchaser of drugs before that is then passed on to the PBM, which is the next level in the chain of the corporate entity.

We hear from employers all the time that they are told by their PBMs I am passing on 100 percent of our rebates to you. We then ask which rebates are we talking about. Oh, once the GPO sells it to us, then everything else flows on to you, of course omitting the fact that they are taking a huge rebate cut between the GPO and the PBM themselves.

I want to say very clearly it is the same company. It is the same company with just two different corporate structures, and I think it is critical that we actually are able to watch the flow of rebates from the moment the initial batch of drugs is purchased by the PBM or the GPO from the employer -- excuse me, from the manufacturer all the way to the very end where we actually receive the final discount.

Mr. Balderson. Thank you very much.

Mr. Chairman, I yield back.

Mr. Dunn. Thank you. Mr. Balderson yields back, and we now call Ms. Fletcher from Texas. Give her five minutes for her questions.

Mrs. Fletcher. Thank you so much, Mr. Chairman, and thank you to Chairman Carter and Ranking Member DeGette, and thank you to all of our witnesses today for your testimony. I was struck at the beginning of this hearing when Chairman Carter said that the true reason that we are having this hearing today is because of a sad and difficult story about one patient and their experience with delayed access to the drugs and the care that they needed. And that is the true reason that we are here doing this work.

But that is not the true reason we are having this hearing today. And I want to associate myself with the comments that Ranking Member DeGette made. The true

reason that we are here is because in December of last year Elon Musk decided that he thought our bill, our continuing resolution, was too big. It had 1,500 pages, or something like that. Too big. Can't possibly all be good. Don't do it. And just like that, years of hard work, including hard work to deal with this very issue, got cast aside. And so we are having a hearing today on something we have already agreed on, we have already worked on, and we have already addressed.

It is important that we do it, so I am glad that we are continuing the work, but I think that what we know is that we have got an agreement here. Commercial market PBM transparency was in the agreement we had in December. Part D delinking and transparency was in the agreement. A ban on spread pricing and Medicaid was in the agreement. We have already made an agreement on this, and the only reason it isn't law is Elon Musk. I think that is important for everyone here to know. I think that is important for everyone in this country to know. This committee and this Congress has consistently allowed Elon Musk to substitute his own uninformed judgment for all of ours, and it has got to stop. It has got to stop.

So instead of rehashing some of these reforms that we have already agreed on, I want to spend the time that I have left talking about and asking about the budget resolution that House Republicans passed last night that directs this committee, the Energy and Commerce Committee, to cut a minimum of $880 billion out of spending.

Now, we heard time and again yesterday in our markup that we weren't going to get to cuts to Medicaid because Medicaid wasn't in that budget resolution. We know on this committee that that is where that money -- it is the only place it can come from.

So Mr. Wright, in your testimony, you made it very clear that threatening access to coverage like Medicaid would increase costs for families far more than any PBM abuses. And I want to ask you to take some time to talk to us about the importance of

Medicaid coverage, especially on an issue that is very important for those of us in Texas as well as people across the country, the importance of Medicaid coverage for pregnant women, which covers -- Medicaid covers 50 percent of births in Texas. Can you talk about what the impacts of losing Medicaid coverage in Texas and states across the country will mean.

Mr. Wright. I mean, obviously, it would be -- have devastating ripples throughout the healthcare system and not jut for the people who do have Medicaid coverage, but for the system as a whole. You -- in many of -- whether it is community clinics or rural hospitals, in many cases Medicaid is the biggest funding source. And so if you are in that community, if those institutions get hit with a big cut, that impacts everybody in the community, whether or not you are in Medicaid specifically.

If a maternity ward, which already has had -- we have seen closures already of -- if they lose funding, and again, 40, 50 percent of births are paid for by Medicaid. If they lose that funding, that actually could potentially mean the closure of a maternity ward for everybody in that area creating further maternity ward -- maternity deserts in our country at a time when folks are talking about how can we better support parents, how can we better support the process of people starting a family. And so it is incredibly important.

And just not -- both the prenatal and postpartum care is so important. Those first few years of life are probably the best investment you can make in terms of a child's health not just for that time. Into their life. That is when brain development happens. And there are -- there is reams of data and research that suggests that those kind of investments are some of the best investments you can make, but if you have a cut of the scale that is being talked about, it is almost impossible to think how those will not be impacted.

Mrs. Fletcher. Thank you so much. I have gone over my time. I do have some more questions for you, so I am going to submit them for the record and look forward to hearing your responses.

Thank you so much, Mr. Chairman. I yield back.

Mr. Carter of Georgia. The gentlelady yields. The chair now recognizes the youngest pharmacist in Congress, Representative Harshbarger from Tennessee, for five minutes of questioning.

Mrs. Harshbarger. Thank you, Mr. Chairman. I appreciate that reference to my age. And thank you to the ranking member and thank you to the witnesses for being here. Yes, I am younger than Buddy. You know, I've been a pharmacist -- well, I better not tell you how long, or then you are going to know how old I am. I have been a pharmacist a long time, and every week I hear from independent pharmacists from east Tennessee, across the state, from all over the country about these manipulative practices of PBMs. And all you have to do is read the last two interim reports from the FTC to understand that PBMs can distort competition. They steer prescription drug coverage to whatever pads the bottom line, and essentially they print their on money.

And I say this in every PBM hearing, and I am going to say it again today. PBMs don't treat a single patient, they don't cure a single disease, and they don't insure a single American. So the bottom line, it is all about the patients, isn't it, gentlemen? It certainly is. And how they are losing access to pharmacy choice, who in most communities are your independent pharmacies who are the most trusted and the most readily available healthcare provider in that community.

So PBM reform is a bipartisan issue, and you know what that means. That means that both sides agree on this issue. It is not an issue of contention. So it is important that we get some PBM reform done.

Mr. Chancy, this is a yes or no question. Is it sustainable for PBMs to often reimburse independent pharmacies below their acquisition costs for drugs? I have had to deal with it in my practice and have to deal with the take it or leave it contracts that they offer, that, you know, the abusive audit practices they do, whether it is a desk audit or they come into your pharmacy and audit. And then what they do after the fact is they reduce pharmacy reimbursements because of ambiguous shifting unpredictable metrics.

RPTR MOLNAR

EDTR HUMKE

[12:01 p.m.]

Mrs. Harshbarger. And I guess my question for you is, is it sustainable for your pharmacy practice, yes or no, sir?

Mr. Chancy. It is not sustainable.

Mrs. Harshbarger. It is not. Exactly. Thank you for agreeing with me.

You know, it is almost like you are playing a high-stakes game without knowing the rules, and really it is a game with no rules, isn't it? That is exactly what it is and -- but it is not a game, is it, because who suffers in the end? It is the provider and the patient.

So, Mr. Chancy -- this is another yes or no -- would you agree that the fairest and most transparent way to reimburse pharmacies for prescription drugs would be to use the national average drug acquisition cost, plus a reasonable dispensing fee, yes or no?

Mr. Chancy. Yes, I do.

Mrs. Harshbarger. Yes. I do too.

Mr. Gremminger, thank you for being here today, sir. We know about the vertically integrated organizations and how they have tremendous influence over which medications patients have access to, when and where they get those drugs, where it can be dispensed or administered, and the amount paid out of pocket by patients. I have had to deal with this.

In your view, is the vertical integration of these companies hindering market diversity and competition, yes or no?

Mr. Gremminger. 100 percent.

Mrs. Harshbarger. 100 percent. And let me tell you about legislation that I proposed. I have introduced a bipartisan legislation called Patients Before Monopolies Act, and that would require health insurers and PBMs to divest from their pharmacies businesses, eliminating conflicts of interest, and creating a more transparent system.

And I am sure people love that, but the PBMs don't like it.

So this is for Mr. Chancy again. Let's talk about patient steering. PBMs are now requiring patients to use PBM-affiliated pharmacies, including mail order and specialty pharmacies to where if you have got a cancer patient, they can't go to their oncologist or their community pharmacist. And now it is filtering over to HIV patients and other chronic-disease patients.

And I believe patient steering myself -- I believe patient steering or mandating the use of a PBM-owned pharmacy should be prohibited across all Federal plans.

Would you support a prohibition on patient steering by PBMs to their affiliated pharmacies, yes or no?

Mr. Chancy. Yes, I would.

Mrs. Harshbarger. Okay. This is going to be a lightning round. I have got 31 seconds.

Mr. Chancy and Mr. Gremminger, many of us in Congress believe that misaligned incentives are at the root of the problem with high prices in America today for drugs, and the PBMs are taking advantage of these misaligned incentives.

Would you agree that if patients have to pay a certain percent of the drug's sticker price, reducing drug sticker prices can reduce patient out-of-pocket costs, yes or no?

Mr. Chancy. Yes.

Mr. Gremminger. Yes.

Mrs. Harshbarger. Okay. Would you agree that PBMs and brand

pharmaceutical manufacturers sometimes enter agreements to exclude lower cost competitor drugs from the PBM's formulary in exchange for increased rebates from the brand-name drug manufacturers?

Mr. Chancy. Yes.

Mr. Gremminger. I would go as far as to say it is often, not just sometimes.

Mrs. Harshbarger. Yes, exactly. Would you agree that higher price out-of-pocket costs for patients can adversely impact adherence to prescription regimens, yes or no?

Mr. Chancy. Yes.

Mr. Gremminger. Yes.

Mrs. Harshbarger. Would you agree that poor patient prescription adherence can lead to poor health outcomes?

Mr. Chancy. Yes.

Mr. Gremminger. Yes.

Mrs. Harshbarger. I have only got three more, Buddy. It is quick.

Do you agree that excluding the lower-cost generics from formularies and offering only the more costly brand-name drugs reduce access to care?

Mr. Chancy. Yes.

Mr. Gremminger. Yes.

Mrs. Harshbarger. Do you agree that brand mandates should be prohibited by Medicare Part D?

Mr. Chancy. Yes.

Mr. Gremminger. We don't have a position on Medicare Part D policy.

Mrs. Harshbarger. Well, you should say yes.

Would you support requiring the inclusion of generic drugs on formularies? Last

question.

Mr. Chancy. Would you repeat that, please.

Mrs. Harshbarger. Would you support requiring the inclusion of generic drugs on formularies?

Mr. Chancy. Yes.

Mr. Gremminger. Yes, so long as the price is -- the net price to the employer is below that of the brand.

Mrs. Harshbarger. Absolutely. Thank you, sir, and I yield back, Buddy. Thanks so much.

Mr. Carter. The gentlelady yields. The chair now recognizes the gentleman from Massachusetts, Representative Auchincloss, for 5 minutes of questioning.

Mr. Auchincloss. Thank you, Chairman. I want to associate myself with the excellent line of questioning from the gentlewoman from Tennessee with whom I am co-leading two pieces of follow-on legislation to these bipartisan reforms -- the Pharmacists Fight Back Act and the Patients Before Monopolies Act.

And indeed we seem to be in vigorous bipartisan agreement on this issue of PBM reform, so I want to actually pursue an area of disagreement, because that is how I learn better.

Dr. Fiedler, in your written testimony, which I try to review pretty carefully, you really seemed to push back on the idea of getting rid of rebates. You really defend rebates and actually kind of emphasize that delinking may not work very well, and I want to engage with you on that question because maybe I will learn something here on this.

One of the things you do emphasize is competition and the value of competition with new PBMs entering the market. How are these new PBMs, most of whom are flat-rate PBMs, though, transparent PBMs, supposed to compete when the plan sponsors

are locked in with rebate deals that the incumbent PBMs have.

That is especially relevant because of the 2021 consolidated appropriations law that made these plan sponsors fiduciaries.

So there is a real opportunity now for competition from these flat-rate PBMs because these plan sponsors are fiduciaries, and they know that their employees are getting screwed over, and so they really have a liability here.

But they are locked in with the rebate. So doesn't your point about rebates contradict your point about competition?

Dr. Fiedler. So I think one of the challenges with the idea that the solution here is more competition in the PBM market -- and I think we should try as well as we can -- but I think one of the real challenges is that it is probably the case that the big PBMs, when they are going up against the manufacturers, have more leverage. And I think that is just the reality of this market.

And so the trade-off is, do we want a more competitive PBM market that I think does mean that PBM profit margins would come down, and that would be good for clients. But I think there is a potential tradeoff in terms of what that does to drug prices.

I think my best guess is the net, consumers save money from that. But I think there is a tradeoff, and I don't think the evidence we have on that question is perfect.

Mr. Auchincloss. Yeah. I am not sure I am ready to cede to consolidation is the only way we can get scale economies. I mean the generitization function is how we get lower prices, not necessarily just through plan-sponsor leverage.

The other question about rebates I have is, of course, rebates inflate list prices, right? They pump them up. Now, we can debate plan sponsors and pharma and PBMs, and they are all kind of shuffling money around, but what we know is that patients pay their out of pocket based on the list price, not the net price.

So your defense of rebates seems to contradict the idea that we are trying to lower out-of-pocket costs for patients, yes?

Dr. Fiedler. So that assumes that if you switch to a different pricing system that the patient's co-insurance rate or deductible are going to remain the same. And I think what is happening in many cases is the insurer or the plan sponsor is setting that deductible or co-insurance rate to get cost-sharing at the level they want it to.

So if you brought the price down to the net price, I think what we would often see is the insurer deciding, okay, we are going to apply a high co-insurance rate, and I am not sure in those cases as a result what the patient is paying is going down.

To be clear, I don't have conviction that the current system is the right system, but I do think there are tradeoffs here.

Mr. Auchincloss. Yeah, I would question why we are putting people in the position of having out-of-pocket exposure to appropriately prescribed medication, right? There is no moral hazard with chemotherapy or --

Dr. Fiedler. And I think that is absolutely right.

Mr. Auchincloss. -- asthma inhalers.

Dr. Fiedler. And I think, that is why, in my view, I think often the solution is simply to regulate the ultimate insurance contract and say, Listen, these are drugs we know patients need access to, and this is the maximum dollar amount of cost-sharing that can apply, you know, particularly, frankly, to generic drugs where there is very little risk of --

Mr. Auchincloss. It is a good idea. Democrats did it last Congress with a $2,000 out-of-pocket cap roughly. No Republican joined us in it.

Continuing your point on competition, biosimilar market is not working quite as well as we want it to. We really want to get that competition to drive down the price of

these large-molecule drugs, because they stay expensive a long time.

Again, we have seen rebates play a really nefarious role here, Humira and other examples where the PBMs are using a dual-pricing structure.

How can an embrace of rebates coincide with wanting a more competitive biosimilar market when they are clearly using rebates to lock in the higher priced brand drug?

Dr. Fiedler. So I think whether it is a rebate or there are other forms of discounts, it is going to always be in the manufacturers' interest to try to keep that biosimilar out of the market. And I think the challenge is because in many cases --

Mr. Auchincloss. Yes, but rebates are the tool that is being used in this tango between the PBMs and pharma to do it.

Dr. Fiedler. And I think --

Mr. Auchincloss. Let's take it away.

Dr. Fiedler. My contention would be that you would have other tools emerge fairly quickly --

Mr. Auchincloss. So I want to close on that point because you talk also in your written testimony about admin fees and then, you know, you squeeze the balloon in one place and it pops out someplace else.

Again, I am not really willing to cede that point. Like our job here in Congress is, like, just pop the balloon.

And to your point, Mr. Gremminger, about the group purchasing organizations, they are one of the two places where the PBMs are already pointing to that they are going to inflate the balloon elsewhere. One is these GPO fees which the PFB legislation will help us get ahead of it, but, my goodness, Congress needs to focus on this because I don't know what they are doing in Ireland and Switzerland, but where there is mystery,

there is margin, right?

And the second thing is specialty steering. I mean, you got Cigna, Express Scripts' CEO bragging on earnings calls about how specialty steering is their new moneymaker. And it is entirely a business, not a medical proposition here. We have got to pop that balloon too.

I yield back.

Mr. Bentz. [Presiding.] Thank you. The chair recognizes the congresswoman from Iowa, Dr. Miller-Meeks, for 5 minutes.

Mrs. Miller-Meeks. Thank you, Mr. Chairman, and I thank the witnesses for testifying before the subcommittee today.

It is no secret that PBM middlemen artificially inflate the cost of and limit access to prescription drugs. This occurs at the expense of patients who receive health insurance in public and private markets and impacts patients of all ages.

The PBM market has become highly consolidated with the three largest PBMs controlling roughly 80 percent of prescriptions. The top six PBMs account for about 97 percent, and in Medicare Part D, four PBMs manage benefits for a combined 90 percent of beneficiaries.

PBMs claim they reduce prices by holding pharmaceutical companies accountable. This is done, they contend, by requiring rebates on drugs, which are then passed on to the beneficiary.

While PBMs often do negotiate discounts from manufacturers, patients are not the ones who benefit from them.

In Medicare Part D, for example, patient cost-sharing is based off the list price of drugs, which are artificially inflated to extract a higher rebate.

As a result of these practices, for 79 of the 100 most rebated drugs in Medicare

Part D, beneficiaries pay more for their drug than their insurer, again demonstrating that beneficiaries -- in this case, seniors -- are not benefitting from the rebates.

This is why I led the bipartisan Share the Savings with Seniors Act which would require full rebate pass-through for chronic care drugs under the Medicare Part D plans.

And that is the not the first time I tried to do PBM reform. My first effort at PBM reform came as a State Senator in 2019, where I passed PBM reform on transparency, but could not get a pass-through of 51 percent of the rebates.

The insurance companies were against me, my manufacturers were against me, as it was alluded to then that drug prices would rise and people would use brand-name drugs rather than generics.

So I have been at this now for 6 years. And when I was in Iowa last week, I read, despite all of the hurdles I had, "PBM saves county money." The county adjacent to my district saved $60,000 of their county expenses with PBM reform, and now States are doing it.

This isn't a partisan issue. We have over 200 pharmacies have closed in Iowa since 2014, which includes not only independent locations but chain pharmacies such as our Hy-Vee Pharmacy, and we know the bigger pharmacy chains are also closing.

I am very proud of the bipartisan work this committee has done to move on meaningful PBM reform legislation through regular order. Last Congress, the Energy and Commerce Committee successfully moved three major PBM policies -- Medicare Part D, delinking commercial market transparency, and banning spread pricing in Medicaid.

And I have done the same thing in the commercial market with the Drug Act.

Mr. Gremminger, we hear from insurers and PBMs that implementing delinking won't have any meaningful action on reducing patients' out-of-pocket costs in the commercial market.

However, we know that commercially insured patients are largely more exposed to list prices through larger deductibles than patients in Medicare Part D.

In fact, in 2024, the average annual individual deductible for employer-sponsored health insurance was $1,787, while the maximum annual individual deductible in Part D could not exceed $545.

Do you believe that if we move to regulate delinking in the commercial market such as my bill, the Drug Act, would do, would that reduce patient out-of-pocket costs?

Mr. Gremminger. In short, yes. The National Alliance supports actually applying delinking to the commercial market. As you know right now, the bill that was considered in December only applies it to the Medicare market.

There is no question it takes away a financial incentive that is currently built into the program, and I absolutely believe that doing it in the commercial market will ultimately lead, in relatively straight order, to lower out-of-pocket costs for consumers.

Mrs. Miller-Meeks. Mr. Clancy, I am going to ask you a question, but I want to dedicate this question to John and Jane Nicholson who run the Mahaska Drug family pharmacy in Oskaloosa, Iowa, which is teetering on closing.

It is my understanding that Caremark, one of the three big PBMs that controls 80 percent of all prescriptions in the country, has a request for proposal out to pharmacies asking them to do two things -- and sometimes this information and contracts are sent by fax which most people don't utilize -- so in order to be considered part of the network of covered pharmacies in their Medicare prescription drug plans, one, offer an amount of reimbursement that is below what it costs a pharmacy to acquire and dispense medicines, force pharmacies to select which of their competitors Caremark should remove from the network, a blatant disregard of Medicare Part D's any-willing-provider requirements for pharmacy which state that any pharmacy that agrees to a Part D plan

standard contract terms and conditions must be allowed to participate in the plan's network.

Is it not the exact type of anticompetitive behavior everyone has been pointing to for years now, and does it demonstrate why we need stronger protections for all pharmacies serving seniors and Medicare, not just those owned by PBMs?

Mr. Chancy. I very much agree. And in Georgia, Caremark covers our State health benefit plan. And I ran my reports before I came, and 24 percent of the prescriptions I dispense, I get reimbursed below my cost of purchasing the drug. Seventy-five percent of the prescriptions that I fill are below my cost of doing business. So 25 percent is actually my gross profit scripts.

Mrs. Miller-Meeks. Thank you so much. I yield back.

Mr. Bentz. Thank you. The chair recognizes the Congresslady from New York, Ms. Ocasio-Cortez, for 5 minutes.

Ms. Ocasio-Cortez. Thank you so much, Mr. Chairman.

I think that in a political environment that we are in right now, it is actually just a tremendous glimmer of hope that people can have in seeing that there are areas in which we can agree, and PBMs are a perfect example in which everyday Americans who live in rural areas, who live in urban areas, working people, are getting totally squeezed by essentially this middleman where their costs are being totally driven up, that their prescription prices are being totally driven up.

And for once we have Republicans who are championing this legislation and tackling lowering these costs, Democrats who are on board with this.

And I can tell you, should this legislation come to the floor, this Republican majority has my vote. You have my vote on this, and you have the vote of many Democrats on this.

Now, we have had this for some time, as what has been mentioned. Last Congress, Republicans and Democrats worked together to draft bipartisan legislation on PBMs, and one provision that made it into the December 17th, 2024, continuing resolution demonstrated how we can work together to rein in PBMs and lower drug costs for patients.

We have seen how this can work, and this is a bipartisan measure that can propose more oversight of the PBM marketplace.

Dr. Fiedler, can you explain how greater oversight in this circumstance can help lower costs for everyday Americans?

Dr. Fiedler. So I think the most promising change, from my perspective, is the proposals to expand transparency which I think would help PBMs' clients get a better deal from PBMs.

You know, this is probably most important for employers, and my view is that over the long run, employers would pass some of those savings along as wages, lower premiums, or better benefits --

Ms. Ocasio-Cortez. And we have seen this at work even, you know, with hospital provisions, forcing a little bit more transparency. We have seen costs go down when there is actual disclosure around what is going into these prices.

Now, this bill was almost passed on December 17th, within a bigger package to prevent the government shutting down. It has all of our support.

For folks following at home, Republicans supported it, Democrats supported it. So why isn't this moving? It is not because there is no substance for it. All four witnesses testifying today are in support of it. Republicans are in support. Democrats are in support. So what happened?

Well, on December 17th, at 4:15 in the morning, Elon Musk began firing off a

barrage of social media posts opposing pharmacy benefit manager reform, PBM reform.

And all of a sudden, this bill that had almost unanimous support fell apart in a matter of hours, and the vote was postponed on that day. After he tweets, it gets cancelled. Elon Musk tweets.

We have nearly 435 Members of Congress all on board with it. He sends one tweet, and all of a sudden, everyone backs off, and it kills drug pricing reform that saves people money on their insulin, on their -- on their asthma inhalers, on everything that they need.

And then, to kick it off, 5 days after he kills pharmacy benefit manager reform, we get this tweet from Elon Musk. "What is a pharmacy benefit manager?" This was at 1:02 a.m. on December 31st of 2024, 5 days or so, couple days after he kills the bill.

So the problem here is not a substance issue. It is not a process issue. It is an oligarchy issue. It is a power issue. And this room is where the power of the people of the United States reside.

Whether you are a Democrat or you are a Republican, everyone here was elected to be accountable to the people of the United States, not to be governed by tweet, but to be governed by their duly elected representation. And so we can get this done because there are more of us than there are of him.

So I would love a commitment from our Republican counterparts, who we agree with on this issue, to just put it on the floor and let us vote for it where there is bipartisan agreement, and we can actually get a result for the American people by booting this guy out from political influence.

And with that, I yield back.

Mr. Bentz. Thank you. The chair recognizes himself for 5 minutes of questions.

My State of Oregon ranks second to last in the country for access to retail

pharmacies. This is a problem that is not going away. It was reported that in 2024, 36 pharmacies closed their doors.

This shortage, like almost every other healthcare shortage, is more acute in rural areas, where often only a small number of pharmacies serve an extremely large area.

My district, for example, is larger than the State of Washington, and we have been losing pharmacies, and it is leaving communities in desperate straits.

Mr. Wright, can you speak to how consolidation in the PBM market and PBM business practices are impacting access to pharmacies in rural areas?

Mr. Wright. Thank you for the question. I think the issue of consolidation, you know, we have talked about the three major PBMs that control 80 percent of the market, but I would also like to stress not just the consolidation -- consolidation goes vertically and horizontally.

The ability of the integration between insurers, PBMs, and pharmacies means that there is a perverse incentive and a misaligned incentive for PBMs to favor the pharmacy chain that they happen to own, which may be unrelated to cost, quality, convenience, customer service, or any of the things that we would want good purchasing to be based on.

It is appropriate to negotiate over those factors. It is not appropriate to negotiate -- or to be undercut by the fact that you are members of the same ownership group.

Mr. Bentz. As long as I am asking you questions, who actually benefits from the rebate?

Mr. Wright. Well, to the extent that the rebate will system creates an incentive for higher list prices, then that is a detriment to all of us who pay the price whether it is patients, payers, employers, union trusts, or anyone.

To the extent that the rebate does go to the -- at least to the payer, although we don't necessarily know what those rebates are, and that is one of the reasons why the transparency legislation is so important.

Mr. Bentz. And going to that transparency piece, you would think what would happen as a result of total transparency? What is the good that comes from it?

Mr. Wright. Well, I think that the main point would be that you would -- that both patients, but in particular the plans, the purchasers, the payers would have a better idea of -- to see if there is a -- if the PBM is negotiating on their behalf for the best cost and quality to be passed through, or to get a bigger rebate on behalf of the PBM.

And that is the misaligned incentive that right now we have. It is an opaque situation.

Mr. Bentz. Dr. Chancy, your family has operated an independent pharmacy for three generations. Some say that PBMs aren't to blame for the closures of these pharmacies and some allege that the new generation is simply incapable or not wanting to carry on the business. I find that not convincing. What is your thought?

Mr. Chancy. I totally disagree. The PBMs are directly related to our unfair reimbursement, and some of the tricks and games that they play are killing independent community pharmacy.

As I shared earlier, we have lost 450 since June of 2023, and when you lose an independent pharmacy in an area, no one is rushing back in to replace them.

So you are not just losing a drug distribution point, you are losing a healthcare provider. And in six counties in Georgia, that is the only healthcare provider in those counties. So it is a critical situation.

Mr. Bentz. Yeah, but your opinion, what is going to fix it? Because I represent many, many, many small communities, and they are losing their pharmacies. What is

the best thing we could do here to help?

Mr. Chancy. Well, I think the transparent -- Chairman Carter's Transparency Act and the no-PBM bill that you guys have worked on is a great start. That is going to impact 55 percent of the business that the average independent does. It is going to do away with the spread pricing. It is going to increase transparency. It is going to have a fair reimbursement model.

And we are going to encourage CMS to put in language that is going to be relevant and reasonable contract language so -- between the PBMs and the pharmacies.

Mr. Bentz. What would the next step be?

Mr. Chancy. Pass this legislation.

Mr. Bentz. I am talking about after we pass it. I am the optimistic sort. Was there something next that you would like us to do?

Mr. Chancy. Well, I think then next we need to tackle the commercial market.

Mr. Bentz. Thank you. I want to thank the witnesses.

Where is our -- am I going to close out -- we got another person? Oh, I am sorry. Apologize for that.

The chair recognizes Congressman Veasey for 5 minutes.

Mr. Veasey. Thank you, Mr. Chairman, and I want to thank the witnesses for being here today.

And like some of the other members have already stated, we had a great opportunity last year to really put in some good bipartisan PBM reforms, but for whatever reason, my Republican colleagues caved to the president of many large companies here in the U.S. and the world.

Everyone knows who the president of those companies are. That is Elon Musk. And President Elon Musk tweeted his disapproval and suddenly Republicans, who had

been negotiating in good faith, decided that they were just going to walk away because President Musk said that we shouldn't stand up for the American people.

And so we backed down, and it is really sad because there are a lot of patients around this country that are really counting on us to do something about this issue.

And so, Dr. Fiedler, let me ask you, if Republicans had kept their word and passed these bipartisan PBM reforms last year, would they have helped reduce the high cost of prescription drugs for Americans, even if it were just a first step?

Dr. Fiedler. I think these reforms would have reduced the cost of PBM services, and in many cases that would have translated into the savings for consumers in the form of, you know, premiums and potentially, you know, in some cases at the pharmacy counter as well.

Mr. Veasey. Yeah, no, thank you very much. And, look, I want to be clear. I support the PBM reforms, but let's not pretend that this hearing is about helping patients because it is not.

It is about Republicans trying to distract from the real agenda, and that is gutting healthcare for millions of Americans so they can hand out more tax breaks to super rich people around the country. And, again, that is sad.

Last night Republicans passed tax cuts that will threaten the healthcare for more than 80 million Americans who rely on Medicaid and CHIP. And so to put that in perspective, Medicaid covers about 40 percent of all births in this country, and nearly 40 percent of all children who get their healthcare through Medicaid.

In my home State of Texas, 1 in 3 children, and 1 in 2 pregnant mothers rely on these services through Medicaid. And I really worry because in the district that I represent, I have one of the highest maternal mortality health rates in the entire country, and we need to really take this seriously.

And so for Mr. Wright, I wanted to ask, if Republicans succeed in this reckless effort to gut Medicaid, what will that mean for the lives of mothers, newborn, and children who depend on this case, and what happens when access to prenatal care disappears, when kids can't get the medications they need, and when families are left without options?

Mr. Wright. Thank you, Congressman. I think you are right that we are in the middle of a maternal mortality crisis, and just to be plain spoken, that means an unacceptable rate of deaths of both moms and of infants.

And there is no better way to do an investment to deal with that issue than in Medicaid. There is no bigger threat to that issue if Medicaid is cut severely, since it is such an important source of funding for maternity wards, for prenatal care, for postpartum care, and for children in those early development stages, and through their school careers, whether it is the identification of learning disabilities and the ability for them to get in school and stay in school, whether it is the ability of those families to be financially whole and not face -- you know, be one emergency away from financial ruin.

So these are very core programs, and, again, these are -- and it has an impact on obviously those folks who have Medicaid coverage, but for a lot of -- but it has ripple effects through the healthcare system that we all depend on as well.

Mr. Veasey. Yeah, yeah, and, you know, and I don't want to get off topic here, but with so much of the country really focused on immigration issues, and we never talk about how the fertility rates in this country have played a role in that.

I don't know why people want to make these maternal mortality rates even higher by not doing something like tackling some of these PBM reforms, and, again, taking the word from, you know, President Elon Musk. That is the president of several companies. I don't understand why we are not doing anything and standing up to these billionaires.

So with that, Mr. Speaker, thank you, and I yield back the balance of my time.

Mr. Carter of Georgia. [Presiding.] The gentleman yields. The chair now recognizes the gentleman from Texas, Representative Crenshaw, for 5 minutes of questioning.

Mr. Crenshaw. Thank you, Mr. Chair. Thank you all for being here on this important issue on PBMs.

You know, PBMs are created to control costs, but we continue to see rising drugs prices that increase patients' out-of-pocket expenses.

Mr. Gremminger, we hear a lot about the difference between list price and net price, but what is missing from that conversation is who benefits from that gap.

From your perspective, are PBMs primarily acting as a cost-control intermediary, or have they positioned themselves as profit centers instead?

Mr. Gremminger. I think at this point they are unquestionably profit centers. A high list, high rebate model tends to benefit both the PBMs and the drugmakers.

Mr. Crenshaw. Yeah. And there is an argument that the business model relies on complexity, that the more opaque pricing is, the easier it is to extract revenue from multiple players.

Do you think PBMs would function the same way if drug pricing were fully transparent? Would we see a fundamental shift in how they operate?

Mr. Gremminger. That is certainly my hope, and I think this legislation creates a foundation for that, to create a fundamental shift in the way that we price drugs in the commercial market.

I think there is no question that the reason that we see both high list prices and ultimately high net costs is because of the complexity, the opacity, and the fact that, you know, the producers of drugs and the people who control the drugs are making quite a

bit of money, whereas the people who are actually purchasing the drugs -- employers, purchasers, working families -- are paying more.

Mr. Crenshaw. Yeah. And we know that formularies, you know, the list of covered drugs, drive prescription drug utilization and that PBMs have significant control over which medications patients can access.

To what extent do you think rebate-driven formulary placement distorts the market, particularly when it comes to generics and biosimilar adoption?

Mr. Gremminger. I think there is a very heavy distortion. As we see in drug formularies pretty commonly, a higher priced, you know, less effective, or just equally effective drug placed at the base of a formulary because it is heavily rebated, because they may be able to tack on higher fees, and then ironically patients actually have to go through some sort of medication management to sort of get through the more expensive drug before they can get access to the cheaper drug.

It is implicit in the way that the model is currently built, functioning on kind of the rebate structure.

There are employers that have worked to try to eliminate wasteful drugs in their formularies. They have created what is called a waste-free formulary and have seen millions of dollars in savings.

It is difficult to do, and it requires a very aggressive employer who has access to their formularies and can negotiate with PBMs.

In most cases, employers tend to just take the formula that they are handed to them by their PBM which, as we know, is heavily distorted.

Mr. Crenshaw. And, you know, PBMs argue that these rebates do help lower overall costs, but they also choose not to cover list price alternatives such as generic and biosimilars.

Can you speak to whether PBMs are truly considering patient costs or outcomes in these decisions or if it is all financial?

Mr. Gremminger. You know, I hate to comment too much on what they are intending to do, right? We know what the outcomes are. So the outcomes are certainly higher profits for the PBMs.

We know that patients often are asked to pay the out-of-pocket costs associated with a higher list price or higher priced drug before they are given access to a lower cost alternative.

We know that the impact of that is lower utilization, more people getting sick, people not being able to afford the drugs that they need.

We heard the story at the very beginning of this about a patient who ended up in the hospital because of a change in the formulary based on a PBM.

I don't want to suggest that I know what is in the heads of the folks that run PBMs, but I know that certainly the end point is higher profits for PBMs and less access for patients.

Mr. Crenshaw. Thank you.

Mr. Fiedler, there has been growing scrutiny of how PBMs interact with vertically integrated health plans and specialty pharmacies. In your view, do these integrations ultimately help patients, or are they reinforcing market dominance in ways that limit competition and drive up costs?

Dr. Fiedler. So at the risk of being the sort of stereotypical two-handed economist, I think there are tradeoffs here. I think the concerns that they are steering business particular to their own pharmacies, and that that is, over time, giving them a dominant position in the pharmacy market, is a real one.

I think there is also opportunities to use an affiliated pharmacy to skirt medical

loss ratio relationships in cases where the insurer, the PBM, and the pharmacy are all part of the same entity.

On the other hand, I think there are instances where it is legitimately more efficient for a PBM to deliver drugs through its own pharmacy in terms of the cost of processing claims or managing utilization.

It may also allow the PBM a sort of way out around market power held by some outside pharmacies.

So I think there are real tradeoffs here, and honestly, from my perspective, the evidence is not clear on what the net effect is.

Mr. Crenshaw. Okay. Appreciate that, and I yield back. Thank you.

Mr. Carter of Georgia. The gentleman yields back. The chair recognizes the gentleman from Ohio, Representative Landsman for 5 minutes of questioning on PBM reform.

Mr. Landsman. Thank you, Mr. Chair. The biggest issue that we are all wrestling with, or should be wrestling with, is the cost of everything, including prescription drugs and healthcare.

And in an ideal world, we get to a place where we are reducing costs and saving taxpayers money, that we are reducing the cost of, let's say, Medicare.

And so with the PBM reforms, one of the bills was our bipartisan bill that would require transparency in the transactions that PBMs have with Medicare so that they are buying at one price and selling to Medicare at another, that we have full transparency.

Ultimately that money has to go to Medicare, the savings, should go to Medicare and to seniors. And it would save Medicare tens of millions of dollars, seniors ultimately tens of millions of dollars.

And thanks to Chairman Carter and other Republicans on this committee, and

Democrats, there was an incredible package of PBM reforms. And it sat there.

We talk a little bit about what happened at the end, but there was this long period of time where it was supposed to come to the floor, and it was going to be up for vote -- a full vote.

Because it passed, as I mentioned to the chairman yesterday, because of his hard work -- and I mean this -- he is so passionate about this and an incredible leader on these reforms which will save people tons of money and will save taxpayer money -- that it sat, you know, in this Congress for, I don't know, 6, 7, 8 months -- and people watching at home should know that we come up here every week. We vote for 4 days. We vote on, like, three bills.

Even though when we went on break for the election, I looked it up, there was 698 bills that had passed out of committee, including all of the PBM reforms. So why didn't it come to the floor?

They get it in the final package, the final spending package, and then, yes, Elon Musk says I don't like it. He raises the question, what is a PBM. It is a middleman. It is the companies that buy and sell prescription drugs on behalf of providers including Medicare.

And it gets cut. And so we can blame Musk, but it was also the Speaker and others who said we are going to take it out of the bill.

And my frustration is -- because this is a hearing on PBM reform -- is this larger issue with committees, including this one, and incredible work from the chairman and others, and it just never goes to the floor.

The one big thing that we passed last year at the end of the year was the Social Security Fairness Act because we forced a vote. We had to force a vote with a discharge petition.

And so I know that Ms. DeGette mentioned the idea of a suspension vote. I would also mention that a discharge petition, whatever it takes.

We have so much compelling evidence that these reforms will fundamentally improve people's lives. It will save people money. At a time when people are struggling to pay their bills including the cost of healthcare and prescription drugs, why wait another day?

Put the package back together, put it on the floor, force a vote if we have to. But I think that is where we are, so that nobody can stand in the way and say, Well, this guy didn't like it, or, you know, maybe next time.

It is just, I do believe that this is one of those moments where the policy is right, people are desperately in need of help, and we should do everything in our power to get this thing done. And I just, I stand with the chairman and the ranking member in making sure that we are doing everything in our power.

I will say, in my final minutes -- or seconds, that Mr. Pallone makes a very important point, which has been brought up many, many times, which is, even if we pass -- we have to pass the PBM reform, but it will only help people who have healthcare.

And if this body decides that it is going to take healthcare away from millions of people in order to pay for tax cuts for big corporations and billionaires, they have failed.

And so we have to do everything in our power to make sure that doesn't happen, that we get the PBM reforms done, and we ensure that there isn't a single dollar cut to people's healthcare.

And I yield back.

Mr. Carter of Georgia. The gentleman yields. The chair now recognizes the gentleman from Michigan, Representative James, for 5 minutes of questioning.

Mr. James. Thank you, Mr. Chairman.

Something actually just came back which is germane to this conversation. I would actually lead with this. Let me back this back up. I am sure you will be able to recognize the voice.

[Audio recording played.]

Ms. DeGette. Mr. Chairman, I have to object to the playing of -- I have to object to this.

Mr. James. You have to object to the words of the President because you don't agree with it?

Ms. DeGette. No, sir. I have to object --

Mr. James. I am reclaiming my time, Mr. Chairman. I am reclaiming my time.

I want to correct the record for all of my Democrat colleagues who are fearmongering, that right now the President of the United States just stated that we are not going to be touching Social Security, Medicare, Medicaid. This is directly from the President of the United States, from his lips.

So what we are here to do is increase accessibility. What we are here to do is lower costs. What we are here to do is increase quality and get rid of waste, fraud, and abuse, and part of that is making sure that PBM reform comes.

I appreciate the opportunity to speak and dispel the rumors and the fearmongering. Donald Trump's election signaled that the status quo is failing the American people.

For decades, healthcare costs have soared while access and quality have declined. Enough is enough. PBMs have been accused of exploiting opaque practices to drive up costs for Michigan families.

We need reforms in order to enable transparency. In fact, the President of the United States just signed transparency reform EO.

Are you telling me right now President Biden couldn't have done that for the past 4 years.

President Trump has done it in the first 60 days. And we are continuing to pass rules, through the last Congress, and working on this one, to make sure we get PBM reform done. Increasing transparency.

So in the 3 minutes that I have here, I would like to hear from our friends across who come -- thank you for your time.

A study analyzing nearly two million generic prescriptions dispensed to Michigan Medicaid-managed care beneficiaries between Q1 2016 and Q1 2018, revealed that PBMs overcharged the State's Medicaid program by at least $64 million through spread pricing -- overcharged.

During this period, the spread margin on oral solid generic drugs escalated from 2 percent to 34 percent of managed-care costs, while pharmacy margins over the national average drug acquisition costs decreased by 50 percent.

By Q1 2018, pharmacies were reimbursed an average of only 0.49 cents above NADAC per prescription, equating to just 5 percent of Michigan's estimated $10.64 dispensing cost per prescription.

These practices have raised concerns about their detrimental effects on patient access to care and the financial viability of independent pharmacies.

Given this context, how have PBM practices, such as spread pricing, rebate-based formularies, patient steering to affiliated pharmacies, and administrative fees impacted your ability to see patients?

Mr. Gremminger, Mr. Chancy, Dr. Fiedler, Mr. Wright, thank you for your time. We have a minute and a half. If any one of you would like to jump in, I would appreciate it.

Mr. Chancy. Well, I agree with you a hundred percent. We have to stop steering, and we have to -- we have to have access, but as long as they continue to be able to pay themselves different than they are paying community pharmacies, it is just an unlevel playing field, and it is not sustainable for the community pharmacies.

Mr. James. Thank you.

Mr. Gremminger. Congressman, thank you for your question. I will say that certainly I know that banning patient steering in the Medicare discussion is here.

We would oppose anything that requires plan sponsors to open up their pharmacy networks and treat sort of any willing pharmacist -- or provide care at any willing pharmacist. We believe it is the role of plan sponsors, employers, and purchasers to identify what the lowest net cost is -- place to provide, whether it is care or prescription drugs.

Often that is at a community pharmacy because of the distorted markets, and we see that PBMs are charging a lot more for mail order pharmacies. But in the end, we want to make sure that we maintain that flexibilities and a free market.

Mr. James. Thank you.

Mr. Wright. I would align myself with Mr. Gremminger on this. I mean -- but the reason we support the transparency reforms that we are talking about in this committee is because we need much more sunlight on even what these processes are, what the problems are, and what the misaligned financial incentives are that actually create all these perverse problems.

But I think with that, then we can have a better ability to then have -- one of the congressmembers mentioned what is next. I think that the transparency would inform additional reform with regard to dealing with these abuses.

Mr. James. Thank you.

Mr. Chairman, I am out of time. I look forward to working with my colleagues on both sides of the aisle to prioritize the American people and not our own political differences. Thank you.

Mr. Carter of Georgia. Thank you. The gentleman yields. The chair now recognizes the gentleman from New Jersey, Representative Kean, from New Jersey for 5 minutes of questioning.

Mr. Kean. Thank you, Mr. Chairman, and thank you to our witnesses here today.

I am interested in hearing how we can change the dominant PBM model to better help patients in New Jersey and across the country.

Mr. Chancy, last year, a New York Times investigation highlighted the experience of a 77-year-old New Jersey man, Joseph Kaplan, had with America's opaque pharmacy benefit system.

Mr. Kaplan explained the scenario where his preferred pharmacy was integrated with a PBM -- Express Scripts. They told him that he could receive a 3-months' supply of his drug for $186.

However, after his own research, Mr. Kaplan discovered that Costco, a nonpreference pharmacy, could provide the 3-month prescription for $56. Mr. Kaplan concisely described this scenario -- it is just nuts.

First, can you explain to us how our current system allows for such a confusing scenario for patients?

Mr. Chancy. Well, I think that it is -- one of our pharmacies is located next to a CVS, and many times we will not be able to fill the medications at our pharmacy. We will have to send them to another pharmacy.

As long as the PBMs are going to continue to be in the game with us, it is going to be unfair. And I will equate it to this. It is almost like Walmart telling Target who can

do business with them and what prices they can charge. That is the environment that we are in right now.

And everybody would say, well, that is ludicrous. Well, that is our world. That is where we are at. Until we make some changes there, we are going to continue to have these problems.

Mr. Kean. And so how does the reform measure that we are working to get through this committee and pass the Congress on a bipartisan basis help Medicare patients like Mr. Kaplan?

Mr. Chancy. Well, with transparency. Start with transparency and eliminating the spread pricing. The 3-Axis Advisor study talks about that the PBMs are paying themselves 35 times higher than they are paying independents for prescriptions. That is ridiculous. And that is on mail order.

But they are paying themselves that much more than we are getting paid in the community.

Even in the State level, from the bricks and mortar stores, sometimes they will get paid $50 to $100 more a prescription than they are paying us. And that is just -- we need a level playing field. We need a fair, equitable reimbursement model, and we need transparency, and we need to eliminate the spread pricing.

Mr. Kean. Okay. And are there any other further actions, as we are looking at reforming this entire ecosystem, that you would encourage Congress to look at to improve our current pharmacy benefit program for patients?

Mr. Chancy. I think the legislation that Representative Harshbarger talked about earlier would address a lot of the issues that we are talking about, and I look forward to that getting more progress as well.

Mr. Kean. Thank you.

I now want to discuss how many PBMs' current rebate model incentivizes high list prices for drugs. In this model, many drug manufacturers offer high list prices so that they can provide a greater discount demanded by their PBM through a rebate. The manufacturer does this to get a better place on insurance plan's formulary.

This can also result in less favorable formulary placement of cheaper generic drugs, or biosimilars, which is concerning because these products are some of the most time-tested tools to lower drug prices through competition.

Dr. Fiedler, could you explain how PBMs' current practices may limit market penetration of these FDA-approved generic and biosimilar products and how this lack of competition affects the drug prices paid by patients?

Dr. Fiedler. So I think it is reasonable to worry that PBMs sometimes favor highly rebated drugs over low-priced drugs even when that is not in the payer's interest. And I think, you know, biosimilar entry is one place where that could have consequences.

I will say that I think where this is happening, the main issue is not necessarily always self-dealing by the PBMs, but frankly it is the manufacturer who is insisting on some of these types of arrangements that can then put both the PBM and the payer in a difficult circumstance where they have got a lot of patients on the reference product, and moving those patients over is going to be very expensive.

So I think this is a place where frankly there is a lot of blame to go around, and, you know, the PBMs' incentives can be misaligned here, but ultimately the manufacturers are, you know, working pretty hard to protect their market position as well, and they need to be part of this conversation as well.

Mr. Kean. Okay. Thank you. I yield back.

Mr. Carter of Georgia. The gentleman yields. The chair now recognizes the gentlelady from --

Mrs. Trahan. Massachusetts.

Mr. Carter of Georgia. -- Massachusetts, of course --

Mrs. Trahan. Thank you, Mr. Chairman.

Mr. Carter of Georgia. -- Representative Trahan for 5 minutes of questioning on PBM reform.

Mrs. Trahan. Yes, absolutely. Thank you, Mr. Chairman. Thank you to all the witnesses today.

As many of my colleagues have already stated, this committee spent the past 2 years working across the aisle to craft a bipartisan package of critical health bills, including long overdue PBM transparency reforms.

After months of negotiations, careful policymaking, we put forward a package that would lower costs, increase transparency, and strengthen healthcare for families across the country.

But one tweet from Elon Musk killed that bill because it was, in his view, too long. How embarrassing. The idea that a billionaire's unserious, off-handed social media post could derail 2 years of serious, bipartisan work, work that would have improved healthcare access and affordability for millions, is just a shameful indictment of the way my Republican colleagues operate.

One of the policies caught in the crossfire was my bill, the Accelerating Kids' Access to Care Act, which would make it easier for children on Medicaid to cross State lines for life-saving care that they need without delay.

That policy, a straightforward and necessary fix, was sacrificed because my Republican colleagues chose to cave to the whims of a billionaire instead of protecting vulnerable kids.

And it is even more infuriating when you consider that the pay for to support this

good policy was a ban on spread pricing in Medicaid, a practice that allows PBMs to siphon off taxpayer dollars that should be going to patient care.

Let's be clear. This is part of a much larger assault on Medicaid. Just last night with their budget resolution vote, House Republicans went on the record in favor of cutting $880 billion from Medicaid. That goes far beyond targeting waste, abuse, and fraud.

Those are the cuts that will rip coverage away from families, children, postpartum moms, seniors in nursing homes, and kids with disabilities.

So while we sit here talking about PBM transparency and Medicaid reform, let's not lose sight of the bigger picture here. There are people in this room who just voted to gut the very program that they claim to want to strengthen. Just unacceptable.

And I know I will be joined with my colleagues on this side of the aisle. We won't stop fighting to protect the kids and families who rely on Medicaid for their care.

And while I am pleased that strengthening Medicaid to help kids cross State lines more easily has bipartisan support, I am concerned with the deep cuts to the program and how they will undermine its impact if States are forced to scale back their Medicaid programs.

This policy would become meaningless.

Dr. Fiedler, as we have seen with last night's budget resolution vote, House Republicans are pushing for nearly $880 billion in Medicaid cuts. If these cuts go through, what would that mean for families already struggling to access care?

Dr. Fiedler. Broadly you are going to see States facing two hards choices, right? They can either raise taxes and cut elsewhere in their budget, whether that is education or transportation or public safety.

Or they can say, we are going to cut our Medicaid programs. And, you know,

that is going to mean their options are, they can cut enrollment, they can narrow what services Medicaid covers. They can put in more utilization restrictions like prior authorization, or they can pay providers less.

And all of those things, we know, reduce access to care, and where people are becoming uninsured, we know that impairs financial security as well.

And I think this is all in the context where we know Medicaid is a fairly stingy payer, certainly relative to private insurance and typically relevant to Medicare as well and, you know, that Medicaid beneficiaries already enjoy worse access to care than people with many other forms of coverage.

Mrs. Trahan. Thank you. And one of the policies in our bipartisan package was a ban on spread pricing in Medicaid. Can you explain how banning spread pricing could free up resources to strengthen Medicaid and, in turn, help policies like the Accelerating Kids' Access to Care Act, ensure children can cross State lines for the care that they need without delay?

Dr. Fiedler. So I think the hope is that banning spread pricing, you know, reduces the cost that States are bearing in their PBM or managed-care contracts.

I think, you know, I have expressed concerns elsewhere in my testimony that PBMs may try to get some of that back in other ways, but I think this is a place where because of the medical loss ratio requirements that apply, that this type of requirement may actually generate some savings for the ultimate payer, and obviously policymakers could use those funds in a variety of ways.

Mrs. Trahan. Thank you. I mean, at the end of the day, Medicaid is a lifeline for millions of children, families, and vulnerable Americans, and we have a responsibility to strengthen it, not dismantle it at the whim of the special interests of a billionaire.

So I hope my colleagues will reconsider the harms these cuts would cause and

work to help us protect and improve access to care.

Thank you. I yield back.

Mr. Carter of Georgia. The gentlelady yields. The chair now recognizes the gentlelady from Florida, Representative Castor, for 5 minutes of questioning on PBM reform.

Ms. Castor. Thank you very much, Mr. Chairman, and thank you to the witnesses for being here today. I strongly support PBM reform. I think it is vital and necessary and urgent, but I have to say that today families are scared, and they are reeling because they know what is coming.

We had a debate yesterday in this committee for about 12 hours as they debated on the floor of the House. As Republicans march forward with drastic cuts to the health and well-being of families across this country, Medicaid health services are in the bull's eye.

Medicaid, of course, is the largest provider of health services for children, for all of our neighbors with disabilities or complex conditions, for our older neighbors in long-term care.

And why gut this and rip coverage away? To provide tax cuts to the wealthiest people in this country.

I just -- it is just really hard to be -- to hear this debate, because I don't think this should be much of a debate.

What they are saying is that this committee will come back in a couple weeks and try to take out $880 billion from the health of our families. That is going to hurt kids, and frankly when all of us hope that -- you know, I hear from my community pharmacists, and they are on a shoe string.

RPTR MCGHEE

EDTR HUMKE

[1:00 p.m.]

Ms. Castor. This is all -- this all comes on the heels of what we saw happen at the end of last year, because we worked so hard on this bipartisan package. And what happens, and I know you have heard it from a number of my colleagues today, but it is just simply not acceptable to allow Elon Musk to come in at the 11th hour and throw a wrench into our bipartisan work that would have reined in the PBMs and said we need more transparency, we need more part D delinking, we need a ban on spread pricing.

And unfortunately, the House Republicans reneged on the agreement, so you can see why we are kind of exercised today, why we are so concerned about it.

But I am particularly concerned about what this means for the health of the nation. When you start to say to children and families that you are not going to be able to see the doctor that you need and get the care that you need. This is so fiscally unwise, too, because it is pretty inexpensive to take care of a child, to take care of a child early and provide the healthcare that they need.

And don't just take it from me. Take it from the independent Congressional Budget Office. They say childhood health coverage leads to higher future earnings and more productivity. This is why all Americans should be concerned about the gutting of this important pillar of the health of the Nation.

Because when you start to deny children access to the doctor's office and early wellness, that means that they are not going to be as successful in life. CBO says that outside of the financial benefits, the positive effects of healthcare are extensive.

Mr. Wright, is it smart and fiscally wise to -- not to provide healthcare to America's

kids? And what do you think is coming?

Mr. Wright. I mean, I think -- I mean, there is several economic -- if we're talking about the economics, there is several economic impacts to these cuts. There is ones just to the community as a whole. Hospitals, health systems are typically the largest employer in the community. If you make these cuts, it has that impact. And the particular multiplier effect, because money spent in a community has a multiplier effect.

Healthcare is not something you can outsource. It is in the community. It circulates in the community. A cut would have a redounding effect in that community economically. To those individual families, obviously, as Mr. Fiedler said, part of the healthcare coverage is about making sure people have access to care, but partially just keeping the family financially whole and not facing huge bills that come with everything from childbirth to chronic conditions to an emergency.

Ms. Castor. And the cost of living certainly is a primary issue in the lives of Americans right now.

Mr. Wright. That's right.

Ms. Castor. Is that going to -- is targeting Medicaid to give tax breaks to billionaires going to help the average person?

Mr. Wright. I mean, the loss that people will have individually will be -- will be much greater because of the financial instability that comes without having health coverage.

Ms. Castor. I agree. Thank you very much.

Mr. Wright. Thank you.

Mr. Carter of Georgia. The gentlelady yields. I believe that is it for questioning today. I want to thank all of our witnesses again for being here today. Members may have additional written questions for you all. I will remind members that they have ten

business days to submit questions for the record, and I ask the witnesses to respond to the questions promptly. Members should submit their questions by the close of business on March 12th.

I also ask unanimous consent to insert into the record the documents included on the staff hearing documents list. Without objection, that will be the order. And without objection, this subcommittee is adjourned.

[Whereupon, at 1:04 p.m., the subcommittee was adjourned.]